Towards salutogenic health promotion

Organizing healthy ageing programs at the local level

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Abstract

Introduction

The increase in the ageing population in the Netherlands is having an impact on national as well as on local level. As people are now living longer, the importance of preventing unnecessary disability, maintaining physical functioning and preventing complications from chronic diseases and adding life to years rather than years to live has become increasingly important. Local governments therefore face challenges to improve healthy ageing for their ageing population.

Aim

In municipalities all kind of facilities and activities to improve healthy ageing are already developed. However the reach of these facilities and activities is often low. Especially among the more vulnerable older people. More insights and new methods are therefore needed to reach these older people or to develop facilities and activities that better fit the wishes and desires of older people themselves. This study aims to contribute to the knowledge base of health promotion professionals about how to develop, implement and evaluate local healthy ageing programs.

Methods

Since in this study, the researcher is at the same time a health promotion professional developing, implementing and evaluating a healthy ageing program in three municipalities in the eastern part of the Netherlands, mainly an action research approach is used. Thereby, action research fits well within the complex setting of a municipality. It aims to analyse the situation and its problems, to find solutions to address the problems, and to look for opportunities to put these solutions into practice. In this thesis multiple methods, such as interviews and participant observation, and different sources of data, such as the ageing population, local organizations and policymakers, were used.

Results

Because intersectoral collaboration and participation of the community, which are essential for developing a new healthy ageing program (coordinated action for health), were not self-generating processes, the HP 2.0 framework is developed. The framework is based on the principles of health promotion and on salutogenesis and exist out of the concepts 'sense of coherence (SOC)', 'resources for health' and 'health'. When 'resources for health' are adapted to the SOC, older people are more likely to identify those resources and make use of it. The HP 2.0 framework is developed to contribute to the discussion concerning the content of a health promotion program. Other issues contributing to coordinated action for health are prerequisites such as time and money. Thereby, in each municipality the extent to which coordinated action

is built and sustained was different, which influenced the processes in the municipalities when developing a healthy ageing program. Four different planning approaches were identified, namely the classical, evolutionary, processual and the systemic approach to planning. In the process of achieving and sustaining coordinated action for health, both context-free – such as epidemiological data and scientific literature – and context-sensitive evidence – stemming from interviews with older people, organizations and local policymakers – were combined. This resulted in a new healthy ageing program, called Neighbors Connected.

Conclusion

Three conclusions can be drawn from this study. The first conclusion is that the HP 2.0 framework contributed to the development, implementation and evaluation of healthy ageing strategies. The framework visualizes the salutogenic relationship between resources for health and SOC, which is not made explicit elsewhere. This means that although a health promotion program in itself has the potential to contribute to health, the framework adds that a program also needs to be perceived as comprehensible, manageable and meaningful. The second conclusion is that coordinated action starts from the moment stakeholders meet and share ideas, and thus before the actual health promotion programs starts. Such a preliminary phase influences local planning processes to develop and implement health promotion programs in the municipality, since in this phase relevant stakeholders have to be found and discussions with stakeholders have to take place about aims and objectives. Therefore, this preliminary phase should be part of the evaluation of the health promotion program as well, next to the evaluation of the impact of the program on (determinants of) health. The third conclusion is that within this study the HP 2.0 framework and the achieved coordinated action for health made it possible to combine different forms of evidence. Combining different forms of evidence, context-free and context-sensitive, contributed to the sharing of knowledge, to the co-creation of a salutogenic health promotion program and to more sustainable changes.

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1

Introduction; Health promotion and healthy ageing in complex contexts

Introduction

In the Netherlands, increased life expectancy and decreased fertility rates in the last century have resulted in a sharp rise and growing share of older people in the population (Boluijt *et al*. 2010; Van der Lucht and Polder 2010). As people are now living longer, the importance of preventing unnecessary disability, maintaining physical functioning, preventing complications from chronic diseases and adding life to years rather than adding years to life has become increasingly apparent (Minkler, Schauffler & Clements-Nolle 2000). Governments therefore face challenges about how to improve healthy ageing for their ageing population. On the local level, all kinds of facilities and activities for especially the more vulnerable older people have already been developed. Examples include: special public transport for older people, meals on wheels, an activity program with workshops, activities to meet other people and discussion groups, courses for people who have lost their partner, a counselor who supports older people to make use of existing facilities and an internet site or a regular newsletter with practical information about local facilities and activities for older people.

The reach of some of these facilities and activities is low. This does not mean that the facilities and activities in themselves do not contribute to healthy ageing, but rather that some of the older population have difficulty accessing these facilities and activities. More insight and new methods are therefore needed to reach these older people or to develop facilities and activities that better fit the wishes and desires of older people themselves. This study aims to contribute to the knowledge base of health promotion professionals about how to develop, implement and evaluate local healthy ageing programs.

In this chapter, the background and the current views concerning health and healthy ageing and health promotion are described in the first and second section, followed by a short description of the context of the study. Then the challenges of research in local health promotion practice are elaborated upon. This is followed by the main objectives, the research questions and the research methodology. Finally, an outline of this thesis is provided in the last section.

Health and healthy ageing

Health is defined in the WHO constitution of 1948 as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 1998). The Lalonde report *A New Perspective on the Health of Canadians* broadened this definition of health. This influential report of the Canadian minister for health asserted that the people's health was influenced by different factors, relating not only to health but also to the environment, life style, the way healthcare is organized and to human biology (Lalonde 1974). The health model developed by Dahlgren and Whitehead (2006) (see Figure 1.1) shows the interrelatedness of individual health and environmental determinants, such as social and community networks,

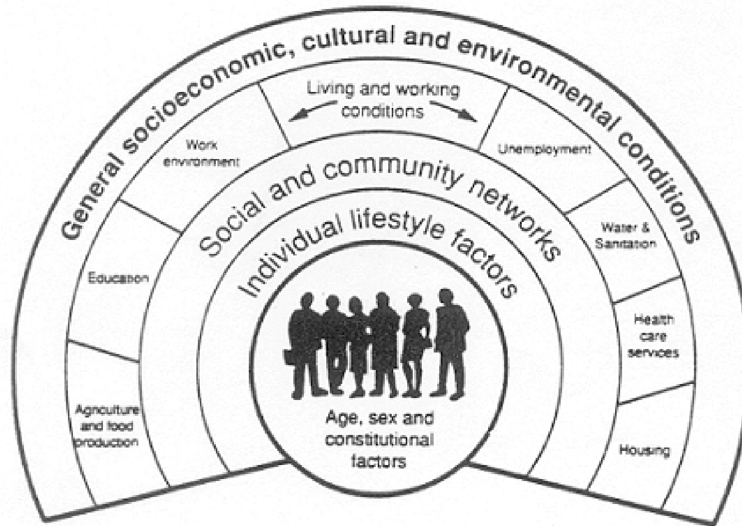

Figure 1.1 Health according to Dahlgren and Whitehead (2006).

living and working conditions, and general socioeconomic, cultural and environmental factors (Dahlgren and Whitehead 2006).

Healthy ageing is therefore, just as health in general, influenced by a variety of interacting determinants. Furthermore, healthy ageing is also an individual constructed concept (Bryant, Corbett and Kutner 2001; Puts *et al.* 2007). Each individual decides for him/herself what he or she needs to age healthily. On the basis of interviews with older people, Bryant and colleagues (2001) developed a model (Figure 1.2) wherein healthy ageing was described according to the perception of older people themselves; thus, as an individual constructed concept. 'Health' in this model of healthy ageing is defined as 'going and doing something meaningful.' To go and do something meaningful, the older person needs four interacting components: 1) something worthwhile and desirable to do, 2) a balance between the required abilities to meet the perceived challenges, 3) appropriate external resources and 4) personal attitudinal characteristics, thus having the will to go and do. The components are interactive, since in some circumstances they have a supportive and/or adaptive role. In other circumstances these components supplement each other to be able to go and do something. Health and healthy ageing in this model are seen as a reflection of the lived experience of daily life (Bryant, Corbett and Kutner 2001).

Summarized, healthy ageing is influenced by determinants such as lifestyle factors, social and community networks, living and working conditions and general socioeconomic, cultural and environmental conditions (Dahlgren and Whitehead 2006). Thereby, healthy ageing is an individually constructed concept (Bryant, Corbett and Kutner 2001; Hansen-Kyle 2005; Puts *et al.* 2007). Older people decide for themselves what 'going and doing something meaningful' is.

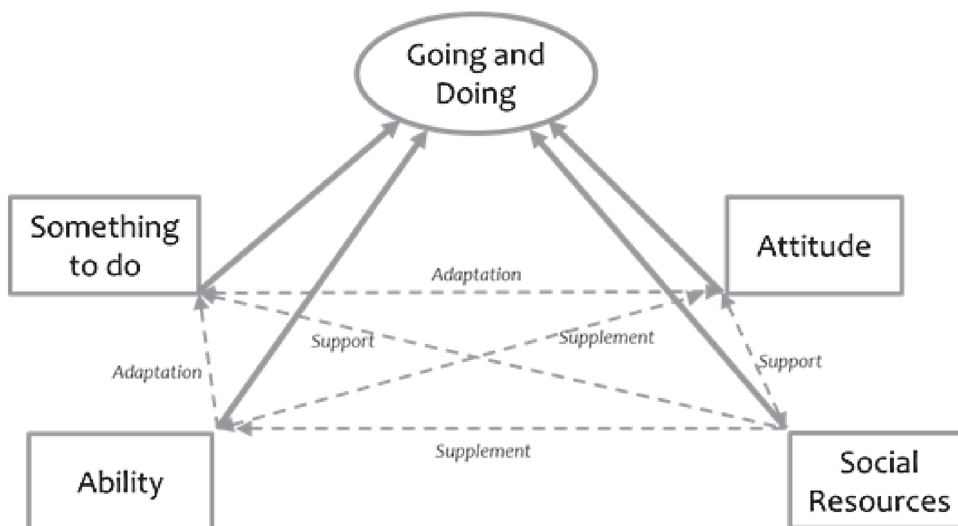

Figure 1.2 A model of healthy ageing (Bryant, Corbett and Kutner 2001).

To promote healthy ageing, the programs developed often stressed the problems and the limitations that occur due to ageing (Minkler, Schauffler and Clements-Nolle 2000). However, ageing can also be approached in a positive way, as illustrated in concepts such as 'active ageing,' 'successful ageing' and 'healthy ageing' (Hansen-Kyle 2005; Minkler, Schauffler and Clements-Nolle 2000; Rowe and Kahn 1997; WHO 2002). The WHO defines active ageing as a process of optimizing opportunities for health, participation and security to enhance quality of life as people age (WHO 2002). Successful ageing is defined as the absence, or avoidance, of disease and risk factors, maintenance of physical and cognitive functioning and active engagement in life (Rowe and Kahn 1997). This model of successful ageing is a widely used approach, although in some studies the model has been complemented with psychosocial factors such as life satisfaction and personal growth (Bowling and Dieppe 2005). In this thesis, Hansen-Kyle's (2005) definition is used. Hansen-Kyle (2005) made a concept analysis of healthy ageing and summarized the definitions of different perspectives, namely medical/gerontological (absence of chronic illness, the ability to overcome chronic illness or the elimination of risk factors that lead to chronic illness) and psychological/sociological (personal accommodation, autonomy, attitude and supportive environments), in the following definition:

> *the process of slowing down, physically and cognitively, while resiliently adapting and compensating in order to optimally function and participate in all areas of one's life (physical, cognitive, social and spiritual).* (Hansen-Kyle 2005, p.52)

The definition includes an understanding of the process of healthy ageing and the factors contributing to healthy ageing and can therefore assist the development of facilities and activities contributing to healthy ageing (Hansen-Kyle 2005).

Thus, to promote healthy ageing, it is essential to develop resources that focus not only on the individual bodily health of the older people and their risk behaviors, but also on their social and physical environment (Bowling and Gabriel 2007; Gabriel and Bowling 2004; Hansen-Kyle 2005; Steverink 2009; Steverink *et al*. 2001). The social and physical environment strongly influence the extent to which older people are able to adapt and compensate in the process of slowing down in order to enable them to do whatever they want to do. Health promotion offers opportunities to deal with all these factors to promote healthy ageing.

Health promotion

Health promotion is defined as: *'the process of enabling individuals and communities to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being'* (WHO 1986: 1). The Ottawa Charter (WHO 1986) following the first international conference about global health promotion, and the Bangkok Charter (WHO 2005) following the conference in Bangkok, were important documents for developing health promotion. Visions, concepts and requirements for health promotion were clarified within the charters (Catford 2007). The Ottawa conference was important in creating the following action areas:

- Build healthy public policy;
- Create supportive environments;
- Strengthen community action;
- Develop personal skills;
- Reorient health services (WHO 1986).

The Bangkok conference in 2005 listed required actions in the charter to make further advances in implementing programs. These actions are:

- Advocate for health based on human rights and solidarity;
- Invest in sustainable policies, actions and infrastructure to address the determinants of health;
- Build capacity for policy development, leadership, health promotion practice, knowledge transfer and research and health literacy;
- Regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people;
- Partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions (WHO 2005).

The action areas of the Ottawa Charter and the strategies in the Bangkok Charter show that health promotion is about strengthening skills and capabilities of individuals as well as it is about changing social, environmental and economic conditions (WHO 1998). Health promotion therefore takes place in the social and political arena (WHO 1986, 1998). For this, health promotion professionals need processes to build and sustain collaboration with policymakers, organizations and communities to develop, implement and evaluate sustainable local health promotion programs (Rootman *et al.* 2001; WHO 1986, 2005). To build and strengthen such processes, working principles (health promotion principles) have been formulated (Rootman *et al.* 2001); these are elaborated in the following section.

Principles of health promotion

The principles of health promotion are formulated to guide health promotion professionals to develop, implement and evaluate health promotion programs within a certain context. The principles make clear that health promotion initiatives (programs, policies and other organized activities) should be:

- *Empowering*, i.e. should enable individuals and communities to assume more power over the personal, socio-economic and environmental factors that affect their health;
- *Participatory*, i.e. should involve those concerned at all stages of the process;
- *Holistic*, i.e. should foster physical, mental, social and spiritual health;
- *Intersectoral*, i.e. should involve the collaboration of agencies from relevant sectors;
- *Equitable*, i.e. should be guided by a concern for equity and social justice;
- *Sustainable*, i.e. should bring about changes that individuals and communities can maintain once initial funding has ended;
- *Multi strategy*, i.e. should use a variety of approaches, including policy developments, organizational change, community development, legislation, advocacy, education and communication in combination with one another (Rootman *et al.* 2001: 7).

Intersectoral collaboration and community participation are the key strategies within health promotion and are also referred to as coordinated action. Coordinated action means that organizations and clients in two or more sectors work together to jointly achieve an outcome (Koelen, Vaandrager and Wagemakers 2008). Coordinated action is needed because of the multidimensionality of health and healthy ageing and so no agency alone has the responsibility to address the wide range of influencing factors (Green, Daniel and Novick 2001; Koelen, Vaandrager and Wagemakers 2008; Koelen and Van den Ban 2004; Saan and De Haes 2005; Wagemakers 2010).

Salutogenesis

Health promotion and ageing, approached in a positive way, such as active ageing (Minkler, Schauffler and Clements-Nolle 2000; WHO 2002) and healthy ageing (Hansen-Kyle 2005), benefits from using a positive theoretical foundation as well. Such a theoretical foundation can be found in the concept of salutogenesis. Salutogenesis focuses on the causes of health, instead of on the causes of disease (pathogenesis). It aims to explain why people, despite stressful situations, stay well (Antonovsky 1987, 1996; Lindström and Eriksson 2005). For this, a continuum is developed ranging from 'ease' and 'disease.' Every person is somewhere on this continuum and moves along it towards the 'ease' side or to the 'disease' side. Antonovsky (1996), Eriksson and Lindström (2008), Lindström and Eriksson (2010) posit that a salutogenic orientation could be an appropriate theoretical foundation for health promotion, because it searches for resources or salutogenic factors to empower people to move to the 'ease' side of the continuum. Salutogenesis is an asset based approach which fits the action areas of the Ottawa Charter and the health promotion principles (Antonovsky 1996; Lindström and Eriksson 2010). Assets are resources that individuals and communities have at their disposal, which protect against negative health outcomes and/or promote health. These assets can be social, financial, physical or human resources, such as education and skills (Morgan and Ziglio 2007). Within health promotion practice when using an asset approach, resources are developed and implemented in collaboration with the community to enable that same community having control about their own (health) situation (Wagemakers 2010; Koelen and Lindström 2005). In this thesis, salutogenesis, and thus an asset approach, plays a central role in the development, implementation and evaluation of a healthy ageing strategy.

Prerequisites for health promotion

If health promotion processes are guided by salutogenesis and the principles of health promotion (e.g. intersectoral collaboration, participation and using a multi strategy), the chance of making sustainable changes in both the social and physical environment to promote health is improved (IUHPE and CCHPR 2008; Rootman *et al.* 2001). Working with the health promotion principles requires competences on the part of the health promotion professional, such as collaborating with stakeholders outside the health sector and strategizing within the political arena (De Jong and Keijsers 2009; Evans *et al.* 2007; Saan and De Haes 2008). In addition to the necessary competences of health promotion professionals, working with the health promotion principles also requires preconditions, such as financial resources, a local infrastructure wherein existing stakeholders participate and local policy, wherein a theme or a target group is prioritized (Evans *et al.* 2007). The working principles formulated within the Ottawa and Bangkok Charters are constructive for local health promotion and are accepted widely, also in the Netherlands, the context of this study. However, this does not mean that everybody is working accordingly to these principles in their professional practice.

Context of Dutch health promotion practice

In the following sections, first public health in the Netherlands and more specifically the role of the Public Health Act is briefly described. This is followed by a section about the role of the community health services within Dutch public health. Finally, AGORA, a collaborative between the community health service GGD Gelre-IJssel, Wageningen University and three municipalities, is elaborated upon as a vehicle to conduct practice-based research.

Public health in the Netherlands: the Public Health Act

One definition of public health is: 'health protection and health promotion measures for the population as a whole or for specific groups, including prevention and early detection of diseases' (Boot and Van Oers 2010: 265). Public health is a state responsibility in terms of policy, organization and funding (Boot and Van Oers 2010). In the Netherlands, public health is guided by the Public Health Act (WPG).

The Public Health Act, which was preceded by the Collective Prevention Public Health Act (WCPV), was enacted in 2008. Within the Public Health Act, the following responsibilities and tasks of public health are divided between local and national government: 1) general public healthcare, 2) youth healthcare, 3) healthcare for older people (from 1 January 2010) and 4) infectious disease control (WPG 2008; Vaandrager *et al*. 2010). Some of these tasks, e.g. youth healthcare and infectious disease control, are mainly steered by national government. For instance, source and contact tracing to control infectious disease, such as TBC and sexually transmissible diseases, are mainly medically driven and are registered within national protocols. Within youth healthcare, the national government has formulated specific tasks for municipalities that are uniform across the Netherlands, so all children living in the Netherlands are assured of a minimum of healthcare. Other parts of the Public Health Act are executed as decided by local governments, e.g. general public healthcare and healthcare for older people (as of 1 January 2010). As a consequence, there is a large variation across the Netherlands. The Public Health Act also determines the existence of community health services.

Local public health: the community health services

Municipalities in the Netherlands are obliged to maintain a community health service to execute a number of the main tasks of the Public Health Act, such as infectious disease control, parts within youth healthcare and the general public healthcare. Two examples of community health service tasks concerning the general public healthcare are:

- to get insight into the health status of the inhabitants of municipalities within the region. For this, community health services conduct regular cross-sectional health surveys among diverse age groups within the population;

- to contribute to the development, implementation and evaluation of prevention programs (including programs to promote health).

Questionnaires used for the health surveys among the population are constructed in close collaboration with the National Institute for Health and Environment (RIVM) and other community health services in other regions of the Netherlands. A similar questionnaire used in different regions makes it possible to compare the health status of population groups between those regions. Furthermore, with the epidemiological data it is possible to identify health problems among population groups (Croezen 2010; GGD Gelre-IJssel 2006; WPG 2008). For municipalities, such health problems are important themes for their local health policy (Donker 2006; Jansen 2007) and for health promotion as well.

When health promotion programs are being developed by health promotion professionals of a community health service, often only local epidemiological data from the health surveys are available. These data are complemented with the general literature about the problem and some information about experiences with a health promoting program elsewhere, for instance from the Intervention Database of the Centre for Healthy Living (Centrum Gezond Leven). However, when developing and implementing local health promotion programs, health promotion professionals need additional local information to supplement the epidemiological data of the health surveys. Epidemiological data are necessary in health promotion practice, because they provide information about health problems and the causal factors and determinants influencing health problems (De Vlaming 2010; Saan, De Haes and Vaandrager 2010). Additional data about the context is needed because epidemiological data do not provide information about how people perceive health and what they think contributes to their health. Neither do epidemiological data provide information about the local stakeholders. Both of these are essential additional information for health promotion professionals when they are developing and implementing local health promotion programs.

AGORA

To strengthen health promotion practice in order to improve health among older people, the academic collaborative AGORA was set up to generate new insights by combining knowledge from practice, science and policy, and from epidemiology and health promotion (ZonMw 2010). This study is part of this academic collaborative.

The Academic Collaborative Centre AGORA was set up as one of the nine academic public health collaboratives. Within AGORA, the community health service GGD Gelre-IJssel (in the eastern part of the Netherlands) and Wageningen University are collaborating to contribute to the development, implementation and evaluation of an intervention program to improve healthy ageing. AGORA aims to bridge the gaps between practice, science and policy by synthesizing knowledge from different disciplines, such as epidemiology and health promotion. A total of four strongly interrelated PhD projects constitute AGORA's healthy

ageing program (see Table 1.1), wherein the researchers work from either a more academic background (Projects 1 and 3) and a professional background (Projects 2a and 2b). All researchers work at the university as well as at the community health service and have access to the resources available at both locations.

This PhD thesis covers the research of the health promoting part of Project 2 (see Figure 1.3), wherein the information gained in the early stages of Projects 1 and 3 is used to set priorities and to guide implementation of an intervention. At the same time, practical experiences from Project 2 were fed back into Projects 1 and 3 in order to contribute to the monitoring system and the knowledge management system (Figure 1.3).

In 2005, just before the start of this study, a health survey to get insight into the health of people aged 65 years and older was conducted in the Gelre-IJssel region. The results highlighted six health problems among older people. These six health problems were:

1. loneliness;
2. overweight;
3. psychological problems and depression;
4. falling incidents;
5. care-giving burden;
6. mobility related problems (GGD Gelre-IJssel 2006).

The results of the health survey and the defined health problems for the older population served as a starting point for the four AGORA PhD projects.

Table 1.1 Objectives and researchers of four interrelated PhD projects of AGORA

Objective	Researchers
PhD Project 1:	
• Describe physical, mental and social health and its determinants in older people, using existing epidemiological data.	• Epidemiologist: Human Nutrition and Epidemiology, Wageningen University
PhD Project 2: divided into a and b:	
• Develop, implement and evaluate an evidence-based intervention program for healthy ageing	• Epidemiologist: Community Health Service, GGD Gelre-IJssel • Health promoter: Community Health Service, GGD Gelre-IJssel
PhD Project 3:	
• Develop a knowledge management system that will support and facilitate intersectoral collaboration for healthy ageing in the Gelre-IJssel region.	• Social scientist: Health and Society, Communication science, Wageningen University

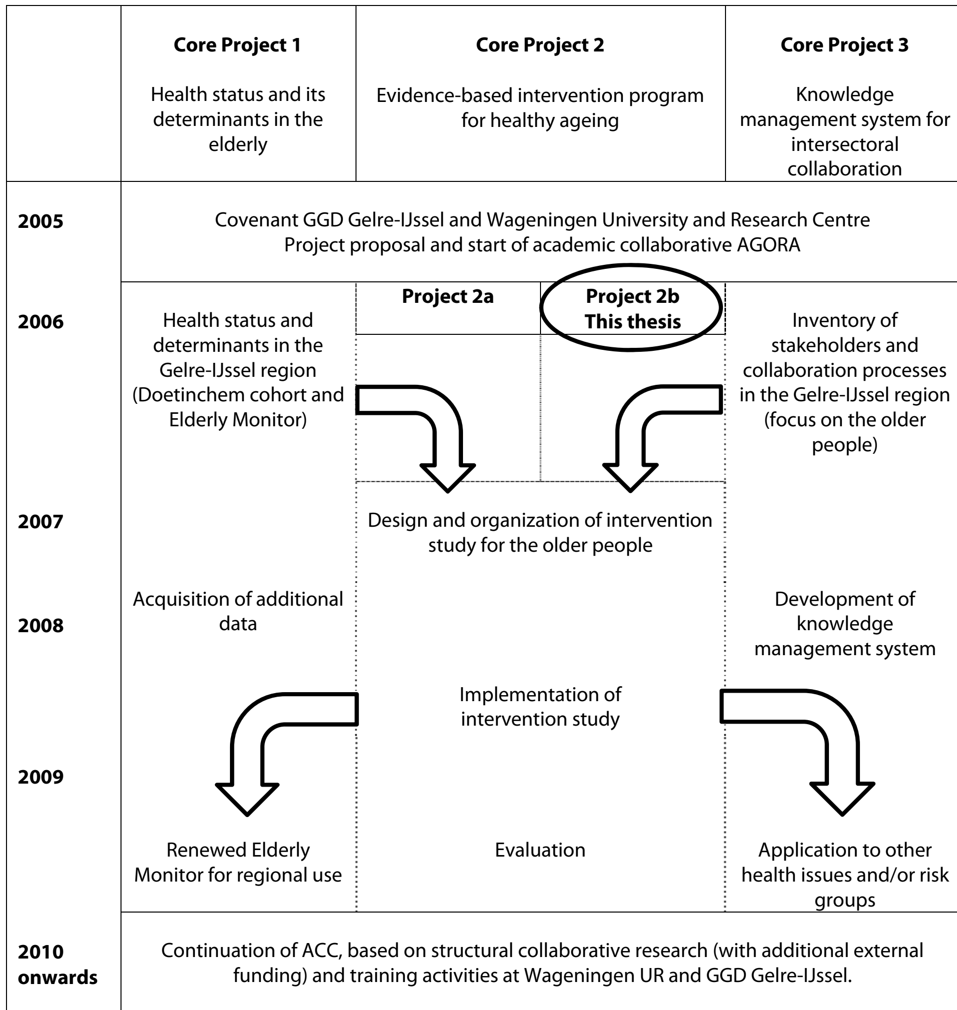

Figure 1.3 Schematic representation of AGORA's work program in three coherent core projects (ZonMw 2010).

AGORA in the municipalities

At the time that the academic collaborative AGORA started in 2006, first three municipalities within the Gelre-IJssel region had to be found to participate in AGORA. Therefore, all 15 municipalities within the region received a letter from the community health service. The letter contained information about AGORA and asked whether the municipality might be interested into collaborating with AGORA for four years to improve healthy ageing. Five municipalities responded positively. AGORA visited these five municipalities, with the manager of AGORA,

the health promoter and/or the GGD epidemiologist (Project 2). In the municipalities, the conversations took place mainly with an alderman and a (senior) policymaker. All five municipalities were enthusiastic about the project and wanted to collaborate. However, AGORA stressed one issue as especially important, namely that the municipal policymaker had to make on average one and a half hours a week available to work for the project. Another important issue for AGORA was that the participating municipalities should be dispersed within the region. These issues determined the choice of the three municipalities, namely Berkelland, Epe and Zutphen (Figure 1.4), and these were the municipalities where the research took place.

Berkelland is a large rural municipality formed on 1 January 2005 by merging four small municipalities. Epe is a rural municipality surrounded by a forested area and consists of four small villages. Zutphen is an urban municipality with a long history back to the Middle Ages. The population aged 65 and older on average in the Netherlands in 2005 was 14% of the total population; the municipality of Zutphen had a similar percentage, but the municipalities of Berkelland and Epe had a relatively higher percentage of older people (Table 1.2).

Figure 1.4 Participating municipalities in the Gelre-IJssel region.

Table 1.2 Demographics participating municipalities in 2005 (Gelre-IJssel 2006)

	Berkelland	Epe	Zutphen
General population	45,226	32,655	46,643
Population density	175 p/km^2	212 p/km^2	1127 p/km^2
Population aged 65 years and older	7,113 (16%)	5,878 (18%)	6,299 (14%)

Challenges to meet in practice

In view of the many and varied factors that influence healthy ageing, a few challenges for health promotion professionals arise in the development, implementation and evaluation of local healthy ageing programs. The first challenge is to find out how older people themselves perceive health and healthy ageing. The lay definition of healthy ageing differs from that of professionals, and both definitions should be part of local health programs. So that chances increase that that the program meets the needs and motives of the targeted group as well as it improves health. So, health promotion professionals will be challenged to find a way to incorporate the interrelatedness of determinants of healthy ageing and older people's perception of healthy ageing into the development of a healthy ageing strategy.

The second challenge is how to mobilize, organize and sustain coordinated action to promote healthy ageing within the complex context of a municipality. Although a set of factors that influence the achievement and sustainment of coordinated action have been formulated, coordinated action is still not a self-generating phenomenon and needs commitment from all stakeholders (Koelen, Vaandrager and Wagemakers 2008). During a process of achieving and sustaining coordinated action, a lot of uncertainties (Mantoura, Gendreon and Potvin 2007) can occur. Examples of such influences are the changing political climate and changing actors within the network.

The third challenge for health promotion professionals is how to make the process and the results of the efforts needed to organize the health promotion strategy visible within the evaluation study. This information contributes to the explanation of whether a health promotion program is effective on health outcomes or not.

Overall aim and research questions

The main aim of this thesis is to gain knowledge about the development, implementation and evaluation of a local healthy ageing program within the complex context of a municipality. Three objectives are formulated, stressing the challenges for health promotion professionals concerning the development, the organization and the evaluation of the healthy ageing program. The three objectives are operationalized into seven research questions, which will be answered in this thesis. Each research question corresponds with one of the chapters of this thesis.

Objective 1: To study existing interventions for healthy ageing based on defined criteria.

1. What are the success criteria for effective healthy ageing programs? (Chapter 2)

Objective 2: To develop an intervention program for different target groups among the older people and intermediaries based on the results of objective 1 and the baseline inventories made in PhD Projects 1 and 3.

2. What are the challenges and preconditions within the three municipalities concerning coordinated action for healthy ageing? (Chapter 3)
3. What is the added value of the coordinated action checklist in health promotion practice? (Chapter 4)
4. What is the added value of using multiple sources for evidence within the development of a healthy ageing program? (Chapter 5)

Objective 3: To evaluate the intervention program for healthy ageing in the Gelre-IJssel region.

5. What elements are essential within the healthy ageing program to ensure that older people participate in it? (Chapter 6)
6. What is the quality assurance of the healthy ageing program and how can we determine it? (Chapter 7)
7. What planning approaches are found within health promotion practice and how can we identify differences between the planning approaches? (Chapter 8)

Research methodology

The evaluation of local health promotion programs needs a combination of different research methods, both quantitative and qualitative, to assess the full effects of it. Such an approach considers the societal context as well as the outcomes of the health promotion program (Wagemakers 2010). The academic collaborative AGORA provides the opportunity to combine and integrate different research approaches, since researchers from different backgrounds, health promotion professionals and local stakeholders collaborate to contribute to the development, implementation and evaluation of a healthy ageing program.

To answer the research questions of this thesis, multiple research methods are used. Each chapter elaborates upon the methods used for that specific topic. In this section, the main research approach is briefly described.

Action research

In this study mainly an action research approach is used to achieve and sustain participation and intersectoral collaboration, to develop, implement and evaluate a healthy ageing program in local practice and to reflect upon local health promotion processes. Thereby, another PhD project of AGORA (project 2a) evaluates the local healthy ageing program on basis of mainly quantitative data. Project 2a and project 2b (this thesis) strengthen and complement each other.

Action research is a logical and suitable approach to use in this study because the researcher is at the same time a health promotion professional of the community health service and thus involved in the processes within the municipalities (Minkler and Wallerstein 2008; Wagemakers 2010). Within action research the action researcher needs to be close enough to the process and the stakeholders to be able to capture 'what has actually taken place' and 'how do stakeholders perceive this' (Wagemakers 2010). The researcher can be seen as an 'observer as participant' or 'participant as observer' (Bogdewic 1992).

Action research fits well with the complex setting of a municipality. Action research aims to analyze the situation and its problems, to find solutions to address these problems, and to look for opportunities to put these solutions into practice (Koelen and Van den Ban 2004). Action research uses the health promotion principles, because stakeholders and community members participate in research. Furthermore, action research reflects on processes of using the health promotion principles and recognizes the complexity of those processes. Results of action research are fed back into practice and help to decide how to continue (Koelen and Van den Ban 2004; Koelen, Vaandrager and Colomér 2001; Rice and Franceschini 2007; Springett 2001; Wagemakers 2010).

Methods used within this study

In this thesis multiple methods and different sources of data were used. Open and semi-structured interviews, in addition to literature review and participant observations. Furthermore, the data sources included the ageing population, local organizations and policymakers. Most of the data were collected within this specific AGORA project; however, some data were collected in close collaboration with AGORA Project 3, such as the interviews with stakeholders in Chapters 3 and 8. The author of this thesis interviewed most of the organizational and policymaking stakeholders. In Chapter 5, evidence derived from Projects 1 and 3 was integrated into a new healthy ageing strategy. Table 1.3 gives a brief overview of the different research methods used in this thesis. These methods are described in more detail in the relevant chapters.

In most of the research described in this thesis, multiple methods or triangulation were used. Using one qualitative method gives a limited insight, and so combining multiple methods provides a richer picture of, in the case of this thesis, health promotion processes. Using multiple methods is an important verification technique to improve the internal validity and reliability of the results (Cohen and Crabtree 2008; Koelen, Vaandrager and Colomér 2001).

Table 1.3 Methods used within this study per chapter

Chapter	Methods
Chapter 2 HP 2.0 framework; Building a theoretical framework for developing a healthy ageing strategy in the complex context of a municipality	Literature review Interviews with local stakeholders Interactive sessions (participant check)
Chapter 3 Coordinated action; Context, dynamics and prerequisites of healthy ageing programs in three Dutch municipalities	Semi-structured interviews with local stakeholders from three municipalities Interactive sessions (participant check)
Chapter 4 Coordinated action checklist; a tool to facilitate and evaluate coordinated action for healthy ageing	Focus group interviews with stakeholders Field observations Document analysis
Chapter 5 Neighbors Connected; a strategy built on multi-method and interdisciplinary evidence	Interviews with local stakeholders Interviews with older people Data analysis quantitative data Interactive sessions (participant check) Literature review
Chapter 6 Neighbors Connected; a strategy to recruit older people to participate at local activities	Semi-structured interviews with participants of activities Semi-structured interviews with organizers of activities Short questionnaire among participants of activities
Chapter 7 Looking back; the quality assurance of Neighbors Connected	Literature review
Chapter 8 Looking back; project planning for healthy ageing in local health promotion practice	Literature review Semi-structured interviews with stakeholders Participant observation External auditing Document analysis

The internal validity refers to truth about claims made regarding a relationship between two variables (Cohen and Crabtree 2008). Other verification techniques used within this thesis are: participant check (Chapters 2 and 5), external auditing (Chapter 8), and multiple cases (Chapter 8). Multiple cases is a verification technique to improve the external validity, which relates to the generalizability of the results to other areas (Cohen and Crabtree 2008).

An academic collaborate such as AGORA provides opportunities using verification techniques such as external auditing and participant check to improve the validity of the research. For instance there were frequent discussions about the local health promotion processes and results of AGORA research within the AGORA project group, which operated ‘outside’ the municipalities. Furthermore, information was continuously checked with stakeholders at the local level. Interactive sessions with older people, local organizations and local policymakers

addressed different views on the interpretation of results. Interpretations with a high level of agreement could be considered as reliable and valid. When there was disagreement, further inquiry was needed (Naaldenberg 2011).

Outline of the thesis

The outline of this thesis is shown in Figure 1.5. This figure visualizes the process of development, implementation and evaluation of a healthy ageing strategy and connects the different chapters to each other.

Chapter 2 develops a framework that contains a rationale for intersectoral collaboration and community participation or, according to Koelen, Vaandrager and Wagemakers (2008), coordinated action. Furthermore, the framework contributes to the content of the program because it stresses the need to incorporate perceptions about health and healthy ageing of older people themselves. Chapter 3 compares collaboration processes within the three participating municipalities in the eastern part of The Netherlands. The chapter elaborates upon how professionals and policymakers within the three municipalities experience collaboration processes within their municipality. In addition, the six factors indicated as important by Koelen, Vaandrager and Wagemakers to achieve and sustain coordinated action for health were used to analyze the local situation concerning coordinated action within the municipalities. Chapter 4 describes a pilot study of six different partnerships using a tool that evaluates and facilitates coordinated action for health. One of the partnerships described in

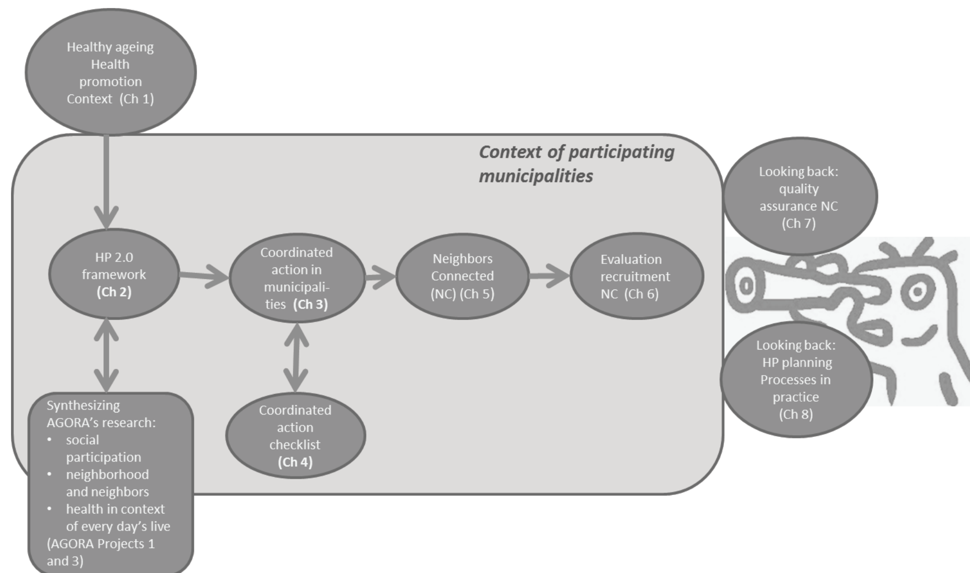

Figure 1.5 Thesis outline and chapters.

this chapter works in one of the three municipalities who participated within AGORA. This partnership contributed to the development and implementation of Neighbors Connected. Chapter 5 describes how interdisciplinary evidence collected using a multi-method approach contributed to the development and implementation of a local healthy ageing strategy, named Neighbors Connected. This chapter came into existence within the Global Program of Health Promotion Effectiveness of the International Union of Health Promotion and Education and has been published in a special issue of *Global Health Promotion* about the effectiveness of using evidence. Chapter 7 describes the evaluation of the recruitment of older people for participation in Neighbors Connected and provides insights into elements of Neighbors Connected that are important for older people to participate in activities. In this evaluation, sense of coherence (SOC) and the dimensions *comprehensibility*, *manageability* and *meaningfulness*, are used. Chapter 6 reflects upon submitting the healthy ageing strategy, Neighbors Connected to the Dutch quality system, to apply successfully for recognition by a panel of experts as (provisionally) 'theoretical sound'. In Chapter 8, the planning processes for the development, implementation and evaluation of a healthy ageing strategy, which was actually deployed in the three municipalities, are analyzed in terms of planning approaches from organizational and management theory. Furthermore, we identified factors that influenced the use of different planning approaches, although they are not common within health promotion. Finally, Chapter 9 addresses the main conclusions. The chapter ends with the contribution to health promotion theory and practice.

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2

The HP 2.0 framework; Building a theoretical framework for developing a healthy ageing strategy in the complex context of a municipality

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Abstract

Healthy ageing is influenced by a variety of interacting determinants. Because no one agency can tackle all these determinants, the promotion of healthy ageing requires an intersectoral approach. The aim of this article is to describe a theoretical basis, the development and possible applications of a framework within a municipality in the Netherlands. This framework supports intersectoral collaboration by guiding and stimulating the development, implementation and evaluation of health promotion activities for healthy ageing. It is based on the principles of health promotion and on the theory of salutogenesis and built upon three interrelated central concepts: 1) sense of coherence, 2) resources for health, and 3) health. The framework visualises the interrelationships of the three concepts within health promotion and salutogenesis. This visualisation makes explicit the value and the contribution with respect to content of intersectoral collaboration and the participation of older people in health promotion. The relationships between the concepts of the framework also indicate the need to undertake different types of research and gather different kinds of data to develop, implement and evaluate healthy ageing strategies.

Introduction

As people grow older, biological changes caused by ageing influence their mental, physical and social state, including their social networks (Borglin *et al*. 2006; Nygren *et al*. 2005; Ciairano *et al*. 2008). These developments can have a large impact on the quality of life of older people, which is largely determined by their ability to maintain autonomy and independence (WHO 2002). Generally, health promotion for older people stresses the problems and limitations that occur due to ageing. However, in today's health promotion, ageing can also be approached in a more positive way. Positive approaches to healthy ageing are illustrated by concepts such as *active ageing* and *healthy ageing* (Minkler, Schauffler and Clements-Nolle 2000; Hansen-Kyle 2005). The World Health Organization defines active ageing as a process of optimising opportunities for health, participation and security in order to enhance quality of life as people age (WHO, 2002). Healthy ageing has several definitions, from different perspectives, i.e. medical/gerontological, psychological and sociological. Hansen-Kyle (2005: 52) has summarised these different definitions and defines healthy ageing as: 'the process of slowing down, physically and cognitively, while resiliently adapting and compensating in order to optimally function and participate in all areas of one's life (physical, cognitive, social and spiritual)'. To function optimally means for older people that they perceive that they have control over the decisions that affect their lives (Forbes 2001). This can also mean, when necessary and in accordance with the older person, that family caregivers are also involved in these decisions (Hansen-Kyle 2005). Thus, perception of control is an essential element of healthy ageing.

Just like health and well-being in general, healthy ageing is influenced by different determinants (WHO 1998). According to Dahlgren and Whitehead (2006) these determinants are: individual lifestyle factors, social and community networks, living and working conditions, and general socioeconomic, cultural and environmental factors. These different determinants interact with each other. For example lifestyle factors are influenced by social norms, but also by living conditions, and vice versa. Because of the variety of these determinants and the interactions between them, health and healthy ageing are subject to complex processes (Saan and De Haes 2005) in which different sectors (Koelen and Van den Ban 2004) have a responsibility. Examples of these sectors for healthy ageing are: health, welfare, housing, transport and infrastructure.

In the Netherlands, although many activities, facilities or services for older people in municipalities have been developed and implemented, the reach is sometimes low. Consequently, outcome evaluation of these strategies shows minor effects on the objective health of older people (GGD Gelre-IJssel 2006); but this does not necessarily mean that this strategy in itself cannot be effective. In a region in the eastern part of the Netherlands, to promote healthy ageing, in which the development, implementation and evaluation of a strategy takes place at the local level, different disciplines, including health promotion professionals, epidemiologists, policy makers and researchers, participate in a consortium called AGORA.

AGORA

AGORA is a collaboration between the Wageningen University and Research Centre, a regional community health service and several municipalities, and aims to develop, implement and evaluate methods and tools to promote healthy ageing. AGORA works in each municipality according to the principles of health promotion, such as: 1) empowerment of individuals and the community, 2) participation of individuals and other stakeholders in the community, 3) holistic view of health, 4) intersectoral collaboration between the different sectors influencing health, 5) equity in health, 6) sustainability of effects of health promotion actions, and 7) use of multi strategies (WHO 1986, 2005; Rootman *et al*. 2001). These principles support AGORA and the collaborating partners in the action and research to promote healthy ageing on the individual, organizational and/or political level. Working in a way that is guided by the principles of health promotion also improves the chance of making sustainable changes in both the physical and social environment of older people in order to promote healthy ageing and contribute to the improvement of the quality of their life in the municipality (IUHPE and CCHPR 2007).

Within health promotion and thus within AGORA, intersectoral collaboration is one of the core principles because it creates opportunities for linking and sharing information, activities, expertise, skills and resources between the sectors. So that action in relation to health can be more effective, efficient and sustainable than might be achieved by the health sector alone (Koelen, Vaandrager and Wagemakers 2008). Intersectoral collaboration, however, is not easy. The different sectors who are involved have different formal structures, and different organizational cultures and values, which are based on professional attitudes, knowledge domains, interests, perceptions and behaviours (Naaldenberg *et al.* 2009). It is therefore a challenge to achieve and sustain intersectoral collaboration. To manage intersectoral collaboration successfully, a stable team which is able to provide a broad range of services is essential (Axelsson and Bihari Axelsson 2006; Koelen, Vaandrager and Wagemakers 2008). AGORA put a lot of effort into creating such stable teams in the municipalities and found that in practice it was rather difficult to achieve and sustain such teams. One of the reasons was that the participating stakeholders all had different views on healthy ageing, but also had different questions on the development, implementation and evaluation of strategies for the elderly people in the municipality. To be able to reach consensus in the teams, common ground was needed. Therefore, a policy framework was developed to support the team working with the principles of health promotion in order to improve healthy ageing. This framework was named the HP 2.0 framework.

This paper describes its development and the theoretical concepts on which the framework is built. First, the salutogenic perspective, and the different concepts of this theory, are described. Second, the development of the HP 2.0 framework is outlined. Third, the supportive framework, the concepts of the framework and the relations between the concepts are elaborated upon. One example of an application of the HP 2.0 framework is described. This is followed by the discussion with some provisos about using concepts like sense of coherence and healthy ageing

in health promotion practice. Consequences for professionals when using the HP 2.0 framework are also discussed. Finally, the usability of the framework and how it can contribute to the development, implementation and evaluation of healthy ageing strategies concludes this paper.

Salutogenesis

Whereas in the past the emphasis was on disease and disease prevention (Lindström and Eriksson 2006; Hansen-Kyle 2005; Nygren *et al.* 2005), nowadays, health promotion is oriented more often to more positive processes, like for example healthy ageing (Eriksson and Lindström 2008). Such a positive approach is based on the theory of salutogenesis, in which the focus is on the causes of health, instead of on the causes of disease (pathogenesis). It aims to explain why people, despite stressful situations, stay well (Antonovsky 1996). Applying this theory to healthy ageing is justified, because the salutogenic approach searches for those determinants or factors which strengthen older people to adapt to and compensate the negative consequences of ageing.

To overcome these negative consequences, generalised resistance resources (GRRs) and sense of coherence (SOC) play an important role in this perspective. The GRRs are, according to the salutogenic theory, resources possessed by people to deal with stressors in life. These GRRs can be biological, like for example genes, intelligence and immune functioning; material, like money and the house in which people live; and psychosocial, like knowledge, capacities, traditions, upbringing, life experiences, social network and marital status (Antonovsky 1996; Lindström and Eriksson 2005; Read *et al.* 2005; Wiesmann and Hannich 2008). To use GRRs in a health promoting way, SOC plays an important role. SOC is defined as a global orientation that expresses the extent to which one has a feeling of confidence that 1) the stimuli from one's internal and external environment in the course of living are structured, predictable, and explicable; 2) the GRR's are available to meet the demands posed by these stimuli; and 3) these demands are challenges, worthy of investment and engagement (Antonovsky 1987, cited in Lindström and Eriksson 2005: 441).

SOC consists of three dimensions, namely: 1) comprehensibility, that is the ability to assess and understand the situation; 2) meaningfulness, that is the extent to which an individual possesses the motivation and desire to cope with encountered situations; and 3) manageability, that is the capacity to do so (Antonovsky 1996; Lindström and Eriksson, 2005). Thus, SOC reflects the interaction between the individual and the environment (Eriksson and Lindström, 2008). Recently, a scale to measure SOC, the Life Orientation Questionnaire, has been validated (Antonovsky 1996; Lindström and Eriksson 2005; Eriksson 2007; Hakanen, Feldt and Leskinen 2007).

To develop, implement and evaluate strategies for healthy ageing in practice, the salutogenic approach offers concepts which facilitate working with the principles of health promotion. The next section elaborates on conceptualising the salutogenic perspective and the principles of health promotion into a supportive framework for healthy ageing: the HP 2.0 framework.

Development of the HP 2.0 framework

As already stated, the practice of healthy ageing should be created by participants from different sectors, and by the interactions between these participants. Without the variety of inputs from their knowledge and visions and discussions among, for example, professionals, older people, family and informal caregivers, policy makers, and researchers, the arena of healthy ageing remains empty. A need was felt for the development of a framework to guide and facilitate these participants to establish what the content should include. Creating content together is a principle which is also found and successfully applied on the internet. These internet applications are referred to as web 2.0 applications and examples include Facebook, Wikipedia, Link'd In and Twitter. The main attribute of web 2.0 applications is that content is created in a participative way and thus these applications facilitate participative processes (Chui, Miller and Roberts 2009), much like AGORA tries to facilitate participative processes in the municipalities. That is why it was decided to call this framework the HP 2.0 framework, the development of which is now outlined.

In the course of AGORA's search for methods to promote healthy ageing in the municipality, together with other stakeholders, at bilateral meetings, interviews and group meetings, three items were repeatedly discussed (Lezwijn *et al*. 2011). These discussions revolved around issues such as 1) why older people in one municipality, which has more activities, facilities and services for older people compared to other municipalities, are not healthier than those older people in other municipalities (GGD Gelre-IJssel 2006), 2) according to Dutch law, the municipality is now responsible for creating supportive environments for all older people to participate in society (Tjalma-van den Oudsten *et al*. 2006). The municipality still wants to appeal to the sense of responsibility of the older persons themselves, and their family members, to actually participate. How can the municipality support these people to participate in society? and 3) there are already so many activities, facilities and services for older people in the municipality, do new ones to promote healthy ageing need to be developed or is it possible to build upon existing ones?

Following these discussions, AGORA developed a conceptual framework to support the municipality and other stakeholders to deal with these themes for discussion. As already stated, the HP 2.0 framework is based on a salutogenic approach and the principles of health promotion. The first draft of the framework and the central concepts within the framework were outlined and explained in three pilot municipalities at bilateral meetings with policymakers, and at interactive group sessions with stakeholders, including the older people. The feedback received from those meetings is that the framework could support healthy ageing at a local level, because it integrates different sectors such as welfare and health. During those different feedback sessions, older participants explicitly recommended that a great effort should be made to reach those older people who are more or less vulnerable and more or less reluctant to avail of the opportunities offered by a municipality to participate in society (Lezwijn *et al*. 2011). This recommendation supports incorporating sense of coherence (SOC) in the HP 2.0 framework, because SOC gives an

explicit value to the differences in cognitions (comprehensibility), motivations (meaningfulness) and capacities (manageability) of older people in society. In addition to SOC, the framework has two other central concepts: resources for health and health (see Figure 2.1).

In the HP 2.0 framework, sense of coherence refers to the way in which older people feel able to use the resources for health and is similar to the SOC in the theory of salutogenesis (Antonovsky 1996; Lindström and Eriksson 2005). The SOC in this framework includes the dimensions *manageability*, *comprehensibility* and *meaningfulness*. The *resources for health* are resources which older people can use in order to be in control of situations affecting their lives (Forbes 2001). The resources for health concept is partially similar to the GRRs from the theory of salutogenesis (Antonovsky 1996) but additionally includes *potential resources in the physical and social environment* which can be used for better health in the future. These resources for health are available, but may not be familiar to everyone. Examples of these potential resources in the social and physical environment are public transport, the healthcare system, the public library and welfare organizations' activities geared to meeting other people. The concept of *health* in this framework includes physical, mental, social and spiritual well-being, like for example self-reported health status and subjective mental health. Because of these different dimensions within health, health is considered as an asset and as the result of a series of complex processes in which an individual interacts with the social and physical environment (Naaldenberg *et al*. 2009). The three central concepts of the HP 2.0 framework are interrelated. Each of the relationships are now described in more detail along with some examples in the area of ageing.

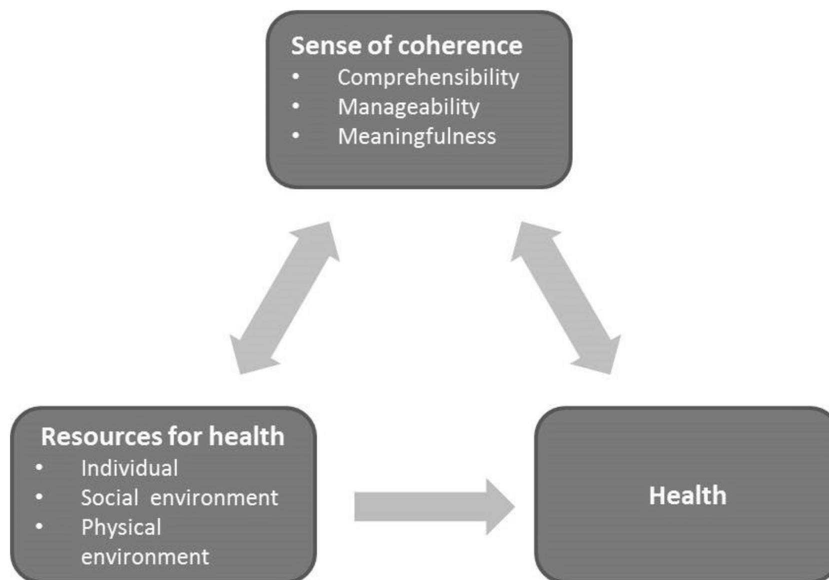

Figure 2.1 The HP 2.0 framework.

Resources for health – SOC

The relationship between resources for health and SOC in the model is also seen as the *salutogenic relationship*. This relation is about the interaction of the individual with the resources for health in the physical and social environment (Lindström and Eriksson 2005; Eriksson and Lindström 2007). This means that the environment is supportive because of the existence of resources for health which enable older people to live their lives despite their possible limitations. The resources for health in the social and physical environment aim to improve health, but can also aim to strengthen one or more of the three different dimensions of SOC, i.e. comprehensibility, manageability and meaningfulness (Antonovsky 1996; Lindström and Erikkson 2005); for example, when an older person experiences difficulties in walking and needs a walking frame. The availability of such a frame can enhance his/her feeling of confidence and this in turn can strengthen the older person's manageability of SOC. Another older person who is provided with the same walking frame may feel more fragile, perhaps because the very fact of needing the walking frame underlines the person's physical difficulties due to ageing (Naaldenberg, Lezwijn and Vaandrager 2009). Thus, the walking frame in this example breaks down self-confidence and influences meaningfulness of SOC. This example shows that different people give different meanings to the same resource for health. Another example of a resource for health which positively influences SOC is having a spouse or partner with whom the older person can share his/her normal daily activities. These older people perceive life as more meaningful and are more motivated to face life's challenges (Ciairano *et al.* 2008).

SOC is an important concept in the HP 2.0 framework. People with a high SOC are more capable of identifying, using and re-using the resources for health to promote healthy ageing (Lindström and Eriksson 2005, 2006; Eriksson and Lindström 2007). These people are more confident about having control over their own choices and their situation by using their resources for health, but probably are also more open to other potential resources for health. An example of this relationship is that older people with a high SOC more often make healthy lifestyle choices. To make these choices, one needs to use personal resources for health and respond to health-related advice (Wainwright *et al.* 2007).

Resources for health – Health

The relationship between resources for health and health is unidirectional and visualises the more biomedical relationship on the individual level. Some examples of the influence of resources for health on health are: exercise classes for older people, courses which help people to deal with the death of a partner and courses about making new friends. These resources contribute to the different dimensions, i.e. social, physical, mental and spiritual, of health. Resources in the physical environment, for example parks, can also contribute to health. In research by Wendel-Vos *et al.* (2004), it was found that when more green space was available,

more time was spent on a bicycle. The influence of the social environment on health is also widely recognised (Dahlgren and Whitehead 2006). Examples of resources for health in the social environment are: neighbours and social networks.

SOC – Health

A strong sense of coherence is found to have a positive influence on perceived health (Eriksson 2007; Söderhamn and Holmgren 2004; Langeland *et al.* 2007; Nesbitt and Heidrich 2000; Geyer 1997; Read *et al.* 2005; Olsson *et al.* 2006; Hakanen, Feldt and Leskinen 2007). People with a higher SOC often feel more confident about their lives and this influences health positively. SOC is also positively associated with quality of life. People with a higher SOC often experience a higher quality of life (Borglin *et al.* 2006).

Conversely, health has an influence on SOC as well. Health is one of the factors responsible for the maintenance of an individual's level of SOC (Read *et al.* 2005). People in good health often find it easier to make use of the resources in the physical and social environment. When older people have no physical limitations, it is easier for them to go cycling, to go to the library or to use public transport. Health can also have a negative influence on SOC (Lundberg and Nyström Peck 1994; Read *et al.* 2005). Anxiety and depression (mental health) are found to have a high negative impact on SOC (Olson *et al.* 2006).

In line with the HP 2.0 framework, the items SOC, resources for health, and the interrelationships between them, deserve equal attention when healthy ageing strategies are being developed, implemented and evaluated. To be able to address them, the involvement of older people is necessary, including information about their motives, about what they find important, what they can understand and what they can manage. Information is needed about the specific contexts in which these older people live, since the salutogenic relationship is about the interaction of the individual with the physical and social environment (Lindström and Eriksson 2005; Eriksson and Lindström 2007). Information about contexts and about motives also provides insight into how to facilitate and stimulate older people to use the resources for health available in the environment, so that they can improve their health and strengthen their SOC. Information about contexts and motives provides insight into important concepts to consider for evaluation. This in turn gives insight into what is needed to adapt the resources for health to the SOC of older people in a specific municipality or neighbourhood. When an intersectoral health promotion team focuses and works together with older people and their family and caregivers, on the interactions between the individual or groups with the environment, the so-called salutogenic relationship, what is at stake is improving individual or community empowerment (Koelen and Lindström 2005; Koelen and Van den Ban 2004). In the next section, an example of a possible application of the HP 2.0 framework within an intersectoral team for healthy ageing is described.

The HP 2.0 framework in practice

The HP 2.0 framework explicitly stresses the need to gather information and to incorporate knowledge from different stakeholders, including the older people themselves. It reveals which relationships require emphasis in practice. For example, in one municipality the team organised evidence-based courses for improving well-being of older people (Bohlmeijer *et al*. 2005). Using the HP 2.0 framework (see Figure 2.1) means that the relationship between resources for health and health is evident. Still, the practitioners in that municipality experienced difficulties attracting participants for these courses. The HP 2.0 framework shows that possibly the preconditions of the course, such as the communication about this course, the location, and the recruitment, insufficiently met the sense of coherence of potential participants. So, more insight was needed about how these older people perceived these courses: whether they met their needs, and whether they felt able to attend and follow the course.

To gain insight into the three relationships of the framework, different kinds of research and different kinds of data are needed. To gather information about the concept of health, an extensive questionnaire can gather quantitative data to get insight into the main health problems. Open interviews can be used to get more insight into how older people experience these health problems, their own health and healthy ageing. Such interviews can supply qualitative data which provide an explanation about the health concept in the HP 2.0 framework. To gather insight into the resources for health, possible research strategies can include: a document analysis of annual reports of different organizations, interviews with family and informal caregivers about the support and the care they give to the older person, interviews with different organizations about their facilities for older people, interactive sessions with these organizations in which they discuss facilities for older people, and interviews or focus groups with older people about these facilities. These different methods of enquiry can also provide useful information and understanding of older people's motives in their choices with regard to, for example, facilities for older people. Older people's SOC can be measured by the validated Life Orientation Questionnaire (Antonovsky 1996; Lindström and Eriksson 2005; Eriksson 2007; Hakanen, Feldt and Leskinen 2007). This questionnaire provides quantitative data on SOC. Another research method to elaborate more on the concept of SOC is interviews and group sessions with older people about the three different dimensions within the SOC, i.e. manageability, comprehensibility and meaningfulness. These qualitative data provide more insight into, according to the older people, desirable preconditions of resources for health.

This example shows that different kinds of research, which provide different kinds of data from a variety of stakeholders, are needed to develop resources for health which will have a certain reach among, or will be used by, older people in the municipality. Furthermore, these data are also needed to build knowledge together with the stakeholders about methods to strengthen SOC and the health of older people in the municipality.

Discussion

The HP 2.0 framework suggests that a resource for health can have effect on the sense of coherence of older people. Therefore, SOC can be a possible indicator of the effect of a resource for health. There is still a lot of discussion about the stability of SOC. Although it is a relatively stable concept (Antonovsky 1996), it is possible to change SOC and/or the dimensions within it (Eriksson and Lindström 2008; Lindström and Eriksson 2009). Some studies show that SOC is more stable among those people who have initially a high SOC (Hakanen, Feldt and Leskinen 2007; Nilsson *et al*. 2003) and is less stable among those people with a low SOC. Reasons for this could be that people with a higher SOC probably have a greater variety of GRRs at their disposal and know better how to use them. In that case, there is an interaction between the GRRs and SOC and therefore they can better deal with stressful events in life (Hakanen, Feldt and Leskinen 2007). Within health promotion for healthy ageing, special attention should then be given to those older people who have a low SOC, because they have more difficulty in making use of the resources for health in the physical and social environment than older people with a high SOC. It is known that a supportive social environment influences health (Dahlgren and Whitehead 2006), and that creating supportive environments for these older people is important for supporting and strengthening SOC.

Within the HP 2.0 framework, the resources for health should be identified by older people as meaningful, comprehensive and manageable resources to use and re-use to promote healthy ageing. However, nowadays municipalities, welfare workers and other professionals often decide which resources for health are important for older people. The ideas of these professionals about healthy ageing often do not match those of the elderly people themselves. Therefore the role of municipalities, welfare workers and other professionals should become more facilitating, so that older people can have a role as well in the development, implementation and evaluation of resources for health. In this way, the HP 2.0 framework also has the ability to support intersectoral collaboration (including older people) for healthy ageing. This is a topic for further research.

The HP 2.0 framework is a promising policy model to improve healthy ageing in a municipality; however, some provisos are needed. First, the HP 2.0 framework relies heavily on the cognitive and judgemental ability of the older person. When older people are not capable of expressing their perceptions and their needs, then it is the responsibility of professionals to do research and to assess the situation of these older people, so that they can adapt the resource, as well as possible, to the understanding, the motives and the capabilities of older people with cognitive impairment. Then there is still a focus on the salutogenic relationship between resources for health and the SOC of the older people: this relates closely to the next proviso.

Within the HP 2.0 framework, the meaning of healthy ageing is determined by the ageing individuals themselves (Hansen-Kyle 2005). This runs the risk of provoking victim-blaming by others (Angus and Reeve 2006). Others can hold, according to their interpretation of healthy ageing, the older person responsible for ageing healthily. It can shift attention away from the responsibility of the government and other stakeholders, who are responsible for

building and sustaining resources, such as living facilities for older people and accessible health care. For older people with a certain degree of cognitive frailty, these resources are particularly essential.

These provisos show that the ideal situation for organizations and policy makers – that older people actively participate in the development, implementation and evaluation of resources – is not always realistic. This means that awareness of possible negative consequences, such as victim-blaming and the difficulty of involving older people with cognitive frailty, of using the HP 2.0 framework is essential in health promotion practice.

Conclusion

This article describes the HP 2.0 framework and how this framework can be applied. The HP 2.0 framework is based on the principles of health promotion and on the theory of salutogenesis. The framework is intended to support an intersectoral team to create a knowledge base which can support the processes and the content of the development, implementation and evaluation of healthy ageing strategies.

The main contribution of the HP 2.0 framework to health promotion practice for healthy ageing is the visualisation of the relationships between three important concepts within health promotion and salutogenesis. By visualising these relationships, the framework highlights the importance of the participation of different sectors and older people in health promotion. The salutogenic relationship between resources for health and SOC also becomes more explicit.

The consequences of the HP 2.0 framework for the development, implementation and evaluation of healthy ageing strategies are threefold. Because of the focus on the salutogenic relationship, the active input of older people and of other stakeholders is essential (WHO 2005). Within the theory of salutogenesis, to improve or maintain health, it is important to create an environment where people can see themselves as active and participating. In such an environment, people can use their resources for health and by doing so strengthen their SOC (Eriksson and Lindström 2008). To create this kind of environment, existing and new resources in this environment should be, to some extent, a product of both older people and the organizations/professionals. The second consequence of a focus on the salutogenic relationship is that a variety of research methods and qualitative and quantitative data are needed to gather information and to gain insight into the motives and the contexts of older people and into desirable preconditions of resources for health. This information and these insights are used as input for the development and implementation of the resources for health for older people. This information can also serve as input for the evaluation of a resource for health. The third consequence is that, within the HP 2.0 framework, all the relationships between the concepts should be evaluated, including the salutogenic relationship. Often, in public health much evaluation is conducted solely on the more traditional relationship between resources for health and health. Consequently, there is little information about the processes that lead to

health and the reasons why a resource does or does not show any effect on subjective health. If the salutogenic relationship is incorporated into the evaluation, information about the influences of the resource for health on the processes towards health and on SOC will give a deeper understanding of the possible effects on health. Therefore, the HP 2.0 framework has the ability to guide and facilitate processes that an intersectoral team in practice may undertake to develop, implement and evaluate resources for health with a view to promoting healthy ageing.

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3

Coordinated action for health; Context, dynamics, and prerequisites for healthy ageing strategies in three Dutch municipalities

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Abstract

This paper investigates the influence of local context on the extent to which local stakeholders perceive their ability to coordinate their activities. Interviews with 44 stakeholders, from three different municipalities, provided the empirical data for a qualitative analysis. Findings reveal how stakeholders share visions on objectives that moved from what issues to address (i.e. health themes) towards how to do so (i.e. how to reach hard-to-reach groups). However, current financing structures and policy strategies, although valuing collaboration, induce competition and isolated approaches. Familiarity between organizations and visibility of intermediate results are perceived as essential to facilitate collaboration. Even though municipalities are all situated in the same region and are quite similar concerning their ageing populations, this study highlights relevant differences concerning context, dynamics, and prerequisites for coordinated action. This indicates that it would be inadvisable to implement the same programs in the same way for each municipality.

Background

The rapid increase in population ageing raises questions and challenges for policymakers at international, national, and local level on how to improve and guide healthy ageing strategies (World Health Organisation 2002; Alongi 2009; Räftegård Färggren and Wilson 2009). In the Netherlands, recent changes in public health policy, influence local policymaking. In Dutch municipal government, the highest authority is formed by the elected municipal council. This council decides on broad policies, oversees their implementation, and appoints aldermen. The day to day administration is in hands of the mayor and these aldermen. Municipalities traditionally have a task to control, promote and protect the health of inhabitants. With the introduction of the social support act (WMO), the national government delegates responsibilities to municipalities at the local level. These responsibilities include to provide support and facilities to ageing and disabled inhabitants, with a special focus on live ability, participation and mobility (Ministery of Health 2004; Tjalma-van den Oudsten *et al.* 2006).

A variety of stakeholders, such as community health services, housing, welfare, and care organizations, are involved in healthy ageing at the local level, but often are not used to work together. However, since most public health issues are multi factorial they need to be approached from different angles at the same time. Therefore, there is an increased call to join forces. (Green, Daniel and Novick 2001; Mays 2002; Koelen and van den Ban 2004; Mantoura, Gendreon and Potvin 2007; Williams *et al.* 2010). In public health and health promotion practice this is also referred to as intersectoral collaboration or coordinated action.

This study investigates the views and experiences of local stakeholders concerning healthy ageing strategies within three different municipalities in the Netherlands. In this way, this study aims to gain insight in challenges and preconditions for coordinated action related to healthy ageing at the municipal level. This study takes place within the context of an Academic Collaborative. In this consortium an university and a Community Health Service work together in order to identify innovative approaches to healthy ageing. The three municipalities participating in this study closely collaborate with this consortium.

Coordinated action can be defined as a recognized relationship between (parts of) different sectors of society which has been formed to take action on an issue to achieve health outcomes in a way which is more effective, efficient, and sustainable than might be achieved by a single sector alone (Nutbeam 1998). Coordinated action creates opportunities for sharing information, activities, skills, and resources. It includes getting involved in new areas, with new people and with various backgrounds, knowledge domains, interests, and perspectives.

Theoretically, health promotion practice should be able to benefit from this diversity. By capturing the knowledge and experiences of diverse stakeholders, a richer understanding of health promotion issues can be obtained, leading to more robust and sustainable health promotion programs (De Savigny and Adam 2009). The principle of synergy seems to be strong. Evaluations of community health programs clearly show the added value of coordinated action (Clark *et al.* 1993; Graham and Bois 1997; Green, Daniel and Novick 2001; Goldman and

Schmalz 2008; Wagemakers 2010; Woolf *et al*. 2011). However, in practice the differences are often the reason why collaboration proves challenging (Graham and Bois 1997; Roussos and Fawcett 2000; Van Eyk and Baum 2002; Koelen and van den Ban 2004; Higgins, Oldman and Hunter 2007; Koelen, Vaandrager and Wagemakers 2008; Fawcett *et al*. 2010; Green, Daniel and Novick 2001).

Next to this, health promotion takes place in increasingly complex environments where many factors can influence success. Strategies to improve health are context sensitive, and consequently, certain strategies may not work in some settings whereas they function perfectly well in others (De Savigny and Adam 2009). Few studies take these challenges into account (Koelen, Vaandrager and Colomér 2001). Collaborative actions are hard to achieve and difficult to sustain. Differences between stakeholders play an important role in this but are hardly the sole challenge. Many factors relating to the context of collaborative efforts can also hinder or facilitate effective collaboration. Existing structures, rules, routines, and institutions – such as laws and financing structures – are examples of this (Klein Woolthuis, Lankhuizen and Gilsing 2005; Leeuwis and van den Ban 2004; Mays 2002).

On the basis of lessons learned from a variety of health promotion programs and a review of relevant literature in this area, Koelen *et al*. (2008) have identified six factors that are relevant to achieving and sustaining coordinated action in collaborative projects. These are: 1) discussing aims and objectives, 2) representation of relevant stakeholders, 3) discussing roles and responsibilities, 4) communication infrastructures, 5) visibility of contributions and results, and 6) management. Each factor represents an essential value or prerequisite to coordinated action. Factors one to three are important to achieve coordinated action, whereas factors four to six are important to sustain collaboration once it has been achieved. The six factors, their value to coordinated action, and related challenges are elaborated on in Table 3.1. Overall, these factors demonstrate that differences between stakeholders in routines, perceptions, and objectives, as well as contextual factors are of importance to coordinated action.

In order to facilitate sustainable and relevant healthy ageing strategies in the participating municipalities, local stakeholders can provide valuable knowledge and experiences. This study will therefore focus on stakeholder views and experiences concerning local healthy ageing strategies. The factors for coordinated action (Table 3.1), though constructed to guide or evaluate existing projects, provide a broad background to gain insight into each municipal context. This study was guided by the following questions:

1. What do stakeholders perceive as important to the success of healthy ageing strategies?
2. What aspects of coordinated action do stakeholders perceive in current strategies and activities within their municipality?
3. Do the three municipal contexts differ in terms of pre-conditions for coordinated action?

Table 3.1 Coordinated action: factors, values, challenges

Factor	Value	Challenge
Discussing aims and objectives	Stakeholders have to agree on the problem definition and objectives of the program or activities in question. Perspectives and definitions of concepts need to be clarified.	The initial assumption that agreement exists is a main challenge since further discussion often reveals this is not the case. Explicit expectations on outcomes often remain unspoken and can lead to friction when they come to the fore at a later stage in the process.
Representation of relevant stakeholders including clients	Since one sector alone has a limited perspective and a limited reach across the population, a variety of sectors needs to be represented.	Different backgrounds of stakeholders and little history with working together are main challenges. Clients and end users are often under-represented.
Discussing roles and responsibilities	A variety of skills, expertise, and experience is needed to strengthen collaborative efforts.	Finding clear definitions of roles and responsibilities is difficult. Stakeholders have to find a balance between collaborating and getting the freedom to fulfill their part of the job in their own way.
Communication infrastructures	The sharing of information, ideas, and experiences needs to be facilitated, for instance through meetings.	Stakeholders differ in their capacity to access information and in their communication skills. Attending meetings can be (perceived as) time consuming.
Visibility of contributions and results	Visibility functions as an incentive for involvement, action, and continuation. It refers to visible activities (for instance in local media), visible outcomes and the visibility of individual contributions. Visibility is necessary to get political and financial support.	Unrealistic outcome expectations discourage the sustainability of collaborative efforts. Invisibility of individual contributions can demotivate participants from continuing to contribute.
Management	The collaboration process needs to be nurtured, a specific role such as a coordinator is needed to facilitate and manage this process.	Often "how to get things done" is more difficult than "what to do"; this means that the focus is on achieving goals instead of on nurturing the collaboration.

Source: after Koelen et al., 2008.

Methods

The three participating municipalities all belong to the operational region of the involved Community Health Service. Around the year 2005, national spatial reorganizations of the Dutch municipal infrastructure resulted in several merges. Table 3.2 provides general background information about each municipality and the main consequences of the spatial reorganizations. Names are replaced with letters because of anonymity reasons.

In each municipality, an initial meeting with the alderman concerned with ageing population policy took place. These aldermen provided information about organizations involved in local ageing population initiatives. Afterwards, the aldermen informed local

Table 3.2 General background information on participating municipalities

	Municipality A rural characteristics	Municipality B between rural and urban	Municipality C urban characteristics
General population	45,226	32,655	46,643
Population density	175 p/km^2	212 p/km^2	1,127 p/km^2
Population aged 65 years and older	7,113 (16%)	5,878 (18%)	6,299 (14%)
Consequences of spatial reorganizations	Merge of four smaller municipalities. Election of new council and appointment of new aldermen. No clear vision on ageing population policies due to these reforms.	Consists of four smaller villages but was not influenced by the 2005 reforms.	One smaller village was added to the central city in this municipality which already fulfilled a central role to this village.
Characterization of healthy ageing in 2005	No clear policy, each merged municipality had own organizations and facilities which need to re-organize themselves within the new structure.	No local infrastructure of organizations involved in public health or healthy ageing issues. Ageing population policy was outdated.	Clear view on ageing population policy and extensive local infrastructure of involved organizations.

organizations about this study in a letter. Information received by the aldermen, local information guides and social maps were used to gain an overview of the local setting and involved stakeholders. From this overview, a selection of stakeholders was made with the aim to include all types of stakeholders.

Potential participants were contacted by telephone in order to provide additional information about this study and to establish an interview appointment. Interviewees were very interested in this study, only in municipality C we did not manage to organize an appointment with a general practitioner and in municipality A, housing was not represented. A total of 44 interviewees participated in this study, summarized in Table 3.3. The focus of this study was on the municipal context of healthy ageing strategies. The number of 14 to 15 participating organizations per municipality provided enough information gain an overview of this context. Interviews were held by the fourth and first author of this paper over the summer of 2007. Conversations lasted between 60 and 90 minutes and were audio-taped with permission of the interviewees.

The focus on perceptions and experiences in the research questions required methods that were sensitive to these personal experiences. However, the need to compare between municipal settings asked for some structuration as well. Semi-structured, face to face interviews were therefore used in this study. Interview questions addressed two main topics derived from the research questions:

1) Perceptions and experiences concerning healthy ageing strategies, were addressed by the six main health issues as identified in the 2005 senior inhabitant survey by the Community

Table 3.3 Participating organizations

Participating organizations and short information	Municipality A	Municipality B	Municipality C
Psychological healthcare Preventive activities concerning loneliness, depression, loss of partner. Often a more regional function providing for several municipalities	1	2	1
General practitioners Physical health care, home doctors	1	1	–
Home care and care organizations Provide care in clients own homes and often also provide sheltered facilities and institutionalized care. Sometimes with a regional function	2	3	2
Volunteer organizations Provide help with small chores around the house, organize courses and many other activities and support	2	1	1
Wellbeing organizations Organize courses, leisure activities and services to support people remain their independence, sometimes with a focus on ageing	4	2	3
Housing Noncommercial rental of houses	–	2	3
Municipal policy makers From different sectors like public health, ageing, and spatial planning	5	4	4

Health Services being: loneliness, mobility challenges, care-giving burden, overweight, psychological issues, and falling incidents (Timmerman-Kok 2006). Since this survey provides important input for the development of policies at the municipal level, these themes are relevant to this study. Between participating municipalities, these priorities did not differ. Interviewees were asked to elaborate on the importance of the themes to ageing populations from their organizations point of view. Next to this, interviewees were asked about their personal definition of what it means to age healthily.

2) Coordinated action and current context, were discussed by presenting interviewees with several newspaper clippings concerning activities within their municipality.[1] The clippings were selected to cover a broad selection of facilities within the concerned municipality such as health, general support, social and leisure-related activities. Clippings differed per municipality but were selected to cover the same subjects. Examples include: courses to refresh driving skills,

1 An overview of these clipping is provided in Appendix I.

local information guides, leisure activities, activities to prevent falling incidents, administrative help, activities to prevent loneliness, and home information projects. Both the clippings and theme cards were used as props to start the conversation and stimulate and guide the interviews.

Interviewees were asked to talk about their ideas about and experiences with working with representatives from other organizations within the municipality. To stimulate interviewees to elaborate on their experiences without having to avoid delicate subjects and resolve to being discrete, we integrated aspects of the organizational change methodology Appreciative Inquiry (Cooperrider 2005) in our approach. Appreciative Inquiry has successfully been used in health promotion approaches (Melander-Wikman, Jansson and Ghaye 2006; Reed *et al*. 2008; Wagemakers 2010) and as an interview tool before (Michael 2005). In practice this meant interviewees were not asked to list main problems within their municipality, but instead were asked to think about successful activities, the causes for these successes and desirable situations in the future.

All interviews transcribed (intelligent verbatim style), notes taken during the conversations were added, after which the final document was anonymized. The qualitative analysis software ATLAS ti 5.0 (Scientific Software Development) was used to manage the data and ensure transparency during the analytical process. When necessary, audio files were used to confirm transcripts and listen to excerpts within their original conversational context. The coding process used a combination of top-down and bottom-up approaches (see Table 3.4) based on a combination of content analysis (Silverman 2006) and domain analysis (Coffey and Atkinson 1996).

The first stage of coding assigned fragments of text to pre-defined codes derived from the research questions, resulting in three groups of fragments with the labels: 1) perceptions on healthy ageing, 2) positive- and 3) negative experiences with coordinated action. Next, within each group, similar fragments were clustered, coded by means of free coding, and organized into conceptual categories derived from the factors for coordinated action. Perceptions on healthy ageing were found to relate mainly to factor 1 whereas found positive and negative experiences could be related to the other five factors. Finally, to answer research question 3, the factors were compared over the three cases. Results are presented following the factors for coordinated action. Quotes provided were selected to be representative for interviewees' reactions and experiences in relation to that specific factor.

Table 3.4 Consequent phases in coding and categorizing data

Phase	1	2	3	4
Action	Assigning fragments of transcripts to groups 1) perceptions, 2) positive experiences 3) negative experiences	Clustering within groups by combining similar fragments and assigning codes (reduction)	Linking themes to conceptual categories derived from factors for coordinated action	Comparing factors over the three municipalities
Approach	Top-down	Bottom-up	Top-down	Comparative

During the analysis, intermediate results were discussed between co-authors several times in order to cross check interpretations. Next to this, results were presented in a workshop format per municipality. The interviewees and other interested organizations were invited to participate. This offered opportunities for participant checks with interviewees and provided a way to crosscheck findings with others participating in the discussions. The outcomes of these workshops did not give cause to major changes in our findings.

Study findings

During the analysis, it became clear that interviewees share a lot of perceptions concerning healthy ageing and what they would like to do to improve healthy ageing strategies. From their personal point of view, interviewees perceived independence, involvement, and empowerment as important values to healthy ageing. Interviewees shared an integral perspective on health and healthy ageing. However, the extent to which interviewees perceived they were able to act accordingly, was largely influenced by contextual factors and dynamics such as financing structures and working routines. Interviewees mentioned that projects that were on too large a scale and too ambitious were hard to adjust to the local practice and the needs of clients. This made those initiatives difficult to implement. Small-scale and adaptable programs were preferred over standard interventions.

Furthermore, concerns were voiced about whether facilities were visible enough to the targeted audience. Reaching so called *hard to reach groups* was explicitly formulated as an aim, but how to do so remained difficult. Differences between municipalities related mainly to factors such as familiarity between organizations and changes due to municipal reforms. Similarities and differences per factor will be elaborated on below and are summarized in Table 3.5.

Aims and objectives

Interviewees work within different organizations, that have different aims and address different health issues. However, interviewees do share a common view on objectives that moved from what issues to address (health themes) towards how to do so. The first shared vision came forth while discussing the presented health themes. When asked to order these themes on importance to ageing individuals, interviewees made solutions in which themes were allowed to overlap, influence, and relate to each other. None of the themes was more important than the other:

> *Overweight is commonly seen when someone experiences mobility problems. That also induces loneliness, people don't get out much anymore.*

Table 3.5 Overview of similarities and differences in compared municipalities

Factor	Similarities	Differences
Discussing aims and objectives	Interrelatedness of health issues. Autonomy and involvement are important. Small size and scale of initiatives is preferred. Involving hard-to-reach groups needs attention.	Municipality C organizes network meetings at which relevant topics can be discussed; this results in a better understanding of differences between stakeholders' perspectives and interests.
Representation of relevant stakeholders including clients	Need for an integrated approach and coordinated action is supported. Representation of target groups is important. Social environment is also a relevant 'stakeholder'.	Municipality A and municipality B would like more participation by target groups and more demand driven approaches. Municipality C uses person-to-person contact to involve target groups as well.
Discussing roles and responsibilities	Role definition is influenced by targeted groups, services provided, and goals. Theme-based aims and objectives hamper collaboration. Financing structures influence relationships and induce competition.	Because of extensive reforms in municipality A, organizations need to familiarize themselves with each other. Informal network meetings in municipality C contribute to familiarity between organizations. In municipality B, organizations feel uncomfortable with each other.
Communication infrastructures	Synchronizing efforts often is effective. Familiarity between organizations is needed. Personal contact between employees of different organizations is essential.	Municipality C uses its current opportunities for communication in a successful way. Municipality A would like to have an infrastructure but this needs to be consolidated. Stakeholders share ideas and visions to do so. Municipality B lacks an infrastructure, and stakeholders have different ideas and interests concerning communication.
Visibility of contributions and results	Difficult to make results and organizations' contribution to healthy ageing visible to other organizations and the municipality. Accountability often focuses on numbers and health themes. Need to create visibility of results at different levels.	Municipality A would like to share positive experiences and make those visible. Municipality C would also like more visible knowledge regarding reach, effect, and cost effectiveness. Both would like to be able to compare their efforts with other municipalities. Municipality B would also like to compare results within its own municipality between stakeholders
Management	Status quo situations due to financing structures, competition, and the focus on cost effectiveness and efficiency management.	Healthy ageing strategies in municipality A are mostly coordinated by policymakers due to the recent reforms. In municipality B, many organizations attribute a coordinating role to themselves. No central coordinator is recognized. Policymakers in municipality C coordinate priority setting and facilitation, and the welfare organization coordinates synchronization between organizations. Both are appreciated and recognized by other stakeholders.

Another shared vision is related to ways in which organizations address their audience. Interviewees question the extent to which they should act pro-active and decide for their clients on what is best, since this hampers autonomy and involvement:

> *Often we create solutions before someone even experiences a problem. We should pay more attention to what people can do themselves instead of immediately providing standard solutions.*

Organizations shared the concern about whether they were reaching the right groups. Familiar faces often attend organized activities and special provisions for frail individuals fail to actually reach those groups, as addressed in the following fragment:

> *Those who provide informal care to a relative may suffer from the burden of giving care, they are one of our target groups. We've organized a 'care giving support desk' but we only received two clients in the past nine months. It makes you wonder, what are we doing wrong? What should we do to reach them?*

A last shared vision concerned the scale of new initiatives. Too large a scale means less attention to local conditions which interviewees experience as a burden in their day to day work:

> *Well, I have noticed the best effects originate in small initiatives. There are so many rules and guidelines that don't provide any support. They don't fit the daily routines.*

Comparing municipalities: municipality C frequently organized network meetings with local organizations to discuss topics relevant to the ageing population. Discussions went beyond health-related themes (what to address?) and increasingly included ways to better address and involve target groups and ways to achieve a multi-disciplinary approach in which organizations would collaborate (how to do so in practice?). At the time of these interviews, the other municipalities lacked such an infrastructure.

Representation of relevant stakeholders

The interrelatedness of health themes as described above, is one of the main reason why interviewees think an integrated approach is required to effectively work on healthy ageing strategies. The notion that one organization alone only has a limited perspective and reach is supported by the interviewees:

> *We really should work towards a more integral approach. Everyone just focuses on their own theme and has little idea about what others are doing.*

Although interviewees stressed the importance of the representation of several organizations, they were not very explicit about who specifically should be involved and in what way this could be facilitated.

However, they were explicit about the involvement of the targeted audience in the development and implementation of services. In this connection, interviewees mentioned client panels, and needs assessments were being used, but there was doubt whether this was sufficient. Better representation of clients was seen as the way to improve the extent to which projects managed to involve hard-to-reach groups. Services such as senior advisory services had positive experiences with the use of person-to-person contact:

> *Together we can work out a solution. On how to support someone until he feels safe and secure enough to be able to move on. But you'll need to ask questions and figure things out together, it's almost never arranging 'meals on wheels' by itself that fixes the problem.*

Interviewees indicated that collaboration should not focus only on the inclusion of professional organizations or targeted groups. Since social support is mainly provided through personal networks, many relevant stakeholders can be found there as well:

> *Care is not about professional organizations alone, it is about the whole environment. Everyone is important, neighbors, family.*

Comparing municipalities: all three municipalities had secured the representation of target groups through panels, advisory committees, and surveys. However, this did not mean that input gained in this way was optimally used. In both municipality A and municipality B, organizations pleaded for more active involvement of target groups – either by more personal contact and target group participation in the development of services (A) or by adopting a more demand-driven approach (B). In municipality C, organizations valued the active participation of target groups through panels and had good experiences when employees of organizations actively approached members of the target group.

Roles and responsibilities

The way roles and responsibility were attributed was influenced by organizations' objectives, the audience they target and the services they provide. Some organizations aim at the whole population and offer extra services to ageing groups. Other organizations use stricter age-related definitions and provide services for people aged 55, 65, or 75 years and older. Homecare and some loneliness and depression prevention programs are examples of services that need a medical indication by another organization, such as the CIZ (central indication in care) or a general practitioner.

Interviewees mentioned that it was hard to work outside of their set aims and targets because that was not what one was paid to do. Moving towards other issues might mean interfering with other organizations' business. Financing structures further enhanced this effect.

If you force a collaborative structure with financial incentives, people will all participate with their own agendas. They come to find out what the competitor will do instead of making something new happen.

Organizations formerly used to acquire funding in many different ways and through different channels and policy acts. With the introduction of the social support act, municipalities became responsible for the central distribution of these finances. Former collaborative partners now see themselves as competitors for the same grants and clients. This has resulted in uncertainty about responsibilities and role definitions and has affected inter-organizational relations.

Comparing municipalities: the three municipalities differed in the way organizations related to and approached each other. The extensive reforms in municipality A have caused extra uncertainties on top of the changes in financing structures enforced by the social support act. Organizations needed to become acquainted and redefine their roles within this new structure. In municipality B, organizations were not very familiar with each other and sometimes even felt uncomfortable with each other, hampering collaboration. Municipality C actively fostered familiarity between organizations by organizing network meetings. During interviews organizations frequently mentioned each other's activities, ways in which they collaborated, and links with other organizations. Roles were defined by the unique contribution organizations could make to healthy ageing within this municipality.

Communication infrastructures

Interpersonal contact between employees of different organizations was mentioned to contribute to more effective approaches:

You have to approach each other, get to know each other. Collaboration happens when you are familiar and you find yourself in a situation in which you think: 'what should I do next? I could phone George, maybe he has a suggestion?' But if you don't know him, how can you think about phoning him?

However, rapid changes in personnel made it hard to get to know each other. Also, it seemed to be easier for employees of different organizations to make contact on work-floor level rather than on management level:

I had good contact with her but they split us up. Our managers were having trouble with each other. So we were told we had to do our jobs separately even though our collaboration worked out fine!

An example from the interviews concerning the way computer training in municipality C was organized illustrates the value of familiarity between organizations in synchronizing activities and developing new initiatives:

We [senior housing] closely collaborate with the welfare organization to open an internet café. We provide the space, furniture and computers. They arrange skilled volunteers, training and information manuals.

Comparing municipalities: the communication infrastructure in municipality C facilitated coordinated action as well as helped to sustain it. Experiences like the aforementioned computer course could be shared with other organizations. Stakeholders in municipality A would have liked to have such infrastructure, but it still needed to be created. The local initiative 'central information points' that provided information to both target groups and organizations were frequently mentioned as a great opportunity to create an infrastructure. Stakeholders in municipality B did not have such a shared vision.

Visibility of contributions and results

Interviewees mentioned many different small-scale successes and outcomes of projects that made them proud. Collaboration with other organizations within the municipality, such as the publication of an information guide, reaching frail seniors through outreaching home visiting projects, and tailored services to clients, were examples of this. However, evaluation reports focused mainly on health outcomes and provided little room for this kind of small-scale successes and intermediate results. Interviewees therefore voiced difficulties in communicating the impact of their contributions to healthy ageing in the right way, at the right place, and the right time. They were mainly asked for results in numbers, whereas the results of many activities could be better measured in terms of experiences.

A lot of money gets allocated to specialist care. No research ever focuses on the effectiveness and opportunities of assisting people with normal and daily challenges. That's where professionals can act swiftly and smoothly and really can make a difference. But what if things really were that simple? The medical industry can't benefit from that now, can they?

Comparing municipalities: to create visibility, evaluation of efforts was perceived as essential. Policymakers in all three municipalities voiced the need to compare their efforts with others in order to find out how well they were doing themselves. Municipality B would also have liked to compare results over organizations within the municipality itself. The following remark was made by one of the municipal policymakers from municipality C:

How can we know whether we are doing the right stuff? I always think we are doing well, have many facilities and good inter-organizational contacts. But when we get the results of a senior inhabitant survey, health is never improved. In 2005, loneliness even increased! That leaves me with many questions you know…

This excerpt illustrates how monitor results were used as evaluation and how information provided was not perceived as sufficient. At the same time, interviewees mention results at health outcome level were often too ambitious. They were hard to achieve and took a long time to become visible. What exactly to evaluate and how to do so were also discussed during the interviews. In this regard, organizations from municipality A would have liked to show what was working well and share positive experiences. Organizations from municipality C expressed the same view, but stressed that they needed more knowledge regarding reach, effect, and cost effectiveness in order to improve their efforts and formulate realistic aims and objectives.

Management

Stakeholders sometimes perceived situations where no new initiatives were undertaken due to the new financing structures and induced competition. Organizations waited to see what others would do, resulting in a status quo situation.

> *Nothing happens anymore, everyone is just looking at each other. If you are going to do this, I will do so as well. So, that's how commercializing turns out to be. No one wants to take responsibility anymore.*

The focus on cost effectiveness in accountability and evaluation also hinders the development of new approaches.

> *You have to WANT something. Organizations are all discouraged by years of efficiency management which still dictates the way decisions are made. That's why results are accounted for in the wrong way, wanting to DO something is what really counts in my opinion.*

Comparing municipalities: because of the recent reforms at the time of these interviews, municipality A was mostly coordinated by policymakers. Most parties, however, including policymakers, would have liked to establish a more objective, central coordinator within the new municipal structure. The need for such a role was generally recognized. In municipality B, many organizations attributed some kind of coordinating role to themselves. No central coordinator was recognized, and organizations were in doubt about the role that other organizations attributed to them. Municipal policymakers tried to fulfill a coordinating role, but the many changes in personnel hindered personal contact and trust in relation to this coordinating role. In municipality C, the coordination of policy, priority setting, and facilitation of coordinated action was mostly in the hands of municipal policymakers. The local welfare organization coordinated synchronization between different organizations, implementation of policy through activities, and the sharing of knowledge through networking. This resulted in a strong and commonly recognized coordinating role.

Discussion and conclusion

Stakeholders from diverse organizations were found to share visions on how to address healthy ageing in practice, for instance how to reach hard-to-reach groups. Financing structures and working routines however were found to emphasize what to address with regard to healthy ageing, like for instance loneliness. Collaborative efforts, although valued by interviewees, were hampered by this approach.

Familiarity between organizations and visibility of results relating to shared visions were found to be essential in facilitating collaboration. Visibility of results is a prerequisite to gain insight in the equal distribution of benefits. Mantoura *et al*. (2007) also identify this as important to facilitate collaboration as well as communication and trust (Mantoura, Gendreon and Potvin 2007). In this regard, familiarity between organizations contributes to both communication and trust.

Municipalities are all situated in the same region and are quite similar concerning health issues in their ageing populations. However, this study has revealed difference in the extent to which prerequisites for coordinated action are fulfilled. Whereas municipality C provides sufficient infrastructures to successfully implement new interventions or activities, municipality A and municipality B need to work towards such an infrastructure before interventions can be implemented. Next to this, recent changes due to reforms and the introduction of the social support act, result in confusion concerning stakeholder roles and induce competition. The resulting lack in coordination hinders collaborative processes.

Klein Woolthuis (2005) refers to such challenges as systems failures. Four categories of systems failures can be distinguished being: 1) Infrastructural failures, concerning both the absence of physical infrastructures and the lack of an adequate knowledge infrastructure. 2) Institutional failures, which concern hard institutions such as rules, regulations and financing structures, and soft institutions being working routines, perceptions, norms and values. 3) Interaction failures, in which contact between involved actors is either too strong, limiting the inclusion of other points of view, or too weak where actors never reach a point of mutual understanding and trust. 4) Capabilities failures, that refer to the extent to which organizations are capable to adapt new working routines and use new knowledge. Entrepreneurship and staff qualifications are essential capabilities in this regard (Klein Woolthuis, Lankhuizen and Gilsing 2005). Main challenges arising from this study can be related to these systems failures and will be addressed in the following sections:

Dominancy of health-theme based approaches

Stakeholders share a vision on several aims. However, in practice, most organizations address specific health-related themes, related working routines hamper collaboration resulting in soft institutional failures. Current financing structures and policy strategies, although valuing collaboration, induce competition and force organizations to stick to their theme-

based objectives, this can be referred to as a hard institutional failure. Also, intended health outcomes usually take a long time to become visible which makes demonstrating the impact of stakeholder's contributions to healthy ageing difficult. Short-term and intermediate level outcomes need to be defined and measured in order to contribute to the visibility of contributions (Koelen and van den Ban 2004).

Interaction gap between supply and demand

The reach of the supplied facilities and activities is questioned by interviewed stakeholders and could be caused by the content of the supplied facility not meeting the demands of the targeted audience. However, this study indicates otherwise. The presentation of supplied facilities might not be adequate to reach the intended audience, resulting in interaction failures. A previous study performed within the same municipalities but with a focus on ageing individuals perspectives on healthy ageing, indicated this as well. This study concluded that ageing persons did see the value of available facilities but did not want to relate to them in terms of usability to themselves. The way facilities were presented with a focus on health risks and age were main reasons for this (Naaldenberg *et al*. in press). Overall, there exists an interaction gap between the way facilities are presented and the way they are perceived by those intended to use them. Findings within this study show how interviewees suggest more active involvement and participation of ageing individuals is needed to close this gap.

Although the health issues may be largely the same for the ageing population in all three municipalities, the differences in context would point to the inadvisability of implementing the same program in the same way for all. This calls into question the current trend towards implementing only uniform, specified, and certified evidence-based interventions (Armstrong *et al*. 2007; Speller, Wimbush, and Morgan 2005). It can be concluded that coordinated action between organizations cannot be taken for granted and requires attention in project plans.

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4

Coordinated action checklist; A tool to facilitate and evaluate coordinated action for healthy ageing

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Abstract

Coordinated action through partnerships is a core approach in community health promotion to deal with the multidimensionality of today's health and societal issues. The number of partnerships is increasing. However, facilitation and evaluation of partnerships is hampered by the lack and/or non-use of feasible tools. As a consequence, health promotion through partnerships is not optimally facilitated and evaluated. This article describes the development and piloting of a tool and guidelines to facilitate and evaluate coordinated action in community health promotion.

The initial development of the tool was based on relevant literature, a conceptual framework to support social environments for health, and an inventory of existing tools. Appreciative inquiry principles contributed to the formulation of items. The result, a checklist for coordinated action, was further developed and assessed for usability in six different partnerships: a national program, an academic collaborative and four local partnerships. Results of the checklist were cross-checked and discussed with partners. Piloting the checklist resulted in a feasible tool helpful to partnerships because of its ability to generate actionable knowledge.

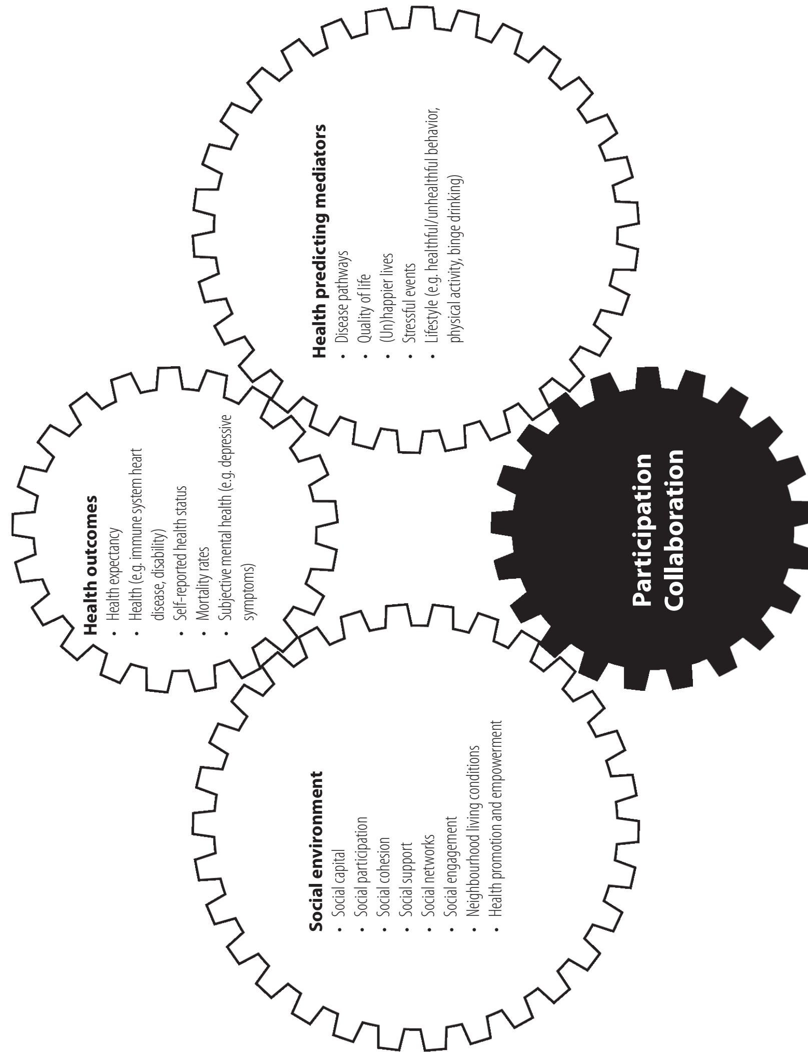
The checklist enables the facilitation and evaluation of community health promotion partnerships that differ in context and level (both local and national), phase of the program and topics addressed. Cross-checking and discussing results with partners and triangulation with interview data increases the reliability of the results of the checklist. Piloting in multiple cases contributes to the checklist's external validity.

Introduction

In today's health promotion the added value of coordinated action for health is generally acknowledged. In coordinated action, organizations of two or more different sectors work jointly to achieve an outcome (Koelen, Vaandrager and Wagemakers 2008). Coordinated action brings about changes in the environment of health and thereby improves the health of individuals and populations and increases awareness of health consequences involved in policy decisions and organizational practice, within and among different sectors. Central to coordinated action are partnerships for intersectoral collaboration and community participation (WHO 1986, 2005). The number of partnerships is increasing rapidly because no agency alone has the resources to address the wide range of determinants of today's multifaceted public health problems (Green, Daniel and Novick 2001; Goldman and Schmalz 2008) such as overweight and obesity, the rapid ageing of the population and the greater longevity of people with chronic conditions.

A review of collaborative partnerships found that partnerships convincingly contribute to supportive social environments of health (Roussos and Fawcett 2000). However, evaluation of partnerships is hampered by lack of information on how interventions bring about change in the social environment in favour of health (Anderson *et al.* 2003; Metzler *et al.* 2007). A lot more happens through partnerships than is measured, evaluated and reported. There seems to be a gap in knowledge on how to effectively facilitate and evaluate coordinated action for health (Metzler *et al.* 2007), and little is known about appropriate strategies to evaluate partnerships (Bowen and Martens 2006). One of the reasons for this gap is the lack and/or non-use of feasible tools in practice (Roussos and Fawcett 2000; Granner and Sharpe 2004; Schultz, Israel and Lantz 2003; South, Fairfax and Green 2005) due to unfamiliarity with existing tools and guidelines. Science advocates the use of validated tools, and practice longs for tools that fit the multifacetedness of health promotion practice. This means that tools and methods need to be scientifically grounded, easy to adapt to specific needs in practice, easy to analyse, and relatively low in time demand and cost (Wagemakers *et al.* 2008).

In previous research (Wagemakers *et al.* 2010) a framework and guidelines to facilitate and evaluate supportive environments for health has been developed (see Figure 4.1). The framework is based on our experiences in case studies and a review of the literature on participation and collaboration. The framework visualizes the relation between the social environment, health predicting mediators (e.g. lifestyle) and population health outcomes (e.g. health status) and provides operationalizable variables that moderate the relation between the social environment and health predicting mediators. In the framework, participation and collaboration, both core concepts in health promotion (WHO 1986, 2005) are used as entry points to make the social enviornment of health researchable and maneageble by partnerships and communities. Participation and collaboration have been operationalized into variables (middle column). The reason for choosing participation and collaboration as moderators is that they have an intermediairy role in health and social change outcomes (Butterfoss 2006; Rütten *et al.* 2008) and are central to the effectiveness of health promotion (Israel *et al.* 1998; Jackson *et al.* 2007;


Health predicting mediators
Disease pathways
Quality of life
(Un)happier lives
Stressful events
Lifestyle (e.g. healthful/unhealthful behavior, physical activity, binge drinking)
Health outcomes
Health expectancy
Health (e.g. immune system heart disease, disability)
Self-reported health status
Mortality rates
Subjective mental health (e.g. depressive symptoms)
Participation
Collaboration
Social environment
Social capital
Social participation
Social cohesion
Social support
Social networks
Social engagement
Neighbourhood living conditions
Health promotion and empowerment

Menu 1: Levels	Menu 2: Variables	Examples of operationalizations
Individual level Characteristics, perceptions and processes. **Organizational level** Characteristics, perceptions and processes. **Coalition level** Characteristics, perceptions and processes. **Community level** Characteristics, perceptions and processes.	**Context** • Community context and readiness • Linkages to other groups • Fund raising, resource mobilization • Resources, (technical/political) support and assistance	• Number and quality of collaboration structures • Amount of funding • Availability of resources
	Participants/stakeholders • Expectation, competences, skills, knowledge, expertise, experience • Diversity of participants, voluntary, paid or consultant, recruitment, drop out, work history, represented organizations • Trust, mutual dependency, power relations/equity, respect	• Experience: number of years worked on issue • Number of partners recruited and dropped out (in the last year) • Number of participants (formal and informal) • Partners work together in a constructive manner
	Partnership/coalition • Role, task, responsibility • Structure, leadership, management • Communication (internal-external), information exchange, openness, dialogue • Evaluation, documentation, visibility, feedback, reflection, flexibility	• Level of agreement on roles • Number of tasks of participants • Number of participants attending meetings or attendance rate • Quality of communication • Comprehensiveness of evaluation
	Processes • Involvement, ownership, commitment, motivation, task-focus • Mission, vision, aims, action plan • Problem solving, decision-making • Participation satisfaction	• Satisfaction with contribution of partners • Scores on quality of action plan • Level of agreement on mission • Opinion about participation • Level of participation
	Outcomes • Satisfaction, perceived effectiveness, benefits and costs • Participation result • Reached target population • Image/public profile, media coverage • Visible outcomes, (type of) activities, change in (physical) environment, institutionalization, policies	• Number of organized activities or services • Number of participants per activity • The intensity of use of facilities and services • The number of resolved problems or the percentage to which they are solved

Figure 4.1 A framework to facilitate and evaluate supportive social environments.

Green and Kreuter 2005; Potvin and McQueen 2008; Rice and Franceschini 2007; Wallerstein 2006). Also, case studies show that (community) participation and (intersectoral) collaboration are measurable (Wagemakers *et al*. 2008; Andersson *et al*. 2005; Naylor *et al*. 2002; Wagemakers *et al*. 2007). The left column shows that the variables are applicable on an interrelated continuum of four levels: individual, organizational, coalition and community. The right column provides some possible operationalizations of variables. The framework serves as a summary of options available to facilitate and evaluate changes in the social environment for health. It can be used as a 'menu of menus' by choosing levels, variables and operationalizations (Wagemakers *et al*. 2010). Based on this framework, a checklist for coordinated action has been developed.

The aim of this paper is to 1) report on the development and piloting of a checklist for coordinated action, 2) assess its ability to generate actionable knowledge to the mutual benefit of partners and partnership work, and 3) assess its usability. The checklist is piloted by a multiple case strategy, that is, by implementing the checklist in different settings. Multiple case studies provide a basis for external validity, which means that the checklist is relevant to other situations. Internal validity is increased by the use of verification techniques such as data triangulation and checking results of the checklist with partners (Koelen, Vaandrager and Wagemakers 2008; Cohen and Crabtree 2008).

First, the rationale and methodology for the development and piloting of a checklist for coordinated action is explained. Second, in the results section, the scores and actions generated in the pilots and the usability of the checklist is evaluated. Third, strengths and limitations of the checklist, its accompanying methods and its output – actionable knowledge – are addressed.

Method

The rationale for developing a checklist for coordinated action derives from both the literature and the practical experiences of community health promotion. The route towards the development of the checklist consisted of two steps: setting criteria for the checklist and piloting the checklist in practice. In piloting the checklist we used an action research approach.

Criteria for the checklist

Three criteria were considered in the development of the checklist. First, an important success factor in coordinated action is visibility because it is an incentive for involvement and action (Koelen, Vaandrager and Wagemakers 2008). Therefore a tool needs to visualize results, for example by scores (Pretty 1995; Verbeke *et al*. 2004) or spiderwebs (South, Fairfax and Green 2005; Rifkin, Muller and Bichmann 1988). Second, a tool needs to faciliate and support communication. Communication, including feedback, cross-checking and discussing results with partners, promotes trust (Bowen and Martens 2006), increases satisfaction with evaluation and consequently increases participation (Naylor *et al*. 2002; Wagemakers *et al*. 2007),

contributes to the evolvement of the partnership (Green, Daniel and Novick 2001), facilitates subsequent action (Koelen, Vaandrager and Colomér 2001) and contributes to the validity of results (Butterfoss 2006; Koelen, Vaandrager and Colomér 2001). Third, a tool must be usable in all phases. To achieve and sustain coordinated action (Koelen, Vaandrager and Wagemakers 2008; Goldman and Schmalz 2008) partnerships need to be nurtured in all phases, e.g. initial mobilization, planning, implementation and evaluation (Florin, Mitchell and Stevenson 1993).

Several tools that measure participation and collaboration were assessed. The tool that best fits the criteria is that developed by Verbeke *et al*. (2004). An asset of the Verbeke tool is that it addresses four well-organized dimensions: task, relation, growth and visibility. The task dimension relates to concrete products and results such as the action plan. The relation dimension concerns interaction among the participants and can be compared to Sicotte *et al*.'s (2002) intra-group processes and Schulz *et al*.'s (2003) dimensions of group dynamics. The growth dimension relates to the achievement and evolution of the partnership and is closely related to the visibility dimension that includes items on perceived image. On the basis of Verbeke's tool, a checklist was developed that reflects the previously mentioned criteria.

Developing and piloting the checklist

We used an action research approach to compose and pilot the checklist in close collaboration with six partnerships: a national program of the National Institute of Sport and Physical Activity (NISB), an academic collaborative (AGORA) and four local partnerships in three cities and one town in the Netherlands: Eindhoven, Zwolle, Delft and Epe. Table 4.1 provides an overview of the partnerships.

The partnerships were convenient samples stemming from the authors' contacts with practice. In three partnerships, one or more authors were part of the partnership (B, C, F). In the other three partnerships (A, D, E), the first author guided the use of the checklist.

In line with our guidelines (Wagemakers *et al*., 2010) items were chosen that can be considered as operationalizations of the variables in our framework (Figure 4.1). The chosen items were opportune for the specific situation and contexts of the partnerships. Some items cover more than one variable and vice versa. The checklist addresses all levels of partnership work, from the individual level to the community level. Therefore, some items are formulated in the 'I-form' whereas others address partners or the partnership.

To contribute to visibility, the checklist items convert the opinions of partners into quantitative variables by asking them to score the items on a Likert-like scale. The five answer categories are: no (score 0), probably not (score 25), no/yes (score 50), probably yes (score 75) and yes (score 100). The mean of items is calculated by adding the scores and dividing the result by the total number of partners. Dimensions are rated by adding the item scores and dividing the result by the number of items. To facilitate and support communication, the appreciative inquiry principles (Cooperrider, Whitney and Stavros 2005) were applied

Table 4.1 Overview of partnerships, characteristics and use of checklist

Partnership	A	B	C	D	E	F
	Project group *Heart for Lakerlopen*	Academic collaborative steering group	Pilot program *Overweight in the Neighbourhood*	Workgroup *Healthy and Affordable Food*	Workgroup *Vitality* Pilot of NISB	Project group *Healthy Ageing* Part of AGORA
	Eindhoven	AGORA	NISB	Zwolle	Delft	Epe
Features	One of six neighborhoods in community program in Eindhoven, a big city in the southern part of the Netherlands, started in 2000	Collaboration between practice and science in Gelre-IJssel Region, the Netherlands, set up in 2006	National program of the Netherlands Institute for Sport and Physical Activity (NISB), set up in 2007	Workgroup, part of program *Healthy Together*, in Zwolle, a city in the rural north-east of the Netherlands, started in 2008	Workgroup to set up integrated care facilities in two neighborhoods in Delft, a city in the western part of the Netherlands, started in 2007	Program to promote healthy ageing in a rural town in the eastern part of the Netherlands, started in 2007.
Theme	Healthy behaviour	Healthy ageing	Overweight	Nutrition	Overweight	Loneliness
Target group	Inhabitants	Elderly	Inhabitants	Low SES women	Low SES children	Elderly
Main partners	Municipal Health Service, Local grassroot organisations, welfare work	Municipal Health Service, Wageningen University, Municipalities	Municipalities, Municipal health services and sport services	Municipal Health Service, Local grassroot organisations	Municipal Health Service, Municipality, Schools, Sport services	Municipal Health Service, Welfare Organisation, Municipality, Mental Health Care
Use checklist	January 2007 in meeting	1. April 2007 Individually (comined with interview) and discussed in a meeting 2. May 2009 in meeting	1. June 2008 in meeting 2. September 2009 in meeting	December 2008 Individually comined with interview) and discussed in a meeting	December 2008 Individually	January 2009 in meeting

in composing the checklist. Appreciative inquiry is an approach that inspires and stimulates partners by appreciating the value of what already exists and using this as a starting point for envisioning, dialoguing on and innovating desired changes. Appreciative inquiry has already been used successfully in health promotion (Melander-Wikman, Jansson and Ghaye 2006; Reed *et al*. 2008) and as an interview tool (Michael 2005). Applying the principles means that items and questions are formulated in a positive way. An example of an item on the checklist is 'The partnership is an asset to health promotion'.

The checklist has been applied in succession, that is, in one partnership after the other. After each application, the checklist itself was evaluated by the partnership, its coordinators and the authors. Results of the evaluation were used to improve the checklist for use in the next partnership. The first checklist was composed of 20 items. The inclusion and exclusion of items resulted in a core checklist of 25 items. In the fourth pilot, the partnership indicated that an item on continuation after the project period was lacking. As a consequence, the last item of the checklist was included. Depending on the situation and specific wishes of the partnerships, more items may be included.

In all six partnerships, the checklist was used to facilitate and evaluate the partnership and its actions. In AGORA and NISB, the checklist has been used twice, respectively with a time-elapse of two years and one year. In both partnerships, reasons to use the checklist again were that evaluation of the partnership was requested by the funding agency, the first positive experience with the checklist and that former results gained by the checklist could be compared with new results. In AGORA (2007) and Zwolle, the checklist was filled in as part of an individual interview. The results, of both the interviews and the checklist, were fed back and discussed in a meeting. In Eindhoven, AGORA (2009), NISB (2008 and 2009) and Epe, the checklist was individually filled in during a meeting and discussed right away. In Delft, partners filled in the checklist individually at their office and the checklist was not discussed. Filling in took a few minutes. The checklist functioned as a discussion opener by asking partners on which items they scored high (and low) and why. In the discussions again the principles of appreciative inquiry were applied.

Results

Scores and actions

Table 4.2 presents the mean scores of the pilots on the core checklist of 25 items.

Discussion centered on establishing the reasons behind the scores, both the high scores (successes) and low scores (points to improve). Feedback and discussion enabled clarification of the reasons for high and low scores and, following from that, action could be taken (see Table 4.3).

All the partnerships view themselves as an asset to health promotion. In particular, the suitability of partners, based on expertise and involvement, is highly appreciated.

Table 4.2 The checklist for coordinated action and calculated mean scores of the partnerships

Partnership Items and scores (means 0–100)		A N=7	B1 N=14	B2 N=12	C1 N=14	C2 N=13	D N=7	E N=8	F N=5
General		**100**	**93**	**90**	**88**	**88**	**96**	**97**	**85**
1	The partnership is an asset (to health promotion).	100	93	90	88	88	96	97	85
Suitability of the partners		**77**	**83**	**85**	**76**	**79**	**88**	**80**	**71**
2	To attain the goals of the partnership, the right partners are involved.	75	80	68	70	69	79	78	60
3	Equity of the partners is essential for good collaboration.	82	79	98	75	81	89	84	85
4	The contribution of the different partners is to everyone's full satisfaction.	61	73	65	70	71	86	72	65
5	I have a special interest in participating in the partnership because of my position or organization.	90	82	94	84	88	93	75	85
6	I am able to contribute to the partnership in a satisfactory way (time, means, etc.).	75	88	83	75	71	86	69	55
7	I feel involved in the partnership.	79	93	94	84	88	93	91	75
8	I can contribute constructively to the partnership because of my expertise.	79	89	90	75	85	93	91	75
Task dimension		**78**	**59**	**76**	**63**	**76**	**87**	**70**	**74**
9	There is agreement on the mission, the goal and the planning within the partnership.	71	45	63	63	73	82	72	75
10	The partnership achieves regular (small) successes.	89	63	100	60	81	89	75	65
11	The partnership functions well (working structure, working methods).	75	59	61	69	71	86	59	75
12	The partnership evaluates progress at regular intervals and makes adjustments if necessary.	*	70	79	58	77	89	72	80

Relation dimension		**84**	**59**	**69**	**66**	**70**	**91**	**67**	**71**
13	The partnership partners communicate in an open manner.	*	61	60	80	77	89	56	75
14	The partnership partners work together in a constructive manner and know how to involve each other when action is needed.	86	61	73	59	63	96	69	75
15	The partnership partners are willing to compromise.	*	50	70	71	69	89	75	80
16	In the partnership conflicts are dealt with in a constructive way.	*	50	60	56	62	**	66	60
17	The partnership partners will carry out decisions and actions loyally.	82	75	83	66	77	89	69	65
Growth dimension		**72**	**71**	**82**	**72**	**77**	**71**	**73**	**70**
18	I create goodwill and involvement for the partnership within my organization.	82	86	90	80	85	92	75	80
19	Giving feedback to the local officials on behalf of the partnership is satisfactory.	58	58	75	59	63	19	72	55
20	The partnership is willing to recruit new partners in the course of time.	79	79	81	79	73	89	88	80
21	The partnership succeeds in mobilizing others for actions.	68	59	82	69	85	82	75	65
Visibility dimension		**82**	**69**	**78**	**66**	**57**	**77**	**63**	**60**
22	The partnership maintains the external relationships in an accurate way.	*	58	65	64	77	89	66	60
23	The partnership is seen as reliable and legitimate by external relations.	*	71	86	71	44	69	59	55
24	The image of my partnership in the outside world is good.	82	79	84	63	54	75	57	55
25	The partnership takes care of continuation after the project period.	*	*	77	*	54	75	69	70
Mean score of all items		**78**	**71**	**79**	**70**	**73**	**84**	**73**	**70**

The numbers are the mean scores of individual partners on a likert-like scale; no (score 0), probably not (score 25), no/yes (score 50), probably yes (score 75) and yes (score 100). * = Item was not included in this case. ** = Item could not be answered because no conflict had occurred.

Table 4.3 Actionable knowledge generated by the checklist and follow-up

Partnership	A Eindhoven	B1 AGORA	B2 AGORA	C1 NISB	C2 NISB	D Zwolle	E Delft	F Epe
Successes	Partners are loyal and the image of the partnership is good.	Partners are suitable, have the right expertise and feel involved.	Involvement of partners and (small) successes achieved.	Right partners are represented and partners feel involved.	Partners work together in a constructive way and successes achieved.	Partnership calls itself a 'dream team' and role of project coordinator is central.	Not discussed.	Partners' expertise is used well and communication is open.
Points to be improved	Participation of inhabitants is low.	Partners have different visions on mission and goal.	Limited communication between partners. Knowledge dissemination to municipalities is weak.	Partners lack opportunities to exchange experiences.	The image and visibility needs to be improved. Activities to continue collaboration need to be set up.	Embedding of partnership in local structures is lacking.	Not discussed.	Involvement of other organisations and the elderly is low.
Follow-up	Developing an action plan to involve inhabitants.	Discussion sessions to clarify roles.	Structures for communication and knowledge exchange. Alderman in steering group.	Special meetings (e.g. work visits), newsletter and e-mail contact.	Articles based on the results of the pilot will be published. In new NISB programs, the partners will be involved.	More attention to growth and visibility dimension of partnership.	Partnership was split into smaller groups on specific activities.	Meetings with organisations (e.g. municipality, church) and the elderly.

In Eindhoven, the score on the item 'The contribution of the different partners is to everyone's full satisfaction' was relatively low. The discussion revealed that the score was low because the number of activities for inhabitants was far less than initially planned. This is an example of a qualitative operationalization by the partners. After discussion, it was agreed that an action plan would be developed to set up activities for inhabitants.

In AGORA (in 2007), the results of the individual interviews and the score on the item 'There is agreement on the mission, the goal and the planning within the partnership' revealed that partners held different views on the mission and goals of the healthy ageing program. Cross-check of those results with partners further clarified that the views on mission and goals ranged from (only) health education to a broad range of facilities and services that contribute to health and wellbeing, like for example transport. Discussion sessions that followed contributed to improved mutual understanding and respect for different visions and disciplines. Two years later, discussing high and low scores on the checklist revealed that many (small) successes had been recorded. The partners agreed that these successes needed to be celebrated as well, and this was done right away. The discussion also revealed that continual attention must be paid to communication. Moreover, it was considered important to involve more municipalities. As a result, it was decided to add an alderman to the steering group. In other partnerships, effected changes included agreement to expand the number of meetings for the partners to exchange experiences (NISB in 2008), the plan to initiate actions to embed the project (Zwolle), and efforts to strengthen involvement of organizations and the elderly (Epe). In Delft, the results of the checklist were not discussed with partners. On the basis of the Delft scores the project coordinator decided to split the partnership into smaller groups in order to increase efficiency. In NISB (in 2009) the checklist was used during the last meeting of the partnership and follow-up focused on publicity of results and development of future activities.

Usability of the checklist

Overall feedback from partnerships about the usability of the checklist was positive: items were understandable, the checklist could be filled in quickly, counting scores was simple, adaptations could be made easily and especially discussing results with partners generated actionable knowledge. According to the partners, the 'I-formulated' questions were easier to answer than items addressing all partners or the partnership. The scores on the checklist were a good starting point for discussion. In general, highly rated items were acknowledged as non-problematic or as successes. The lower rated items were of most interest for discussion because they unraveled differences between partners and points to improve. Overall, use of the checklist and the accompanying methods (feedback and discussion) was found to be complementary to day-to-day partnership work, contributing to team building and enabling partners to sustain coordinated action. In addition, partnerships used the results for external evaluation purposes, such as in progress reports required by funding agencies.

Discussion

Checklist

Items on the checklist often address more than one variable of participation and collaboration. They can also be applicable for different levels (individual, organizational, coalition and community), and to a broad range of dimensions (task, relation, growth, visibility) of partnership work. This can be a limitation because only a few items can be included in each dimension. Moreover, items can be, and in our pilots were, interpreted differently by partners. Both limitations however can be assets as well. The strength of the checklist is not the number of items but the inclusion of the 'right' items: items that initiate discussion, which in turn generates actionable knowledge at all levels and on all dimensions. In our pilots it appeared that discussion about the meaning of items between the partners helped to reveal the actual dynamics of the partnership and to unravel ongoing processes. A significant element of the checklist is the scoring system because it visualizes strengths (e.g. successes) and weaknesses (points to improve) on items and on dimensions. In AGORA and NISB, the 2009 results could be compared with the 2007 results respectively 2008 results. In 2009, in both partnerships scores and discussion revealed that collaboration had improved and that many successes had been recorded. In AGORA, improvement has been considerable. In NISB the improvement has been moderate, because visibility needs to be improved in order to end the pilot program in a proper way.

The positive approach, based on appreciative inquiry, builds on strenghts and assets of partnerships and their work and thereby contributes to the partners' enjoyment in using the checklist and to increasing preparedness to take action. The positive approach possibly also generates (purposely) bias. However, in most of the pilots the discussion about successes and points to improve came up simultaneously. Michael (2005) also reported that negative experiences were conveyed as well as positive experiences and that, all in all, appreciative inquiry contributed to a richer undertanding. Therefore, the scores need to be interpreted relatively and in combination with the results of checking among partners, discussion and, if possible, interviews. When the checklist is being discussed, probing the reasons behind relatively high and low scores works very well, as our pilots show.

Facilitating participation

The checklist was developed in a participatory way, and consecutively applied and evaluated. This resulted in continual improvement of the checklist. To support participatory use, the checklist is flexible, both in items to be included and accompanying methods to discuss the outcomes. Partnerships that use the checklist, should realize that the main function of the numbers in the checklist is to summarize strengths and areas for improvement at a glance and that the main asset of the checklist is to stimulate feedback and discussion.

In feedback and discussion, partners are challenged to reflect on the dynamics of their work, ongoing processes, outcomes, their own and other partners' position and contribution and so on. This was confrontational in two partnerships, but in the end sustained coordinated action. Confrontation presents an opportunity to clarify different views. However, partners need to feel safe and comfortable to do so. When a partnership is not running smoothly, we advise to conduct individual interviews in combination with the checklist. This may help to unravel what is going on and facilitate discussion. By discussing the different views, the partners set in motion a learning process that potentially creates a way to combine different views, reach consensus and thus leads to an innovative project. In general, active facilitating increases the chance of successful collaboration and desired outcomes for all partners (Cook 2008).

Actionable knowledge

In this study, we used an action research approach, resulting in the generation of actionable knowledge in all partnerships. Cook (2008) recommends 'action' as a legitimate component in research designs for programs that aim to effect community-level change. A tool needs to meet validity criteria: both internal validity (Granner and Sharpe 2004), which is addressed by using verification techniques (participant check, triangulation), and external validity, which is based on practice-based research with attention to context and to connectedness of program levels (Glasgow and Emmons 2007). Paying greater attention to the issues of external validity and to intermediate or process outcomes enhances relevance to particular settings and will lead to better applications and programs (Green and Glasgow 2006; Tones 2000). Therefore, we expect the results of this study to be relevant to other partnerships. However, a number of relevant issues still need to be addressed. These issues are the further refinement and improvement of the checklist and its use, the optimum composition and number of required items, the most appropriate accompanying methods and the features and context of partnerships that need to be taken into account. Up to now, our research is characterized by its explorative nature. To address the mentioned issues and to further validate the checklist, more research is needed. Future research can be focused on the continuation of the present research: evaluate the use of the checklist in more partnerships and to re-use the checklist at multiple times in the same partnerships. Also, future research can focus in more detail on how items are interpreted by partners.

Conclusion

The action research approach facilitated the development and piloting of a checklist with 25 core items. The checklist is a useful means for partners to overview their working and monitor their successes as a partnership promoting change. In combination with feedback and discussion, the developed checklist enabled the facilitation and evaluation of community health promotion

partnerships that differ in context, phase of the program, scale (national and local), topics addressed (overweight, healthy ageing) and number of partners. The use of the principles of appreciative inquiry in the checklist and methods contribute to improving communication and communication structures, to visibility, to clarifying outcome expectations, to celebrating (small) successes and to facilitating regular evaluation.

Cross-checking and discussing results with partners and triangulation with interview data increases the reliability of the results of the checklist. Piloting in multiple cases contributes to the checklist's external validity. The parallel investigation of the checklist in different partnerships resulted in all cases in actionable knowledge. The checklist helped partnerships in this study to understand processes and to create community and systems change and hence can potentially contribute to achieving population-level health outcomes.

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5

Neighbors Connected; The effect of using interdisciplinary evidence

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Abstract

Neighbors Connected is a community-based intervention supporting the active older people to organize social activities for their less active older neighbors, facilitated by practical and financial support from the Community Health Service. The intervention is the outcome of a combination of semi-structured interviews with the older people, with organizations for older people and with local policymakers, epidemiological data and interactive discussions, all of which support the notion that engaging in social activities is a way to enhance healthy aging within the community. The use of different sources of evidence resulted in a comprehensive picture and actionable local knowledge.

Introduction

As people grow older, biological changes influence their mental, physical and social state, including their social networks. This can have a large impact on their quality of life and their health. Healthy ageing is a complex issue about which stakeholders each have their own views that must be included in the development of interventions in order to create effective programs. To include relevant stakeholders and their opinions, the Gelre-IJssel community health service closely collaborates with two municipalities in the eastern part of the Netherlands. Within these municipalities, local organizations for older people, welfare organizations and older people themselves participate in the development and implementation of Neighbors Connected. Within Neighbors Connected, active older people are *invited* to organize an activity and invite less active older people in their neighborhood. Examples of such activities include: starting a club for people with mobility scooters and making Christmas cards. The initiators are responsible for inviting participants. The collaborating partners of Neighbors Connected facilitate these activities by practical support, such as advertising for the event. Financial support can be provided up to an amount of €500 per initiative. For one year it was possible to finance 20 activities within two municipalities. The organisational support was funded by a community health service. The aim of the intervention is to improve and sustain social participation and engagement of older people. Another goal is to build an infrastructure that facilitates older people to be active in the community and creates greater awareness of health promoting resources for the older people within their municipality.

The evidence

Neighbors Connected is part of an academic collaboration between Wageningen University, Gelre-IJssel community health service and municipalities within its region to bridge the gap between research, policy and practice. This academic collaborative (AGORA) is funded by the Netherlands Organization for Health Research and Development. AGORA aims to develop, implement and evaluate methods to promote healthy ageing within municipalities. AGORA's interdisciplinary and intersectoral way of working provides opportunities to integrate evidence from different perspectives and practical, policy and scientific approaches into a coherent evidence base for healthy ageing (Naaldenberg *et al*. 2009). Disciplines collaborating together include, for example, researchers, health promotion professionals, epidemiologists and policymakers, from different sectors such as policy, research, welfare and health.

To develop a healthy ageing program, evidence was collected in three different ways: first, interviews with main stakeholders including target groups; second, an extended analysis of quantitative monitor data; and third, interactive sessions with stakeholders.

1. Relevant stakeholders and older inhabitants were approached to participate in interviews that explored differences in perceptions and goals with respect

to healthy ageing. These interviews showed that older people do not approach health and ageing as separate from their daily lives (Naaldenberg *et al*. 2011). Furthermore, older people with serious physical problems can be very able to function up to a satisfactory level. This indicates that physical health status alone does not explain the way older people experience health, but that a feeling of control plays an essential role (Naaldenberg *et al*. 2011). To feel in control, respondents indicated that being able to use facilities by themselves is important, especially local resources. Neighbors are very much appreciated resources for all kind of chores. Interviews with local organizations underline the importance of control.

2. Epidemiological analysis of data from a health monitor among older people was used to determine risk factors of ageing and indicators contributing to healthy ageing. Cluster analyses of the monitor data revealed different groups. The clusters in which older people were less socially engaged scored lower on perceived health than the clusters of older people who were more socially engaged in the form of leisure or work (also voluntary) (Croezen *et al*. 2009). This quantitative result supports the findings from the interviews that revealed the importance of social support and social capital. Neighbors in particular were found to contribute to well being.
3. The results from 1 and 2 were discussed with relevant stakeholders in order to validate findings, set priorities and think about what steps to take next. In these discussions, the problem of hard-to-reach groups, such as the lonely older people, played a central role.

On the basis of this evidence it can be concluded that social participation, reduction of loneliness among the older people and perceived feeling of control are determinants of healthy ageing. Factors contributing to this feeling of control are: 1) a positive approach to healthy ageing, 2) a supportive environment in which neighbors play an active role, 3) clear communication and visibility of facilities, and 4) the active involvement of older people in their in own situation (Naaldenberg *et al*. 2011).

How is the evidence used?

Evidence was used and valued at different levels. First, close collaboration between epidemiologists and social scientists resulted in mutual learning and synthesizing of approaches. Questions that arose in interpreting quantitative data were added to the interviews, and the results from these interviews were strengthened by investigating them quantitatively. Difficulties with this interdisciplinary approach concerned interpretation of concepts and validity of results. The close interpersonal collaboration between the disciplines created mutual trust in which

these differences could be overcome (Koelen, Vaandrager and Wagemakers 2008). Second, the interactive discussions among stakeholders created learning from each other's perspectives, familiarity with other organizations within the municipality, and input for researchers on how to present their findings in a way local organizations and policymakers could put them into practice. Difficulties encountered concerned the time it took to come to shared goals and objectives. Planning health promoting programs often requires pre-defined goals and evaluation methods. This resulted in uncertainty, and an alternative approach to planning had to be adapted to overcome this. Third, the interactive session with both stakeholders and target groups revolved around several issues such as 1) the importance of issues such as health, happiness, pleasure and convenience as motivations to be socially participative, 2) the ideal social and physical environment for older people, 3) the support older people need to participate in society, and 4) the need for new activities vs. improvement in the quality of existing activities. In other words, these discussions resulted in a more applicable formulation of key points. During the sessions, participants also brainstormed about continuing the process to improve healthy ageing. Afterwards, all participants and other known stakeholders received a report about the sessions and about the next steps to be taken. Combining these different forms of evidence, a positive intervention approach (Lezwijn *et al.* 2011) was proposed, and again this was discussed with the older people and the collaborating partners. A challenge within this approach was to find ways to combine all input into an intervention and to do justice to all the ideas suggested by participants. How to integrate these goals into (scientific) evaluation planning is still a challenge to overcome.

Neighbors Connected is the outcome of a combination of different forms of evidence. Social participation, neighbors, local resources, lonely older people and concrete communication were all used to build this intervention. It removes obstacles for active older people who are willing to do something for the community, but who are facing, for example, financial and practical constraints. Getting financial and practical support for the initiative is easy and fast. The project worker builds a personal relationship with the initiator, assesses the idea and helps with the actual organization of the activity. For this, a local or community organization is an essential factor within Neighbors Connected. Furthermore, the intervention removes obstacles that might prevent the less socially active older people from participating. These older people are *invited* by their neighbors to participate in nearby activities that are meaningful for them.

Conclusion

The development and implementation of the Neighbors Connected intervention is a process in which different kind of evidence from research conducted in AGORA were used. The academic collaborative setting facilitates these processes because it simplifies the creation of opportunities to share knowledge and create social learning among the different disciplines and policy, science and practice (Naaldenberg *et al.* 2009). Another factor that facilitated the

use of different sources of evidence is the broad theme of healthy ageing. During the process in the municipality, the objectives and aims became more specific. Such a systemic approach to planning makes it possible to adapt processes to the local culture and values and to define objectives in collaboration with that same community.

However, because of the active involvement of organizations, policymakers and older people, these processes were not as straightforward as expected. For example, the objectives of the intervention were developed during the process of development of the intervention. Furthermore, we found that capacity and time were needed for intersectoral collaboration and participation (Koelen, Vaandrager and Wagemakers 2008). Involving the community within the different phases of the intervention, however, is essential to build supportive communities — just as important as the involvement of relevant stakeholders. It gives the opportunity to link the intervention to existing social and cultural networks. For Neighbors Connected, this resulted in a grant of the province Gelderland to expand the intervention into another community.

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6

Neighbors Connected; A strategy to recruit older people to participate at local activities

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Neighbors Connected; exploring the recruitment of Dutch older people for local activities.

Abstract

The recruitment of older people to engage in actions aimed at promoting health is an issue that does not receive much attention within health promotion practice. Many activities for older people are organized; however, less socially active older people do not participate in such activities. Therefore, in this study, the process of how to attract less socially active older people to participate in activities, organized within the program Neighbors Connected, was evaluated by means of the sense of coherence and the dimensions of comprehensibility, manageability, and meaningfulness. The aim of this study is to evaluate the elements of activities that were perceived by participants as comprehensible, manageable, and meaningful, so the recruitment of older people can be improved. By means of a short evaluation form completed by 254 participants, and interviews with 12 participants and 9 organizers, we identified four elements that facilitate the perception of activities as more comprehensible, manageable, and meaningful. These elements are 1) personal contact with organizers, 2) social support, 3) proximity and easy access, and 4) opportunities for social interaction and for learning. We conclude that the elements that improve recruitment of activities merely relate to the context in which the activity is organized, rather than to the content of the activity. For future programs this means that the context in which an activity takes place is as important as the content of the activity within the organization as well as within the evaluation.

Introduction

Healthy ageing is defined as "the process of slowing down, physically and cognitively, while resiliently adapting and compensating in order to optimally function and participate in all areas of one's life (physical, cognitive, social and spiritual)"(Hansen-Kyle 2005: 52). This definition clearly stresses that older people have to be an active participant in their own life. Healthy ageing, just as health, is influenced by a variety of interacting determinants (WHO 2002), such as individual lifestyle factors, social and community networks, living and working conditions, and general socioeconomic, cultural, and environmental factors (Dahlgren and Whitehead 2006). An important determinant of healthy ageing is social participation (Croezen *et al.* 2009; Naaldenberg *et al.* 2011; Richard *et al.* 2009; Utz *et al.* 2002), which is defined as social interaction with persons other than one's spouse (Utz *et al.* 2002).

One form of social participation is taking part in activities that create opportunities for meeting other people. Meeting people is needed to build social relationships. In municipalities, all kind of activities are being organized where older people can meet each other. However, less socially active older people often do not take part in such activities. Local organizations do not know how to recruit this group (Lezwijn *et al.* 2011a).

This study is not about the impact that participating in an activity has on health or a determinant of health; rather, this paper addresses the question of how to recruit less socially active older people to participate in social activities. To investigate the reasons of older people, whether or not activities are perceived as comprehensible, manageable and meaningful, the recruitment of activities of the Dutch program 'Neighbors Connected' is evaluated. Neighbors Connected is a community based program in which socially active older people are supported to organize activities for their less socially active older neighbors.

Development of Neighbors Connected

Neighbors Connected has been developed by means of the HP 2.0 framework (Lezwijn *et al.* 2011a) and a participatory approach, based on the principles of health promotion (Rootman, *et al.* 2001). The HP 2.0 framework (Figure 6.1) is based on salutogenesis, which is a theory that focuses on the causes of health rather than on the causes of disease (pathogenesis) (Antonovsky 1987, 1996; Ciairano *et al.* 2008; Eriksson and Lindström 2008; Lindström 2005, 2006).

The framework is meant to support development, implementation and evaluation of health promotion strategies by making the relationships between the concepts 'sense of coherence (SOC)', 'resources for health' and 'health' explicit (Lezwijn *et al.* 2011a). The SOC is a feeling of confidence that one is able to make use of resources in a way that positively influences health and wellbeing (Antonovsky 1987, 1996; Eriksson and Lindström 2008; Lindström 2005, 2006). The SOC exists out of three dimensions; comprehensibility, manageability and meaningfulness. The resources for health are resources which can be used in order to be in control of situations affecting their lives and can be found in the social and physical environment. Examples are

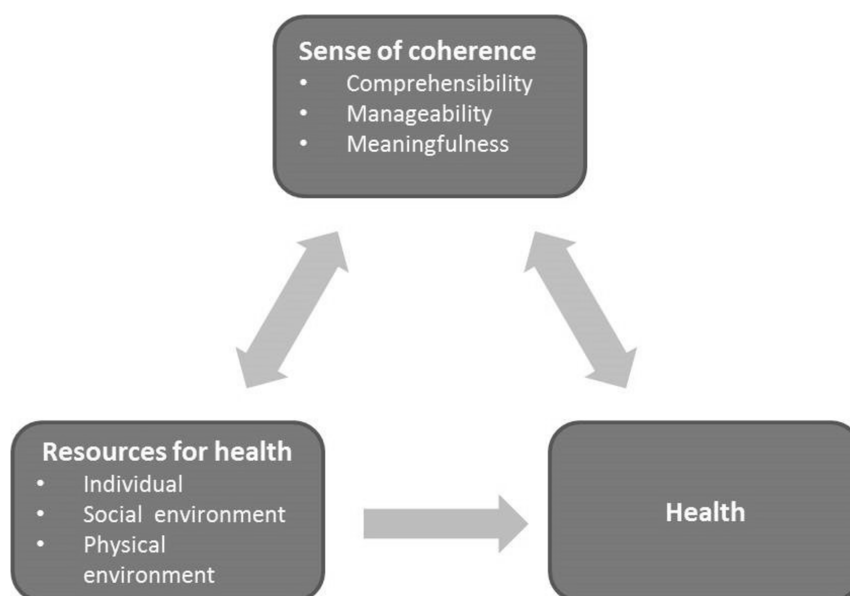


Figure 6.1 The HP 2.0 framework.

facilities for older people, shopping facilities, neighbors, and health services. Individual resources for health are for instance knowledge, education level and experience. Health includes physical, mental, social and spiritual well-being (Lezwijn *et al*. 2011a).

Related to the recruitment for activities, comprehensibility reflects a person's perception that the information he/she is getting about an activity is structured and explicable. One is able to judge whether one wants to participate. Manageability reflects a person's perception of his/her resources, including his/her own capabilities to meet possible barriers to participating in the activity. Meaningfulness reflects a person's perception about whether or not the activity will give meaning to him or her at an emotional level (Antonovsky 1996; Ciairano *et al*. 2008; Lindström 2005).

In the participatory approach, researchers, local professionals, policymakers and older people were involved to develop Neighbors Connected. To consider what kinds of strategies were needed to improve healthy ageing within a municipality, different studies were conducted. These studies were: 1) interviews with local stakeholders and older people (Naaldenberg *et al*. 2011; Lezwijn *et al*. 2011b), 2) local epidemiological data (Croezen 2010; Croezen *et al*. 2009), and 3) interactive sessions with policymakers, local stakeholders, and older people to discuss the results from the interviews and the epidemiological analyses (Lezwijn *et al*. 2011b). The outcomes of these different studies, which provided criteria for a new healthy ageing strategy, included: 1) a positive approach to healthy ageing, 2) a supportive environment in which

neighbors play an important role, 3) clear communication and visibility of activities, and 4) the active involvement of older people in their own situation (Lezwijn *et al*. 2011b).

The literature shows that neighbors and a neighborhood, where older people are satisfied and where they feel at ease, can contribute to healthy ageing (Bowling and Gabriel 2007; Croezen 2010; Mohnen *et al*. 2011; Naaldenberg *et al*. 2011). Neighbors are more familiar with the context in which less socially active older people live, such as living circumstances, physical and/or mental limitations, and their contact with neighbors, because it is partly their context as well (Laverack 2009).

Neighbors Connected

Neighbors Connected is a community-based program supporting socially active older people (hereafter formulated as the organizers) to organize activities for their less socially active older neighbors (hereafter formulated as the participants); such an approach improves the chance of possible participants actually take part in activities. The organizers are facilitated by Neighbors Connected by means of practical support, such as printing leaflets, writing press releases, and arranging a location for the activity, and financial support up to a maximum of €500 (Lezwijn *et al*. 2011b). Furthermore, the Neighbors Connected project worker and the organizer of the activity regularly discuss the activity, the planning, and the methods to reach possible participants.

In the period May 2009 to May 2010 different kinds of activities were organized. Some examples include: a course to make Christmas cards, an afternoon in the village with sketches and music in the local dialect, an afternoon in a village playing bingo with music and song, and one-day excursions. The activities were divided into three categories, namely 1) a creative course, 2) an excursion, and 3) a nice afternoon close by (Table 6.1).

Table 6.1 Breakdown of the activities of Neighbors Connected

Activities
Creative course
▪ Course: Making Christmas cards (November/December 2009)
▪ Course: Plaster molding (December 2009/January 2010)
An excursion
▪ By bus to Holiday on Ice (November 2009)
▪ Excursion to Maastricht (April 2010)
▪ Excursion to historical farm (April 2010)
▪ Excursion to an open-air theater (May 2010)
▪ Excursion to Giethoorn (August 2010)
▪ Excursion to Keukenhof (May 2010)
An afternoon close by:
▪ Cooking for neighbors (during the year 2009/2010)
▪ An afternoon with sketches and music in local dialect (April 2010)
▪ Founding of a club for mobility scooter drivers (May 2010)
▪ An afternoon with music and bingo (May 2010)

This study

In this study, a multi-method strategy was used to evaluate the elements of activities that were perceived by participants as comprehensible, manageable, and meaningful. This knowledge gained by this study might help local organizations in organizing activities in such a way, that older people are more likely to participate. By adapting resources to older people's SOC, the relationship within the HP 2.0 framework between SOC and resources for health – also called the salutogenic relationship (Eriksson and Lindström 2008; Lindström 2005) – will be improved.

Using SOC within health promotion research is not new. SOC is already frequently used as an outcome of health promotion strategies (i.e. Bauer 2006; Eriksson and Lindström 2008; Langeland and Wahl 2009; Lindström and Eriksson 2009; Wainwright *et al.* 2007). However, in this study, SOC is used to evaluate the perception of older people of the comprehensibility, manageability and meaningfulness of activities. As far as we know, SOC has not been used before in this way.

The article is structured in four sections. In the first section, we elaborate more upon the methods of data collection and the analytical framework of this study. In the second section, we present our findings. In the third section, we discuss the results, and some considerations concerning the research. In the last section, we give the main conclusions from this study.

Methods

To evaluate whether the activities of Neighbors Connected are perceived as comprehensible, manageable, and meaningful for participants, a multiple methods approach was used. Using multiple methods is an important verification technique to improve the reliability of the results (Cohen and Crabtree 2008; Koelen, Vaandrager and Colomér 2001; Silverman 2006).

Data collection and analysis

Three methods were used: 1) a short evaluation form among the participants, 2) in-depth interviews with participants, and 3) interviews with the organizers of the activities.

Short evaluation form completed by participants in activities

The participants filled in a short evaluation form directly after the activity (N=254). The evaluation form consisted of open-ended questions about how they became aware of the activity, what they thought about the activity, and whether there was any likelihood that they would participate again if the opportunity arose. The evaluation form also provided the opportunity to recruit participants for the in-depth interview.

Interviews with participants

The first author conducted twelve interviews with participants. Their year of birth ranged from 1923 to 1944. All participants were women. On the basis of the short evaluation form, the first author randomly phoned 22 participants to ask if it was possible to do an in-depth interview about the activity. Reasons not to participate (10 respondents) included: feeling too old, feeling unable to share their thoughts and experiences, and being too busy. Four of the interviewed participants were from a creative course, three from an afternoon close by, and five from an excursion. The interviews took place at the homes of the participants, were approximately 30-45 minutes in length, and were audio-taped and transcribed intelligent verbatim for analysis. The interview contained open questions which were inspired by the 3-item scale of the Life Orientation Questionnaire. The Life Orientation Questionnaire is a scale, in a variety of number of items, frequently used to measure SOC (Antonovski 1996; Wainwright *et al*. 2007).

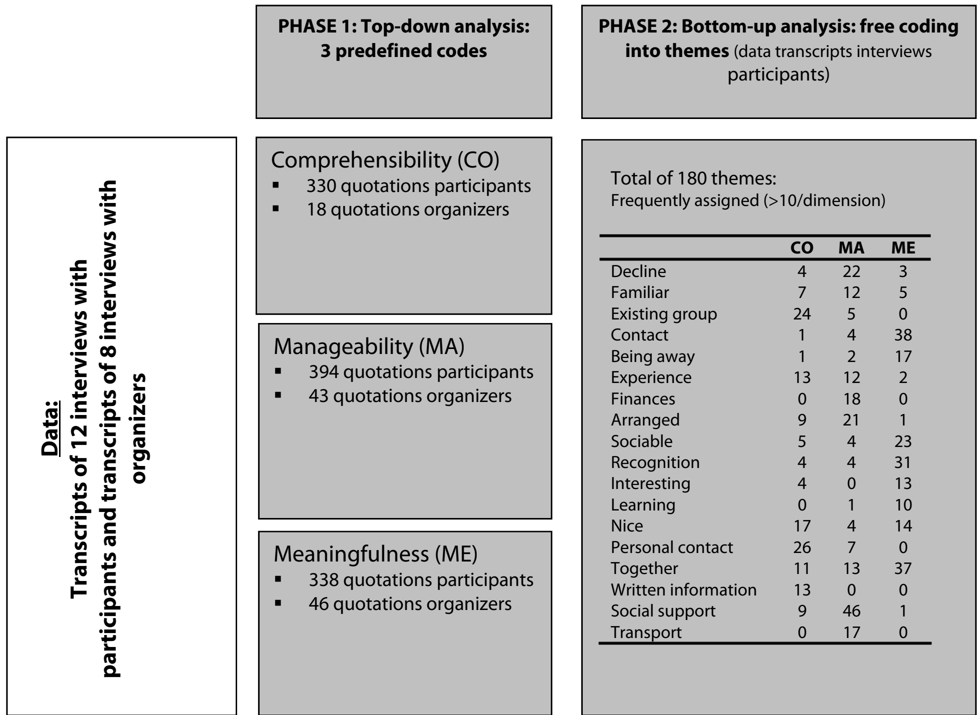
The interviews were analyzed using the qualitative analysis software ATLAS ti 5.0 (Science Software Development), which fosters transparency during the analytical process. The data were analyzed using a combination of a top-down and a bottom-up approach (Figure 6.2).

First, three pre-defined codes, namely comprehensibility, manageability, and meaningfulness, were used to assign fragments of the transcripts. To assign fragments to the pre-defined codes, the 29-item Life Orientation Questionnaire was used to support the coding process. Second, the data from the quotations about comprehensibility, manageability, and meaningfulness were freely coded into several elements. This process provided 180 themes and 1,062 quotations partly divided between the three dimensions of SOC.

Interviews with organizers

The first author conducted nine interviews with organizers of activities, the so-called socially active older people. These interviews probed what they thought about Neighbors Connected and why and how they organized the activity within Neighbors Connected. The interviews took place at the homes of the interviewees, were approximately 60-75 minutes in length, and were audio-taped and transcribed verbatim for analysis. During the analytical process ATLAS ti 5.0 was used.

In the analyses of the interviews, the part in which the organizers explained why and how the activity was organized was especially relevant for this study. From these interviews, it was possible to create an understanding of what organizers do, consciously or not, to organize comprehensible, manageable, and meaningful activities for the participants. A top down approach was used to analyze the data. The pre-defined codes comprehensibility, manageability, and meaningfulness were assigned to quotations. A bottom-up approach in analyses, as carried out on the data of interviews with participants, was not appropriate, because of the small number of quotations within the pre-defined codes (Figure 6.2).



	CO	MA	ME
Decline	4	22	3
Familiar	7	12	5
Existing group	24	5	0
Contact	1	4	38
Being away	1	2	17
Experience	13	12	2
Finances	0	18	0
Arranged	9	21	1
Sociable	5	4	23
Recognition	4	4	31
Interesting	4	0	13
Learning	0	1	10
Nice	17	4	14
Personal contact	26	7	0
Together	11	13	37
Written information	13	0	0
Social support	9	46	1
Transport	0	17	0

Figure 6.2 Analysis of interviews with participants and organizers of activities.

Interpretation of data

The data from the participant interviews about the recruitment and the appreciation of the current activities and about the visioning of important aspects of future activities revealed elements that contribute to the comprehensibility, manageability, and meaningfulness of activities. Some of these elements are characteristics of the older people themselves, such as experience and physical or mental decline. We focus on the elements that are characteristic for the activity itself. Those elements are, consciously or not, added by the organizers. The data from the evaluation forms serve as a check of the first findings from the participant data. The data from the interviews with organizers was used to assess whether and how organizers deal with issues – deemed important by participants – concerning the comprehensibility, manageability, and meaningfulness of activities. The quotations in the results section have been selected on the basis that they best articulate the discourse arising in relation to an element.

Results

Elements supporting comprehensibility

Two elements of an activity that make respondents perceive it as comprehensible are: 1) personal contact and 2) written information. First, personal contact between the organizers and older people and among older people helps the respondents to perceive the activity as comprehensible. Personal contact may be necessary to convince people that the activity is meant for them as well. It can take place in an existing group where the majority of the people already know each other, such as a weekly coffee morning at Elderly Welfare or the monthly evenings of the women associates. Within such groups, it is possible to ask the organizers questions and the organizers can distribute information about the activity. Another form of personal contact is when someone is asked by a neighbor, or another familiar person, to join the activity. In such cases, participants felt more able to judge if he or she wanted to participate as well. Data from the evaluation forms confirm the importance of personal contact, because the majority replied that personal contact with, for example, neighbors, but also with organizers, convinced them to go.

Second, written information, such as leaflets and newspapers is needed; however, it should always complement personal contact to attract people to the activity and to show that the activity could be nice for them as well. Written information should always provide clear information about the program, date, place, and time, without using difficult words, as following quotation shows:

> *...and sometimes people read the newspaper and then you think "what do they mean by that?" That is everywhere and we have not learned those difficult words at school.*

Written information is necessary to remember the activity and to talk about it with family, neighbors, or acquaintances. Furthermore, when written information about the activity is offered in several ways, such as in local newspapers, in leaflets, and via an organization or acquaintances, this increases the chance of participants actually seeing and noticing the activity. As one of the organizers experienced, without personal contact and with only articles in local newspapers, people are not attracted to the activity.

Elements supporting manageability

Important elements to ensure that participants perceive the activity as manageable are: 1) an accessible location close by, 2) arranged transport, and 3) experiencing social support. First, an accessible location close by, especially for older people with some limitations, is a positive prerequisite to participate, as following quotation shows:

> *Those things I find important. If I have to go to the other site of the city, then I say no. If I can just cross the street, then that's pleasant for me. And if I want to, I can go home again.*

Second, a practical issue such as arranged transport takes the manageability dimension of participants into account, as was the case with the excursions. The older people found this very easy.

> *I: You were picked up by your niece to get on the bus? R: Yes, and the bus also brought us back home again. That was lovely and afterwards you had a good feeling. That is what I experienced.*

Third, the most important issue for manageability is when participants experienced social support from neighbors, friends, or family. Participants enjoy going together to an activity. In such cases, participants experience mutual support to actually participate and, as one participant told us:

> *With the two of us, we know more than alone.*

Within one activity, the organizers were very conscious of the social support that older people needed to participate. The organizers themselves were very active in organizing this social support, as following quotation shows:

> *I called the man and I said "take your brother as well."*

The social support of the organizers themselves can also be very helpful when people arrive alone for the first time at an activity. One woman's experience was that you should sometimes help people to cross the threshold. One way of helping these people to cross the threshold is to offer coffee or tea and to talk with them.

Elements supporting meaningfulness

The following two elements contribute to meaningfulness: 1) the content of the activity should, according to participants, be interesting, new, or nice, and 2) the activity should create opportunities to meet other people. First, the participants take part in activities that they find interesting, that are new to them, and that they perceive as nice. Older people find meaning in activities in which they can learn. This was especially seen in the creative courses and during the excursions. As this older woman finds:

> *I: And for the next time, what would especially be meaningful for you to participate in such activity again? R: Yes, especially the people and you can hear of other things. Yes, you can learn something about it.*

Second, and according to the participants more important, is that when they actually participate, they also meet other people. In some cases, these people are new people, but in other cases they are neighbors from the past, with whom they have a shared history. Life stories from the past, but also from the present, sometimes have similarities with their own, and they recognize themselves in those stories; this is highly appreciated.

> *To go away for the afternoon and during the break, well yes, we drink a Crodino. We always do. There is nothing in it, but that's nice. To have a chat and yes, that is so nice. But it is very important as well to chat with all those people. Yes, because here [at home] I feel a little bit lonely.*

Organizers realize that doing things together is important for participants. Therefore, within all organized activities, meeting other people and doing things together is an important part. As one of the organizers said about her course:

> *I don't do the course to make cards. I do the course for the sociability, for those people.*

The data gathered by the evaluation form also showed that the sociability of the activity and being together were seen as main success factors.

Elements supporting more than one dimension

In the analyses, some elements of an activity support more than one dimension of SOC. These elements are: "nice" and "together." The first element, nice, means that, when participants perceive an activity as nice, they also perceive the activity as more comprehensible and meaningful. In such cases, the participant notices the activity more easily than when an activity is not perceived as nice. Furthermore, participants understand the content of the activity in advance and therefore they can more easily judge if the activity is meant for them as well (comprehensibility). And nice activities are, according to the respondents, meaningful activities. The participant can have some prior experience with similar activities or be familiar with positive stories about similar activities. An activity that is perceived as nice will increase the chance of someone participating in the activity. Because when the activity is seen as comprehensible and meaningful, then there will be a strong motivation to find the resources (Antonovsky 1996) to actually participate. The second element, "together", contributes to comprehensibility, manageability, and meaningfulness. This means that discussing the information and the activity with others, and having an opportunity to decide with others whether to participate or not, contributes to comprehensibility. The activity is perceived as manageable when the participants perceive mutual support when they go together. It seems easier to overcome possible barriers, doing it together. And the activity is perceived as meaningful, because older people find meaning in doing things together, and this contributes to building and sustaining social relationships as well.

Discussion

Many activities for older people are organized in municipalities; however, less socially active older people do not participate in such activities. Therefore, in this study, the process of how to recruit less socially active older people to participate in activities, organized within the program

Neighbors Connected, was evaluated by means of SOC and the dimensions comprehensibility, manageability, and meaningfulness. This is an innovative approach, since these concepts are used for the recruitment of activities, rather than as an outcome of a health promotion strategy.

The research question to be answered related to the elements that an activity needs to be perceived by participants as comprehensible, manageable, and meaningful. The findings from the multi-method approach show that, although the physical and mental condition of the older people themselves is a very important issue in whether they will take part in activities or not (Bowling and Gabriel 2007), some elements of activities itself can influence participation as well. These elements are: 1) personal contact with organizers, 2) social support in the decision phase about participating and the phase of actually going to the activity, 3) the close proximity and accessibility of the activity location, and 4) the opportunity provided by the activity for social interaction and for learning new things. These elements improve the chance of less socially active older people taking part in the activity and will therefore probably enhance social participation.

Interestingly, the four elements focus merely on the question of how the activity is organized, namely, the circumstances in which the activity takes place and the opportunities for social interaction, rather than on the content of the activity. Especially creating opportunities for social contact and social support prior to and during the activities seem to be essential for the perception that activities are comprehensible, manageable, and meaningful. A possible reason for this is that social contact with similar others contributes to self-identity (Sheldon and Burke 2000; Utz *et al*. 2002), and perceiving support from familiar social contacts helps people to decide to go. Thereby, participants feel more comfortable going together to an activity than going alone; this was also found by Naaldenberg *et al*.'s (2011) study. When people have to be convinced about the question of whether this activity is also meant for them (comprehensibility), or to cross the threshold (manageability), personal contact or social support is needed from the organizers of the activity. In these cases, the organizers fulfill the role of similar experts (Suls, Martin and Wheeler 2002), who are people with some similarities to potential participants, but who are more knowledgeable concerning the activity. In Neighbors Connected, the organizers belong to the older population from the same neighborhood or village. When participants compare themself with the organizers contributes to acknowledging that the activity is meant for oneself as well (Suls, Martin and Wheeler 2002).

The location, which makes an activity more manageable, contributes to perceiving control of the situation. People can come more easily, but can also decide to leave the activity. To a lesser extent than social contact, learning or hearing new things is also important for older people to find meaning in the activity. What people find interesting to learn relates to their identity (Krause 2004).

Neighbors Connected has been developed because of difficulties experienced by local organizations with the recruitment of less socially active older people for activities in municipalities. This is a very relevant subject, because when one is not able to recruit people to participate in an activity, the activity is not effective. Neighbors Connected is an innovative approach within the field of healthy ageing because the focus of Neighbors Connected is not

on the content of the activity, but rather on the process of organizing, and on the circumstances in which activities are organized. There are some similar projects (Bobbitt-Cooke 2005; Foster-Fishman *et al*. 2006; Hartwig *et al*. 2006; Schmidt *et al*. 2009; Tan *et al*. 2010) however, within these programs the combination of financial and practical support was not available for older people organizing an activity for their neighbors, only for organizations.

One consideration concerns the recruitment of participants for the interviews. Some participants were not willing to participate, because they felt they were too old and felt were not able to share their thoughts and experiences with the interviewer. Thoughts which could also inhibit them to participate at activities. However, the non-respondents did participate in activities organized by their neighbors. So, within this inquiry more attention for recruiting the older people to participate in our interviews, would have been beneficial for the research. It also shows that similarities can be found between recruiting certain groups of older people for participating in activities and recruiting the same groups of older people for participating in research.

Conclusion

Neighbors Connected aims to improve the social participation of less socially active older people by offering them comprehensible, manageable, and meaningful activities. For this, four elements to improve recruitment to the activities are formulated, so that barriers to participate at the activity are removed. These elements are: 1) personal contact with organizers, 2) social support in the decision phase about participating and the phase of actually going to the activity, 3) close proximity and easy accessibility of the location of the activity, and 4) an opportunity offered by the activity itself for social interaction and for learning new things.

Using salutogenesis, and specifically the SOC concept, in the evaluation of the activities of Neighbors Connected led us to conclude that, for older people, the environment and the context in which activities are organized are as important as the content of the activity. However, in health promotion practice, activities are often organized around a specific health theme. The context in which the activity takes place and how the activity is organized often receive limited attention during organizing the activity as well as within the evaluation of the activity. In our view, SOC and the three dimensions of SOC are useful concepts within health promotion practice to improve the recruitment, so that more less socially active older people will participate.

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7

Looking back; The quality assurance of Neighbors Connected

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Part of this chapter includes the description of Neighbors Connected that was submitted to the Dutch recognition system for the Intervention Database of the RIVM Centre for Healthy Living. Within this database, Neighbors Connected has provisionally been accepted as 'theoretically sound' by a committee of experts.

Introduction

Neighbors Connected is a healthy ageing program developed in three Dutch municipalities and implemented in two of these municipalities (see Chapter 8). The program has been developed and implemented on the basis of the principles of health promotion (Rootman *et al.* 2001). Those principles support health professionals to build and strengthen collaboration with policymakers, organizations and communities for sustainable local health promotion strategies (Rootman *et al.* 2001; WHO 1986, 2005). For Neighbors Connected, the health promotion principles contributed to the development, implementation and evaluation of the program in a participatory way with older people, local organizations and policymakers. The thorough process included different studies, such as a qualitative study among older people, organizations and policymakers, analysis of a health survey among older people and interactive sessions with all involved to discuss the results and steps forward toward a new healthy ageing program. The results of these studies contributed to the evidence base of Neighbors Connected (Lezwijn *et al.* 2011a, see Chapter 5). This development process is different from the more traditional approach wherein mainly health behavior theories are utilized to develop a program.

Quality systems in health promotion

The quality and effectiveness of health promotion programs is currently an issue that is high on national, but also on local, health policy agendas (Vaandrager *et al.* 2010; VWS 2006). Since health promotion is one of the tasks of the Public Health Act (WPG 2008), national and local governments want to invest in health promotion strategies if the quality of such programs meets certain norms and if it is evidence based. Furthermore, governments may expect health promotion professionals to deliver a certain quality when working on health programs funded by those governments. So, the quality of programs is a relevant issue, because programs that meet a certain quality standard are generally more effective (Aro, Van den Broucke and Räty 2005).

The trend towards centrally promoting evidence-based interventions to improve the quality of Dutch health promotion practice is growing (Vaandrager, Wagemakers and Saan 2010; Wagemakers 2010). In line with this trend, a quality assurance system for health promotion practice has been developed. The system aims to provide local policymakers and health professionals with information about the quality and effectiveness of available health promotion programs. Consequently, the system promotes the use of good practice and evidence-based interventions (Brug *et al.* 2010). The quality system also contributes to knowledge dissemination about existing health promotion programs, making positive and negative experiences with a program explicit so that others do not have to re-invent the wheel (Vaandrager *et al.* 2010).

The quality system distinguishes four levels of recognition. These levels are: 1) theoretically sound, 2) probable effectiveness, 3) established effectiveness and 4) established cost effectiveness. For each level (except for level 4 for which criteria will be established in 2011), criteria are set and, for each higher level of recognition, the criteria for the lower levels should be met as well.

Concerning the first level of recognition, theoretically sound, the health problem should be described in terms of (local) epidemiological data. The methodologies and strategies used to tackle the health problem and the process through which these are supposed to impact the targeted determinants or risk factors should be described and based on established empirical health behavior theory (Brug *et al*. 2010: 3). So the way in which the system judges the quality of the health promotion program, within all levels of recognition, is whether or not it is plausible that outcomes will be reached on the basis of the epidemiological data and the described health behavior theory.

A quality label for Neighbors Connected supports further implementation of the program. Working protocols and communication materials are available on the website of the quality system. Although the Neighbors Connected program is not based solely on individual health theory and epidemiological data, but also on contextual evidence derived from older people, local organizations and policymakers, we argue that Neighbors Connected is a high quality program. Therefore, the goal of this chapter is to reflect upon the Neighbors Connected submission to the Dutch quality system.

In Box 7.1, a shortened description is provided of the Neighbors Connected submission to the Dutch quality system. Second, we reflect upon the completion of the submission documentation and open up the discussion about some additional norms that the Dutch quality system might consider adopting.

Box 7.1 Submission Neighbors Connected to the Dutch quality system

Problem description and problem analyses

Old age is on the increase in the Netherlands. According to Statistics Netherlands prognoses, the number of people over the age of 65 will have risen from 14% in 2005 to 22% in 2030 (www.CBS.nl). Ageing significantly affects physical, mental and social well-being, which is partly caused by the fact that the social networks of older people often become smaller (Borglin 2006). Local authorities have responded to the growing ageing population by undertaking action towards the development and implementation of a variety of activities for older people. However, certain groups of older people rarely participate in such activities (Lezwijn *et al.* 2011a; Lezwijn *et al.* 2011b). While this does not necessarily mean that the activity in itself fails to meet the needs of older people, it may indicate that the recruitment method or the circumstances in which the activity has been organized, are not in tune with what this group of older people knows and can handle in their environment (Lezwijn *et al.* 2011a). Possible explanations for the lack of participation in these activities include the following: 1) older people are not familiar with the activity or facility; 2) older people have difficulty recognizing that an activity or facility may be relevant to them; 3) older people feel the challenges are too high to make (independent) use of a provision or activity; 4) older people do not feel that making use of a facility or participating in an activity is important/meaningful for them (Lezwijn *et al.* 2011b).

Research

In order to develop a new intervention for healthy ageing, which would encourage this group to opt for participation, AGORA carried out several types of research and collected a variety of data. This context analysis was undertaken to obtain a broad picture of the local opportunities and the possibilities for change in the participating municipalities (Naaldenberg *et al.* 2008). A number of different research methods involving various stakeholders were used (Vaandrager, Wagemakers and Saan 2010), making it possible to get a clear picture of what 'healthy ageing' means in the local context, prior to selecting the theme and methodology for the promotion of healthy ageing. The following research methodologies were used: 1) an extensive analysis of existing Municipal Health Service data (2005) from a health survey among older people (Croezen *et al.* 2009); 2) interviews with older people, organizations and policy makers relating to healthy ageing, health, activities and working together (Naaldenberg, Lezwijn and Vaandrager 2009; Naaldenberg *et al.* In press; Naaldenberg *et al.* submitted for publication); 3) six discussion meetings with local parties and older people in which the initial results of the interviews and the analyses of the health survey among older people were discussed and where priorities were set towards developing an intervention for healthy ageing (Lezwijn *et al*. 2011a).

Monitoring data show that social participation is an important determinant for healthy ageing (Croezen *et al.* 2009), and international research has equally concluded that social participation has a positive influence on healthy ageing (Richard *et al.* 2009; Utz *et al.* 2002). Monitoring data from the whole of East Netherlands show that roughly 50% of older people in East Netherlands are socially less active. This group assesses its health as less good in comparison with other older people who are socially active (Croezen *et al.* 2009). This was confirmed by AGORA research (Naaldenberg *et al.* In press), which through the analysis of interview data gave insight into the way older people themselves defined ‘healthy ageing’ and what they felt to be important preconditions for healthy ageing. The interviews also revealed that the issue of health as a component of daily life is a major focus point in developing interventions, as is the importance of neighbors, a positive attitude, a better communication, and the lowering of thresholds. Older people often do not sufficiently recognize typical health themes, such as falling, loneliness, or physical activity, as being relevant for their well-being and therefore fail to make use of activities with such themes (Naaldenberg, Lezwijn and Vaandrager 2009; Naaldenberg *et al.* In press). Interventions around a specific theme or subject that are felt to be recognized and relevant to these older people, are more likely to lead to increased participation. When older less socially active people take part in any - yet to be developed – activity, this constitutes a form of social participation. In addition, neighborhood and neighbors play an important role in promoting social participation (Bowling and Gabriel 2007; Croezen 2010; Gabriel and Bowling 2004; Naaldenberg, Lezwijn and Vaandrager 2009; Naaldenberg *et al.* In

press). Putting the focus on socially less active older people by involving socially active older people in the neighborhood, was an important result of the discussion meetings in the municipalities (Lezwijn *et al.* 2011a). Socially active older people tend to know the socially less active in their own neighborhood better than do the professional organizations working there (Laverack 2009). Neighbors often know more about family situations and the social networks in the area. Activities organized by these socially active older people will, therefore, be more in tune with the experiential world of socially less active older people, with their knowledge, needs and possibilities. They are also better able, as neighbors, to interest this group in taking part in an activity. In the Ph.D. thesis by Voorham (2003) the notion of peer education is dealt with at length (Voorham 2003). It includes a number of characteristics that are important not only for peer education, but also in relation to the circumstances within which 'peers' (i.e. neighbors) organize activities that accord with the wishes, knowledge and capabilities of older people within their own environment. These characteristics are: similarity, context and subject (Voorham 2003). International literature shows that social support, when given by 'equals' promotes health (Dennis 2003; Kim 2004), particularly when this support also includes a greater familiarity with an activity (Suls, Martin and Wheeler 2002). Social participation, then, is an important determinant for healthy ageing. Social participation is defined as social interaction with persons other than spouses (Utz *et al.* 2002) and therefore also involves engaging in and building up social relationships. One form of social participation is participation in activities where one meets other people, which affords opportunities for building up or extending the social network. Research results show the importance of the following basic principles with regard to intervention development:

- a positive approach for healthy ageing;
- participation by older people;
- intersectoral action.

Neighbors Connected

Goal

The aims of Neighbors Connected concern the promotion of social participation of socially less active older people, by organizing social activities that are in tune with the SOC and with any resources already in place for older people.

Sub goals

- 10 applications annually, to be submitted and realized by active older people in line with the requirements of Neighbors Connected;

- The recruitment of activities and the circumstances in which those activities take place are to be in tune with the SOC of socially less active older people;
- Barriers, whether physical or psychological, with regard to participation in activities are seen to have been lowered in older people's perception;
- At the end of one year a local infrastructure is to be in place, consisting of at least four organizations and a volunteer organization in support of activities within Neighbors Connected.

Target group: Socially less active older people

Research shows that socially less active older people rate their health less highly in comparison to older people who are socially active (Croezen *et al.* 2009). A socially less active older person is someone aged 65 or older, who does not go out very much, has hardly any role in society, and needs a little extra support. Approximately 50% of older people in East Netherlands are less active in the community. This group comprises many people over the age of 75, many women, people with physical disabilities, people with little or no education, people caring for a partner, and single people (Croezen *et al.* 2009).

Intermediary target group: Socially active older people

Research reveals that socially active older people consider themselves healthier than do socially less active older people (Croezen *et al.* 2009). Approximately 50% of older people in East Netherlands are active in their community. This manifests itself in voluntary work (productively engaged), sports activities (leisure-engaged) and in caring for others, often not a partner (socially engaged caregivers). These socially active older people are mostly aged between 65 and 75 years, and are often more and better educated than the socially less active older people (Croezen *et al.* 2009).

Content

The intervention consists of setting up and organizing activities by socially active older people for socially less active older people within an area or municipality.

If necessary the initiator is to receive support in terms of:

- a financial contribution of no more than €500 to set up the activity;
- practical support from a Community Care worker when starting up and organizing the activity.

A number of conditions must be met to be eligible for the practical and financial support sought within Neighbors Connected. These conditions, derived from the data obtained from the context analysis, have been formulated for Neighbors Connected as follows:

- Activities are aimed at older people who are socially less active. Initiators select participators for the proposed activity;
- All socially less active older people within the neighborhood can participate in the activity;
- The activity is to take place within the neighborhood or surrounding area
- Initiators will organize and implement the activity themselves;
- Initiators are themselves responsible for recruiting socially less active older people;
- A subsidy not exceeding €500 per activity may be applied for;
- Any unused part of the subsidy will be refunded by the initiator.

Neighbors Connected: Theoretical substantiation

Three basic principles with an important bearing on the development of the Neighbors Connected program were derived from the context analysis. These are as follows:

- A positive approach for healthy ageing;
- Participation by older people;
- Intersectoral action.

These three basic principles will be substantiated below.

A positive approach for healthy ageing

In order to secure a positive approach for healthy ageing, use has been made of the theory of 'salutogenesis' (Antonovsky 1996; Eriksson and Lindström 2008; Lindström 2006; Lindström and Eriksson 2005; Lindström and Eriksson 2009). Salutogenesis is a theory which focuses on factors that promote health. Salutogenesis is the opposite of pathogenesis, which focuses on the causes of disease. Nowadays interventions for the promotion of health are often aimed at lowering risk factors and directed mostly at people's behaviour. The interviews revealed that older people do not view the classic 'health themes' (often the negative consequences of ageing) as applying to themselves (Naaldenberg, Lezwijn and Vaandrager 2009; Naaldenberg *et al.* In press). This is significant as older people tend not to want to participate in an activity if they fail to recognize that activity as relevant to themselves. The interviews also showed that older people are unhappy about the often negative tone in media coverage about old age. A positive approach to healthy ageing, therefore, has been opted for. From a salutogenic perspective any intervention must be aimed at supporting older people in a positive way in dealing with ageing within their environment. Social participation and engaging in social relationships are important positively formulated determinants which positively influence healthy ageing. The way older people are recruited for activities organized in the context of

Neighbors Connected and the circumstances in which these activities are to take place are important to participants. Activities, therefore, must be organized in such a way that also those older people who are socially less active can and want to take part in such activities to meet other people.

The concept ‘sense of coherence’ (SOC) is central within salutogenesis. Within Neighbors Connected the SOC is operationalized as 'the confidence people feel in availing themselves of facilities and services, and in participating in activities in a way that promotes their well-being'. There are three dimensions to SOC: comprehensibility, manageability and meaningfulness. Comprehensibility means that people expect to understand a situation and to be able to assess whether a particular situation could be relevant for them. In the context of Neighbors Connected this means that people can get an understanding of the activity beforehand and can assess whether this activity is indeed relevant for them. Manageability concerns people's expectation to have sufficient resources made available to them to enable them to act in any given situation. Within Neighbors Connected this means that older people are able to assess beforehand whether they will manage to cope with possible difficulties when participating in an activity. Meaningfulness indicates that people assess a situation as being meaningful and are thus motivated to actively engage with it. Within Neighbors Connected this means that older people feel motivated to actively participate in an activity. A recently published article by Lezwijn (Lezwijn *et al.* 2011b), indicates that activities for older people in the social and physical environment of older people must come as close as possible to what older people experience as comprehensible, manageable and meaningful (SOC). This implies that when that is the case they are well able to participate in an activity (Lezwijn *et al.* 2011b).

Target group participation

Target group participation is one of the principles of health promotion (Rootman *et al.* 2001; WHO 1986, 2005). The target group, in this case older people, is one of the stakeholders in the development, implementation and evaluation of the intervention Neighbors Connected. By involving older people in Neighbors Connected at various stages and in various ways (by taking part, informing, giving input, decision-making, implementing) (Koelen and van den Ban 2004; Pretty 1995), activities will be more in tune with what older people experience as comprehensible, manageable and meaningful (SOC). The project team of Neighbors Connected 'merely' plays a facilitating role, in that they serve to support the organizers who decide what they themselves want to do and who they want to do it for. In this way the participation of older people is being positively influenced (Wagemakers 2010). The participation ladder conceived by Pretty (1995) consists of seven stages, the top one representing the highest form of participation and the bottom one zero participation. The stages are as follows: 6) self-mobilization; 5) interactive participation; 4) functional

participation; 3) participation through consultation; 2) participation through information; 1) passive participation; and 0) zero participation (Pretty 1995; Wagemakers 2010). The organizers of the activities participate on a different level on Pretty's ladder (1995) than those who are participants in the activities. The Neighbors Connected program contributes to the participation of socially active older people, in that some of the initiators would not have organized an activity outside the Neighbors Connected program. Neighbors Connected is close by, the people in the project team are usually familiar, and financial and practical support is given. The barriers involved in organizing something are therefore significantly lower than if a national organization had to be involved. Moreover, those participating in activities tend to move higher up on the participation level: formerly they would often have declined to participate in this type of activity.

Intersectoral action

Health is influenced by various determinants, not all of which can be properly classed within the health domain. Examples of these determinants are: individual behavioural factors, living and working conditions, social networks and socio-economic factors (Dahlgren and Whitehead 2006). These determinants also influence each other so that a complex process is generated in which different sectors carry responsibility (Koelen, Vaandrager and Wagemakers 2008; Koelen and van den Ban 2004; Saan and de Haes 2005; Vaandrager, Wagemakers and Saan 2010; Wagemakers 2010; Wagemakers *et al.* 2010a). This also applies to healthy ageing (Hansen-Kyle 2005; WHO 2002). Intersectoral cooperation, therefore, is one of the principles of health promotion (Rootman *et al.* 2001; WHO 1986, 2005).

Healthy Ageing can be defined as follows: *'The process of slowing down, physically and cognitively, while resiliently adapting and compensating in order to optimally function and participate in all areas of one's life (physical, cognitive, social and spiritual)'* (Hansen-Kyle 2005). Within Neighbors Connected a number of different sectors work together to facilitate the activities. Community Care workers support the initiator and can contribute, for instance, by asking volunteers to help with the implementation of the activities. The municipality can grant the subsidy to organize the activities. Often this already happens in various forms. Municipal housing corporations, too, can be involved and asked to make available suitable space for an activity in, for example, an assisted living/care home. Neighbors Connected is a project in development. This makes it possible for further partners to join along the way to facilitate active older people with the organization of a project. However, Neighbors Connected can also make a small-scale start with just a Community Care organization and the Municipal Health Service involved. This makes it possible to make a quick start and show others what Neighbors Connected stands for and how it works.

Connecting problem analysis, goal, target group and approach

As neighbors are often closer to socially less active older people than professionals, activities organized by neighbors for socially less active older people will be more in line with the SOC of socially less active older people than activities organized by professional organizations. Socially less active older people are more likely to experience such activities as comprehensible, manageable, and meaningful. The probability that socially less active older people join in, which is one of the forms of social participation, is therefore greater. Such a – frequently positive - experience makes it more likely for someone to join in a next time and this promotes social participation.

Neighbors Connected makes it possible for various different activities to be organized in the area and the choice of possibilities enables socially less active older people to participate in activities that are less challenging and where they can meet other people. Some of these activities fit well within the Community Care already available locally. Other municipalities may well have such activities already in place, organized by volunteers of their own Community Care groups. However, the activities in question are initiated and organized by active older people themselves and are therefore in line with Neighbors Connected. Neighbors Connected, therefore, is not concerned with isolated activities that are being organized, but is about building up an environment in which activities are organized by older people, so that socially less active older people can participate (= social participation).

Working factors and mechanisms

The working factors and mechanisms within the Neighbors Connected program are:

1. The participation of socially active older people to reach out to socially less active older people by organizing activities that are in tune with the SOC of socially less active older people in their neighborhood. Participation barriers are thus lowered because the activities are being organized by people they know. More people are aware of the activities and it is probable that a greater number will join the activity;
2. The practical support extended by Neighbors Connected to the initiators. This reduces the challenges for initiators to organize an activity. People do not have to take action on their own and can get help when they ask for it. Neighbors Connected also regularly get in touch with the initiator to ask about progress and to offer help if appropriate;
3. The financial contribution towards the activity. This makes it possible to organize something, without the initiators having to pay for it themselves. Often these are small amounts and people are usually very creative with the limited finances available to them. Some research has already been undertaken within health promotion concerning the benefit of micro-grants (Hartwig *et al.* 2006; Hartwig *et al.* 2009; Johnson, Smith and Bruemmer 2007; Schmidt *et al.* 2009). This indicates that micro-grants can provide

a useful impulse to realize change in the neighborhood, for example by stimulating community action. However, in the cases cited the micro-grants were available to local organizations and not to community members themselves;

4. The activity takes place in the neighborhood. The participation barriers are lowered because the location where the activity is being organized is familiar among the socially less active older people. In addition, a nearby location also makes it possible for socially less active older people to return home if they are not enjoying themselves. An activity close to home also makes it more likely that older people will meet acquaintances there, which increases the chances of their participating in an activity;
5. The input of the local community care group within Neighbors Connected. They have their local network, both in terms of the organizations and the availability of older people themselves, whereas the Municipal Health Service - as a regional organization - lacks such an extensive network. Optimum use of existing networks is also one of the principles of health promotion;
6. The salutogenesis theory, which is fundamental to the Neighbors Connected program. In adopting this theory two notions are central to the development and implementation of activities: the notion of the individual within his/her own environment (Antonovsky 1996; Eriksson and Lindström 2008; Lindström 2005; Lindström and Eriksson 2006; Lindström and Eriksson 2009), and the individual's response to the relevant activity in terms of comprehensibility, manageability, and meaningfulness. This is in contrast to approaches that focus on specific risk factors for disease (as often happens, for instance, in programs or activities aimed at reducing smoking or encouraging physical activity). The salutogenic theory ensures a holistic view of health, which is also one of the principles of health promotion (WHO 1986, 2005).

Reflection on submitting Neighbors Connected to the Dutch quality system

Box 7.1 has provided a shortened description of the health promotion program Neighbors Connected submitted to the Dutch quality system. In this section, we reflect upon some issues that arose while we were describing the Neighbors Connected program for the quality system.

The first issue related to writing the problem description and analysis. One of the criteria was to use epidemiological data to determine the nature and the prevalence of the problem or the risk for which the described intervention was developed. Neighbors Connected has been developed in a participatory way, with the involvement of older people, local organizations and policymakers. The Neighbors Connected program was not in the first instance developed to tackle problems or risks that arise because the population is ageing, since that was not what

the stakeholders found important. Neighbors Connected was meant to increase opportunities for older people to participate in local activities in their neighborhood. This was a priority that organizations and policymakers, as well as older people themselves, found important. So, to conform with the submission documentation, the problem of an ageing community was briefly elaborated upon in terms of an increase in population density and the importance of social participation for healthy ageing. To describe Neighbors Connected, it was more relevant to describe the contextual data that contributed to the search for opportunities for a healthy ageing program. The contextual data contributed to evidence about how the stakeholders perceive health, what they think contributes to their health and how they think about local activities in their community. Furthermore, information about local stakeholders and existing coordinated action within a municipality was essential for getting insight into local opportunities for a healthy ageing program.

The second issue about describing Neighbors Connected for the submission was to describe the goals and sub goals (preferably Specific Measurable Acceptable Realistic Time bound) of the program. In cases wherein only epidemiological data are used to determine the risks and individual health theory to diminish those risks, formulating goals and sub goals is a logical next step in formulating the problem. However, within Neighbors Connected, in addition to epidemiological evidence, the problem analysis included contextual evidence used to get an insight into the problem and into local opportunities. Those problems and opportunities did not concern individual healthy ageing; however, they did concern contextual factors of existing local health promotion programs and activities. For instance, a group of older people was not taking part in local activities organized by welfare organizations. The organizations experienced difficulties in recruiting less socially active older people, who would probably benefit most from participating in such activities, compared to older people who were more easily recruited. Because the problems and opportunities on which Neighbors Connected is based did not relate to individual health, but to contextual factors of healthy ageing programs, formulating SMART goals was a challenge. Some contextual factors, such as social support, social participation and social cohesion are related to the social environmental level, a less measurable area, but nevertheless essential within health promotion practice (Wagemakers *et al.* 2010b). The formulated sub goals for instance were about the number of activities organized within Neighbors Connected and about the number of partners in an existing network after one year of Neighbors Connected. No sub goals were formulated to improve individual health, because Neighbors Connected was in the first instance developed to search for methods to improve the recruitment of less socially active older people for local activities. Participating in local activities contributes to health (Croezen *et al.* 2009).

The third issue within the description of Neighbors Connected in the submission documentation was about describing the actual program. One of the comments of the expert committee was that the activities organized to improve participants' social participation were not of the quality expected. The critique was that the content of the activity was not

likely to contribute to social participation by individuals. The fact that these activities were organized by socially active older people for their less socially active older neighbors was not perceived as the intervention, whereas that is the critical issue within Neighbors Connected. The main idea of Neighbors Connected is that the context wherein an activity is organized is more important than the content. Neighbors Connected does not interfere in what activities the socially active older people want to organize for their neighbors. Neighbors Connected facilitates initiatives in the neighborhood, so that less socially active older people perceive fewer barriers and are more able to take part in local activities than when those activities are organized by professionals.

In the case of Neighbors Connected, it was possible to work according the principles of health promotion and to do a thorough problem analysis wherein, in addition to epidemiological evidence, contextual evidence derived from interviews with older people, organizations and policymakers was also gathered. Combining the evidence resulted in Neighbors Connected, with a focus on creating inviting and supporting conditions. The organizers of the activity estimate themselves what kind of activity and what subject would be comprehensible, manageable and meaningful for their less socially active older neighbors.

Discussion and conclusion

It was not self-evident that Neighbors Connected met the quality criteria of the Dutch quality system. Within the current Dutch quality system, it is easier to describe an intervention that aims at individual behavior change than to describe a comprehensive health promotion program to promote healthy ageing. This can also be seen within the database of the quality system itself. The majority of the interventions with a quality label are courses to improve, for instance, physical health or to decrease mental problems (www.loketgezondleven.nl) (Brug *et al*. 2010). Overall, the use of theory in practice is promoted because of the quality criteria of the Dutch quality system. Nevertheless, the implementation of programs, building and sustaining coordinated action and recruiting people for local activities require equal attention for innovation.

Such issues are also reflected upon by Hawe, Shiell and Riley (2009), who argue that many health promotion community programs are based too heavily on individual health theory alone. Health promotion is often seen as just a matter of 'aggregating up' (Hawe, Shiell and Riley 2009). The process of building and sustaining coordinated action to be able to organize such interventions, or the process of how interventions fit within the context of daily life, are both processes for which theories can be used to understand and evaluate them. However, such processes are often neglected as part of the evidence base (Potvin *et al*. 2005). In such cases, the importance of the context in health promotion programs is not taken into account. This means that the efforts of all stakeholders, the results of those efforts and the evidence collected during such processes are not made explicit. The reasons for the successful – or unsuccessful –implementation of a health promotion program remain unknown.

Vaandrager *et al*. (2010) recently discussed evidence in health promotion and addressed so-called context-free and context-sensitive evidence (Vaandrager, Wagemakers and Saan 2010). Context-free evidence is the type of evidence striven for in biomedical science. Randomized Controlled Trials (RCT) are seen as the ideal approach to determine evidential value. Context-free evidence is derived from research carried out in a controlled situation and therefore has high internal validity. It is often a causal relationship between an independent variable and a dependent variable that is under study (Green and Glasgow 2006). In contrast, context-sensitive evidence is evidence wherein the context is part of that which is under study. This evidence is mainly about what works and how it is implemented within specific circumstances of local practice (Vaandrager, Wagemakers and Saan 2010). This type of evidence is similar to so-called practice-based evidence and often has high external validity (Green 2006).

Combining evidence, context-free as well as context-sensitive, contributes to the development and implementation of health promotion programs. The evaluation of such interventions requires a combination of research methods to show context-free and context-sensitive outcomes. Both these outcomes can be utilized to build the evidence base of health promotion programs as well as to build health promotion theory.

To conclude, quality systems are important instruments contributing to the improvement of health promotion practice. However, the quality criteria used to qualify health promotion interventions are not in line with the current tendency to use the health promotion principles in practice and include the context when health promotion programs are being developed, implemented and evaluated. For instance, programs such as Neighbors Connected have in practice great potential because of the participation of the community and intersectoral collaboration during all phases of the program. However, these principles of health promotion do not (yet) have a firm place within the quality system of the Dutch recognition system. Organizing health promotion processes within the local context contributes to health outcomes (Koelen and van den Ban 2004; Merzel and D'Afflitti 2003; Saan *et al*. 2010; Wagemakers *et al*. 2010b; Wells 2006), so it would be beneficial for health promotion practice to include the health promotion principles as important criteria within the Dutch quality system.

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8

Looking back; Project planning for healthy ageing in local health promotion practice

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Planning in Dutch health promotion practice, a comprehensive view.

Abstract

Health promotion has a strong tradition of using planning models based on a priori set goals and processes defined by professionals. Those rational models only partly fit with today's view and practice of health promotion, where programs can be considered as processes because they are guided by principles like community participation and intersectoral collaboration.

The aim of this paper is to provide a comprehensive view on approaches to planning in health promotion practice. To investigate approaches to planning, Whittington's typology has been used. Whittington identifies four approaches to planning, i.e. classical, evolutionary, processual, and systemic. In a retrospective multiple case study, we described actual planning processes used in the development and implementation of a healthy ageing program in three Dutch municipalities. These processes were described using data gathered by: interviews, participant observation, document analysis, and external auditing. The four planning approaches were used to interpret the data. In practice, all forms of planning approaches were used, depending on the degree of complexity and dynamics of the context, the phase of the health promotion program, powerful stakeholders, and the available time. Our findings suggest that health promotion practice uses different approaches to planning fitting emergent health promotion practice. However, approaches other than the classical planning approach are not made explicit. Explicit use of complementary approaches may contribute insights into the evolvement of a program that will contribute to the evaluation, the quality assurance, and the accountability of the program.

Introduction

In health promotion practice, planning models like the Precede-Proceed model (Green and Kreuter 2005) and Intervention Mapping (Bartholomew *et al.* 2006) have a firm place. Those models have been developed to guide the professional to identify factors that influence a population's health status or quality of life, support in designing and evaluating interventions, and help to make effective decisions at each phase of the program. In the planning models, roughly five phases are distinguished: problem definition, goal setting, program development, program implementation, and evaluation. The focus is mainly on the content of a program (e.g. a specific topic or lifestyle) and is often formulated in terms of determinants of health and health outcomes or determinants of health-related behavior (Butterfoss 2007; Koelen and Van den Ban 2004; Green and Kreuter 2005; Bartholomew *et al.* 2006; Laverack and Labonte 2000; Wagemakers *et al.* 2010a). Health professionals are academically trained to explicitly use planning models when developing, implementing, and evaluating health promotion programs. In funding schemes, detailed planning is one of the quality criteria to assess programs. The underlying assumption of using such models is that health goals and objectives for health promotion activities can be defined in advance and that a health promotion program needs to be planned in advance.

However, the current definition of health promotion, 'the process of enabling individuals and communities to increase control over, and to improve their health' (WHO 1986, p. 5), but also the current practice of health promotion, challenges stakeholders (i.e. scientists, health professionals, policymakers, the local community, and the target population) to develop, implement, and evaluate health promotion programs in complex contexts (Koelen and Van de Ban 2004; Rootman *et al.* 2001). Together, stakeholders set goals and objectives, and opportunities are addressed in a flexible and tailored way. This means that principles like building and sustaining community participation and intersectoral collaboration, also called coordinated action (Koelen, Vaandrager and Wagemakers 2008), are core approaches because of the changes they can bring about in both the physical and social environment of health (WHO 1986, 2005; Evans *et al.* 2007; Wagemakers *et al.* 2010a). Coordinated action processes are often dynamic and complex, because of stakeholders' different backgrounds, interests, values, perceptions, and knowledge (Boutilier, Mason and Rootman 1997; Butterfoss 2007; Koelen, Vaandrager and Wagemakers 2008; Naaldenberg *et al.* 2009). So, in reality health promotion is a process in which a program gradually develops and is subject to ongoing adaptations and changes that can relate to topics, to partners involved – as partners drop out and new ones join – but also to processes to reach the program goals and objectives.

The problem is that because of the complex, dynamic, and therefore unpredictable circumstances wherein stakeholders participate (Laverack and Labonte 2000; Van Woerkum, Aarts and De Grip 2007; Evans *et al.* 2007), the frequently used planning models, based on means-end planning (Van Woerkum, Aarts and De Grip 2007), do not completely fit. This has not gone unnoticed by the creators of these models, since already several adaptations have been

made to their models, especially regarding the context and external influences. Our assumption is that a more comprehensive view on planning in health promotion practice is needed. Such a comprehensive view also includes planning approaches that do more justice to the dynamics and complexities of the context wherein the health promotion program takes place. Such planning approaches are found in the organizational and management literature. In these sectors, issues have been raised concerning planning and dealing with the unpredictability of markets and environments, and the importance of context and local rules (Mintzberg 1994; Whittington 2001; Leleur 2008; Van Woerkum *et al*. 2007). Consequently, different approaches to planning have come into existence, fitting these emerging practices. One example of a frequently used planning approach is Whittington's typology.

This typology is based on processes of what really happens in practice (Mintzberg 1994) and especially on the dynamic environment of commercial enterprises. Whittington (2001) distinguishes four types of planning approaches: 1) classical, 2) evolutionary, 3) processual, and 4) systemic.

The classical approach to planning, which is the oldest approach and often used in health promotion, presumes a rational process of deliberate calculation and analysis a priori, designed to reach predefined goals and objectives (Whittington 2001). Within a classical planning approach, the context is seen as predictable (Whittington 2001; Boyne *et al.* 2004; Van Woerkum, Aarts and De Grip 2007). The evolutionary approach to planning is a strategy wherein a variety of products, or activities, are developed and offered to beneficiaries. Their reaction is decisive in whether a product is successful and will survive or continue. The processual approach is a stepwise strategy wherein one starts with a promising situation, with a selected useful product or activity. Evaluation of this situation is needed to decide upon the next step. The systemic planning approach assumes a high interdependency between relevant actors in a project, with which relationships have to be developed. When a certain degree of collaboration is established, stakeholders together will formulate specific goals and objectives (Whittington 2001; Wink, Van Woerkum and Renes 2007; Van Woerkum, Aarts and De Grip 2007). It is characteristic of the three latter approaches, in contrast to the classical approach, that at the start of a program, goals and/or planning processes are not yet specified, although the direction is clear. Table 8.1 explicates the differences between the four planning approaches.

In this study, the planning processes with regard to healthy ageing strategies of three Dutch municipalities are analyzed according to the four planning approaches based on Whittington's typology. The aim of this paper is to provide insight into the use of different approaches to planning in health promotion practice. Two research questions are formulated: 1) What planning approaches are actually used in local health promotion practice? and 2) What factors influence the use of a particular planning approach?

First, we describe the methods used to collect and analyze the data. Second, in the results section, we address the planning processes in the three municipalities and interpret them according to the planning approaches derived from Whittingtons' typology. The five phases

Table 8.1 Planning approaches for health promotion practice based on Whittington

Planning approach	Goals to reach	Planning processes
Classical	Predefined by professionals	Predefined by professionals; professionals define the processes to reach the health goals
Evolutionary	Predefined by professionals	Defined during process; variety of products is created. Evaluation of the adoption by community defines success
Processual	Defined during the process possibly in collaboration with stakeholders	Defined during process; after every step evaluation by professional possibly in collaboration with stakeholders, but dependent on reactions after the first step
Systemic	Defined during the process in close collaboration with community	Predefined by professionals; the professionals define the processes to reach coordinated action for health necessary to formulate health goals

of health promotion and the assigned planning approaches within the three municipalities are described. Finally, we reflect upon the actual use of different planning approaches in health promotion practice and the implications for the practice and science of health promotion.

Methods

Setting

The research took place in the academic collaborative AGORA, wherein a university and a community health service collaborate to improve healthy ageing in three municipalities.

Data collection and analysis

In order to describe the planning processes for the development and implementation of the healthy ageing strategy in the three case studies, several data collection methods were used, namely: analysis of interviews, participant observation, document analysis, and external auditing. For a complete overview of the data used, see Table 8.2.

First, the data from 44 semi-structured interviews were used to describe the local situation in the three municipalities. The 44 interviews, 36 of which were conducted by the first author, were held during the summer of 2007 and transcribed verbatim. Originally, these interviews aimed at getting more insight into the coordinated action for healthy ageing that the three municipalities were undertaking at that time and at building relationships with relevant stakeholders. Furthermore, the data available from the interviews could be used to reconstruct the local situation in the municipalities, as a starting point for a new program.

Table 8.2 Overview of data collection methods in the three municipalities

Methods	Data
Interviews	Transcriptions of 44 semi-structured interviews with aldermen, local policy-makers and representatives of organizations in three municipalities. Of these interviews, 36 were conducted by the first author. Mental healthcare: 4 interviews General practitioners: 2 interviews Home care organizations: 4 interviews Volunteer organizations: 4 interviews Wellbeing organizations: 7 interviews Public housing: 5 interviews Care institutions: 3 interviews Aldermen: 3 interviews Municipal policymakers: 11 interviews
Participant observation	Field notes of the first author's formal and informal contacts within three municipalities in 2007 and 2008.
Document analysis	Epe: Agendas and minutes program 'Healthy ageing in Epe' Concept local policy document 'Ageing in Epe' Local policy document 'Local health policy' Berkelland: Evaluation report of 'Pluspunt' (local office window for inhabitants of Berkelland, for questions and facilities concerning care and wellbeing) Zutphen: Report of policymakers 'AGORA in Zutphen' Concept local policy document 'Ageing in Zutphen' Policy document 'Local Health Policy' Minutes of discussion meetings 'Living, wellbeing, and care' with inhabitants of Zutphen organized by Elderly Welfare and municipality
External auditing	3 researchers from AGORA and the Community Health Service not involved in this specific study, but familiar with the healthy ageing project, reflected on the processes in the three municipalities and read drafts of this paper.

Second, participant observation was carried out. To gain insight into the planning process, field notes were compiled of both formal and informal personal contacts of the first author with local stakeholders, and of local group sessions about healthy ageing. The elements described in the field notes were the Who, What, When, Where, Why, and How of actions within the municipality and, when possible, their underlying decisions (Bogdewic 1992). Examples of elements described in the field notes are: Who is involved?, What role do they have?, Why are they involved?, What happens in that municipality?, When does it happen?, Where does it happen? Why does it happen?, and How is the process going?

Third, document analysis was carried out on agendas, minutes of meetings, and local policy documents on healthy ageing strategies. The documents were analyzed using the same elements as Bogdewic (1992) to make local visions on healthy ageing, actions, and (underlying) decisions transparent.

Fourth, an external audit was carried out to examine the accuracy and interpretation of the description of the planning processes (Cohen and Crabtree 2008). Three researchers, who were not involved in this study but were familiar with the healthy ageing project in the three municipalities, commented on drafts of this paper.

Triangulation of the data obtained by the different research methods made it possible to reconstruct some of the actual planning processes in the three municipalities for the years 2007 and 2008. Triangulation contributes to the reliability of the data (Koelen, Vaandrager and Colomér 2001; Cohen and Crabtree 2008).

Finally, the first two authors categorized the described planning processes in terms of the differences between the planning approaches based on Whittington's planning typology.

Results

The planning processes are described using five phases, i.e. problem definition, goal setting, program development, program implementation, and evaluation, to show evolvement in local planning processes (see Table 8.3).

Planning processes in Epe; a classical start

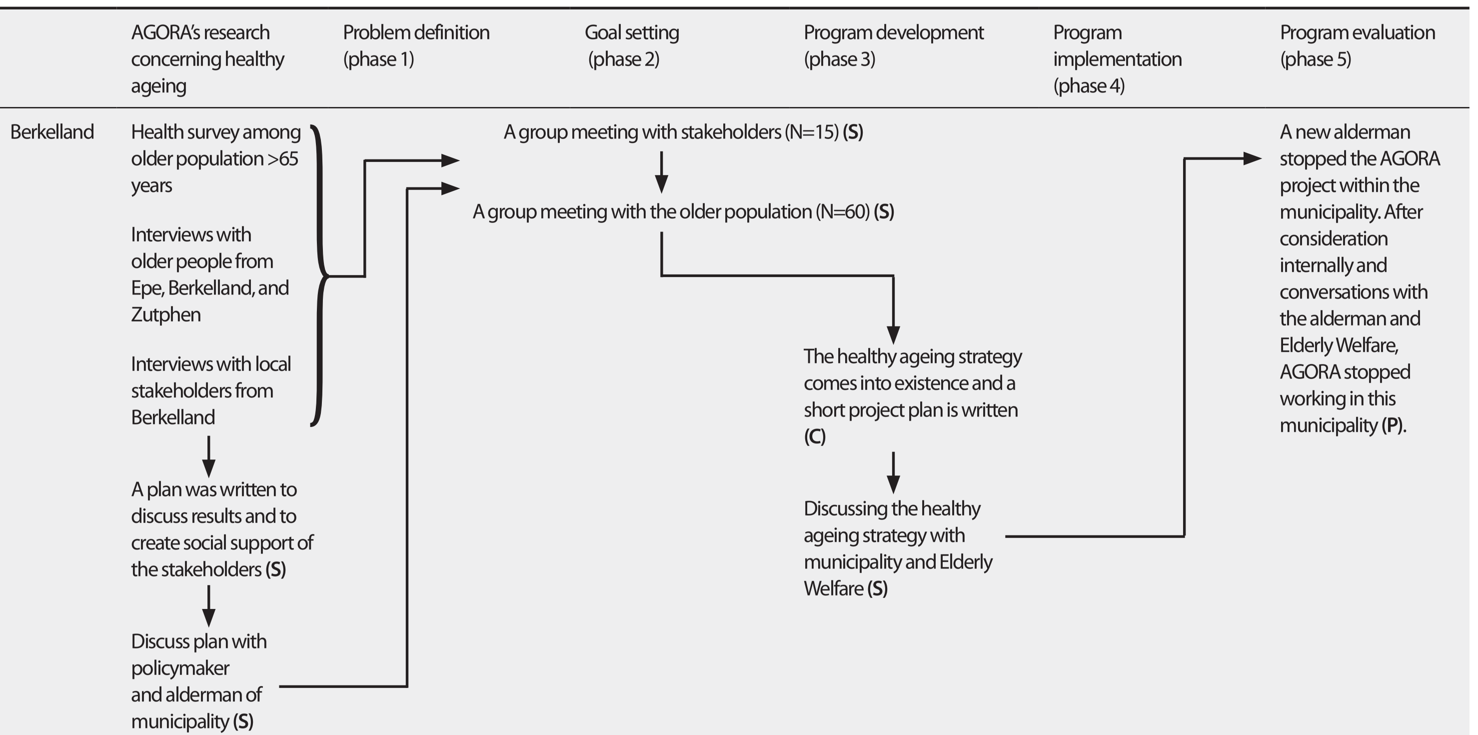
Epe is a rural municipality surrounded by a forested area and consists of four small villages. Until 2007, an active local network in the public field of healthy ageing did not exist, because stakeholders lacked a vision on healthy ageing and consensus on roles and responsibilities within the field of healthy ageing. Two strategies on healthy ageing have now been developed and implemented in Epe. The second strategy, when implemented, was a component of the first strategy.

In 2007, the first strategy was initiated by the community health service and the regional mental health organization. A pilot program on prevention of loneliness was set up, which was in line with national policy (Ministerie van VWS 2006). On the basis of a health survey among the older population (GGD Gelre-IJssel 2006), the two organizations defined the problem and formulated the goal. The goal was to reduce loneliness among non-institutionalized older people aged 65 years or over by 10% in two years, i.e. from a mean score of 2.6 to 2.4 on the De Jong-Gierveld loneliness scale (De Vlaming *et al.* 2010) – a scale frequently used in the Netherlands (De Jong-Gierveld 1987). AGORA was made responsible for the evaluation of the project.

Setting such a specific goal prior to the actual development and implementation of the program can be categorized as a classical approach to planning. Once the goal and objectives on loneliness had been defined, a group session (June 2007) (N=39) was organized to obtain input for the development of the program to reduce loneliness. Participating stakeholders, e.g. local organizations including homecare, Elderly Welfare, women associates, several churches, and representatives of elderly associations, discussed the problem of loneliness and possibilities to prevent and reduce loneliness. Organizing such a group session can be categorized as a systemic

Table 8.3 Planning processes in three municipalities

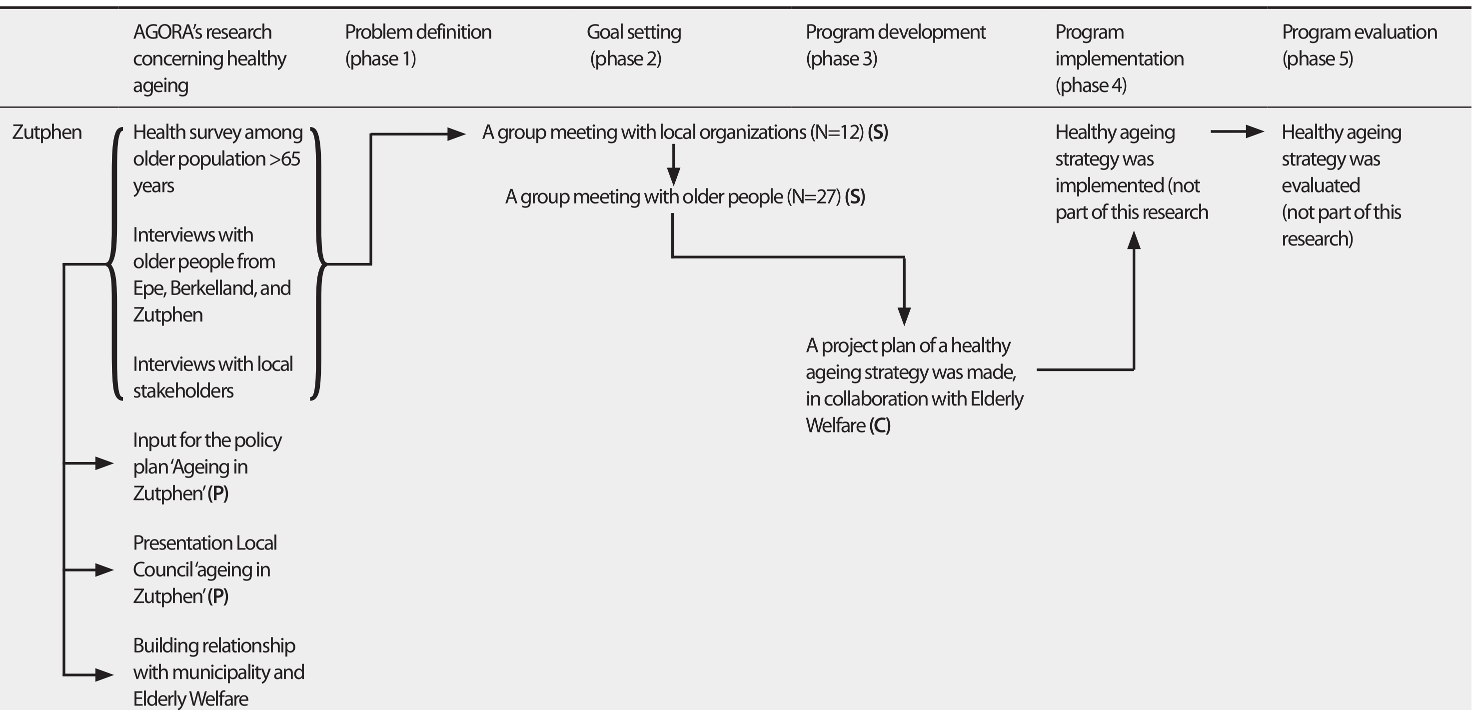
	AGORA's research concerning healthy ageing	Problem definition (phase 1)	Goal setting (phase 2)	Program development (phase 3)	Program implementation (phase 4)	Program evaluation (phase 5)
Epe	Health survey among older population >65 years →	2 organizations start a project to reduce loneliness **(C)** →	2 organizations set goals to reduce loneliness **(C)** →	Group meeting (N=39) is organized to provide input for the development of the program to reduce loneliness **(S)** ↓	The project group starts implementation with (existing) activities under the umbrella of 'Healthy ageing in Epe' **(C)** + **(E)** →	The implementation of some activities does not go according plan. Project group has to reconsider **(P)**
	Interviews with older people from Epe, Berkelland and Zutphen			A project plan was written; different activities for different risk groups for loneliness were scheduled for two years **(C)** + **(E)** ↓		
	Interviews with local stakeholders from Epe			The two organizations complemented with municipality and Elderly Welfare and AGORA (evaluation) form a project group **(S)**		
			Extra project group discussion about goals and objectives for each organization **(S)** ←	Project group discussed opportunities to improve implementation **(S)**		
	Outcomes group sessions Epe, Berkelland, and Zutphen + project plan Zutphen →	Problem definition healthy ageing strategy under the umbrella of 'Healthy ageing in Epe' **(C)** →	Goal setting healthy ageing strategy **(C)** →	Project plan healthy ageing strategy was written in collaboration with Elderly Welfare **(C)** →	Healthy ageing strategy was implemented (not part of this research) →	Healthy ageing strategy was evaluated (not part of this research)



	AGORA's research concerning healthy ageing	Problem definition (phase 1)	Goal setting (phase 2)	Program development (phase 3)	Program implementation (phase 4)	Program evaluation (phase 5)
Berkelland	Health survey among older population >65 years Interviews with older people from Epe, Berkelland, and Zutphen Interviews with local stakeholders from Berkelland A plan was written to discuss results and to create social support of the stakeholders **(S)** Discuss plan with policymaker and alderman of municipality **(S)**		A group meeting with stakeholders (N=15) **(S)** A group meeting with the older population (N=60) **(S)**	The healthy ageing strategy comes into existence and a short project plan is written **(C)** Discussing the healthy ageing strategy with municipality and Elderly Welfare **(S)**		A new alderman stopped the AGORA project within the municipality. After consideration internally and conversations with the alderman and Elderly Welfare, AGORA stopped working in this municipality **(P)**.

Table 8.3 continues on next page

Table 8.3 *Continued*



	AGORA's research concerning healthy ageing	Problem definition (phase 1)	Goal setting (phase 2)	Program development (phase 3)	Program implementation (phase 4)	Program evaluation (phase 5)
Zutphen	Health survey among older population >65 years Interviews with older people from Epe, Berkelland, and Zutphen Interviews with local stakeholders	→	A group meeting with local organizations (N=12) **(S)** ↓ A group meeting with older people (N=27) **(S)** →	A project plan of a healthy ageing strategy was made, in collaboration with Elderly Welfare **(C)** →	Healthy ageing strategy was implemented (not part of this research →	Healthy ageing strategy was evaluated (not part of this research)
	Input for the policy plan 'Ageing in Zutphen' **(P)**					
	Presentation Local Council 'ageing in Zutphen' **(P)**					
	Building relationship with municipality and Elderly Welfare					

(C) = Classical approach to planning; (E) = Evolutionary approach to planning; (P) = Processual approach to planning; (S) = Systemic approach to planning.

approach to planning as it contributes to achieving coordinated action. On the basis of the discussion, the community health service wrote a program plan with specific objectives and accompanying activities. Such a plan can be categorized as a classical approach to planning. The plan entailed the implementation of a variety of new and existing activities, such as courses for older people and intermediaries, health education activities, newspaper articles, posters, and the evaluation of each activity. This can be seen as a form of evolutionary planning.

At the end of 2008, some activities were going according to plan, like for example the publication of articles in local newspapers and the distribution of posters about the program. However, some planned activities, such as the training course for intermediaries, were not successful. Furthermore, most of the courses for older people to prevent and reduce loneliness had to be cancelled because of no interest among the target groups. Although not intended, in the end the successfulness of activities depended on whether or not the stakeholders participated. Consequently, the launch of a variety of activities can be seen as a form of evolutionary planning.

In order to search for new opportunities, the recruitment of target groups was discussed within the project group and decided upon (Wagemakers *et al*. 2010b). The steps undertaken in reaction to cancelled activities can be categorized as a processual approach to planning. Furthermore, during the discussion about recruitment, stakeholders indicated that they perceived the goals and objectives of the program as unclear. In reaction, another discussion session was organized to discuss the goals and objectives of the program 'Healthy ageing in Epe.'

The second healthy ageing strategy in Epe is mainly based on experiences of group sessions in the Berkelland and Zutphen municipalities (Lezwijn *et al*. 2011). The outcome, Neighbors Connected, became one of the activities of 'Healthy ageing in Epe.' Because of the discussions with stakeholders in the other municipalities about opportunities for healthy ageing and a new healthy ageing strategy, the planning processes of Neighbors Connected in Epe moved fast from problem definition to implementation. Such a process resembles a classical approach to planning, because health goals and objectives and the processes by which to reach them had been formulated before implementation in Epe.

The program 'Healthy ageing in Epe' at the start resembles a classical approach. Over time, planning processes evolved to a more processual approach, due to unexpected situations. Systemic approaches to planning are also seen, however not intended to build and sustain coordinated action for health. Evaluation on the initial goal, a 10% reduction on the loneliness scale, still stands, and so this process partly retains the classical approach as a guideline (see Table 8.3).

Planning processes in Berkelland; a systemic start

Berkelland is a large rural municipality formed in 2005 by merging four small municipalities. A new local council was elected and new aldermen were appointed. The alderman for health and the local council were advised by a panel of seniors and former representatives of other municipalities. As those stakeholders had formerly operated in different municipalities, they

did not yet know each other. As a consequence, a vision and policy on healthy ageing had to be developed. The coming of AGORA was seen as an opportunity to support this. AGORA started by formulating a working plan with a predefined strategy to improve coordinated action for healthy ageing. AGORA discussed this strategy with the alderman and local policymakers. The alderman subsequently supported the organization of two group sessions by the local municipal policymaker, Elderly Welfare, and AGORA. In the group sessions for older people (N=60) and the group session for local organizations (N=15), the outcomes of research undertaken in the municipality – i.e. the interviews with older people, organizations, and local policymakers (Naaldenberg *et al*. 2011; Lezwijn *et al.* 2011) and in-depth analyses of monitor data (Croezen *et al*. 2009) – were presented and discussed using techniques from soft systems thinking, such as mind mapping (Trochim and Kane 2005) and stakeholder matrixes (Groot 2002). Issues discussed, like 'what is needed to build a nice neighborhood' and 'opportunities to collaborate', provided input to formulate a problem to work on and goals to reach, and to develop possible healthy ageing strategies.

The process described above resembles a systemic approach to planning, because it started by consciously building relationships with relevant stakeholders to explore opportunities to collaborate. The process in Berkelland was the precursor to formulating a program plan for older people; this resembles a classical approach to planning. Unfortunately, before the plan could be prepared, a new alderman was appointed who decided to stop all AGORA activities abruptly. In reaction, the health professionals of AGORA and their executives made several efforts to convince the new alderman to continue the program, without success. Those efforts can be categorized as a processual approach to planning.

Planning processes in Berkelland mainly resembled a systemic planning approach, wherein local stakeholders actively participated. Still, health promotion is dependent on the political context, as the case in Berkelland shows.

Planning processes in Zutphen; a processual start

Zutphen is an urban municipality. Contrary to the municipalities of Epe and Berkelland, Zutphen already had quite an extensive infrastructure wherein organizations and older inhabitants participated. As there were many formal and informal meetings, coordinated by Elderly Welfare and subsidized by the municipality, stakeholders had a clear view on the different roles and responsibilities of the organizations. Furthermore, the results of the formal meetings about specific subjects in the field of living, welfare, and care were used as input in policymaking.

For AGORA, it was quite complicated to become a stakeholder and to gain a role in the existing infrastructure of healthy ageing. AGORA became step by step a stakeholder by using every opportunity to have contact with stakeholders in Zutphen to present AGORA. This stepwise process to become a legitimate stakeholder resembles a processual approach. After a

while, AGORA, supported by the policymaker and Elderly Welfare, participated in two group sessions, one within the existing network (N=12) and one with some local organizations and older people (N=27). On the basis of experiences of the group sessions in Berkelland, AGORA provided information in order to stimulate discussion on healthy ageing strategies and on ways to recruit older people for local activities. These meetings can be categorized as a systemic approach to planning. The group sessions facilitated local organizations and community members to participate in the development of a healthy ageing strategy and to define the problems, goals, and objectives of a healthy ageing strategy.

In Zutphen, the planning processes initially resembled the processual approach to planning. Gradually, as AGORA became a legitimate stakeholder, a more systemic approach to planning could be identified (see Table 8.3).

Factors influencing the use of certain planning approaches

The results show that in practice the planning approaches proposed in Whittington's (2001) typology are used both alternately and simultaneously. The use of different approaches to planning depends upon several factors. In this study, we identified four factors: 1) the degree of complexity and dynamics of the context, 2) the phase of the health promotion program, 3) powerful stakeholders, and 4) available time. These factors are now discussed.

When the context wherein the programs takes place is overlooked by the health professional, it is more likely that a classical approach will be used, as seen for instance in Epe when the program was being publicized, when health education activities for women associates were being planned and organized, or when training courses for intermediaries were being planned. However, municipalities are often complex and dynamic contexts, especially when many stakeholders are involved. So to build supportive environments for a health promotion program, systemic and processual approaches have to be used to deal with the complexity of the context – for instance, when relationships are being built with relevant stakeholders, as was the case in Berkelland. In Zutphen, AGORA's role and responsibilities within the existing network were not clear from the start. So a processual approach was used to clarify a role and responsibilities for AGORA. In Zutphen and Berkelland, such processes took place before the problem definition phase.

A second factor influencing the type of planning approach used is the phase of the program. A systemic approach is often used in the phases of problem definition, program development, and to a lesser extent goal setting, because of the need for collaboration with stakeholders and community members in these phases. When a classical approach is used during the phases of problem definition, program development, and/or goal setting, during implementation unforeseen circumstances can happen, for instance because there is no interest in the activity among the intended target group. In such cases, it can happen that during implementation local stakeholders are still needed to create opportunities for dealing with

those unforeseen circumstances. Therefore, systemic and processual approaches have to be used to build the coordinated action that is indispensable in complex contexts, as the Epe case also shows. During the program implementation phase, a classical approach is used for timely implementation and evaluation of an activity.

The third factor influencing planning processes are powerful stakeholders – for instance, the lack of support from the new alderman in Berkelland, who is such a powerful stakeholder. He decided to permanently stop collaboration with AGORA, contrary to the former alderman who was very supportive. In reaction to the decision of the new alderman, a processual approach to planning was used – unsuccessfully – to convince the alderman to continue collaboration.

The fourth factor is the available time for health promotion programs. Usually, a program has to be carried out in two to four years. It looks as if the classical approach fits in this time span, as defining goals and processes is rather quickly done by professionals, thus leaving time for the latter phases. However, as the Epe case shows, stakeholders experienced the goals and objectives as unclear, so they had to revert to the goal setting phase, and this was time consuming. In contrast, in the municipalities of Berkelland and Zutphen, coordinated action had been established before the problem definition phase. In this way, support for the program had been built before the content of the program was decided. A positive consequence of such an approach is that the context for which the program is intended becomes more supportive towards the program, although unexpected influences always materialize. A negative consequence of such an approach is that it can take a long time before activities within the community actually start and become visible for the community as well as for politicians. As can be seen in Table 8.3, the newly developed healthy ageing strategy did not reach the implementation phase within two years.

Discussion

In health promotion practice, approaches to planning other than the classical approach are usually not described in program documents. This case study indicates nonetheless that in health promotion practice health professionals, consciously or not, use approaches to planning similar to Whittington's typology. Health professionals only use the classical approach to planning in program documents, as they are trained to do and as required by funding programs. However, the fact that reality is complex has several consequences relating to the evaluation and the evolvement of programs.

Evaluation is often based only on the classical approach to planning, because the complementary approaches are not documented (Wink, Van Woerkum and Renes 2007). This means that processes and in-between results of coordinated action are not reported and therefore are not made visible. Making explicit the complementary approaches to planning results in information on the proceedings of coordinated action and about whether or not a healthy ageing program influences health. Action research can contribute to such insights (e.g.

Koelen, Vaandrager and Colomér 2001; Butterfoss 2006; Nutbeam and Bauman 2006; Rice and Franceschini 2007; Wagemakers *et al*. 2010a) and to the effect evaluation as well. Action research adds to the evaluation of the impact of the healthy ageing strategy on health outcomes.

Insight into the evolvement of a program is stimulated by making the complementary approaches more explicit, within for instance program documents. In such cases, opportunities arise to search for reasons why planning processes in practice evolve in a certain way; this in turn stimulates co-learning and capacity building among the stakeholders (Israel *et al*. 2008). Furthermore, it gives an opportunity to assure the quality of a process by discussing and setting norms with external experts and to reflect upon the planning processes in practice (Wink, Van Woerkum and Renes 2007; Van Woerkum, Aarts and De Grip 2007).

Making the complementary approaches explicit in project documents also creates opportunities for the relevant stakeholders to be held accountable for processes in addition to being accountable for outcomes (Van Woerkum and Aarts, In press). Consequently, this can lead to improved professionalism concerning planning processes in health promotion practice among health promotion professionals and hopefully also among funding agencies.

This study shows that different approaches to planning are used in health promotion practice. In light of the influencing factors discerned in this study, the competence of the health professional is a relevant issue. Since this was not examined in this research, we cannot comment on what competences health professionals need within complex contexts. However, currently it is a frequently discussed issue.

We are aware that the choice of Whittington is quite arbitrary, since his typology was developed in another field. In health promotion, Whittington's typology has previously been used only in the Dutch study by Wink *et al*. (2007). In this study, success criteria and points of improvements of strategies for a national Dutch program were analyzed. Whittington's typology did enabled us to identify meaningful processes in practice contributing to the evolvement of the program in a complex context, which otherwise would not have been identified. So, using Whittington's typology supports theory building to understand health promotion processes within complex contexts. To substantiate the theory however, additional research is necessary.

Conclusion

To conclude, in local health promotion practice, different planning approaches are used. Often the use of a planning approach is a consequence of several factors within health promotion practice, such as 1) the degree of complexity and dynamics of the context, 2) the phase of the health promotion program, 3) powerful stakeholders, and 4) available time. A classical approach to planning, which is often the planning approach described in project documents, alone does not fit the complex, dynamic, and unpredictable circumstances of health promotion.

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9

Discussion; Main conclusions and future directions

Introduction

A recent report on healthy ageing in the Netherlands shows that 95% of people aged 65 years and older live independently. Of all older people, 20% get help or care at home, which is often provided by homecare organizations (Schoemaker and Van der Wilk 2011). More people stay at home, supported by the Social Support Act of 2007 (Tjalma-van den Oudsten *et al*. 2006) and the 'new' Public Health Act of 2008 (WPG 2008), which requires municipalities to develop and implement disease prevention activities and healthcare facilities and to create supportive environments for healthy ageing and participation in society. Thus, Dutch policy appeals to people's own strengths and their personal responsibility for health and healthy ageing.

Healthy ageing is both a complex and an individual issue. It is complex, because healthy ageing is influenced by individual lifestyle factors, and general socio-economic, cultural and environmental factors, such as social and community networks (Dahlgren and Whitehead 2006). Healthy ageing is an individually constructed concept, because each individual decides for him/herself what is meaningful for him or her to age healthily (Bryant, Corbett and Kutner 2001). To promote healthy ageing, it is therefore necessary that the facilities and/or activities not only address individual health, but also issues which are meaningful for older people, and the social and physical environment.

This thesis aims to provide an insight into the process of developing, implementing and evaluating a local healthy ageing program. In three municipalities, responsible for this process are the community health service Gelre-IJssel and Wageningen University, who collaborate in a Dutch academic collaborative called AGORA. The healthy ageing program is strongly informed by the principles of health of promotion (Rootman *et al*. 2001) and the salutogenic approach (Antonovsky 1996; Lindström and Eriksson 2005). The health promotion principles and the salutogenic approach both stress the importance of incorporating older people's perceptions about healthy ageing, the environment wherein older people live and the context wherein the healthy ageing program takes place.

In this chapter, the main conclusions of this thesis are stated, followed by methodological reflections and the contribution of the thesis to health promotion theory and practice.

Main conclusions

Municipalities often have already all kinds of facilities and activities available to prevent disease and to promote the health of their older population. However, the reach of at least some of these facilities and activities is low, which has raised a lot of concern among local organizations. Frail older people in particular did not make use of facilities and did not participate in activities. This means that in new facilities or activities, such as a new healthy ageing program, the recruitment and the involvement of older people merits extra attention. This study showed that it is crucial to incorporate the perceptions of older people. Therefore,

to improve healthy ageing in the municipality, different sectors, including outside the health sector, and older people themselves have to be involved. Coordinated action for health, i.e. intersectoral collaboration and community participation, is needed to develop and implement a new local healthy ageing program.

HP 2.0 framework: making the salutogenic relationship explicit

Coordinated action in a healthy ageing program was not a self-generating process and had to be organized. All participating local stakeholders (local organizations, policymakers and older people) had different views on healthy ageing and had different questions on the development, implementation and evaluation of healthy ageing programs. To be able to structure the discussion about these issues and reach consensus concerning program content, the HP 2.0 framework was developed (Chapter 2) on the basis of a salutogenic approach and the principles of health promotion (see Figure 9.1). Salutogenesis aims to explain why people, despite stressful situations, stay well (Antonovsky 1996; Lindström and Eriksson 2005). A salutogenic approach to healthy ageing searches for determinants or factors that strengthen older people to adapt to and to compensate the consequences of ageing. An important concept within salutogenesis is the sense of coherence (SOC), which is also part of the HP 2.0 framework.

The SOC is about people's confidence to make use of individual and environmental resources, and it offers health promotion professionals the opportunity to incorporate people's perceptions about those resources. Health promotion programs are part of these resources. SOC consists of the dimensions comprehensibility, manageability and meaningfulness (Antonovsky 1996; Lindström and Eriksson 2005).

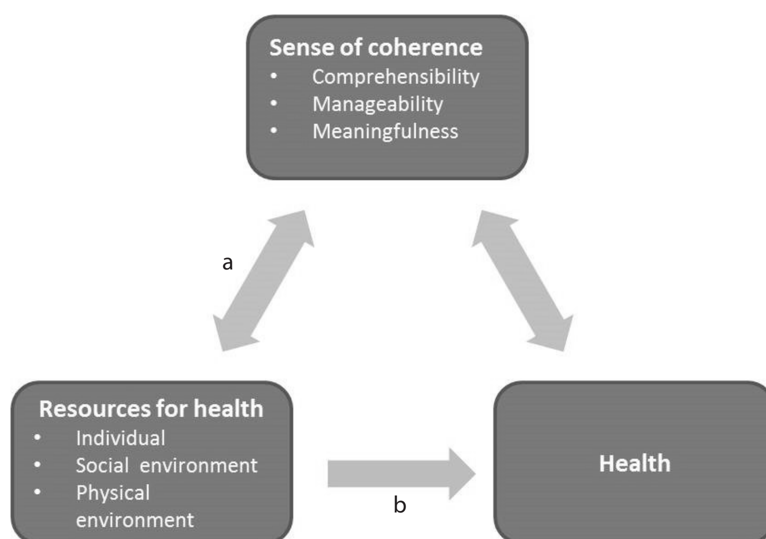

Figure 9.1 The HP 2.0 framework. a = salutogenic relationship; b = logic model/causal relationship.

The HP 2.0 framework visualizes the salutogenic relationship between resources for health and SOC, which is not made explicit elsewhere. This relationship adds a new dimension to health promotion theory, as well as to practice and research.

Up to now, most health promotion programs focus on the relation between resources for health and health. Although a resource in itself has the potential to contribute to health (=logical model/causal relationship), the framework adds that a resource also needs to be perceived as comprehensible, manageable and meaningful. So that targeted groups are able to identify and to actually make use of the resource for health. After all, if older people do not perceive the resource in this way, the resource is not effective and does not contribute to health.

The framework is innovative, because it makes the relationship between resources for health and SOC – the so-called salutogenic relationship – explicit. When applying the HP 2.0 framework, one searches for reasons why people do or do not make use of the resources for health, or in this thesis the healthy ageing program. Furthermore, insight is gained about how to change the resource for health so that it will be perceived as comprehensible, manageable and meaningful (Chapter 6).

To conclude, in practice, the HP 2.0 framework functioned as a basis for discussion on the content of the healthy ageing program with all stakeholders. Consequently, the framework contributed to coordinated action for health.

Coordinated action for health; influencing local health promotion processes

Coordinated action is an autonomous process that has to be organized during all phases of health promotion (problem definition, goal setting, program development, program implementation and program evaluation). The HP 2.0 framework has the ability to facilitate coordinated action for health with regard to the content of a healthy ageing program, since it visualizes relationships on which insight is needed. For the process side, the coordinated action checklist has shown to be a valuable instrument that measures items concerning the suitability of the partners, the tasks of the partners within the program, the relationship between partners, the opportunity and the willingness to grow and the visibility of the partners. The checklist can be used to facilitate and evaluate the process of coordinated action. In one of the municipalities it also proved to be useful to discuss problems and solutions – for instance the problem of not having the right stakeholders involved to recruit older people for activities. After discussion, relevant action could be subsequently undertaken. In addition, the coordinated action checklist contributed to teambuilding (Chapter 4).

In Figure 9.2, coordinated action for health is visualized as a spiral. The spiral reflects the action research cycle of coordinated action. The stakeholders follow the phases of reflection, planning, acting and observing (Wagemakers 2010). The spiral becomes larger when more stakeholders collaborate, and thicker when collaboration becomes more intense.

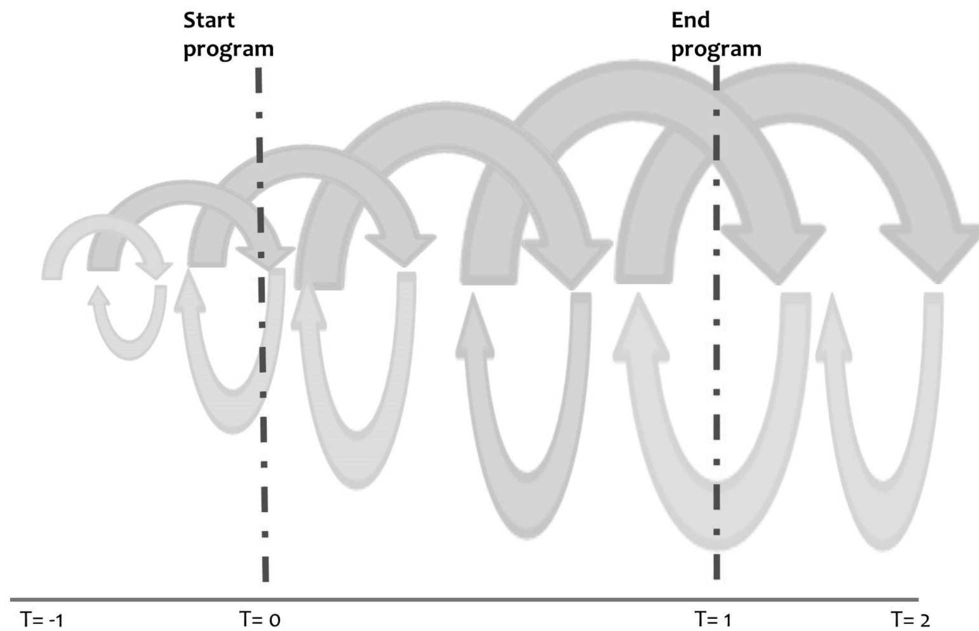

Figure 9.2 Spiral of coordinated action.

Building coordinated action starts at T=-1, from the moment stakeholders meet one another and talk about opportunities for a possible health promotion program (see Chapter 8). The idea develops and relationships between stakeholders grow in tandem with the discussions about opportunities for a health promotion program. This first phase of coordinated action (Figure 9.2; T=-1 – T=0), when relationships and intentions to develop a health promotion program are not yet formalized, has an important influence on the resulting health promotion program (Pluye *et al*. 2005; Wells *et al*. 2006). In this phase the question is answered how to cope with the two main prerequisites to start a health promotion program: representation of relevant stakeholders and discussion with them on aims and objectives (Koelen, Vaandrager and Wagemakers 2008). Those prerequisites need to be achieved before a health promotion program can actually start at T=0.

We discerned that coordinated action differed per municipality (Chapter 3). As a consequence, the effort and the time needed to organize (Figure 9.2; T=-1–T=0) coordinated action for the health promotion program differed as well. In the two municipalities where all stakeholders collaborated to define the aims and objectives, processes evolved smoothly. In another municipality, where aims and objectives were formulated in advance by health promotion professionals, the stakeholders had later to backtrack (to T=-1) to discuss and reach consensus on the aims and objectives (Chapter 8). In one municipality, the process of coordinated action can be categorized as a systemic approach to planning. A systemic approach

to planning stresses the process of organizing coordinated action before aims and objectives are identified (Chapter 8).

In sum, the development, implementation and evaluation of a health promotion program requires coordinated action. Coordinated action has to be achieved before health promotion activities start (T=0). The HP 2.0 framework is a basis for coordinated action as it visualizes the relationships between health, resources for health and SOC and therefore contributes to the content of the program. A systemic approach to planning facilitates coordinated action for health because it stresses the importance of defining aims and objectives in collaboration with local stakeholders. The coordinated action checklist facilitates and evaluates the process of coordinated action as it helps to identify problems and undertake subsequent necessary action.

Combining evidence; essential for healthy promotion programs

Although in different ways, coordinated action was accomplished in all three municipalities. In the process of achieving and sustaining coordinated action, both context-free evidence – such as epidemiological data and scientific literature – and context-sensitive evidence – stemming from interviews with local organizations, policymakers and older people – were combined. This resulted in a healthy ageing program: Neighbors Connected (Chapters 5 and 7). Epidemiological evidence and the scientific literature showed that social participation positively influences healthy ageing, and that neighbors contribute to healthy ageing (Croezen 2010; Bowling and Gabriel 2007). Qualitative data from interviews with older people showed that older people do not recognize facilities or activities with specific health themes, such as loneliness, depression and overweight, as contributing to their health. Older people experience health in the context of their daily lives. For example, people are not lonely, but do find it very pleasant that their neighbors come by to drink a cup of coffee (Naaldenberg *et al*. in press). Organizations stressed the problems that they experienced in reaching the right groups of older people (Chapter 3). In interactive sessions with local stakeholders (see Appendix II), discussions made clear that issues such as happiness, pleasure and convenience contribute to reaching older people for social activities. The sessions also made clear that socially active older people might be better able to approach and recruit less socially active older people in their neighborhood than health professionals or welfare workers might be. The outcome of the discussions resulted in the development of Neighbors Connected. Neighbors Connected is a program, supporting socially active older people by practical and financial support, to organize social activities for their socially less active older neighbors. So, the interactive sessions provided essential knowledge for the program. This knowledge is additional and complementary to the epidemiological data and qualitative data from the interviews (Chapters 5 and 7).

Although it is time consuming to collect, integrate and discuss both context-free and context-sensitive evidence, the benefits outweigh the cost. Combining the different forms of evidence contributed to the sharing of knowledge, co-creation of health promotion programs and to more sustainable changes (Chapter 7). To illustrate, in 2011, Neighbors Connected

is still continuing in one municipality without additional funding. Over a two-year period, more than 20 activities have been organized by active older people. Other municipalities are interested in the program. Oral presentations and poster presentations at national conferences have engendered a willingness to consider this approach as applicable in their situation (Lezwijn *et al.* 2010a; Lezwijn *et al.* 2010b).

To conclude, different forms of evidence are essential and need to be combined to develop, implement and evaluate healthy ageing programs.

Methodological reflection

In this thesis, we opted for an action research approach with qualitative methods to develop, implement and evaluate a healthy ageing program because we were especially interested in how and why health promotion programs work in municipalities. Health promotion is action oriented, takes place in the social and political arena and is often about making social changes within a community to promote health (World Health Organization 1986, 1998). An action research approach fits health promotion practice because it has the ability to facilitate social changes (Minkler and Wallerstein 2008; Stoecker 2008; Wagemakers 2010). Therefore action research fits the dual role of researcher and health promotion professional (Trondsen and Sandaunet 2009; Wagemakers 2010). The qualitative data from our action research were complemented by data gathered in the other three AGORA projects (Croezen 2010; de Vlaming *et al.* 2010; Naaldenberg 2011).

Doing scientifically sound qualitative research needs different verification techniques to improve the internal and external validity, reliability and objectivity of the data (Cohen and Crabtree 2008; Koelen, Vaandrager and Colomér 2001; Silverman 2006; Wagemakers 2010). This is especially the case when the researcher is also the health promotion professional, which, according to others (e.g. Bogdewic 1992), could have consequences for the objectivity of the data. To improve internal validity and reliability, different methods were used: 1) triangulation of methods (Chapters 2, 4, 5, 6 and 8), such as literature review, interviews with local stakeholders, participant check, external auditing and document analysis, 2) triangulation of sources, wherein data from different AGORA projects, and from ageing people, organizations and local policymakers, were analyzed (Chapters 2, 3, 4, 5, 6 and 8) and 3) participant check (Chapters 2, 3 and 5) because results were shared on a regularly basis and discussed with stakeholders (see Appendix II). To improve external validity, multiple cases -three municipalities- were studied and compared on coordinated action and health promotion planning processes (Chapters 3 and 8). To improve the objectivity of the data, ongoing documentation of minutes took place, as also observation of processes and both published and unpublished documents. This documentation gives other researchers the opportunity to transfer our conclusions to other cases.

This study brought the two worlds of health promotion research and practice closer. As such it contributed to the initial idea of Academic Workplaces, to have better linkages between research

and practice. It even intertwined research and practice. Two factors were especially important in bridging the gap, namely 1) the dual role as researcher and as health promotion professional and 2) the action research approach used. First, the dual role of researcher and health promoter provided the opportunity to build relationships with all stakeholders. Such relationships facilitated access to health promotion processes to analyze those processes, and to share and discuss the gained knowledge with stakeholders. This enabled the researcher to uncover relevant health promotion issues that had not been studied in detail so far, like the salutogenic relationship and the first phase of coordinated action for health within health promotion programs.

Second, the action research approach contributed to connecting practice and science. Essential data collection methods were the sharing and discussing of knowledge during the interactive sessions with local stakeholders (Appendix II) and continually making field notes about the processes in the municipalities. Although sharing and discussing knowledge with stakeholders is acknowledged as an essential element of an action approach (Koelen, Vaandrager and Colomér 2001; Koelen and van den Ban 2004; Minkler and Wallerstein 2008; Rice and Franceschini 2007; Springett 2001; Wagemakers 2010), it is often not recognized that data generated in discussion are useful for scientific research. Such data, generated by all stakeholders, contribute not only to understanding the processes for health (Israel *et al*. 2008; Naaldenberg *et al*. 2009), but also to the further implementation of the program. Field notes about what actually happens in practice are useful for scientific research, especially when insights based on the field notes are discussed and reflected upon with stakeholders and when an external audit is carried out. Reflections with stakeholders about for instance 'are we still doing the right thing?' contribute to the evaluation of health promotion programs. An external audit contributes to the quality, accuracy and interpretation of the data (Chapter 8).

This study shows that the quality of action research can be ensured by applying a combination of different verification techniques. Action research approaches contribute that researched issues are relevant to practice and vice versa. The dual role of researcher and health promotion professional results in studying relevant health promotion issues that have not been researched before.

The dual role of researcher and health promotion professional

In this study, in two of the three municipalities, the researcher was also a health promotion professional. This dual role raised a number of questions.

The first question is whether all methods used in action research can be applied by the researcher who is also the health promotion professional. For instance, when collaboration processes are discussed and evaluated, the dual role implicates that this person is supposed as researcher to lead the discussion independently, and as health promotion professional to participate in the discussion, thus having a vested interest. This may lead to conflicts about whether or not this person can be independent.

The second question concerns the competencies that are needed for such a dual role. Competencies for the action researcher are diverse. What is important is that an action researcher is competent to respond to the real and emergent need of stakeholders, to bring stakeholders together and build relationships to support and sustain the program, and has a high level of personal energy to take a proactive stance (Wagemakers 2010). Competencies for health promotion professionals involve dealing with catalyzing change, leadership, assessment, planning, implementation, evaluation, advocacy and partnership, as formulated in the international Galway Consensus Conference Statement (Barry *et al.* 2009). The competencies of both action researcher and health promotion professional are socially driven, which is not typically part of education programs at universities (Wagemakers 2010). Further, it is hard to imagine that all competencies could be united in one person. It is perhaps most important that a person in such a dual role is able to critically reflect upon his or her role in every situation.

The third question is how to deal with a shift in focus in roles over time. At the start of AGORA, the health promotion professional role was most important. In order to develop and implement the healthy ageing program, in the role of health promotion professional, relationships were built and interactive sessions were organized on the basis of data gathered by all AGORA projects. All this resulted in Neighbors Connected. In time, the role of researcher became more dominant as it was required to publish results and write this thesis. As a consequence, relationships with practice could not be sustained, which is important for coordinated action and for continuing the program (Axelsson and Axelsson 2006; Wells *et al.* 2006). For practice, the health promotion professional role ended at a crucial point of time, when Neighbors Connected was not yet a program embedded within the local setting. In one of the municipalities, the consequence was that local stakeholders at that moment did not put much effort into the program anymore. Probably, the reorganizations of both the municipality and the welfare sector were an added reason. In the other municipality, throughout the healthy ageing program, next to the researcher/health promotion professional, a second health promotion professional facilitated the coordinated action process. Therefore, the Neighbors Connected program could continue just as before. So, a coordinator facilitating the process is needed to sustain coordinated action.

In summary, the dual role of researcher and health promotion professional is possible and contributes into gaining insight into processes. However it raises a number of questions relating to independence, competencies required and how to deal with changing roles of researcher and health promotion professional. This study implicates several implications for practice and research, namely 1) both research and practice, need to justify the dual role, 2) health promotion professionals need additional research competences and 3) researchers should become more familiar with challenges of health promotion practice.

The next steps; lessons for theory and practice

In this study, we managed to recruit less socially active older people for a healthy ageing program. This makes our program unique, because many health promotion programs (national and international) face difficulties in the recruitment and participation of the target population (Harting and van Assema 2007; Horstman and Houtepen 2005; Koelen and van den Ban 2004; Merzel and D'Afflitti 2003). One reason is that those health promotion programs stress risk factors and health problems that are not identified or recognized as such by the target group (Horstman and Houtepen 2005; Laverack 2009; Naaldenberg *et al.* in press).

In our healthy ageing program, we added the salutogenic approach and the health promotion principles, we elaborated upon coordinated action in local practice and we used multiple sources for evidence. All this contributes to the theory and practice of health promotion but also raises a number of issues relating to the HP 2.0 framework and coordinated action for health.

HP 2.0 framework

The salutogenic relationship between resources for health and SOC is an innovative approach. In health promotion, the SOC has been used frequently before as an indicator of effect or as an outcome measure (i.e. Bauer et al. 2006; Eriksson and Lindström 2008; Langeland et al.2007; Langeland and Wahl 2009; Lindström and Eriksson 2009; Wainwright et al. 2007), because SOC can be measured by the validated Life Orientation Questionnaire (LOQ) (Antonovsky 1996; Eriksson and Lindström 2005; Hakanen, Feldt and Leskinen 2007; Lindström and Eriksson 2005; Wainwright et al. 2007). Now, for the first time, we have used SOC and its dimensions as input for the development of (new) resources in such a way that people are able to identify and use these resources. Research indicates that different groups of people have different SOC scores (Naaldenberg et al. 2011); this implicates that people with a weak SOC have a harder time identifying and using resources than people with a strong SOC. This also holds true for related concepts, such as empowerment, health literacy, locus of control and coping. Currently these differences in SOC or related concepts are not being taken into account. A variety of health promotion programs are needed for better adjustment to different SOC levels in the target population.

The HP 2.0 framework visualizes the relationships between resources for health, SOC and health, but it does not indicate the strength of those relationships. As SOC can be measured by the LOQ, it is possible to use statistical analysis to determine their strength. The results could be used as indicators in the evaluation of health promotion programs as well.

In this study, we faced difficulties in operationalizing the three SOC dimensions, comprehensibility, manageability and meaningfulness. The dimensions were operationalized in different ways in different studies (Antonovsky 1987, 1996; Ciairano *et al.* 2008; Hubbard, Tester and Downs 2003; Krause 2004; Langeland *et al.* 2007; Langeland and Wahl 2009; Milberg and Strang 2003, 2004; Strang and Strang 2001; Utz *et al.* 2002; Volanen *et al.* 2004; Wolff and Ratner

1999). Further operationalization will be helpful in for example further developing interview items that address SOC to gain insight into coping mechanisms and indicators of success.

In this study, the HP 2.0 framework specifically functioned as a basis for the development, implementation and evaluation of a local healthy ageing program. As the salutogenic approach is also used with regard to nutrition (Bouwman 2009), mental health (Langeland *et al.* 2007; Langeland and Wahl 2009), quality of life (Ekwall, Sivberg and Hallberg 2007; Eriksson, Lindström and Lilja 2007; Moons and Norekvål 2006), families (Löyttyniemi, Virtanen and Rantalaiho 2004; Sagy 1992; Sagy and Antonovsky 2000) and mortality (Surtees *et al.* 2003; Wainwright *et al.* 2007), the framework might also be useful for other population groups and in other settings. For instance, the 'Center for Youth and Families' is a new resource in Dutch municipalities. These centers are intended as low-threshold central information points for parents, children and young people (from infants to 23-year-olds) seeking effective and appropriate support (VWS 2008). It might be worthwhile to use the HP 2.0 framework as a basis to develop the information points in such a way that parents will use this resource when they have questions concerning their children.

In general, the HP 2.0 framework offers a basis for municipalities and other local stakeholders who want to collaborate to improve health. The framework inherently propagates the view that people are active participants in their own life and have a responsibility to live their own life. Resources in the social and physical environment are being developed to support their being able to take this responsibility. This is in line with national and local policy, which aims to support social participation and independent living and to improve self-management (Gezondheidsraad 2005; Ministery of Health 2004; VWS 2008, 2010; Zantinge *et al.* 2011).

Coordinated action for health

This study revealed that coordinated action has to be organized before the aims and objectives of the health promotion program are defined. Then stakeholders also can contribute to discussing and defining aims and objectives. This means that, in practice, health promotion programs have a preliminary phase (Figure 9.2: T=-1 – T=0), which is essential and an autonomous part of the health promotion program (Green 2006; Minkler *et al.* 2003; Saan, De Haes and Vaandrager 2010). However, in many cases, this phase is not recognized or even neglected, both in practice and research. Subsequently, evaluation reports and papers report findings from the moment the program formally starts (often when activities start) to the moment the program ends (T=0 – T=1), but do not report about processes before T=0 and after T=1. As a consequence, coordinated action is not evaluated under all relevant headings. Evaluation of the phase before T=0 provides insight into why a program is successful or not. The phase after T=1 contributes to insight into spin-offs from the program, such as new programs, and into factors that contribute to program sustainability.

Although in the first place coordinated action requires commitment from all stakeholders (Koelen, Vaandrager and Wagemakers 2008; Roussos and Fawcett 2000; Axelsson and Axelsson

2006; Butterfoss 2007; Merzel and D'Afflitti 2003; Saan *et al*. 2010; Wagemakers 2010), coordinated action, especially the preliminary phase, is also a process for which time and funding is required. For instance concerning time: when a program at the very beginning does not include the target population in the development of a health promotion program, it can happen that, later on, the inclusion of the target population's perception has to be arranged. As a consequence, the actual program (T=0) starts later than originally planned and, consequently, there is insufficient time to achieve the goals formulated at T=1, and this may lead to the unjustified conclusion that the program has not proven to be effective.

Since stakeholders are often not funded to participate in coordinated action they are also not held accountable to their superiors or funding agencies concerning their contribution to achieving and sustaining coordinated action as well (Crisp, Swerissen and Duckett 2000). If stakeholders are held accountable, it contributes to make processes explicit. They can be held accountable for the quality of the decisions made while achieving and sustaining coordinated action, because such decisions influence the course of the program. Such decisions must be made explicit and open for deliberation between the stakeholders (Daniels 2000). Van Woerkum and Aarts (in press) refer to this form of accountability as decisional accountability.

Action research can contribute to decisional accountability because it makes processes and actions that actually happen explicit (e.g. Butterfoss 2006; Koelen, Vaandrager and Colomér 2001; Rice and Franceschini 2007; Wagemakers *et al*. 2010b). Monitoring, documentation and reflection with others, inside and outside the program, upon health promotion processes contribute to the evaluation of coordinated action, to the negotiation of the steps needed to continue (Boutilier, Mason and Rootman 1997; Butterfoss 2007; Fleming 2007; McQueen and Jones 2007; Parish 2001; Van Woerkum, Aarts and de Grip 2007) and to learning processes (Horstman and Houtepen 2005; Minkler and Wallerstein 2008; Wagemakers 2010).

The methods described – documenting, monitoring, reflecting – can be applied in health promotion practice, as they are already part of the daily work of health promotion professionals. However, these are not treated as relevant data for the evaluation of a health promotion program. To secure this form of evaluation in practice, it is recommended that data, for instance of field notes, will be collected systematically and that moments of reflection with others should be deliberately planned in advance and valued by the group members. Furthermore, different theories, models and instruments can be used in health promotion practice to achieve and sustain coordinated action. Examples include the coordinated action checklist (Koelen, Vaandrager and Wagemakers 2008; Wagemakers *et al*. 2010a), the Diagnosis of Sustainable Collaboration model (DISC) (Leurs *et al*. 2008), the Community Coalition Action Theory model (CCAT model) (Butterfoss 2006) and Axelsson and Axelsson's (2006) conceptual framework for collaboration in public health. Using such devices contributes to making processes visible by acknowledging coordinated action as an autonomous process within the health promotion program, even during the preliminary phase when aims and objectives are being formulated.

As far as research is concerned, one main challenge emanates from this study, that is, to

appreciate the value of different forms of evidence. Coordinated action provides the opportunity to combine context-free and context-sensitive evidence, so insight can be gained into health problems and into local opportunities for change (Green 2006; McQueen 2007; Naaldenberg *et al.* 2008; Potvin *et al.* 2005; Vaandrager, Wagemakers and Saan 2010). Since programs which are developed in a participatory way, are mainly based on context-sensitive evidence, it would be useful to study how the successful mechanisms can be translated to other health promotion practices.

To conclude

Within this study the co- creation of a local health promotion program was described and analysed. The results illustrated the added value of a health promotion professional as a coordinator and facilitator of health promotion processes. Traditionally, the expertise of health promotion professionals mainly focuses on the development of interventions. Recently, this role increasingly includes the coordination and facilitation of local processes and collaboration with 'new' partners in order to facilitate the co-creation of health promotion programs. This role also changes the place of the health promotion professional within local practice. Health promotion takes place there where people live and work. Health promotion professionals have to collaborate with people, who are expert of their own health. Changing roles changes the way in which the results of efforts can be made visible. It is not about health outcomes alone, it is also about the processes that lead to the health outcomes.

This thesis contributed to the understanding of the changing role of the health promotion professional from developer to a facilitator of health promotion programs.

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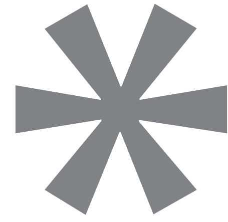


Appendix I
Newspaper clippings as used in Chapter 3

Newspaper clipping

Translation of title

Berkelland municipality

Ouderen in Berkelland bundelen hun krachten

Door onze verslaggever

EIBERGEN - In de nieuwe gemeente Berkelland is ongeveer 30 procent van de inwoners ouder dan 55 jaar. Om de belangen van deze bijna 15.000 ouderen bij het nieuwe gemeentebestuur te behartigen, wordt er een speciale seniorenraad opgericht. 'Zo kunnen ze niet meer om ons heen.'

Als er in Berkelland een politieke partij voor ouderen was opgericht, zou dit met een achterban van 15.000 mensen in één klap de grootste machtsfactor in de gemeenteraad zijn geweest. "Inderdaad", lacht Joop Kolijn. "Maar een politieke partij oprichten is niet ons doel. Al willen we wel invloed uitoefenen op het nieuwe gemeentebestuur."

Seniors in the Berkelland municipality join forces

Oldtimers toeren met ouderen door regio

EIBERGEN - Een stoet van zo'n honderd oldtimers toert zondagmorgen door de regio. De oude auto's maken een rondrit van 55 kilometer met zeventig-plussers uit Berkelland. Dit ter ere van de eerste ouderendag, die in wandelpark De Maat in Eibergen wordt gehouden.

Old-timer cars tour organized for senior citizens

Project 'sleept' senior huis uit

Project 'drags' seniors out of their homes

EIBERGEN - De gemeente Berkelland gaat een 'vitaliteitscentrum' opzetten, een bureau om vereenzaamde senioren een zinvolle dagbesteding te geven.

Uit onderzoek blijkt namelijk dat bijna de helft van de Berkellandse ouderen thuis zit weg te kwijnen achter de geraniums. Het centrum moet daar een einde aan maken, door met ouderen te praten, hen een medische keuring te geven en uit te zoeken waar problemen zijn. Daarna kunnen de ouderen gekoppeld worden aan vrijwilligerswerk of aan andere activiteiten.

Voorlichting ouderen

Senior education (home information projects)

BORCULO - Volgens de gemeente Berkelland weten veel senioren niet van welke voorzieningen en regelingen zij gebruik kunnen maken. Daarom belt de gemeente samen met de welzijnsorganisaties Het Hof en Animo de ouderen op om hen op de verschillende regelingen te wijzen. Onder het motto 'kleine moeite, groot plezier' bieden zij de senioren aan op bezoek te komen, om de regelingen en voorzieningen toe te lichten. Een groep van dertig vrijwillige voorlichters is deze week begonnen met het bellen van ongeveer zeshonderd ouderen. De vrijwilligers zullen zaken die tijdens een huisbezoek aan de orde komen, niet met anderen bespreken.

Voorkomen van valpartijen bij ouderen thuis

door RUDI HOFMAN

25 JANUARI 2005 - LOCHEM/GORSSEL - Senioren in de gemeenten Lochem en Bathmen kunnen vanaf februari de valrisico's in huis laten inventariseren. Speciaal hiervoor getrainde vrijwillige veiligheids-adviseurs leggen op aanvraag een huisbezoek af, bekijken de risico's en komen met adviezen om valpartijen te voorkomen.

Prevent falling incidents at home

Rijvaardigheidstest 50-plussers

Van een van onze verslaggevers

5 oktober 2005 – LOCHEM – Senioren van vijftig jaar en ouder kunnen donderdag 10 november in Lochem weer hun rijvaardigheid bewijzen. Stichting welzijn ouderen Lochem en omstreken en verkeersveiligheidsorganisatie 3VO houden gezamenlijk rijvaardigheidstesten.

Driving instructions for senior

Consultatiebureaus voor ouderen

Uit onderzoek van de Vrije Universiteit Amsterdam blijkt dat mensen boven de vijftig ongezonder leven dan tien jaar geleden. Ze drinken meer, bewegen minder en zijn te zwaar. Vijftigplussers hebben door hun ongezonde leefstijl en grotere kans op levensbedreigende ziektes als kanker, diabetes en hartkwalen. Vaak blijken ouderen zich niet bewust van de gezondheidsrisico's. Door regelmatige gezondheidscontroles en adviezen over een gezonde leefstijl kunnen gezondheidsproblemen bij ouderen voorkomen worden. Dit kan op een consultatiebureau voor ouderen.

Information bureau for seniors opened

Epe municipality

Stichting stopt met uitgave De Wegwijzer

EPE - Stichting Welzijn Ouderen Epe (SWO/E) stopt met het uitgeven van het informatieboekje 'De Wegwijzer'. De gemeente heeft besloten de subsidie stop te zetten en in eigen beheer een informatiegids voor ouderen uit te geven.

Publication of senior information guide gets cancelled

Ouderen willen zich maar niet melden voor valcursus

EPE - Ouderen vinden het kennelijk heel moeilijk om toe te geven dat zij vallen of kunnen vallen. Dat concludeert Linda Seinstra van de Stichting Welzijn Ouderen Epe, omdat bijna niemand zich opgeeft voor de 'valcursus' In Balans die de SWOE organiseert.

Seniors don't apply to course aimed at prevention of falling incidents

Kookcursus

Piepers jassen en koken en pureren, groente wassen, snijden en koken en vlees bakken en braden. Voor de meeste deelnemers aan de kookcursus voor mannen van de Stichting Welzijn Ouderen Epe is dat hocus - pocus. Docente H. Vijge wil het ze in acht lessen, die worden gegeven in trainingscentrum Woldyne aan de Oenerweg in Epe, leren. Na de les mogen ze proeven of het gelukt is.

Cooking classes

Hulp bij invullen belastingaangifte

EPE - Mensen die wat hulp nodig hebben bij het invullen van de belastingformulieren en geen gebruik kunnen maken van een accountant of boekhouder, kunnen in Epe en Vaassen terecht bij belastingspreekuren van de Stichting Welzijn Ouderen.

Administrative help provided

Gesprekskring zoekt leden

EPE – De Stichting Welzijn Ouderen (SWO/E) heeft een gesprekskring waarin uiteenlopende onderwerpen ter tafel worden besproken.

Conversational group in search for new members

Massale deelname preventief huisbezoek

31 MAART 2006 - EPE - Ouderen in de gemeente Epe hebben massaal deelgenomen aan een onderzoek naar wonen, welzijn en zorg. Het onderzoek werd uitgevoerd door de Stichting Welzijn Ouderen Epe. Doel ervan was inzicht te krijgen in de wensen en behoeften van senioren en anderzijds de ouderen te wijzen op mogelijkheden rond dienst- en hulpverlening.

Massive participation in home–information projects

Ouderen mogen hun rijbewijs opwaarderen

EPE - Verkeersschool De Weerd en de Stichting Welzijn Ouderen (SWO/E) stellen senioren in de gelegenheid het rijbewijs op te waarderen.

Seniors refresh their driving skills

Zutphen municipality

Tentoonstelling toont valkuilen voor ouderen

ZUTPHEN - ‘Halt U Valt’ is de naam van de tentoonstelling die op woensdag 18 en donderdag 19 april te zien is in Warnsveld en Zutphen. De organisatie is in handen van de vier lokale ouderenbonden.

Exhibition focuses on hazards that cause falling incidents

Rijvaardigheidsritten 50+

Veilig verkeer Nederland afdeling Zutphen/Warnsveld organiseert voor de 15e keer, in samenwerking met de Stichting Born Zutphen, Stichting Bevorderen Welzijn Ouderen Warnsveld, Pearl opticiens en Beter Horen de jaarlijkse senioren rijvaardigheidsritten op woensdag 28 maart 2007 vanaf De Hanzehof in Zutphen.

Deze ritten worden voorafgegaan door een voorlichtingsavond op dinsdagavond 27 maart 2007. Daar worden verkeerssituaties, verkeersregels en tekens in Zutphen en Warnsveld uitgebreid toegelicht.

De kosten bedragen 15 euro pp. Verder kan men tevens voor of na de ritten in De Hanzehof schilderijen en foto’s over oud Zutphen bekijken.

Driving skills

Cursussen en Activiteiten Centrum De Born

Maandag	Yoga
Dinsdag	Engels Kegelen (2x per maand in De Hanzehof) Tennissen (bij Hotel Intell)
Woensdag	Geheugentraining Meer bewegen voor allochtone vrouwen
Donderdag	Meer bewegen voor ouderen Bridgeclub TOP Engels Sjoelclub
Vrijdag	Engels Volksdansen Tekenen en Schilderen Uit de put Vrij internetten (bij abonnement)

Courses and activities at Born social centre

Hulp bij invullen aangifte inkomstenbelasting

In februari/maart zullen nieuwe “verzoeken” tot het doen van aangifte inkomstenbelasting weer in de bus vallen.

Zoals ieder jaar staan de belastinginvullers van de Ouderenbonden weer voor u klaar.

Vanaf 1 februari a.s. kunt u zich telefonisch melden bij één van de onderstaande heren.

De belastinginvullers werken voor alle leden dus u mag bellen wie u wilt; én -zij komen bij u thuis!

Administrative help provided

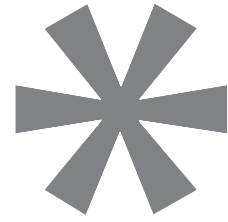
Informatiepunt Zutphen Online!

Door webmaster Born

Maandag 12 maart j.l. hebben MEE-Oost Gelderland, Stichting Welzijnswerk Zutphen, Stichting Bevordering Welzijn Ouderen (SBWO, Warnsveld) en Born Ouderenwerk in Centrum de Born de website Informatiepunt Zutphen gelanceerd.

Wat is het Informatiepunt Zutphen
Het Informatiepunt Zutphen is een digitaal informatiesysteem voor jongeren, ouderen en mensen met een beperking. Informatie over regelingen en voorzieningen in Zutphen kan op een eenvoudige manier worden opgezocht.

Informationguide Zutphen online available



Appendix II
Interactive sessions within the municipalities

	Method used by AGORA	Participants	Outcomes
Municipality of Berkelland			
March 18, 2008 Interactive sessions stakeholders, Organized by municipality and AGORA	Presentation results of the interviews Stakeholder matrixes ▪ Influence and importance matrix ▪ Perception matrix ▪ Objectives matrix ▪ Role matrix ▪ Pluspunt (local office window for questions and services about health and welfare)	15 local stakeholders: e.g. home care organization, welfare organization, apartments building for older people, regional organization for people with limitations, sports federation, counsel representing seniors, local library, union of volunteers, churches, political party representatives.	▪ Tasks, roles and responsibilities of stakeholders have similarities ▪ Stakeholders want to improve collaboration ▪ Stakeholders want to better adjust their activities and facilities to the needs and the perceptions of the older people. ▪ Pluspunten are seen as a suitable vehicle to spread information of the organizations
April 24, 2008 Interactive sessions with older people, Organized by municipality, Elderly welfare and AGORA	Presentation results of the interviews Rich Pictures: ▪ Neighborhood ▪ Pluspunt	Approx. 60 older individuals, some of them representing organizations such as: volunteering organizations, churches, union of farmer women and residence for older people	A nice neighborhood is: ▪ Take care of each other ▪ A place for young and old people ▪ Green and clean, ▪ Accessible for people with limitations ▪ Sociable Important for Pluspunt: ▪ Telling your story once ▪ Support in increasing/improving social contacts; ▪ Contact with general practioner deserves special attention.
June 5, 2008 Meeting coordinating stakeholders of Pluspunt (municipality and Welfare organization)	Short introduction of AGORA and results from sessions March 18 and April 24. First ideas around Neighbors Connected in combination with Pluspunt are spread.	6 stakeholders from the municipality (policy) and the main welfare organization.	Continuation of project Neighbors Connected, linked with Pluspunt

Municipality of Epe			
June 22, 2007 Round Table Meeting 1 for interested people (older people and other stakeholders), Organized by the municipality, community health service and mental health organization	Short presentation results interviews Interactive policy development (IB-sessie) to determine solutions for loneliness among older people in Epe	28 local stakeholders e.g. association for older people, home care client counsel, churches, mental health organization, women associates, elderly welfare, housing	▪ A lot of facilities and services for older people already exist in Epe ▪ Improve information about welfare work, services and activities ▪ Improve signaling loneliness among volunteers and health professionals ▪ Central office window for information, services and activities
June 13, 2008 Round Table Meeting 2 for interested people (older people and other stakeholders), organized by project group 'healthy ageing' and AGORA	Presentation results (interviews and epidemiological data) Rich Pictures ▪ Less loneliness is more…? ▪ All initiatives contribute to more…?	39 local stakeholders e.g. churches, home care organizations, social work, volunteering organizations, municipality, elderly welfare, mental health organization, women associates and housing	▪ Important to bring the (existing) activities/ facilities close to the older people. It is not about what to do, but it is about doing something. ▪ Taking care of each other is important ▪ Improve recognition of activities / services / facilities as part of a large program
June 12, 2009 Round Table Meeting 3 for interested people, organized by project group 'healthy ageing' and AGORA	Presentation of AGORA and municipality to discuss the results of AGORA in relation to policy plan 'Ageing in Epe' Introduction Neighbors Connected	25 local stakeholders e.g. churches, home care organizations, social work, volunteering organizations, municipality, elderly welfare, mental health organization, women associates and housing	▪ Social support Neighbors Connected ▪ Input policy plan 'Ageing in Epe'

Table continues on next page

Table – continued

	Method used by AGORA	Participants	Outcomes
Municipality of Zutphen			
October 8, 2007 Meeting with policymakers of different policy area's for input for the policy plan 'Ageing in Zutphen', organized by municipality	Community health service: presentation results health survey AGORA: presentation first results interviews	12 policymakers representing different policy areas: health, wellbeing, local infrastructure, housing, sport and environment	▪ Input for policy plan 'ageing in Zutphen' ▪ Familiarity AGORA
March 13, 2008 Meeting of the Local counsel about ageing in Zutphen	Presentation about results of interviews and extra analyses of healthy survey	Approximately 40 local stakeholders	▪ Social support project ▪ Familiarity of AGORA in Zutphen
October 2, 2008 Network 'A vital Zutphen', organized by Elderly welfare, as one of their regular tasks. AGORA initiated to do a presentation	An interactive presentation about the results of the interviews and the epidemiological data. During the presentation the present stakeholders discussed the results by means of questions our side.	20 local stakeholders: e.g. municipality, elderly welfare, welfare organization, public and senior housing	▪ Social support ▪ Familiarity of AGORA in Zutphen ▪ Building relationships ▪ Participant check

November 12, 2008 WWZ-panel (civilians panel about: living, welfare and care to advise policymakers) 'Health, Challenge and Involvement', organized by elderly welfare, as one of their regular tasks. AGORA initiated to do a presentation	An interactive presentation about the results of the interviews and epidemiological data. Concerning activities, social contacts and environment: ▪ Health in daily life is... ▪ Enjoyment in daily life is... ▪ Convenience/ease in daily life is... ▪ Ordinary in daily life is... ▪ Happiness in daily life is... ▪ Sociability in daily life is... (Saan and De Haes, 2005)	30 local citizens	Older people perceive activities, social contacts and environment and the support they possible need, differently Involvement of older people when developing support is necessary Important when giving support: ▪ Close by (invited by people (e.g. neighbors), community building, together) ▪ Concrete (meetings on fixed moments, make clear what expectations are for volunteering work)
April 20, 2009 Meeting with policymakers of different policy area's to discuss about the concept policy plan, organized by the municipality and AGORA	An interactive presentation about the results of on-going research within AGORA in relation to issues within the policy plan 'Ageing in Zutphen'.	8 local stakeholders: local policymakers of the municipality representing different policy area's (older people, sport, wellbeing and health, housing), community health service and a consultant agency	▪ Social support project AGORA ▪ Building relationship ▪ Input policy plan 'ageing in Zutphen ▪ Involvement application Grant province of Gelderland 'Thuisgeven in Gelderland'

Summary

Summary

The increase in the ageing population in the Netherlands is having an impact on national as well as on local health policy. Municipalities have been made responsible for preventive healthcare and for creating supportive environments to enable older people to participate in society to contribute to healthy ageing. For municipalities and local organizations, improving healthy ageing is a complex issue, since it is influenced by individual lifestyle, social and environmental factors. Besides, healthy ageing is also an individually constructed concept, meaning that each individual has different needs to age healthily. Developing local healthy ageing programs is therefore a challenge.

This thesis elaborates upon the process of development, implementation and evaluation of local health promotion programs. The health promotion principles and the salutogenic approach provide the underlying framework and stress the importance of including both the context wherein people live and the perception of older people themselves. The process of development, implementation and evaluation took place in three municipalities, who collaborate with a community health service and a university in a Dutch academic collaborative called AGORA.

HP 2.0 framework

Since intersectoral collaboration and community participation, the so-called coordinated action for health, are not self-generating processes, in **Chapter 2** the HP 2.0 framework has been developed to facilitate discussions concerning the content of healthy ageing program. The HP 2.0 framework makes the salutogenic relationship between 'resources for health' and 'sense of coherence' (SOC, including the dimensions of comprehensibility, manageability and meaningfulness) explicit, in addition to the relationship between 'resources for health' and 'health.' The HP 2.0 framework shows that when 'resources for health' are adapted to the 'SOC,' older people are more likely to identify and make use of the resources for health. For local organizations this is a relevant issue, because recruitment among certain groups of older people, especially the frail older people, is often found to be a problem.

Coordinated action for health

To develop and implement a local healthy ageing program, coordinated action for health is necessary to improve the salutogenic relationship to adapt resources for health to older people's SOC. Coordinated action supports creating a shared knowledge base to enable the co- creation of a healthy ageing program. In **Chapter 3**, the extent to which coordinated action is achieved and sustained is analyzed by a case study in three municipalities. The extent of coordinated action differs between, whereas in one municipality organizations are familiar with each other and meet on a regular basis. In another municipality local organizations do not know each other,

due to extensive reforms in the municipality. Furthermore, the prerequisites and challenges involved in building coordinated action are described. One of the challenges for instance is that, within each municipality and for each program, coordinated action should become an explicit issue. Then stakeholders can be facilitated by their subsidizers with prerequisites, such as time and finance, and possibly altered working routines as well. As a consequence, stakeholders should be held accountable for such collaboration processes.

Chapter 4 introduces a tool that can be used to increase accountability. The coordinated action checklist, and a discussion with stakeholders after completion of the checklist, evaluates processes of coordinated action. In addition to the possibility of evaluating processes, the coordinated action checklist contributes to facilitating processes, since the discussion afterwards reveals strengths, weaknesses and corresponding reasons, so that new improvements can be discussed as well.

Collaborating with older people, organizations and local policymakers provides the opportunity to combine different forms of evidence, as described in **Chapter 5**. Evidence from interviews with older people, organizations and local policymakers and the results of a health survey among older people were discussed in six group meetings and contributed to the evidence base of the newly developed healthy ageing program. Therefore, the whole process of involving older people, organizations and policymakers in the development contributed to building supportive environments to implement and possibly also embed the new healthy ageing program, Neighbors Connected. Neighbors Connected is a program, supporting socially active older people by practical and financial support, to organize social activities for their socially less active older neighbors.

Combining evidence

Chapter 6 identifies elements of healthy ageing programs that contribute to the recruitment of older people to participate in the activity. These elements are 1) personal contact with organizers, 2) social support, 3) proximity and easy access, and 4) opportunities for social contact and learning to make the activity more comprehensible, manageable and meaningful to older people, so that they are more likely to participate. The elements found show that, for older people, the environment and the context in which activities are organized are as important as the content of the activity. However, in health promotion practice, the focus is often only on the content of the program and whether or not the program changes health and/or health determinants.

When context, such as neighborhood and neighbors, is part of the program as in Neighbors Connected, recognition by the Dutch quality system that it is 'theoretically sound' is not a foregone conclusion. Since one of the quality criteria is that a program should be 'based on individual health behavior theory' and Neighbors Connected is not, several difficulties arose when the application form was being completed. **Chapter 7** reflects upon describing Neighbors Connected in the application form of the Dutch quality system. Difficulties arose

and solutions had to be sought when the problem (analysis), the goals and objectives, and the program itself were being described. Neighbors Connected is the result of careful consideration and a thorough process wherein a participatory approach is used to check the results from research and to be able to combine different forms of evidence from different sources. At this moment, Neighbors Connected is provisionally recognized as theoretically sound.

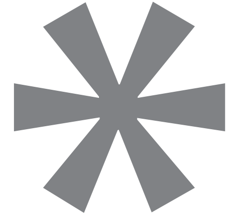
Health promotion strategies should not only be evaluated in relation to outcomes, but also in relation to planning processes during development, implementation and evaluation. The study in **Chapter 8** describes actual planning processes in three participating Dutch municipalities. The findings show that, as a consequence of complex contexts as is coordinated action in a municipality, the planning processes that happen in practice are not always the same as the processes that were intended. This research shows that, consciously applied or not, four planning approaches derived from organizational and management theories can be identified in health promotion practice. These planning approaches are the classical, evolutionary, processual and the systemic approach to planning. The use of different planning approaches is influenced by factors such as: 1) the degree of complexity and dynamics of the context, 2) the phase of the health promotion program, 3) powerful stakeholders and 4) available time. Describing the different approaches in program documents provides a legitimation to explicitly reflect, with local stakeholders and with external experts, upon why processes in practice happen as they happen, why this is different from what should happen and how to react to that. Reflection on processes contributes to learning processes and professionalism among stakeholders and to future health promotion programs in practice.

Concluding

Three concluding points can be made about salutogenic health promotion strategies.

1. The HP 2.0 framework contributes to the development, implementation and evaluation of healthy ageing strategies, because it explicitly stresses the need to incorporate the perception of older people. The relationship between resources for health and SOC focuses on the development of comprehensible, manageable and meaningful healthy ageing programs, so that older people are more likely to identify resources and to make use of the resource on a health promoting way.
2. Achieving and sustaining coordinated action starts from the moment stakeholders meet and share ideas, and thus before the actual health promotion program starts. Meaning that processes of coordinated action should be monitored at an early stage before any initiatives have taken place. Such preliminary phase is often not recognized as being part of the health promotion program and as such will not be part of evaluation reports or papers as well. However, this data provide insight into why a health promotion program is successful or not. Action research can contribute gaining this insight, since it makes processes and actions that actually happen explicit.

3. The third concluding point is the added value of combining different forms of evidence into a health promotion program. The HP 2.0 framework shows the necessity of including the perception of the priority group in the development of the health promotion activity, in addition to expert knowledge about a health problem. Coordinated action for health provides the opportunity to develop a health promotion program in a participatory way and to combine qualitative and quantitative data, and context-free and context-sensitive evidence. Combining evidence contributes to salutogenic local health promotion programs, which contribute to health in such a way as to be comprehensible, manageable and meaningful for, in this thesis, older people in the municipality.



Samenvatting
(Summary in Dutch)

Samenvatting

De Nederlandse samenleving vergrijst. Dit heeft invloed op zowel nationaal gezondheidsbeleid als op lokaal gezondheidsbeleid. Als gevolg van landelijke wetgeving, de Wet Publieke Gezondheid (WPG) en de Wet Maatschappelijke Ondersteuning (WMO), hebben gemeenten meer verantwoordelijkheden gekregen ten aanzien van de oudere populatie. Zo is de gemeente vanuit de WPG verantwoordelijk geworden voor de preventieve gezondheidszorg voor ouderen. Zij kunnen vooralsnog zelf bepalen hoe ze dat invullen. Daarnaast zijn gemeenten vanuit de WMO verantwoordelijk voor het creëren van voorzieningen zodat ouderen in staat worden gesteld om deel te nemen aan de maatschappij. Beide verantwoordelijkheden dragen bij aan gezond ouder worden.

Het bevorderen van 'gezond ouder worden' is complex, omdat gezond ouder worden wordt beïnvloed door onder andere individuele leefstijl, door sociale invloed en door de omgeving. Daarnaast bepaalt ieder individu voor zichzelf wat voor hem of haar 'gezond ouder worden' betekent. Dit houdt in dat elk individu verschillende behoeften heeft om gezond ouder te kunnen worden. Dit alles te samen maakt programma's om gezond ouder worden te bevorderen een uitdaging voor veel gemeenten.

Dit proefschrift beschrijft de ontwikkeling, implementatie en evaluatie van een lokaal programma voor gezond ouder worden. Dit programma vond plaats in drie gemeenten in Oost Nederland, namelijk de gemeenten Berkelland, Epe en Zutphen. Deze gemeenten werkten samen met de GGD Gelre-IJssel en de Wageningen Universiteit, in een academische werkplaats, genaamd AGORA. Het lokale programma is gebaseerd op de principes van gezondheidsbevordering en op salutogenese. Belangrijke principes van gezondheidsbevordering zijn participatie van de doelgroep en intersectorale samenwerking. Salutogenese is een benadering, waarin gezocht wordt naar factoren die bijdragen aan gezondheid. Salutogenese is complementair aan pathogenese, waarin gekeken wordt naar de risicofactoren van ziekte. De principes van gezondheidsbevordering en salutogenese benadrukken het belang om de context waarin ouderen leven en de perceptie van ouderen zelf mee te nemen bij de ontwikkeling van het programma.

HP 2.0 framework

In **hoofdstuk 2** is de totstandkoming van een nieuw model, het HP 2.0 framework, beschreven. Dit model faciliteert discussies met ouderen, organisaties en lokale beleidsmakers die samenwerken voor gezond ouder worden, over de inhoud van een programma. Het HP 2.0 framework bestaat uit drie concepten, namelijk 1) sense of coherence (SOC, een belangrijk concept uit de salutogenese), 2) bronnen voor gezondheid, en 3) gezondheid. Het model maakt de salutogene relatie tussen 'bronnen voor gezondheid' en 'sense of coherence' zichtbaar, hetgeen vernieuwend is binnen de gezondheidsbevordering. Het model laat zien dat wanneer 'een bron voor gezondheid' afgestemd is op de SOC (inclusief de drie dimensies

begrijpelijkheid [comprehensibility], hanteerbaarheid [manageability] en betekenisvolheid [meaningfulness]) van mensen, deze mensen beter in staat zijn om een dergelijke bron te identificeren en daadwerkelijk te gebruiken. Voorbeelden van bronnen voor gezondheid zijn een rollator, bibliotheek, buren en het activiteitenaanbod van een lokale welzijnsinstelling. Voor lokale organisaties was werving een relevant onderwerp, vooral werving van de kwetsbaardere ouderen. Deze groep ouderen maken vaak geen gebruik van het bestaande lokale aanbod.

Samenwerken voor gezondheid

Samenwerken voor gezondheid draagt bij aan het bouwen aan gedeelde kennis, die nodig is om samen een gezond-ouder-worden-programma te ontwikkelen. Samenwerken draagt dus bij aan co-creatie van gezondheidsprogramma's.

In **hoofdstuk 3** is de mate waarin samenwerking met ouderen, organisaties en lokale beleidsmakers is bereikt en ingebed, geanalyseerd in de drie deelnemende gemeenten. De manier van samenwerking en de mate waarin dit is opgebouwd verschilt per gemeente. Bijvoorbeeld, in één gemeente zijn organisaties bekend met elkaar en ontmoeten zij elkaar regelmatig. In een andere gemeente zijn de organisaties niet bekend met elkaar, onder andere door een recente gemeentelijke herindeling. Dit heeft invloed op hoe en wanneer gezondheidsprogramma's kunnen starten.

In hoofdstuk 3 zijn ook enkele voorwaarden en uitdagingen om lokale samenwerking op te bouwen, beschreven. Eén van de uitdagingen is dat in elk gezondheidsprogramma samenwerking met organisaties, beleidsmakers en met de doelgroep een expliciet onderdeel zou moeten zijn. Op deze manier is het mogelijk om een lokaal programma af te stemmen op de SOC van die doelgroep. Samenwerking als onderdeel van het gezondheidsprogramma houdt dan ook in dat er aan bepaalde randvoorwaarden, zoals tijd en geld, voldaan moet zijn. Het samenwerkingsproces en de resultaten van een dergelijk samenwerkingsproces moeten inzichtelijk gemaakt worden.

In **hoofdstuk 4** wordt een instrument beschreven, de 'coordinated action checklist', dat ingezet kan worden om het proces en de resultaten van een samenwerkingsproces zichtbaar te maken. De 'coordinated action checklist' draagt bij aan het faciliteren van het samenwerkingsproces. Op basis van de individuele scores van de samenwerkingspartners kan een discussie plaatsvinden over de successen en de verbeterpunten in de samenwerking van het programma. Op grond hiervan kunnen de samenwerkingspartners actie ondernemen.

Hoofdstuk 5 beschrijft het combineren van verschillende vormen van bewijs, dat mogelijk wordt doordat ouderen, organisaties en lokale beleidsmakers met elkaar samenwerken. Resultaten uit interviews met ouderen, organisaties en lokale beleidsmakers en de resultaten van de analyses van een lokale monitor onder ouderen, zijn bediscussieerd in zes groepssessies waar ouderen, organisaties en lokale beleidsmakers aan deelnamen. Het hele proces van het betrekken van ouderen, organisaties en lokale beleidsmakers leverde input voor de ontwikkeling

en implementatie van het nieuwe programma 'Voor Elkaar in de Buurt'. Voor Elkaar in de Buurt is een programma waarin sociaal actieve ouderen worden uitgenodigd om iets te organiseren voor hun sociaal minder actieve oudere buren. Voorbeelden van activiteiten zijn een dialectenmiddag georganiseerd door Vrouwen van Nu en een cursus kaarten maken in een woon-zorgcentrum. De sociaal actieve ouderen worden gefaciliteerd door Voor Elkaar in de Buurt door middel van praktische ondersteuning en een financiële bijdrage van maximaal € 500,-.

Combineren van bewijs

In **hoofdstuk 6** zijn elementen van het programma Voor Elkaar in de Buurt geïdentificeerd, die bijdragen aan de werving van ouderen voor lokale activiteiten. Deze elementen zijn 1) persoonlijk contact met organisatoren, 2) sociale steun, 3) nabijheid en een gemakkelijk toegankelijke locatie en 4) mogelijkheden voor sociaal contact en voor het opdoen van nieuwe kennis. Deze elementen maken een specifieke activiteit begrijpelijker, hanteerbaarder en betekenisvoller: de drie dimensies van SOC. De kans dat ouderen daadwerkelijk gaan deelnemen aan een activiteit wordt groter wanneer zij de activiteit als begrijpelijk, hanteerbaar en betekenisvol ervaren. Dit onderzoek laat zien dat voor ouderen, om deel te nemen, de omgeving en de context waarin activiteiten zijn georganiseerd net zo belangrijk zijn als de inhoud van de activiteit. Binnen gezondheidsbevordering is de focus vaak alleen op de inhoud van het programma en of het programma invloed heeft op de (determinanten van) gezondheid.

Voor Elkaar in de Buurt is ingediend bij het kwaliteitssysteem van het Centrum Gezond Leven (RIVM) voor de erkenning 'theoretisch goed onderbouwd'. Het was echter niet vanzelfsprekend dat Voor Elkaar in de Buurt als zodanig erkend zou worden. Eén van de kwaliteitscriteria voor erkenning is namelijk dat een gezondheidsprogramma gebaseerd is op een gedragstheorie. Voor Elkaar in de Buurt is echter niet enkel gebaseerd op een gedragstheorie, maar op een bredere visie waarin de context en de visie van ouderen zelf op basis van kwalitatief en kwantitatief onderzoek zijn meegenomen. Door het includeren van de perceptie van ouderen en de lokale context (buurt en buren) bij de ontwikkeling van Voor Elkaar in de Buurt was het lastig om het probleem, de doelen en het programma zelf te beschrijven volgens de richtlijnen van het Centrum Gezond Leven. **Hoofdstuk 7** van dit proefschrift reflecteert op het indienen van Voor Elkaar in de Buurt voor erkenning en beschrijft de oplossingen die gebruikt zijn tijdens het beschrijven. Op het moment van verschijnen van dit proefschrift is Voor Elkaar in de Buurt erkend als (voorlopig) theoretisch goed onderbouwd.

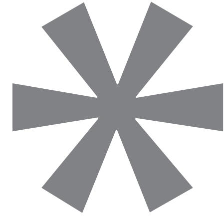
Hoofdstuk 8 beschrijft de analyse van planningsprocessen in de drie deelnemende gemeenten. De analyse laat zien dat de processen in de deelnemende gemeenten niet gaan zoals van te voren was gepland. Dit komt onder andere door samenwerking met ouderen, organisaties en lokale beleidsmakers tijdens het ontwikkelen en implementeren van het programma. Dit vindt vaak plaats in een complexe omgeving, zoals een gemeente dat is. Voor de analyse van

planningsprocessen is gebruikt gemaakt van vier verschillende planningsbenaderingen bekend uit de management- en organisatietheorie. Deze vier benaderingen worden, al dan niet bewust, gebruikt in de dagelijkse praktijk van gezondheidsbevordering. Deze vier benaderingen zijn de klassieke, evolutionaire, processuele en systemische benadering. Het gebruik van deze planningsbenaderingen door gezondheidsprofessionals wordt beïnvloed door verschillende factoren: 1) de mate van complexiteit en dynamiek van de context, 2) de fase waarin het programma zich bevindt, 3) invloedrijke partners in het veld, en 4) beschikbare tijd. Het beschrijven van de verschillende planningsbenaderingen in relevante documenten legitimeert de investering om met partners en met externe experts te reflecteren op lokale processen, op redenen waarom processen anders gaan dan gepland en hoe hier mee om te gaan. Dit draagt bij aan gezamenlijk leren en aan de expertise van partners.

Conclusie

In dit proefschrift zijn drie conclusies getrokken over salutogene programma's voor gezond ouder worden.

1. Het HP 2.0 framework draagt bij aan de ontwikkeling, implementatie en evaluatie van gezond-ouder-worden-programma's, omdat dit model het belang van de perceptie van ouderen zélf benadrukt. De relatie tussen 'bronnen voor gezondheid' en 'SOC' benadrukt het ontwikkelen van begrijpelijke, hanteerbare en betekenisvolle gezond-ouder-worden-programma's, zodat ouderen beter in staat zijn om bronnen te identificeren en te gebruiken.
2. Het bereiken en het inbedden van samenwerking met organisaties, beleidsmakers en doelgroepen begint op het moment dat zij elkaar ontmoeten en ideeën uitwisselen. Dit vindt dus plaats voordat het programma start. Dit houdt in dat samenwerkingsprocessen al voordat activiteiten van het programma starten gevolgd moeten worden. Deze fase wordt echter vaak niet herkend als onderdeel van het programma en is daarom vaak ook geen onderdeel van de evaluatie. Informatie over deze inleidende fase kan waardevol kan zijn om inzicht te verkrijgen in redenen waarom gezondheidsprogramma's al dan niet succesvol zijn. Actie-onderzoek kan bijdragen om dit inzicht te verkrijgen, omdat deze vorm van onderzoek processen en acties die daadwerkelijk gebeuren inzichtelijk maakt.
3. Het combineren van verschillende vormen van bewijs is van meerwaarde voor een gezondheidsprogramma. Het HP 2.0 framework laat de noodzaak zien dat de perceptie van de doelgroep meegenomen moet worden bij de ontwikkeling van een programma. Daarnaast is ook kennis over gezondheidsproblemen van experts nodig. Samenwerking voor gezondheid geeft de mogelijkheid om een programma op een participatieve manier te ontwikkelen door kwalitatieve en kwantitatieve data en door contextgevoelige en contextvrije data te combineren. Het combineren van verschillende vormen bewijs draagt bij aan salutogene gezondheidsprogramma's die gezondheid bevorderen op een begrijpelijke, hanteerbare en betekenisvolle wijze.



Dankwoord
(Acknowledgements)

Dankwoord

Mijn proefschrift is af!! Vijf jaar lezen, discussiëren, onderzoeken, schrijven en reizen tussen verschillende werkplekken, zitten er op. Dit heeft deels geleid tot dit proefschrift, maar het heeft ook geleid tot Voor Elkaar in de Buurt. Ik heb dit niet kunnen doen zonder tal van mensen die ik graag wil bedanken.

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Jeanette

About the author

Curriculum vitae

Jeanette Lezwijn was born on 11 January 1975 in Beilen, the Netherlands. In 1994 she started the Bachelor program, Nutrition and Dietetics, at the Hanze University in Groningen, the Netherlands, with an exchange program at the Metropolitan University in Leeds, United Kingdom. In 1998 she obtained her Bachelor's degree and started working as a dietician with a homecare organization. After one year she enrolled on the master's program, Health Promotion and Education, at the department of health sciences of Maastricht University in Maastricht, the Netherlands. In 2002 she obtained her master's degree by writing a master's thesis about the effects of a mass media campaign of the Dutch Cancer Society about sun protection behavior on attitudes and beliefs amongst youngsters.

In 2001 she started working at the community health service GGD Regio Stedendriehoek (now: GGD Gelre-IJssel) as a health promotion professional. She was a project leader of different projects such as a local education program about preventing Lyme disease and a local program in three municipalities preventing falling incidents among older people. In 2005 she became a policymaker of the community health service and she was assigned several tasks which were not directly health related. From that experience, she decided in 2006 to apply for the job of researcher and health promoter within the new academic collaborative AGORA. AGORA provided her the opportunity to work at the community health service as well as at the Health & Society group of Wageningen University, and this enabled her to approach science from a practice perspective.

Her project was one of four PhD projects in AGORA, all concerned with healthy ageing. Her research focused on processes in municipalities to develop, implement and evaluate a local healthy ageing program, called Neighbors Connected. As part of her PhD training, she participated in 2008 in the course 'The evidence base and practice of salutogenic research' at the Folkhälsan Institute in Helsinki. Furthermore, she participated in the 2009 ETC PHHP summer course 'Exploring salutogenic pathways to health promotion' in Cagliary, Italy. In June 2011 she completed her thesis and continued working for the community health service GGD Gelre-IJssel.

Publications

Journals

Lezwijn J., Vaandrager L., Naaldenberg J., Wagemakers A., Koelen M.A. & van Woerkum C.M.J. (2011). Healthy ageing in a salutogenic way: building the HP 2.0 framework. *Health & Social Care in the Community* **19**, 1, 43-51.

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Lezwijn J., Vaandrager L., Wagemakers A., Koelen M. & van Woerkum C. Neighbors Connected; exploring the recruitment of Dutch older people for local activities. (submitted for publication).

Naaldenberg J., Vaandrager L., Koelen M., Lezwijn J. & Leeuwis C. Coordinated action for healthy ageing: comparing local stakeholder perspectives within three different contexts. (submitted for publication).

Research report

Naaldenberg J, Lezwijn J, Vaandrager L. (2009) *Gezond ouder worden. Verslag van interviews met ouderen in Epe, Berkelland en Zutphen*. Wageningen, Wageningen Universiteit.

Abstracts, proceedings and presentations

Lezwijn J., Naaldenberg J., Wagemakers A., Van Beek A., Haveman-Nies, A. & Vaandrager L. (2010) *De ontwikkeling van een lokale strategie voor gezond ouder worden 'Voor Elkaar in de Buurt'* [in Dutch]. 10e Nationaal Gerontologiecongres: Mythen, feiten en ontwikkelingen, Ede, The Netherlands, 1 October 2010.

Lezwijn J., Vaandrager L., Wagemakers A. & Van Woerkum C. (2010) *A systemic approach to the planning of health promotion within the context of healthy ageing*. 20th IUPH World Conference on Health Promotion, Geneva, 11-15 July 2010.

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De Vlaming R., Croezen S., Lezwijn J, Naaldenberg J. & Coenen, I. (2010) *GTST in de Academische Werkplaats, we zijn ONM: 'ervaringen uit het programma gezond ouder worden'* [in Dutch]. Nederlands Congres Volksgezondheid 2010. In Balans, preventie en zorg beter in balans, Rotterdam, The Netherlands, 8-9 April 2010.

Lezwijn J., Naaldenberg J., Croezen S., Evertse E., Vaandrager H.W. & Brethouwer J.W. (2008) *Een positieve benadering voor gezond ouder worden in beleid en wetenschap* [in Dutch]. 9e Nationaal Gerontologiecongres 'Langer leven in de Nederlandse samenleving: De nationale uitdaging', Ede, The Netherlands, 3 October 2008.

Naaldenberg J., Vaandrager L., Lezwijn J. & Wagemakers, A. (2008) Energie voor verandering: *Op zoek naar veranderrichtingen en interventiestrategieën met participatie van doelgroep en uitvoerende organisaties* [in Dutch]. 9e Nationaal Gerontologiecongres 'Langer leven in de Nederlandse samenleving: De nationale uitdaging', Ede, The Netherlands, 3 October 2008.

Lezwijn J., Naaldenberg J., Croezen S., Evertse E., Vaandrager H.W. & Brethouwer J.W. (2008) *Een positieve benadering voor gezond ouder worden in beleid en wetenschap* [in Dutch]. Nederlands Congres Volksgezondheid 2008. Samen investeren in gezondheid, Groningen, The Netherlands, 9-10 April 2008.

Education certificate

Completed Training and Supervision Plan

Description of the activity	Department/Institute	Year	ECTS*
A) Project related competences			
The Evidence Base and Practice of Salutogenic Research	Folkhälsan Institute Helsinki	2008	5
2 conferences Empowerment (Nina Wallerstein and Glenn Laverack)	NIGZ/University of humanistic studies	2007-2008	0.6
Communication in interdisciplinary Research	WGS/Ceres	2008	1
ETC-PHHP summer school public health & health promotion, Cagliari, Italy: "Exploring salutogenic pathways to health promotion"	European Training Consortium in Public Health and Health Promotion	2009	8
Hoe werkt een gemeente?	Bestuursacademie Nederland	2009	0.8
B) General research related competences			
Multidisciplinair Seminar	AGORA Academic Collaborative	2006-2010	1
Scientific Writing	WGS	2009	1.8
Practicum ATLAS ti.	Wageningen University	2008	0.5
Writing a research plan	Health & Society	2006	4
C) Career related competences/personal development			
PhD competence assessment	WGS	2007	0.3
Personal coaching	Wenneke Ong	2009	1
Teaching – and supervising activities	Health & Society	2006-2010	4
D) Presentations at conferences			
A systemic approach to the planning of health promotion within the context of healthy ageing	20th IUHPE conference Geneva, Switzerland	2010	1
De ontwikkeling van een lokale strategie voor gezond ouder worden 'Voor Elkaar in de Buurt'	10de Nationale Gerontologie congres Ede	2010	1
Goede tijden, slechte tijden, zijn we ONM	Nederlands Congres Volksgezondheid	2010	1
Total (minimum 30 ECTS)			**31.0**

*One ECTS on average is equivalent to 28 hours of course work.

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