Wellbeing and Healthy Choices for Older Adults and their Carers

Intellectual Output 1:
Needs for implementing healthy choices for older adults and their carers: the stakeholder view

O1 A5 Needs Analysis Report

28.10.2016

WHOLE

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Erasmus+

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Abstract

This needs analysis report presents and discusses the findings from research carried out as part of the EU funded project, WHOLE: Wellbeing and Healthy Choices for Older Adults and their Carers.

The purpose of the needs analysis is to establish concrete data and a methodological framework on which to base the future intellectual outputs (IO) of this project including IO 2 (*Healthy choices in geriatric home care and tailored learning opportunities*), IO 3 (*Development of the platform*), IO 4 (*Pilot and validation study: feasibility, acceptance, adherence*), and IO 5 (*Market and business study: reach, finance model*), as well as dissemination plans in order to ensure long term exploitation and sustainability of this project.

The report includes an introduction to the project and an outline of the methodology behind the needs analysis before demonstrating the results of each partner's findings as well as an overview of the findings from an international perspective. The international findings are discussed under five key headings identified in the introduction comprising current attitudes and habits of carers and care recipients in relation to physical activity [PA], nutrition [NU], and the health and wellbeing program proposed by WHOLE. It also examines the best means of reaching carers and their attitudes towards e-learning. The report ends in a methodological framework for the development of the training programs in direct connection with the users' needs and a specification of the target group.

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Acknowledgements

Each partner organisation collected national data via interviews for case studies, focus groups and in a written survey via questionnaires, which formed the basis of this international needs analysis report:

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- Bulgaria: Association Generations – Tanya Gebova & Simona Hristova
- Germany: Wohlfahrtswerk fuer Baden-Wuerttemberg – Ruth Dankbar & Mareike Drescher
- Germany: Muenster University – Stefanie Dahl & Nils Dasler
- Greece: ATOM – Giorgos Koumanakos, Konstantina Zoi & Dimitris Theodoropoulos
- Ireland: ProActivate Ireland – Emma Murtagh
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1 Introduction

WHOLE: Wellbeing and Healthy Choices for Older Adults and their Carers is a three-year, EU-funded project that began in September 2015 and includes a consortium of experts in the field from Germany, Austria, Israel, Greece, Bulgaria, and Ireland.

The WHOLE project's main objective is to promote active and healthy ageing through physical and nutritional training for frail older adults at home, using as a means the personalised home care services provided to them by formal and informal carers. At the same time, WHOLE equally emphasises the effect of physical activity and good nutrition on the wellbeing and relief of formal and informal carers. An important aspect is that WHOLE will allow people to educate themselves about a healthy lifestyle and exercise from home. This is particularly important given our target groups who are often confined to the home due to mobility issues or disabilities, or live in rural or isolated circumstances, which would make it difficult for them to avail of external health or exercise programmes.

The first of this project's five projected outputs is *IO 1: Needs for implementing healthy choices for older adults and their cares: the stakeholders view*. This output is intended to form a foundation of comprehensive research on which the rest of the outputs will be built. It will ensure the appropriateness and relevancy of the project's outputs to the target groups. It will identify stakeholders' needs and specific barriers in relation to health, nutrition and exercise as well as attitudes and experiences regarding the adoption of official health behaviour recommendations.

The leader of *IO 1* is the Irish partner in the consortium, ProActivate Ireland, who with the support of the rest of the partners formulated a methodology and carried out three phases of research between September 2015 and August 2016 (see Chapter 2, Methodology, on pages 6 to 8). The results will be analysed in this report with the intention being to gain an insight into the following key points:

- Current attitudes and habits of carers and care recipients in relation to physical activity
- Current attitudes and habits of carers and care recipients in relation to healthy nutrition
- Current attitudes of carers towards e-learning
- Best means of reaching carers
- Attitude of carers and care recipients towards the WHOLE project

The main findings of our three-phase needs assessment are demonstrated by country and in an international overview. The results will be discussed in the international context highlighting some national particularities if they occur. The results furthermore are divided into a section dealing with the carers' results (Chapter 3.1) and a section dealing with the care recipients' results (Chapter 3.2). After demonstrating the demographical data, each section is structured following the named key points for the carers. For the care recipients, their attitudes on the impact of healthy lifestyle on personal health are analysed instead of their attitude towards e-learning and the best means to reach carers. Finally, the next steps will outline how we will proceed and continue with project development (Discussion and Consequences, Chapter 4).

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2 Methodology

The methodology for this IO was finalised by ProActivate Ireland in the Final Methodological Plan (Outcome O1, A1), which contained specific instructions, goals, materials, and deadlines for each of the three research phases (Outcome O1, A3 and A4). All materials used in this IO were reviewed and agreed upon by all of the partners before work commenced on the first phase. An overview of all phases and actions is given in Figure 1.

In addition to the research and needs assessments of the target group reported in this document, an international literature review (Outcome O1, A2) was compiled based on national research of all partners in his or her partner country regarding the current situation in relation to care of older people and the provision of health promotion programmes for older adults.

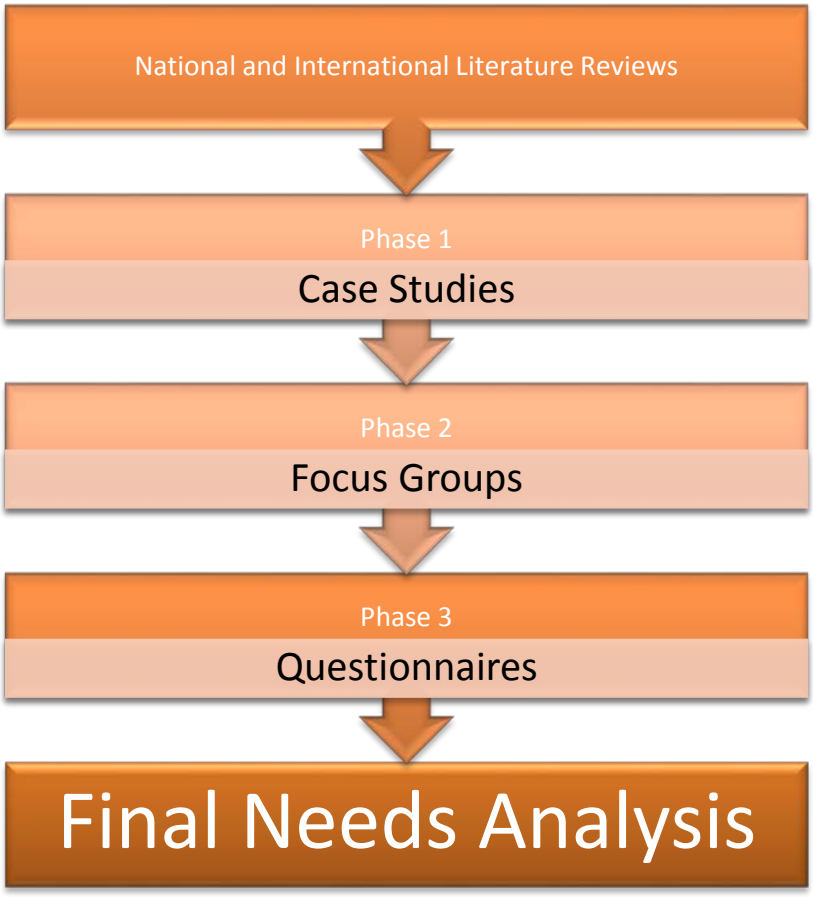

Figure 1. Summary of the Methodology Needs Analysis

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Phase 1:

Phase 1 consisted of case studies, which were conducted by each partner with at least three older people and two formal or informal carers between December 2015 and February 2016. All case studies followed a fixed agenda (Table 1) according to case study guidelines. The findings of the case studies, which were reported in a report form by all partners, informed the next research phase: the focus groups.

Table 1. Points of discussion for the Case Studies

Topics	Target Group	
	Care Recipients	Carer
Background	▪ Age ▪ Gender ▪ Relevant medical history/conditions.	▪ Age ▪ Gender ▪ Relevant education, formal and informal experience, and background. ▪ Type and length of relationship to the individual for whom they are caring. ▪ Any obstacles that make caregiving difficult or challenging.
Current situation	▪ Current lifestyle, routines and care arrangements. ▪ Current activity level and attitude towards physical activity. ▪ Current nutritional habits and attitude towards dietary changes. ▪ Physical activity overall and physical activity as part of daily care.	▪ Current lifestyle, routines and care arrangements. ▪ Thoughts on physical activity and nutrition and their place in caregiving. ▪ Current level of physical activity in their caregiving and attitude towards change. ▪ Current nutritional habits in their caregiving and attitude towards dietary changes.
Barriers and obstacles	▪ Any complications or considerations that are potential obstacles to introducing changes in diet or exercise for oneself or as part of daily care.	▪ Any complications or considerations that are potential obstacles to introducing changes in diet or exercise for oneself or as part of daily care. ▪ Any obstacles to using an e-learning platform to improve health promotional skills.

Phase 2:

Phase 2 consisted of focus groups, two of which were conducted by each partner with at least 6 – 8 participants in each group in March 2016. One group was for carers and the other group was for older care recipients. The focus groups also followed strict guidelines during implementation and a specific reporting procedure. The points of discussion were based on the findings of the case studies. As an example, the focus group discussion agenda for the topic physical activity and nutrition are depicted in Figure 2. The combined findings of the case studies and focus groups consequently informed the content of the final research phase: the questionnaires.

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1. Activities for healthy living

1.1. Do you currently engage in any practices at home in order to prevent frailty and decline (independently or as part of care giving/receiving)?

1.1.1. If **YES**, let the people explain what they do, how and why they started and what inspired or motivated them to start and try to define whether those factors were:

- Inner supporting factors (e.g. motivation, attitude)
- External supporting factors (e.g. availability of programs)

1.1.2. If **NO**, ask whether the other participants could imagine such a program/practice/activity and whether they see the possibility to implement such a practice for people in need of care. Try to find out what would motivate or inspire them and whether those factors are more likely to be:

- Inner supporting factors (e.g. motivation, attitude)
- External supporting factors (e.g. availability of programs)

1.1.3. If they say they could not imagine such a thing, ask them why they don't have practices at home at the moment. Have they had negative experiences? Would they like to do practices but it doesn't work? Try to find out if the factors at play are:

- Inner inhibiting factors (e.g. motivation, attitude)
- External inhibiting factors (e.g. availability of programs)

1.1.4. What does this mean for our project? What should we consider after your opinion?

1.2. Have you ever participated in a programme like the one proposed by WHOLE in your life or work (activities for health promotion, not competitive sports)?

1.2.1. If the answer is **YES**, let the people explain what they have done, how and why they started and how they experienced the participation. Try to define whether the motivational factors were:

- Inner supporting factors (e.g. motivation, attitude)
- External supporting factors (e.g. availability of programs)

1.2.2. If the answer is **NO**, ask what has stopped the participants from doing so and try to find out if the factors at play were:

- Inner inhibiting factors (e.g. motivation, attitude)
- External inhibiting factors (e.g. availability of programs)

1.2.3. What does this mean for our project? What should we consider after your opinion?

Figure 2. Points of discussion for the Focus Group

Phase 3:

Phase 3 consisted of the questionnaires, which were distributed by each partner within the local area of each partner organization with the aim of reaching and receiving feedback from at least 17 formal or informal carers and 46 recipients of formal or informal care per partner. The content of the questionnaires was based on the research conducted in Phases 1 – 2 of this IO and was intended to provide concrete data on which to base this final Needs Analysis Report. The written survey took place between May and July 2016. This phase represented the culmination of all of the research that had taken place thus far. The following needs analysis report focuses on the results of the questionnaires. All questions are mentioned in the results section.

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3 Results

The following results section shows the data gained from the survey of carers (3.1) and care recipients (3.2). The questionnaires were based on the previous needs analysis conducted in interviews and focus groups. In the following, only the results based on the questionnaires will be reported as they represent the final needs analysis' results. All results are structured according to the questionnaires and — with a few exceptions — displayed with all national and international results. The number of participants (especially for the care recipients) varied widely between the countries, which should be kept in mind while reading and interpreting the results.

3.1 Carers

The first chapter shows the results of carers for their demographical data (3.1.1), their current attitudes and habits in relation to physical activity (3.1.2), nutrition (3.1.3) and e-learning (3.1.4). The best mean to reach carers is part of section 3.1.5. This chapter finishes with the attitudes of carers towards the WHOLE project (3.1.6).

3.1.1 Demographical data

Table 2. Demographical data of the carers per country and international in total (No.) and percent (%)

Participants		Austria		Bulgaria		Germany Muenster		Germany Stuttgart		Greece		Ireland		Israel		International	
		16		19		15		28		15		17		17		127	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Age	20 - 29	0	0,0	0	0,0	0	0,0	0	0,0	0	0,0	2	11,8	4	23,5	6	4,7
	30 - 49	6	37,5	7	36,8	9	60,0	7	25	14	93,3	3	17,6	9	52,9	55	43,3
	50 - 69	6	37,5	10	52,6	6	40,0	11	39,3	0	0,0	9	52,9	3	17,6	45	35,4
	70 - 89	1	6,3	1	5,3	0	0,0	1	3,6	0	0,0	1	5,9	1	5,9	5	3,9
	90 - 109	0	0,0	0	0,0	0	0,0	1	3,6	0	0,0	0	0,0	0	0,0	1	0,8
	Missing	3	18,8	1	5,3	0	0,0	8	28,6	1	6,7	2	11,8	0	0,0	15	11,8
Gender	Male	2	12,5	1	5,3	2	13,3	7	25,0	5	33,3	3	17,6	9	52,9	29	22,8
	Female	14	87,5	18	94,7	13	86,7	21	75,0	10	66,7	14	82,4	8	47,1	98	77,2
Kind of carer[1]	Formal	10	62,5	12	63,2	11	73,3	13	46,4	8	53,3	7	41,2	7	41,2	68	53,5
	Informal	6	37,5	6	31,6	3	20,0	14	50,0	6	40,0	10	58,8	10	58,8	55	43,3
	Other[2]	0	0,0	3	15,8	0	0,0	1	3,6	0	0,0	1	5,9	0	0,0	5	3,9
	Missing	0	0,0	0	0,0	1	6,7	0	0,0	1	6,7	0	0,0	0	0,0	2	1,6

[1] Formal care: 'providing professional care'; informal care: 'caring for a friend, relative, neighbour, etc.'
[2] Other kinds of care: care assistant, special course for health carers, sanitarian in a hospital, caring for the disabled

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Of the carers surveyed by the seven partner organisations, the age distribution was quite varied, mainly between the age groups 30 – 49 and 50 – 69 and was relatively evenly distributed across the two groups (see Table 2). Only four carers from Israel and two from Ireland were between 20 and 29 and one carer from Stuttgart (Germany) was 92. Five carers from different countries were in the age group 70 – 89. With 43.3%, the carers in the age group of 30 – 49 formed the biggest group followed by 50 – 69 year olds with 35.4%. The mean age was 47.5 years. Overall, 77% of the surveyed carers were female. The Israeli carers were the only carers evenly split between male and female. There were more formal carers (53.5%) compared to informal carers (43.3%), which was caused by the recruiting process as some partners started the recruitment in the formal care service setting.

3.1.2 Current attitudes and habits of carers in relation to physical activity

Carers were asked if they implement physical activity into their caregiving and, if not, what has prevented them from doing so. Those that answered affirmatively were asked to list what kind of activities they included and those that did not were asked to list the factors preventing them from including physical activity in their caregiving. Carers were also asked whether they would be confident implementing gentle physical activity with their care recipients if provided with training. Table 3 presents the results.

A majority (68%) of the carers surveyed reported that they did implement physical activity into their caregiving. All but the Bulgarian carers demonstrated this trend. Of those who did implement physical activity into caregiving, walking was the preferred exercise (83%), followed by stretching (26%), and strength training (21%). Other activities mentioned by the carers were special physiotherapeutic exercises, assistance on exercise bikes, stair training, hiking, Zumba, swimming, physical activity during personal care, mild physical training, farming jobs and repairs, passive bed gymnastics in a lying or sitting position, and age-based exercises. Those who did not implement physical activity mostly attributed it to a lack of programmes, resources, and information (39%) as well as anxiety about causing injury (34%). Besides these barriers and outside of the given examples, the carers mentioned a lack of motivation, lack of time, lack of resources (money), and physical condition as barriers to implement physical activity into their caregiving. A majority (71%) stated that they would be confident implementing physical activity if provided with training. 16% were unsure and only 8% showed no confidence.

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Table 3. Physical activity in caregiving in the view of carers, kind of activities, barriers and confidence in implementing gentle physical activity (PA) in caregiving per country and internationally in percent (%)

Participants		Austria	Bulgaria	Germany Muenster	Germany Stuttgart	Greece	Ireland	Israel	Inter-national
		16	19	15	28	15	17	17	127
		%	%	%	%	%	%	%	%
PA in care	Yes	87	42	80	68	53	82	71	68
	No	13	53	20	29	47	18	29	30
	Missing	0	5	0	3	0	0	0	2
Kind of activities (if yes)	Walking	79	63	83	89	100	86	83	83
	Stretching	29	25	33	21	43	29	17	26
	Strength training	36	0	33	37	14	0	8	21
	Armchair aerobics	7	0	0	5	14	21	0	9
	Others	29	13	17	5	0	7	8	10
	Missing	0	13	0	5	0	0	0	2
Barriers (if no)	Availability of programs / information / resources	50	60	0	25	57	33	20	39
	Anxiety about causing injury	50	60	33	0	43	0	40	34
	Care recipients uninterested	0	0	0	38	29	33	20	18
	Against protocol	0	0	0	0	14	33	20	8
	No priority	100	0	0	25	43	0	0	18
	Others	50	20	67	0	0	0	0	16
	Missing	50	0	33	0	0	0	0	5
Confidence in implementing PA in care	Yes	50	84	67	65	87	76	71	71
	No	6	11	6	7	13	6	23	8
	Unsure	38	5	20	14	0	18	6	16
	Missing	6	0	7	14	0	0	0	5

Carers were also asked if they currently implemented non-work related physical activity into their own lives and what motivating or preventing factors were involved in their levels of physical activity. Table 4 presents the results.

The majority (77%) said that they currently implement physical activity into their own lives, mainly as a means of promoting general health (78%), relieving stress (53%), and controlling weight (45%), while lack of time (79%) and motivation (41%) were the main factors preventing exercise. The kinds of physical activities implemented by the carer can be divided into different kinds of activities. Some activities are physical or sporting activities such as walking, jogging/running, skipping, gym, weight class, cardio class, aerobics, swimming, biking, fascia training, Zumba, hiking and nature walks, horse

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riding, or golf. Others implemented physical activities in their daily life such as walking with the dog, housekeeping, or gardening. Another category can be built from more relaxed exercises, such as Pilates. Two more barriers prevented carers from implementing physical activity into their daily life: pain (specifically hip pain) and the perception that exercise was only necessary for weight control. Other factors that motivated them were promoting overall health, feeling better, relaxation, and improved mood.

Table 4. Physical activity (PA) in the daily life of carers, motives, and barriers per country and internationally in percent (%)

Participants		Austria	Bulgaria	Germany Muenster	Germany Stuttgart	Greece	Ireland	Israel	Inter-national
		16	19	15	28	15	17	17	127
		%	%	%	%	%	%	%	%
PA in daily life	Yes	87	53	73	82	80	82	82	77
	No	13	47	27	18	20	18	18	23
	Missing	0	0	0	0	0	0	0	0
Motivation (if yes)	General health promotion	93	90	100	83	67	71	43	78
	Weight control	64	40	64	48	25	50	21	45
	Stress relief	57	50	100	48	33	79	14	53
	Fun / Socializing	57	0	73	57	17	29	36	41
	Competition	0	0	0	4	8	0	7	3
	Others	0	10	9	4	0	0	0	2
Barriers (if no)	Availability of programs / information / resources	0	44	0	20	0	0	33	21
	Lack of time	52	100	75	100	33	67	67	79
	Disability	0	22	25	0	0	0	33	14
	Lack of motivation	0	67	50	40	33	33	0	41
	Bad experience through unsuccessful attempts	50	0	0	40	0	0	0	10
	Others	0	0	0	0	0	33	0	3
	Missing	0	0	0	20	33	0	0	7

3.1.3 Current attitudes and habits of carers in relation to nutrition

Regarding their attitude and habits in relation to nutrition, carers were asked if they currently implemented healthy nutritional practices into their caregiving. Those that answered affirmatively were asked to list what kind of nutritional practices they included and those that did not were asked to list the factors preventing them from including good nutritional practices in their caregiving. Carers were also asked whether they would be confident implementing healthy nutrition with their care recipients if provided with training. Table 5 presents the results.

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Table 5. Healthy nutrition in caregiving in the view of carers, kind of nutritional practices, barriers and confidence in implementing nutrition practices (NU) in caregiving per country and internationally in percent (%)

Participants		Austria	Bulgaria	Germany Muenster	Germany Stuttgart	Greece	Ireland	Israel	Inter-national
		16	19	15	28	15	17	17	127
		%	%	%	%	%	%	%	%
NU in care	Yes	87	58	80	68	80	76	82	73
	No	13	42	20	29	20	24	18	26
	Missing	0	0	0	3	0	0	0	1
Kind of practices (if yes)	Food pyramid	43	27	8	26	17	38	64	33
	Reduced salt / fat products	50	67	67	53	75	54	43	56
	Controlling diets for medical conditions e.g. diabetes	21	67	33	26	25	23	7	26
	Following medically prescribed nutritional programs	7	22	25	11	8	15	7	13
	Others	7	22	8	5	0	8	0	6
	Missing	0	0	8	5	0	0	0	2
Barriers (if no)	Availability of programs / information / resources	0	100	0	13	33	0	33	35
	Anxiety about damaging health	0	30	0	0	0	0	0	10
	Care recipients uninterested	50	0	33	13	67	25	33	23
	Against protocol	0	0	0	0	33	25	33	10
	No priority	50	0	0	38	0	0	0	13
	Others	0	0	33	13	0	25	0	10
	Missing	0	0	0	25	0	25	0	13
Confidence in implementing NU in care	Yes	62	69	80	79	93	94	76	79
	No	13	5	0	7	0	6	12	6
	Unsure	19	26	13	14	7	0	12	13
	Missing	6	0	7	0	0	0	0	2

73% of carers implemented healthy nutritional practices into their caregiving, including using low fat/salt alternatives (56%), following the food pyramid (33%), and controlling diets for specific medical

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conditions (26%). Other nutritional practices that carers implemented in their caregiving are low carbohydrate diets, diversifying the daily menu, a diet with lot of water and fruits, vegetarianism, or a balanced diet overall. Of those that did not implement healthy nutritional practices into their caregiving (26%), 35% cited a lack of programmes, resources, and information as the main reason preventing them from doing so as well as a lack of interest from care recipients (23%). Other reasons for not implementing healthy nutritional practices in daily care included not having control over the care recipient's diet or that that the care recipients already have a good understanding of healthy choices and options from their general practitioners. Carers also suggested that they preferred to prepare foods that their care recipients enjoy or that nutrition was not part of their care plan. Again, the majority (79%) said that they would be confident implementing healthy nutrition if trained while 6% of carers said that they would not be confident or would be unsure (13%).

The final question in regards to carers and nutrition was whether they implemented healthy nutritional practices into their own lives and what factors motivated them to or prevented them from doing so. Table 6 presents the results.

Table 6. Healthy nutrition in daily life of carers, motives and barriers per country and internationally in percent (%)

Participants		Austria	Bulgaria	Germany Muenster	Germany Stuttgart	Greece	Ireland	Israel	Inter-national
		16	19	15	28	15	17	17	127
		%	%	%	%	%	%	%	%
NU in daily life	Yes	100	84	93	89	93	94	94	92
	No	0	16	7	11	7	6	6	8
	Missing	0	0	0	0	0	0	0	0
Motivation (if yes)	General health promotion	63	50	93	64	50	63	25	58
	Weight control	63	56	57	56	57	56	50	56
	Preferring healthier food	44	56	50	56	71	56	25	51
	Others	0	0	7	8	0	0	6	3
	Missing	6	0	7	8	0	0	0	3
Barriers (if no)	Availability of programs / information / resources	0	100	100	0	0	0	0	40
	Lack of time	0	100	0	67	0	100	100	70
	Lack of motivation	0	100	100	67	100	100	0	80
	Bad experience through unsuccessful attempts	0	0	0	0	0	0	0	0
	Others	0	0	0	0	0	0	0	0
	Missing	0	0	0	0	0	0	0	0

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The majority (92%) also reported eating healthily in their own lives mainly for general health promotion (58%), weight control (56%), and a preference for healthier foods (51%). Nutritional practices that are implemented by carers for their own health are: avoiding foods such as sugar, fat, carbohydrates, white flour, salt, fizzy drinks, fast or deep fried foods, treats, bought cakes, crisps, and/or red meat. Healthy practices included having lots of fruits, vegetables, water, proteins, Greek olive oil, and other foods with high nutritional value. Some also use a certain kind of diet such as a Mediterranean diet. Other practices are eating home cooked foods; eating a balanced diet; counting calories; avoiding unhealthy food; following the food pyramid; eating small portions; planning meals and snacks; or eating a high fibre diet. One individual took iron supplements as he or she is vegetarian. Those that did not eat healthily (8%) cited a lack of motivation (80%) and a lack of time (70%) as the main factors contributing to their eating habits.

3.1.4 Current attitudes of carers towards e-learning

Carers were asked if they were currently or if they had ever learned through an online programme. Those that answered affirmatively were asked to rate their experience on a five-point Likert scale and those that did not were asked to list the factors that prevented them from doing so. Carers were also asked if they would be confident receiving training in health, exercise, and nutrition from an online learning platform. Table 7 and figure 3 present the results.

Table 7. Carers' experiences with e-learning programmes and barriers per country and internationally in percent (%)

Participants		Austria	Bulgaria	Germany Muenster	Germany Stuttgart	Greece	Ireland	Israel	International
		16	19	15	28	15	17	17	127
		%	%	%	%	%	%	%	%
Experience in e-learning	Yes	44	26	53	32	67	6	41	37
	No	56	74	40	64	33	94	59	61
	Missing	0	0	7	4	0	0	0	2
Barriers (if no)	Availability of programs / information / resources	33	29	17	28	40	19	10	24
	Lack of technical ability	33	43	50	44	40	31	0	36
	Lack of interest	22	0	33	28	20	19	20	19
	Lack of trust	11	7	33	28	20	0	30	17
	Others	33	0	0	6	0	25	40	15
	Missing	11	21	17	11	0	19	0	12
Confidence in learning via e-learning	Yes	44	53	20	46	53	53	59	47
	No	37	16	0	25	47	23	23	19
	Unsure	19	21	73	25	0	24	18	31
	Missing	0	10	7	4	0	0	0	3

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Figure 3. Carers' experiences with e-learning international results in percent (%)

Most carers (61%) surveyed had never experienced e-learning before. The Irish participants in particular had had very little contact with e-learning (94%) while some of the carers in Greece, Germany (Muenster), Austria, and Israel had experienced e-learning before (see Table 7). Of those who did, most rated the experience between "good" and "excellent" on a five-point scale (see Figure 3). Lack of technical ability (36%) was listed as the main deterring factor although lack of opportunity was also a big factor (24%) (see Table 7). Other reasons that prevented the carers from learning through an e-learning platform were lack of necessity, not having the necessary devices (computers, etc.), lack of opportunity, and preferring to learn through personal interaction with a tutor/class. Confidence in receiving training in health, exercise, and nutrition from an e-learning platform was varied with 47% saying that they would feel confident, 19% saying they would not, and another 31% reporting that they would be unsure. The German participants of Muenster in particular were sceptical about e-learning while the Israeli participants demonstrated greater confidence.

3.1.5 Best means of reaching carers

Carers were asked about the best ways to reach and inform carers (formal and informal) about new programs and resources available to them.

Carer/care providing organisations (86x) was the most cited means of reaching carers with social media (54x) also highlighted as an effective means. Traditional advertising such as advertisements in print publications (46x) and TV and radio (39x) were also rated highly (see Figure 4). Another suggestion made by one carer was to use email as an effective method of dissemination.

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Figure 4. Best ways to reach carers internationally (in total numbers)

3.1.6 Attitudes of carers towards the WHOLE project

Participants were asked about whether they feel there is a necessity for a programme like WHOLE which would teach carers about how to implement healthy practices to prevent frailty and decline in older care recipients. Carers could also provide their feedback and opinions about the project.

The overall attitude to WHOLE by carers was positive, 64% reported that there is a necessity for a program like WHOLE, although a significant amount (12%) reported not seeing a need for it and an additional 21% reported being unsure (see Figure 5).

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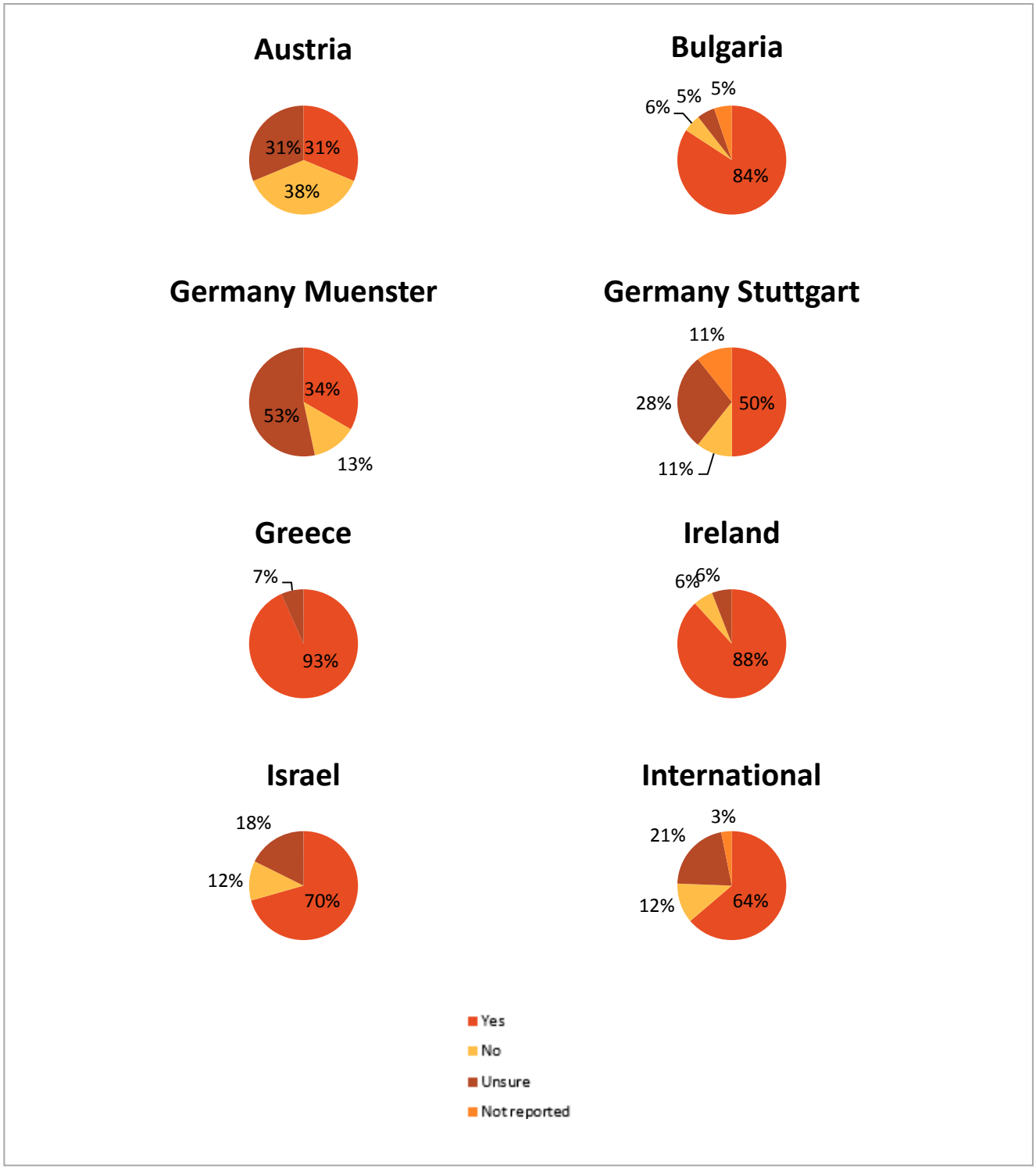

Figure 5. Carers' opinion of the need for a program like WHOLE per country and international in percent (%)

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General feedback about the project – opinions[3]

Positive

- 'I think the project will be beneficial not only to current carers to older people, but also to future experts in this area.'
- 'With my busy schedule, e-learning is the best way for me to apply this programme and take part.'
- 'I would like to have professional training in order to keep my mother in shape and boost her energy — e-learning could be fun!'
- 'E-learning provides us with visual information that will make the learning process much easier.
- 'The goal of the WHOLE programme is to promote health; there is nothing more important than that.'
- 'Wonderful idea! Would love to learn more about healthy eating and exercise. I think that any exercise series would have to be short (10-15 min) due to care recipients' short attention spans.'
- 'I think a programme for carers to introduce physical activity (gentle) and healthy eating advice into their caregiving to help older people would be very good. It would prevent frailty and promote health and mental wellbeing for longer. I work with Irish home care as a carer/home help calling to my clients and assisting them in keeping and maintaining their independence and. I treat them with dignity and respect and always stay observant to make sure that they are happy in their own home. An online programme for music would be very relaxing for older clients if you had access to internet.'

Negative

- 'Difficult to integrate because of lack of time.'
- 'It's hard to change what you've been doing all your life.'
- 'I'm not sure of the necessity for further training. As a carer, the everyday work of caring takes over your life as the "cared for one" gets more dependent. There is a huge amount of info already available, booklets on "food care", nutrition, exercise, etc. In my experience, it's not lack of information; it is habit, respecting the likes/dislikes of your loved one, fitting in with other family members. Your loved one has to relinquish so much of their former life, their independence, their ability to enjoy food, increased medications that alter taste, affect digestion. As a carer we are the ones "pushing" them to change all the time. On a personal note, when I get old I want to do what I like doing/eating what I want to eat. If it shortens my life, I would rather be happy than healthy!'

Neutral

- 'I like that I am part of an evolving industry. Things are changing fast.'
- 'I don't need a programme like "WHOLE" as I constantly inform myself about health-relevant topics. For our society in general, I think it is undoubtedly necessary.'
- 'More independent living, more integration into community, making people more aware of people with intellectual disabilities, carers should be vetted a lot more, everyone is entitled to a voice.'
- 'My work invokes independent living so I just help people to maintain independence in their own home.'

[3] Note that some feedback may have been translated or edited for clarity.

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General feedback about the project — suggestions to consider

- 'In my opinion, the project should include not only topics related to physical activity and healthy nutrition, but also problems related to social exclusion of older people.'
- 'The main problem in Bulgaria among informal carers is lack of time and information about the behavioural patterns of older people. Dementia, which can lead to behavioural problems, is also a problem. Perhaps some brief information relevant to that could be included in the course.'
- 'Organise more workshops and meetings for carers.'
- 'I would like to see a community-based programme that allows carers to meet up maybe once every 3 months to chat, share ideas, and support each other, so as not to feel alone and see how others are getting on in their lives.'
- 'It would be nice to see an information programme set up for the carers, especially those who care for their family members at home, so that they can understand and learn as much as possible about caring for people and to help them along the way. Make a network of people to care for the carers and to help with information and feedback. Who cares for the carers?'
- 'Easy handling on the computer tablet with big font.'
- 'On-the-job training.'
- 'Some rural areas have very little internet coverage and may not be able to avail of an online programme.'
- 'Clients appear to completely follow guidelines regarding diet and exercise given to them by their GP so I feel that if GPs were aware of the project they could encourage clients to partake for their own benefit.'
- 'Carers are in general busy people, caring for their love ones or clients. Motivation may be an issue as they may be physically and emotionally drained. There are courses available, iPhone training, and others that a small number of people use.'
- 'In my case, I had a lot of help from professionals who directed me what to do and where to get advice from the outset. Others may not have this or may not be in a position to ask through their upbringing/education/family/social network, etc.'
- 'It would be advisable to ensure that the product is easily followed and can be accessed by all age groups as carers come in a wide range of ages.'

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3.2 Care recipients

The second part of this chapter shows the results of care recipients including demographical data (3.2.1) and their current attitudes and habits in relation to physical activity (3.2.2) and nutrition (3.2.3). It also demonstrates their perceptions about the impact of a healthy lifestyle on personal health (3.2.4) as well as their overall attitude towards the WHOLE project (3.2.5).

3.2.1 Demographical data

Table 8. Demographical data care recipients per country and internationally in total (No.) and percent (%)

Participants		Austria		Bulgaria		Germany Muenster		Germany Stuttgart		Greece		Ireland		Israel		International	
		26		37		9		64		51		12		45		244	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Age	60 – 69	3	11,5	5	13,5	1	11,1	6	9,4	17	33,3	0	0,0	4	8,9	36	14,8
	70 - 79	2	7,7	18	48,6	2	22,2	13	20,3	22	43,1	3	25,0	13	28,9	73	29,9
	80 – 89	11	42,3	13	35,1	4	44,4	29	45,3	11	21,6	4	33,3	22	48,9	94	38,5
	90 - 99	4	15,4	0	0,0	1	11,1	9	14,1	1	2,0	3	25,0	6	13,3	24	9,8
	Missing	6	23,1	1	2,7	1	11,1	7	10,9	0	0,0	2	16,7	0	0,0	17	7,0
Gender	Male	4	15,4	13	35,1	3	33,3	15	23,4	24	47,1	4	33,3	24	53,3	87	35,7
	Female	19	73,1	24	64,9	6	66,7	46	71,9	27	52,9	7	58,3	21	46,7	150	61,5
	Missing	3	11,5	0	0,0	0	0,0	3	4,7	0	0,0	1	8,3	0	0,0	7	2,9
Kind of care[4]	Formal	6	23,1	2	5,4	2	2,22	8	12,5	9	17,6	2	16,7	12	26,7	41	16,8
	Informal	0	0,0	22	59,5	3	33,3	5	7,8	30	58,8	2	16,7	21	46,7	83	34,0
	Mixture of both	14	53,8	7	18,9	4	44,4	15	23,4	11	21,6	7	58,3	12	26,7	70	28,7
	Other[5]	2	7,7	6	16,2	0	0,0	4	6,3	1	2,0	1	8,3	0	0,0	14	5,7
	None	0	0,0	0	0,0	0	0,0	28	43,8	0	0,0	0	0,0	0	0,0	28	11,5
	Missing	4	15,4	0	0,0	0	0,0	4	6,3	0	0,0	0	0,0	0	0,0	8	3,3

The largest percentage of care recipients (38.5%) were between the age of 80 and 89 while 29.9% were in the age group 70 – 79. The overall mean age was 79.18 years. It is worth noting though that most care recipients surveyed were in receipt of informal care (34%) or a mixture of formal and informal care (28.7%). Some countries had higher levels of care recipients receiving informal care, namely Bulgaria (59.5%), Greece (58.8%), and Israel (46.7%) with the remaining countries (Austria, Ireland, and Germany) demonstrating more older people receiving formal or mixed care. 61.5% of participants were female.

[4] Formal care: 'providing professional care'; informal care: 'caring for a friend, relative, neighbour, etc.'
[5] Other kinds of care: personal assistance, guidelines from a doctor, friends

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3.2.2 Current attitudes and habits of care recipients in relation to physical activity

Care recipients were asked if they implement physical activity into their everyday life. Those that answered affirmatively were asked if the physical activity they engaged in was offered as part of the care they received or undertaken of their own motivation. They were also asked to list the kinds of physical activity they did. Those that did not engage in physical activity were asked to give details of the factors preventing them from doing so. Care recipients were also asked to say whether they would be confident receiving physical activity training from their carer if that carer were trained. Table 9 presents the results.

The majority of care recipients (67%) said that they exercise in their everyday lives and listed walking (87%) and stretching (30%) as the preferred means of exercise followed by strength training (20%). Of those who are physically active in everyday life, 14% do it as part of daily care and 39% through their own motivation.

Other activities undertaken by the care recipients were for example:

- activities of daily living such as housekeeping, temporary work, cooking, gardening, farmer jobs, repairs, or personal care;
- physical activities such as dancing, gymnastics, 5 Esslinger, biking, physiotherapy, sport for seniors, swimming, physical therapy, ergo therapy, mild physical training, physical exercise every morning, gym three times a week together with other older people;
- relaxing activities such as yoga or Qigong;
- passive activities such as massage or lymph drainage;
- other activities such as commuting.

Of those who did not exercise, anxiety about injury (34%) was the main factor preventing physical activity along with unavailability of programmes, resources, and information (27%) and lack of motivation (26%). Other reasons for not implementing physical activity into everyday life included particular medical conditions such as multiple sclerosis, Parkinson's Disease, and emphysema as well as general poor health such as physical limitation due to illness, physical limitations/disabilities, immobility, visual defects, tiredness, breathing problems, no activity due to stroke, or lack of physical strength and energy.

Although the majority (55%) said that they would be confident receiving physical activity training from a carer if they were appropriately trained, 20% said they would not be confident and a further 19% were unsure.

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Table 9. Physical activity (PA) in everyday life of care recipients, kinds of activities, and barriers. Confidence in receiving gentle physical activity as part of caregiving per country and internationally in percent (%)

Participants		Austria	Bulgaria	Germany Muenster	Germany Stuttgart	Greece	Ireland	Israel	Inter-national
		26	37	9	64	51	12	45	244
		%	%	%	%	%	%	%	%
PA in everyday life	Yes	58	76	44	89	49	67	71	67
	No	38	21	56	11	51	33	29	30
	Missing	4	3	0	0	0	0	0	3
PA specification (if yes)	As part of daily care	31	35	0	9	10	17	0	14
	Own motivation	42	46	33	70	33	33	0	39
	Missing	4	8	11	14	8	25	71	21
Kind of activities (if yes)	Walking	40	100	100	91	84	75	75	87
	Stretching	27	18	25	41	20	63	22	30
	Strength training	20	7	25	34	4	0	22	20
	Armchair aerobics	0	4	25	18	0	13	19	12
	Others	33	21	0	29	20	13	3	21
	Missing	33	0	0	2	8	0	0	5
Barriers (if no)	Availability of programs / information / resources	10	25	0	13	38	50	31	27
	Anxiety about injury	50	13	40	50	42	0	15	34
	Lack of interest	10	0	0	13	12	50	31	15
	Lack of time	0	0	0	13	0	25	0	3
	I don't think I need to	10	13	0	13	12	0	0	9
	Lack of motivation	20	63	20	13	35	0	8	26
	Others	30	25	60	63	4	25	8	22
	Missing	40	0	20	13	0	0	0	8
Confidence in receiving PA in care	Yes	34	68	56	44	80	50	45	55
	No	50	0	22	16	0	33	42	20
	Unsure	8	32	22	20	20	17	13	19
	Missing	8	0	0	20	0	0	0	6

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Table 10. Interest in taking part in WHOLE per country and internationally in percent (%).

Participants		Austria	Bulgaria	Germany Muenster	Germany Stuttgart	Greece	Ireland	Israel	Inter-national
		26	37	9	64	51	12	45	244
		%	%	%	%	%	%	%	%
Interest in participation in WHOLE	Yes	8	14	34	31	80	67	69	45
	No	73	35	33	31	6	16	24	29
	Unsure	15	51	33	25	14	17	7	22
	Missing	4	0	0	13	0	0	0	4

A similar lack of confidence was demonstrated in response to the question about whether the care recipients surveyed would be interested in taking part in a programme like WHOLE (see Table 10). 45% said that they would while 29% said that they would not be interested and 22% said they would be unsure. Austria and Bulgaria in particular demonstrated a weak interest while care recipients in Greece, Ireland, and Israel showed more interest. The main motivational factors (see Figure 6) for getting involved with WHOLE were that it would encourage the care recipients surveyed to exercise and would improve overall health (124x) and help towards the management of medical conditions (81x), keeping busy/active (78x), and avoiding health problems and frailty (72x). Improved mood, socialising, and fun were also cited frequently as motivational factors (73x). Other factors that would encourage care recipients to be physically active included combating pain (1x), having better overall health (1x), feeling better while moving (1x), and stroke recovery (1x).

Figure 6. Motivation for international care recipients to become active (in total numbers)

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3.2.3 Current attitudes and habits of care recipients in relation to nutrition

Regarding their attitude and habits in relation to nutrition, care recipients were asked if they currently implemented healthy nutritional practices into their everyday lives. Those that answered affirmatively were asked to list what kind of nutritional practices they implemented and those that did not were asked to list the factors preventing them from practising good nutrition. Table 11 presents the results.

The majority of care recipients said that they practised good nutrition (78%) mainly by using reduced fat/salt products (52%) and following the food pyramid (41%) and controlling diets for medical conditions (33%). Nutritional practices implemented by care recipients for their own health include: avoiding sweets, avoiding meat (vegetarianism), and including a lot of vegetables, fruits, wholemeal products, vitamins, minerals, enzymes, and water in their diet. Other practices were eating a varied diet, eating food appropriate to lactose intolerance, eating in the canteen, organic food, age-appropriate nutrition and healthy dishes, following their individual habits, knowing what is good for them, producing their own organic vegetables and fruits, only eating breakfast and lunch or fasting from 4 p.m. Those who did not eat healthily generally said that it was not a priority for them (76%) and that they lacked interest (30%). Other barriers for healthy nutrition included relying on canteen food, the perception that there is no need to focus on nutrition if they are currently in good health, only cooking what they like daily, and other complaints such as lack of appetite or obstipation. A majority (61%) said that they would be confident receiving nutritional advice from trained carers with only 34% reporting having received some sort of nutritional advice from carers already.

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Table 11. Healthy nutrition (NU) in the everyday life of care recipients, kinds of activities and barriers. Confidence in receiving nutritional advice as part of caregiving per country and internationally in percent (%)

Participants		Austria	Bulgaria	Germany Muenster	Germany Stuttgart	Greece	Ireland	Israel	Inter-national
		26	37	9	64	51	12	45	244
		%	%	%	%	%	%	%	%
Healthy NU	Yes	77	86	78	78	71	100	78	78
	No	23	14	22	14	29	0	22	19
	Missing	0	0	0	8	0	0	0	3
Kind of practices (if yes)	Food pyramid	35	47	14	8	19	50	100	41
	Reduced salt / fat products	37	34	43	70	58	33	29	52
	Controlling diets for medical conditions e.g. diabetes	30	50	57	28	39	33	11	33
	Following medically prescribed nutritional programs	5	28	0	6	28	8	11	20
	Others	20	6	14	28	3	8	6	13
	Missing	10	0	14	12	0	0	0	5
Barriers (if no)	Availability of programs / information / resources	0	0	0	14	20	0	30	15
	Anxiety about damaging health	33	0	0	57	0	0	20	17
	Lack of interest	17	0	50	43	47	0	20	30
	Against protocol	0	0	0	0	13	0	0	4
	No priority	33	100	50	86	53	0	20	76
	Others	17	0	0	29	0	0	0	7
	Missing	33	0	50	86	0	0	0	20
Confidence in receiving healthy NU in care	Yes	38	81	56	52	88	67	38	61
	No	35	0	44	23	0	16	49	21
	Unsure	15	19	0	13	12	17	13	13
	Missing	12	0	0	12	0	0	0	5

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3.2.4 Attitudes of care recipients on the impact of healthy lifestyle on personal health

Care recipients were asked to rate how convinced they were that even small amounts of gentle physical activity and slight changes to diet can have a significant impact on overall health, mood, and level of independence, as well as helping improving common medical conditions. Overall the participants were convinced (see figure 7).

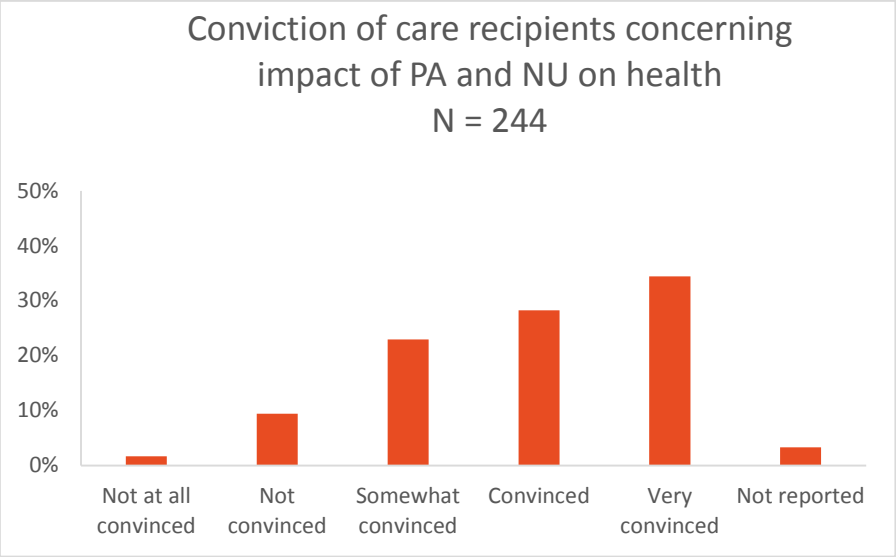

Figure 7. Conviction of care recipients concerning impact of physical activity (PA) and healthy nutrition (NU) on health in percent (%)

3.2.5 Attitude of care recipients towards the WHOLE project

Care recipients were also asked if they think there is a necessity for a programme like WHOLE, which teaches carers how to implement healthy practices to prevent frailty and decline in older care recipients. Carer recipients could also provide their feedback and opinions about the project.

Care recipients in comparison to the carers were a little more receptive with 67% reporting that they believed a programme like the one proposed by WHOLE is necessary (see Figure 8). 7% said that it is not necessary and 20% were unsure. The care recipients from Austria, Bulgaria, and Germany demonstrated more doubt on this question than the care recipients from Greece, Ireland, and Israel.

General feedback about the project

- ‘She thinks it would be good.’
- ‘In your work, you should consider the illnesses of older people and their skills. Just a few older people in our country have computer skills.’
- ‘The participant would prefer to receive the information through presentations.’
- ‘Considerations: What should a carer learn besides their knowledge so far? At the end, only graduates from high schools can become carer.’

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Figure 8. Care recipients' opinion of the need for a program like WHOLE per country and international in percent (%)

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4 Discussion and consequences for the programme

The questionnaires were created based on the results gained in case studies and focus groups, which were also part of the needs analysis process. All results are based on the contributions of the partnership. Almost all partners could use their existing networks in the formal care sector while also reaching some informal carers, which facilitated contact to this often difficult to reach target group. The results are therefore not representative of carers or care recipients overall because these existing networks were used instead of a random sample. All partners tried to spread the questionnaires as broadly as possible to get variation among formal and informal carers in different age groups as well as care recipients receiving formal, informal, and mixed care. Overall, the response rate for carers was 80% and for care recipients 47%, which shows that, even with existing networks, reaching care recipients was problematic. The fact that some could use their existing networks and others did not have such networks is evident in the variation in the numbers of participants (especially care recipients) between the partner countries.

The following section will discuss the results gained in the needs analysis conducted through questionnaires for carers and care recipients, which focused on the topics of attitudes and habits in relation to physical activity (4.1) and nutrition (4.2) for carers and care recipients as well as attitudes in relation to e-learning for carers (4.3) and the best ways of reaching carers (4.4). Chapter 4.5 covers the attitudes of from both carers and care recipients to the WHOLE project in general. A conclusion for the target group will be drawn in chapter 4.6. The needs analysis research report ends with a methodological framework for the development of the training programmes for physical activity and nutrition and for the e-learning model (4.7).

4.1 Current attitudes and habits of carers and care recipients in relation to physical activity

The overall results concerning the attitudes and habits in relation to physical activity demonstrate a need for a programme like WHOLE for physical activity in caregiving from the carers' perspective. 68% of all carers are currently implementing physical activity into their caregiving. In Austria, Ireland, and Germany (Muenster) in particular, 80% or more are physically active with their care recipients. On the other hand, only 40% of the carers in Bulgaria are implementing physical activity into their daily care. The most typical activity among the care recipients is walking. Other common methods of physical activity are strength exercises or stretching, which are implemented by 21% and 26% of participants respectively. Possible reasons may be that they do not see the necessity or that they do not know what they could do. This supports the partnership's stance that there is a need for a programme that addresses the lack of resources and programmes available and which provides information that will explain the benefits of physical activity to support care recipients and carers in maintaining independent living for as long as possible while also promoting fun ways for carers and care recipients to be active together. The fact that those carers who do not implement physical activity in their caregiving see the lack of available programmes as the biggest barrier does support this assessment.

Another barrier that has to be considered is the anxiety about causing injury (mentioned by 34% of carers). All exercises have to be simple and safe and safety precautions and tips have to be given to

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create trust in being active without causing injuries. In spite of this anxiety, 71% would be confident implementing such a programme if provided with training.

A majority (77%) of all carers are implementing physical activity in their daily life, mainly for general health promotion, stress relief, weight control, and fun/socialising. Those carers who do not implement physical activity in their own lives cited lack of time and motivation as the main deterring factors. A programme like WHOLE could potentially aid towards remedying both hindering factors while supporting the health promotional aspect of physical activity by integrating exercise into the normal routine of daily caregiving. This would also mean that carers would not have to take time away from their care recipients in order to exercise, something that can be difficult, particularly for full-time informal carers. Participating in physical activity with another person — in this case, the care recipient — also provides motivation and a stronger likelihood of consistently following a physical activity plan.

The majority (67%) of care recipients also implement physical activity into their everyday lives, some through their own motivation while others do it as part of daily care. Their most common activity is walking. Only a few engage in strength exercises or other activities that are important to retaining physical capacities. Additionally, physical activities could bring fun and variety into their everyday (care) life when done together with the carer. Lack of motivation, availability of resources, and anxiety about injuries are the most common reasons for not implementing physical activity into daily life. It is very important that these factors are addressed by the project consortium as the programme developed will not be used if the target group cannot see the benefits and are not convinced of the safety of the exercises. Comprehensive and good quality information together with an appealing and safe programme will therefore be critical. The problem with motivation and information is demonstrated in the contradiction that most care recipients are convinced that even small changes to nutrition and physical activity can make a difference to overall health, mood, and level of independence (chapter 3.2.4) but, despite this, many are not active. Additionally, half of all care recipients would be motivated to be active if overall health would be improved (chapter 3.2.2) and most believe that this is possible through small changes to physical activity and nutrition. This gap between motivation, possible encouraging factors, and current behaviour has to be considered in the design of the programme. Another important point that has to be addressed is the care recipients' confidence in the carers' abilities, as only half of the care recipients would currently trust trained carers to guide them in exercise.

4.2 Current attitudes and habits of carers and care recipients in relation to nutrition

A majority of carers are already monitoring the nutrition of both their care recipients' and their own diet. Additionally, the care recipients report that they also monitor their own diets. Most do avoid certain kinds of food, such as salt and fat, and a large percentage also follow the food pyramid. For a healthy diet, a mixture of several aspects combined with some general healthy behaviour would be optimal. One additional observation made by the Irish project partners when addressing this question in the case studies and focus groups with care recipients is that often the older adults thought that their diet was better than it actually was, which was revealed upon further questioning on the topic.

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Those who do not implement healthy nutrition in care mention the lack of resources and the lack of interest from care recipients as the main hindering factors.

For carers, the main barriers to good nutrition were lack of motivation and lack of time. In this case, the carers could also benefit from the preparation of healthy meals for their care recipients, which they could also enjoy, and from the nutritional tips they would learn. For care recipients, healthy nutrition is not a priority but neither carers nor care recipients exhibited any insecurity with implementing healthy diet guidelines as part of care. This means that small tips to improve nutrition may be the best way to address the carer and care recipients instead of changing the whole diet of both parties. Additionally, for those care recipients and carers that already do eat healthily according to their own personal assessment, these tips will provide the possibility to compare their habits and introduce more variation if desired.

4.3 Current attitudes of carers towards e-learning

The majority (61%) of carers that participated in this survey have not experienced e-learning yet. However, even without experience, almost half of them would be confident in training received via e-learning, but a large percentage expressed uncertainty with some stating an outright lack of trust in e-learning. This demonstrates that there is some willingness. It also suggests that making the platform as easy to utilise as possible should be a major priority. This assessment of the importance of accessibility and ease of use is also supported by the fact that lack of technical ability is the biggest barrier to carers using e-learning programmes.

4.4 Best means of reaching carers

For the planning and implementation of dissemination activities for the WHOLE project, the project consortium should take into consideration that carer or care-providing organisations are the best means to reach and inform carers about new programmes according to their own assessment. A mix of social media and advertisements in print publications would bring additional dissemination opportunities as those ranked second and third in the carers' own recommendations. To reach a broad target group, a mixture of all of these suggestions combined with personal and organisational networks will be essential.

4.5 Attitudes of carers and care recipients towards the WHOLE project

Generally, both carers and care recipients show an interest in and a need for a programme like WHOLE. However, participants from some countries are more convinced than others. German and Austrian carers and care recipients are the most sceptical, while, for example, the Israeli, Irish, and Greek participants are more certain in the necessity for such a programme. The well-established information policy that will be needed to show the benefits and the safety of the programme (see Chapter 4.1) may be more important in countries that are sceptical than in those that already are more open to such

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programmes. Important aspects that may cause some difficulties in the implementation have been mentioned and the feedback of carers and care recipients about the programme will be considered in the development. Overall, the results show that there is enough of a necessity for WHOLE to launch it successfully with the long-term goal being to encourage more people to participate once the project is established and has demonstrable results, usability, and high quality standards.

4.6 Conclusion for the target group

The general feedback about the project and the results of this needs analysis show that there is a general interest in WHOLE. Carer and care recipients both agree that there is a need for such programmes. However, even if both target groups agree on the need for it, carers have more trust in their abilities to implement physical activities and nutrition if trained than the care recipients do in their carers' abilities. The care recipients will have to be convinced to trust their carers and be motivated to test the WHOLE programme with the support of their carers. Of course, there are also doubts and barriers from the carers' side that were mentioned. The biggest challenge will be the lack of time and resources of formal carers and the anxiety about injuries from the informal carers. Most of the formal care systems of the participating countries do not allow additional activities outside what has been recommended, agreed, and paid for in their care plans. The formal carers therefore cannot implement the programme even if they are convinced of its merit. The focus for the target group will therefore lie in informal carers who can use the e-learning platform and implement the activities with their care recipients. Ideally, the formal carers would disseminate the programme (see also best means of reaching carers) and would support the informal carers in the implementation process.

4.7 Methodological framework

During the needs analysis research process, including the case studies, focus groups, and the questionnaires, the project consortium felt assured about the importance of physical activity and healthy nutrition for the care sector. They could also see that the positive social interaction element of healthy practices is an important point for the health and wellbeing of carers and care recipients, especially for those care recipients who are supported by formal carers and live alone. Based on these experiences, the research in the literature review, and knowledge from various experts in different fields, we could define the following goals for our programme (see Figure 9).

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Figure 9. Goals specified for carers (left) and care recipients (right) as well as goals for both target groups (middle)

Based on this interaction with the target groups, the consortium could draw some conclusions for the methods that they will integrate into the development of the training programmes for the physical activity and the nutrition section. They also got some insight into how to develop the e-learning platform. These are depicted and summarised in Figure 10.

- Use pictures and videos
- Use short and simple lessons
- Accommodate different fitness levels and fitness components
- Use adult-focused activities
- Provide information about safety precautions

- Use pictures and videos
- Use short and simple lessons
- Consider cultural backgrounds
- Consider specific health problems

- Create a platform that is accessible and easy to use with an inviting layout
- Provide a safe environment to enhance trust in online programmes
- Consider user support
- Provide written materials and plans

Figure 10. Methodological Framework

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