GINKGO
The social link factory

Co-funded by
the European Union

Training Program

Table of Contents

Introduction

This training program was designed to strengthen the knowledge and skills necessary to prevent social isolation among older adults, particularly those at risk of losing touch with social life. It aims to promote their participation and increase opportunities for inclusion.

The training program is the result of a structured and collaborative process, developed in several stages with the active involvement of project partners and their Local Technical Committees (LTCs), composed of local stakeholders concerned with this issue.
The goal is to build a curriculum based on concrete data, capable of addressing the specific needs of the regions involved, through a shared definition of key concepts, training priorities, and best practices.

The first phase involved identifying, through focus groups and questionnaires, core values, concepts, and keywords. These contributions helped to develop a detailed understanding of local perceptions and needs, thereby providing a solid foundation for the program's design. Analysis of the collected data then made it possible to identify training priorities and highlight the most relevant existing practices, while ensuring alignment with the project's other work packages (WP3 and WP4) to ensure consistency and complementarity.

Meetings with the CTLs were a key part of the process: they allowed for the sharing and discussion of results, the gathering of specific feedback, the refinement of concepts, and the confirmation of training priorities. Based on these elements, modules were designed and developed to provide practical solutions to the identified needs. A review phase followed, incorporating further discussions with the CTLs to adjust and improve the program's structure.

The final version of the program thus produced reflects an inclusive and participatory approach. It not only ensures alignment with local realities but also emphasizes cooperation, knowledge sharing, and the strengthening of local expertise.

Key Concepts

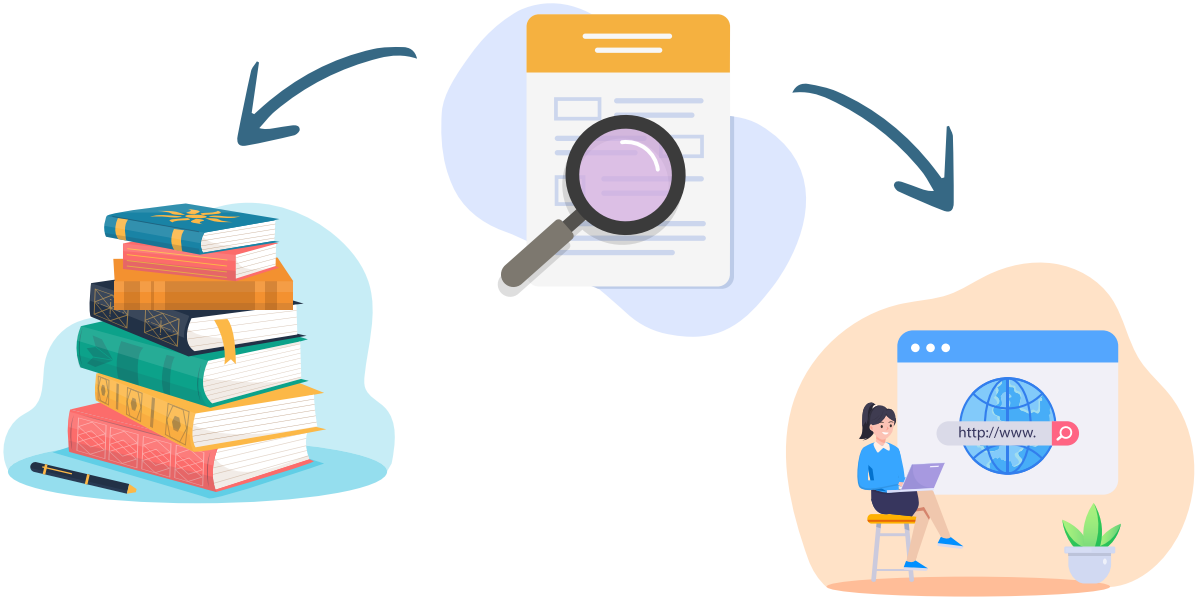
Key Concepts: an essential theoretical framework for “ ”

Before delving into the training modules, it is important to introduce the fundamental concepts that underpin the entire program.

These key concepts provide an essential theoretical framework for understanding the challenges related to aging, social inclusion, and wellbeing.

Each of these concepts is presented clearly and thoroughly, with a structured theoretical explanation, references from academic literature, and a selection of online resources—including websites where available—for further exploration.

This approach aims to balance intellectual rigor with accessibility, enabling each reader to explore these topics according to their needs and level of interest.



Isolation, Loneliness, and Social Exclusion

Social isolation has generally been defined as being "alone", that is, as an objective condition characterized by limited or infrequent social contacts and interactions with others (Cornwell & Waite, 2009; Dickens et al., 2011).

Older adults are often at greater risk for this due to factors such as retirement and the loss of loved ones and reduced mobility (WHO, 2021). Furthermore, changing family dynamics and geographic dispersion can exacerbate social disconnection among older adults (Smith & Victor, 2019). Nicholson (2009) proposes a multidimensional conception of social isolation, emphasizing the importance of considering not only the number of contacts but also a sense of belonging, the quality of relationships, and social engagement.

Loneliness, on the other hand, delete refers to the feeling of "being alone." Psychological approaches, particularly cognitive models, have been predominant in explaining this concept. Loneliness is defined as a subjective and emotional experience arising from a discrepancy between desired and actual social relationships (Peplau & Perlman, 1982). Weiss (1983) and De Jong Gierveld & Van Tilburg (2010) distinguish between two types of loneliness: emotional loneliness, linked to the absence of meaningful relationships, and social loneliness, linked to the absence of connections within one's immediate social circle. Relationships perceived as ideal are not universal but vary according to cultural and social contexts.

Furthermore, loneliness is generally perceived as a negative experience with a significant impact on the well-being of those who experience it. However, it can also be a choice, although in such cases it is often accompanied by negative stereotypes (Sagan & Miller, 2018), such as a lack of social skills or an inability to maintain satisfying relationships.

Several studies have focused on the individual characteristics, personality traits, and social and contextual factors that may predispose people to loneliness. It has been found that, although loneliness increases with age, it affects all age groups (Dykstra et al., 2005; Czaja et al., 2021). Evidence shows that it is particularly prevalent among people in poor health, those who have experienced a loss (such as widowhood), or those in precarious economic situations (D'Hombres et al., 2018; Niedzwiedz et al., 2016). It is also a subjective phenomenon, varying from person to person, both in terms of the likelihood of experiencing it and in the way it is experienced. Although social isolation and loneliness are distinct, they are related but do not always occur together (Deluigi & Ricci, 2023). The COVID-19 pandemic illustrates this point, with the worsening of loneliness due to social distancing, travel restrictions, and lockdowns.

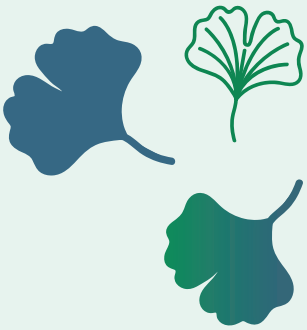
According to research, 25% of European Union citizens experienced persistent loneliness more than half the time during this period (Baarck et al., 2021; Berlingieri et al., 2023).

With the growing recognition that loneliness is largely a product of social dynamics and structural factors, this phenomenon has begun to receive greater attention in sociology, particularly among those studying processes of social exclusion. Social exclusion is a polysemic concept, with meanings that vary according to territorial and historical contexts. It generally refers to the breakdown of social ties and the difficulty of achieving of well-being (Walker & Walker, 1997; Seifert et al., 2021).

The weakening of these ties is linked to loneliness and isolation, as excluded individuals have fewer protective factors.

Rapid changes in our environment, such as shifts in family structures, the weakening of social and professional relationships, increased in mobility, and the decline in the quality of social services, significantly affect individuals' ability to build and maintain support networks.

To learn more...



REFERENCES

- Berlingieri, F., Colagrossi, M. and Mauri, C., *Loneliness and social connectedness:* insights from a new EU-wide survey, European Commission, 2023, JRC133351. https://publications.jrc.ec.europa.eu/repository/handle/JRC133351
- Cornwell, E.Y. & Waite, L.J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *J. Health Soc Behav.* 50(1), 31-48. doi: 10.1177/002214650905000103
- Dickens, A.P., Richards, S.H., Greaves, C.J. & Campbell, J.L. (2011). Interventions targeting social isolation in older people: a systematic review. *BMC Public Health* 11(647), 2-22. https://doi.org/10.1186/1471-2458-11-647
- Nicholson Jr., N.R. (2009). Social isolation in older adults: an evolutionary concept analysis. *Journal of Advanced Nursing*, *65*. 1342-1352. https://doi.org/10.1111/j.1365-2648.2008.04959.x
- Niedzwiedz, C. L., Richardson, E. A., Tunstall, H., Shortt, N. K., Mitchell, R. J., & Pearce, J. R. (2016). The relationship between wealth and loneliness among older people across Europe: Is social participation protective? *Preventive Medicine*, *91*, 24-31. https://doi.org/10.1016/j.ypmed.2016.07.016

WEBSITES

The European Union Survey on loneliness: https://joint-research-centre.ec.europa.eu/projects-and-activities/survey-methods-and-analysis-centre/loneliness/eu-loneliness-survey_en?prefLang=fr

Global initiative on loneliness and social connection: https://www.gilc.global/

Ageism

Ageism, a term introduced by Robert Butler in the 1960s, refers to stereotypes and prejudices related to age.

Butler (1975), as well as subsequent researchers such as Whitley and Kite (2006) and Nelson (2005), examined how age-related stereotypes influence perceptions of individuals' traits and abilities. Ageism is perpetuated by the way society thinks, feels, and acts toward people based on their age, leading to discriminatory behaviors. Decades of research highlight the impact of ageism, particularly on older adults and adolescents, who are often associated with negative stereotypes that, once internalized, influence cognitive, emotional, and social aspects. This can lead to implicit biases and explicit actions, reinforcing the perception of aging as a problem rather than as a natural part of societal evolution.

Ageism manifests itself through direct, indirect, associative, erroneous, and intersectional forms, often influenced by additional factors such as gender. Ayalon and Tesch-Römer (2017) identify the effects of ageism at three levels: the macro level (cultural stereotypes influencing public policy), the meso level (effects on organizations and services), and the micro level (impact on older adults' self-image and social relationships). This framework categorizes ageism into institutional, interpersonal, and self-inflicted ageism. Institutional ageism involves laws and practices that limit opportunities based on age, while interpersonal ageism manifests itself through marginalizing interactions.

Self-inflicted ageism occurs when individuals internalize negative stereotypes, thereby limiting their potential and restricting their personal development and social participation.

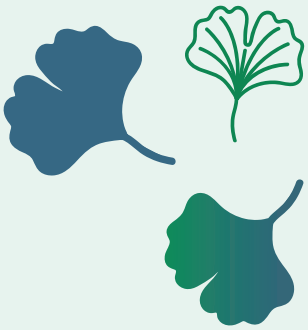
Widespread ageist beliefs imply that older adults lack abilities or social value, which leads to their marginalization in decisionmaking and a downplaying of their contributions to society. These biases limit our understanding of aging, ignoring the great diversity within the older population and the varying degrees of autonomy, active engagement, and dependence that characterize their experiences. Age is not the sole determinant of aging; factors such as genetics, behavior, socioeconomic status, culture, environment, and lifestyle also play a role, as highlighted by Rowe and Kahn (2015).

Recognizing the impacts of ageism, the World Health Organization (WHO) has included it in its Global Strategy on Ageing and Health and the Decade of Healthy Ageing (2021–2030).

The WHO strategy highlights the potential effects of ageism: reduced life expectancy, poorer health, increased risk of poverty, greater vulnerability to abuse, and increased social isolation (WHO, 2021). Women, in particular, may suffer more from ageism in health care due to biased medicalization and a reductive view of their health.

In short, ageism remains deeply rooted in society. Combating these prejudices requires recognizing and transforming stereotypical views of older adults in all areas—personal, family, social, and professional. Valuing older adults by presenting a realistic and diverse picture of aging can foster inclusive and diverse societies that respect and support individuals of all ages.

To learn more...



REFERENCES

- Ayalon, L., & Tesch-Römer, C. (2017). Taking a closer look at ageism: Self- and other-directed ageist attitudes and discrimination. *European Journal of Ageing, 14(1)*, 1–4. https://doi.org/10.1007/s10433-016-0409-9
- Butler, R.N. (1975). Psychiatric and the elderly: An overview. *American Journal of Psichiatry, 132*, 893-90
- Nelson, T.D. (2005). Ageism: Prejudice Against Our Feared Future Self. Journal of Social Issues, 61: 207-221. https://doi.org/10.1111/j.1540-4560.2005.00402.x
- Rowe, J. W., & Kahn, R. L. (2015). Successful aging 2 0: Conceptual expansions for the 21st century. *The Journals of Gerontology: Psychological Sciences and Social Sciences*, 70(4), 593–596. https://doi.org/10.1093/geronb/gbv025)
- World Health Organization. (2021). *The Global report on ageism.* Geneva: World Health Organization. Available: https://iris.who.int/bitstream/handle/10665/340208/9789240016866-eng.pdf?sequence=1

Person-Centered Approach

In recent decades, there has been a major paradigm shift away from the traditional model of care. The personcentered approach has its origins in humanistic psychology, more specifically in Carl Rogers' (1951) client-centered therapy, also known as non-directive therapy.

This form of psychotherapy is based on the constructive and positive tendency toward human development, viewing the individual as an active agent of change, and moves away from the behaviorist approach. Later, Tom Kitwood (1997) applied this framework to the care of people with dementia. According to Kitwood, dementia is not only a neurological condition but also a psychological and social one, in which various factors—whose interaction is crucial to understanding each person's behavior and well-being of each person—such as personality, life history, health, and social environment. It is therefore a psychosocial perspective, in which the disease or pathology is not the sole or predominant aspect. This idea is presented within the VIPS framework (*Valuing; Individuals; Perspective - Perspective; Social Environment* by Dawn Brooker (2007), which involves "valuing" people with dementia and their care environments, treating them as "unique individuals," take their "perspective" into account, and provide a "social environment" that supports their psychological needs.

Kitwood's person-centered approach has been adapted to various care contexts, such as education, health care, gerontology, and disability services.

Unlike traditional approaches, which focus on the individual's problems and institutional functioning, professional practices based on the person-centered care model (known as "Person-Centered Planning" or PCP) aim to provide individualized care and promote people's autonomy and participation in their care processes. The PCP model is a key component of best practices, supported by international organizations such as the World Health Organization (WHO, 2024). According to Collins (2014), the principles underlying PCP are (1) care grounded in dignity and respect, (2) the coordination of support and care over time, particularly during transitions between services, (3) personalized care, avoiding generalized approaches centered on disease or diagnosis, and (4) the development of a supportive environment that fosters the individual's capabilities and helps maintain their autonomy.

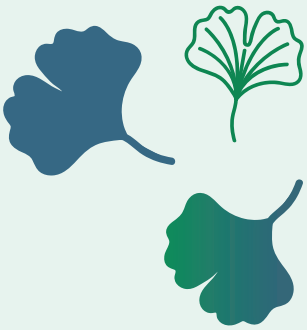
Within the PCP model, the dialogic approach can be incorporated as a professional care methodology aimed at fostering a participatory dialogue with the person receiving care and their immediate environment (both personal and professional). Rogers himself sought to be congruent and authentic in his approach, treating his client-centered therapy as a relationship of encounter and implicitly incorporating dialogical understanding into his model. Interpersonal relationships are essential for human beings; we are born into and live in relationships, and our brains are wired for dialogue (Alderson-Day et al., 2016). This is why we need others to develop our identity, and we need others' responses to understand that we exist for them. All of this is achieved through dialogue, which should not be understood as a speechcentered process, but rather one whose main premise—and that of this model— is listening and the cultivation of this ability. The dialogic approach seeks to find new solutions and possibilities for action through a slow dialogue and the empowerment of the person being assisted. At the very heart of the approach is listening; therefore, professionals must listen carefully to the people they work with so that they feel acknowledged in decision-making regarding their own life processes (Arnkil, 2019).

This dialogue aims to achieve new states and processes based on the individual's own potential. Furthermore, it encourages professionals to establish horizontal relationships with the people in their care, so that they do not tell them what to do, but rather help them express themselves and achieve their set goals.

There are several common tasks involved in creating and sustaining spaces for dialogue, such as (Arnkil, 2019):

- **Organizing the physical space in a way that is conducive to dialogue.**
- **Ensuring that there is sufficient time and that it is allocated in a way that fosters dialogue.**
- **Include all key individuals in the patient's support network and encourage them to participate in person in the dialogue.**
- **Foster a mental space open to respectful curiosity and empathy.**
- **Maintain a dialogic tone with others during meetings and avoid authoritarian language on the part of professionals.**

To learn more...



REFERENCES

- Arnkil, T. (2019). Co-generating dialogic spaces. Challenges for open and anticipatory dialogues and dialogic practices in general. *International Journal of Collaborative -Dialogic Practices, 9(1)*, 51-64.
- Brooker D. (2007). *Person-Centred Dementia Care: Making Sevices Better*. Jessica Kingsley Publishers, London.
- Collins, A. (2014). *Measuring what really matters Towards a coherent measurement system to support person-centred care.* The health Foundation. https://www.health.org.uk/sites/default/files/MeasuringWhatReallyMatters.pdf
- Kitwood T. (1997) *Dementia Reconsidered: The Person Comes First*. Open University Press, Milton Keynes.
- Rogers, C. (1951). *Client-Centered Therapy, its current practice, implications and theory*, éd. Houghton Mifflin.
- World Health Organization (WHO). (2024). *Long-term care for older people: package for universal health coverage.* Geneva: World Health Organization.

WEBSITES

https://www.fundacionpilares.org
(Fundación Pilares para la autonomía personal, Espagne)

https://www.acpfrance.fr/
(training institute,, France)

Life Course Perspective

The life course perspective is a theoretical approach that explores the biological, cognitive, and psychosocial changes, as well as the constants, that occur throughout the life course.

This approach offers fundamental theoretical and methodological principles regarding the nature of human development. The various perspectives on which this view is based form a sort of "family of perspectives" that together contribute to an understanding of the phenomenon (Baltes, 1987). Paul Baltes, a German psychologist and one of the leading experts in the study of development and aging, proposes an approach based on a series of fundamental principles that define the course of in an integrated and continuous manner.

The life-span perspective is based on a number of principles:

(1) Development lasts a lifetime: development is not limited to a specific phase but continues throughout life, from childhood to old age (Baltes, 1987). This implies that processes of change and growth are present at all ages.

(2) Development is multidimensional: according to this principle, development involves several dimensions, including physical, cognitive, and emotional factors, which interact with one another in a (Baltes & Lindenberger, 1997). For example, as a person ages, cognitive changes can influence their emotional well-being and vice versa.

(3) Development is multidirectional: it does not follow a linear path, but is characterized by gains and losses at all ages (Baltes, 1987). For example, a young adult might improve their professional skills but lose certain social skills due to work-related pressures.

(4) Development is plastic: according to this principle, human characteristics are malleable and can change over time in response to external and internal factors (Baltes, 1987). An example of this plasticity can be seen in older adults' ability to adapt to new technologies and lifestyles, demonstrating that development and learning do not stop with age.

(5) Development is influenced by contextual and sociocultural factors: the context in which one lives plays a crucial role in shaping the developmental process. For example, the development of a person growing up in a disadvantaged socioeconomic context will differ from that of a person raised in a privileged environment (Bronfenbrenner, 1979).

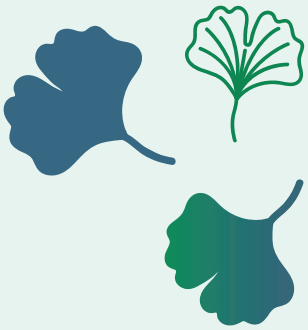
(6) Development is multidisciplinary: the study of development requires the integration of various disciplines, such as psychology, biology, sociology, and anthropology (Sternberg, 1999). This multidisciplinary approach offers a comprehensive view of the many forces that influence human development.

Numerous international public policy documents and European policies have incorporated a life-course perspective, particularly to address the challenges posed by an aging population and the need to promote well-being throughout life. In particular, it should be noted that, in its Global Strategy and Action Plan on Aging and Health (2016), the WHO adopted a life-course approach to promote health at all stages of life. A practical example of this approach is the program for the prevention of chronic diseases in adulthood.
Through health education campaigns—such as promoting active lifestyles and a balanced diet starting in childhood, the goal is to reduce the risk of chronic diseases such as diabetes and cardiovascular disease in later stages of life. In the document "European Pillar of Social Rights" (2017), the European Commission recognized the importance of promoting lifelong learning and active aging. For example, many European initiatives focus on providing training to adult and older workers, enabling them to remain competitive in the labor market. A significant project is the Erasmus+ program for adults, which promotes lifelong learning, enabling individuals to acquire new skills regardless of their age. The United Nations' global initiative, the United Nations Decade of Healthy Aging (2021–2030), is based on a life-course perspective (WHO, 2023).
An example of the practical implementation of this policy is support for projects that engage older adults in social and physical activities, thereby improving their quality of life.

For example, intergenerational volunteer programs, in which older adults offer their time and experience for the benefit of younger people, have been promoted as part of this initiative, fostering connections between generations and the transmission of knowledge.

In conclusion, the life-course perspective provides a fundamental theoretical framework for understanding human development at all stages, from birth to old age. The emphasis on the multidimensionality and plasticity of development highlights how individuals, even in old age, have the capacity to change, learn, and grow. Furthermore, international and European policies are increasingly adopting this perspective, recognizing the need to promote well-being and development throughout life. Finally, scientific research continues to show that aging is not merely a period of decline, but also a period of growth and adaptation, with significant practical implications for promoting the health and well-being of older adults.

To learn more...



REFERENCES

- Baltes, P. B. (1987). Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline. *Developmental Psychology*, 23(5), 611–626.
- Baltes, P. B., & Lindenberger, U. (1997). Emergence of a powerful connection between sensory and cognitive functions across the adult life span: A new window to the study of cognitive aging? *Psychology and Aging*, 12(1), 12–21. https://doi.org/10.1037/0882-7974.12.1.12
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Harvard University Press.
- Sternberg, R. J. (1999). *Handbook of creativity.* Cambridge University Press.

WEBSITES

WHO (2016). Global Strategy and Action Plan on Ageing and Health, https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_17-en.pdf?ua=1

European Commission (2017). European Pillar of Social Rights https://op.europa.eu/webpub/empl/european-pillar-of-social-rights/en/

WHO (2023). Progress report on the United Nations Decade of Healthy Ageing, 2021-2023. https://iris.who.int/bitstream/handle/10665/374192/9789240079694-eng.pdf?sequence=1

Active Aging and Critical Gerontology in Education

Aging is a complex and multifaceted process that varies considerably from one person to another. Research has shown that, although aging is often associated with cognitive decline, not all older adults experience it in the same way.

Many older adults are able to maintain high levels of physical and cognitive functioning, leading to what is often referred to as Successful Aging. The aim here is to provide a brief description of key concepts related to aging, with an emphasis on Active Aging, Successful Aging, and critical perspectives in Educational Gerontology.

Active aging was defined by the World Health Organization (WHO) in 2002 as "the process of maximizing opportunities for health, participation, and security to improve people's quality of life as they age." This concept emphasizes the importance of remaining engaged in social, economic, cultural, and civic activities. It shifts the focus from mere survival to a meaningful life, regardless of physical and cognitive limitations.

Key factors contributing to active aging include:

- **Physical activity:** Regular physical activity helps maintain mobility and reduces the risk of chronic diseases.
- **Cognitive engagement:** Participating in mentally stimulating activities helps delay cognitive decline and maintain or increase cognitive reserve.
- **Social participation:** the inclusion and involvement of older adults in social life, which promotes their well-being and quality of life.
- **Access to healthcare:** Preventive healthcare and medical interventions are essential for managing chronic diseases and maintaining quality of life.

Successful aging is a widely studied model that describes how older adults can age in a healthy and active manner. According to the theoretical framework proposed by Baltes & Baltes (1991), **successful aging involves three main components:**

- **Low likelihood of illness and disability:** Older adults maintain their physical health and minimize the impact of chronic diseases.
- **High level of cognitive and physical functioning:** cognitive abilities, such as memory, reasoning, and problemsolving, are preserved, and physical health is maintained.
- **Active engagement in life:** A sense of purpose and involvement in meaningful activities—both social and productive—contributes to overall well-being.

However, critics of this model suggest that it places too much emphasis on health and physical ability, thereby excluding individuals who do not meet these criteria. This concept may unintentionally marginalize people with disabilities, failing to account for diverse life trajectories.

Critical Gerontology challenges traditional views on aging and emphasizes the importance of social context, diversity, and empowerment. It advocates for a broader understanding of aging that goes beyond medical models, focusing instead on how societal structures, cultural norms, and personal life stories shape the experience of aging.

According to Holstein & Minkler (2007), Critical Gerontology highlights the following aspects:

- **Cultural ideals and norms:** Experiences of aging are influenced by implicit and explicit cultural ideals about what it means to age successfully.
- **Political and social realities:** aging is shaped by policies and societal structures that can either empower or marginalize older adults.
- **Intersectionality:** Factors such as gender, ethnicity, socioeconomic status, and interact, creating unique experiences of aging for each individual.
- **Empowerment through education:** Education is viewed as an ongoing process that can strengthen autonomy and engagement, promoting a more inclusive understanding of aging.

Critical gerontology emphasizes the educational implications of aging, as it is essential to promote lifelong learning opportunities for older adults.

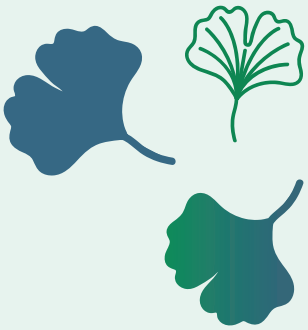
This includes:

- **Compensatory strategies:** educational programs should help older adults develop compensatory mechanisms to cope with age-related challenges.
- **Strengthening and enhancement:** Learning should be viewed as a tool to enhance cognitive functions and strengthen existing abilities, rather than merely mitigating losses.
- **Inclusion and diversity:** Educational efforts must incorporate the diverse experiences of aging, recognizing that not all individuals follow the same path of aging.

In conclusion, models of active aging and successful aging offer valuable insights into how individuals can navigate the aging process.

However, it is equally important to incorporate critical perspectives that highlight the role of social and educational factors in shaping experiences of aging. By emphasizing intersectionality and empowerment, Critical Educational Gerontology offers a more inclusive and humanistic approach to understanding the complexities of aging.

To learn more...



REFERENCES

- Baltes, P. B., & Baltes, M. M. (1991). *Successful aging: Perspectives from the behavioral sciences. Cambridge, MA: Cambridge University Press.*
- Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. In P. B. Baltes & M. M. Baltes (Eds.), *Successful Aging: Perspectives from the Behavioral Sciences* (pp. 1-34). Cambridge University Press.
- Bernard, M., & Scharf, T. (2007). *Critical perspectives on ageing societies*. Policy Press.
- Holstein, M. B., & Minkler, M. (2007). Critical gerontology: Reflections for the 21st century. In M. Bernard & T. Scharf (Eds.), *Critical perspectives on ageing societies* (pp. 13-26). Policy Press.
- Schaie, K. W., & Carstensen, L. L. (2006). *Social structures, aging, and self-regulation in the elderly*. Springer Publishing Company.
- WHO. Active Aging: A Policy Framework. Geneva, Switzeland: WHO; 2002.

WEBSITE

TED TALK Jane Fonda: Life's third act
https://www.ted.com/talks/jane_fonda_life_s_third_act?utm_campaign=tedspread&utm_medium=referral&utm_source=tedcomshare

Intersectionality

The concept of intersectionality emerged in the late 1960s and early 1970s within Black feminist movements, first in the United States and then in Europe.

These movements contributed to postcolonial and queer studies, challenging an essentialist view of women and shifting the focus away from the sex/gender distinction, which until then had dominated the agenda of white feminism. Following these critical studies on gender and race, the term "intersectionality" was first coined by legal scholar Kimberlé Crenshaw in 1989.

Crenshaw (1989) defines intersectionality as a critical analysis that explores how different social identities—such as gender, race, class, ethnicity, sexual orientation, physical abilities, among others—intersect to create unique experiences of oppression and privilege. For example, a woman with a disability may experience both sexism and disability-based discrimination; these two factors combined make her life more complex than that of someone who experiences only one of these forms of discrimination. This perspective is crucial for understanding that identity categories do not exist in isolation, but operate simultaneously and synergistically, generating inequalities that cannot be reduced to single categories.

In addition to this definition, Collins and Bilge (2016) describe intersectionality as an analytical framework for understanding how multiple, interconnected power structures—such as patriarchy, racism, capitalism, and colonialism—work together to produce inequalities.

Another important definition is that of Hancock (2007), who focuses on the dynamic nature of identity categories and emphasizes that intersectionality is not limited to the analysis of oppressed identities, but also involves recognizing the intersections between privilege and inequality. Although the various definitions of intersectionality converge around the concept of "interaction" between identity categories, they vary in their methods and areas of application.

In this regard, Crenshaw (1989) emphasizes the importance of the concept in the legal field, suggesting that laws addressing single forms of discrimination do not adequately address cases of multiple discrimination. This perspective was expanded by Hancock (2007), who proposes that intersectionality can be applied to analyze all social identities to the extent that they are embedded in power relations—not just those of marginalized groups.

Intersectionality has gradually gained widespread acceptance and has begun to influence international policies and human rights legislation. In this context, within the United Nations, the Committee on the Elimination of Racial Discrimination (CERD) and the Committee on the Elimination of Discrimination against Women (CEDAW) have formally recognized the importance of addressing discrimination in their reports.

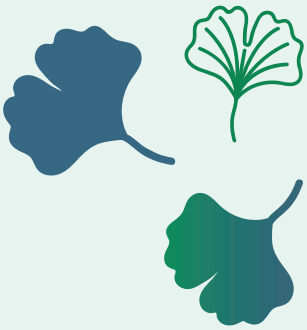
In particular, the Committee on the Elimination of Racial Discrimination has deepened its understanding of intersectionality by addressing topics such as how racial discrimination interacts with health and social status (United Nations, 2023).

At the European level, intersectionality is integrated into European Union (EU) policies. In this regard, the EU's Gender Equality Strategy 2020–2025 explicitly refers to an intersectional approach in the fight against gender inequalities, recognizing that women may face multiple and cumulative forms of discrimination (European Commission, 2020). However, in many cases, laws do not take these intersectional experiences into account, treating each type of discrimination as if it were isolated (Kantola & Lombardo, 2017).

Applying the concept of intersectionality to aging studies is a rapidly growing field. Indeed, aging is a process influenced not only by biological variables but also by social and identity-related factors, such as gender, ethnicity, social class, and sexual orientation (Calasanti & Giles, 2018; Katz, 2005). In particular, the experiences of older adults are not uniform. For example, older women may face discriminationrelated to both sexism and ageism. If she is also a person of color or of modest economic status, these challenges may be exacerbated. Furthermore, it has been observed that older LGBTQ+ individuals face unique challenges stemming from a lifetime of discrimination, which are exacerbated by aging.

In conclusion, intersectionality is a powerful theoretical tool for understanding the interconnections between different forms of inequality. However, integrating the concept of intersectionality into remains an evolving process, requiring more holistic approaches and greater attention to individuals' multiple identities.

To learn more...



REFERENCES

- Calasanti, T., & Giles, S. (2018). The challenge of intersectionality. *Generations*, 41(4), 69–74.
- Collins, P. H., & Bilge, S. (2016). *Intersectionality.* Polity Press.
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989(1), Article 8.
- Hancock, A.-M. (2007). When multiplication doesn't equal quick addition: Examining intersectionality as a research paradigm. *Perspectives on Politics*, 5(1), 63–79. https://doi.org/10.1017/S1537592707070065
- Kantola, J., & Lombardo, E. (2017). *Gender and political analysis.* Bloomsbury Publishing.
- Katz, S. (2005). *Cultural aging: Life course, lifestyle, and senior worlds.* University of Toronto Press. http://www.jstor.org/stable/10.3138/j.ctvg254gf

WEBSITES

European Commission. (2020). A Union of Equality: Strategy for Gender Equality 2020–2025. https://ec.europa.eu

United Nations. (2023). «The Committee on the Elimination of Racial Discrimination Holds Its Seventh Meeting with the States Parties." https://www.ohchr.org/en/news/2023/12/committee-elimination-racial-discrimination-holds-seventh-meeting-states-parties

Quality of Life

The concept of quality of life has been applied over the years in various fields and from different theoretical perspectives.

In 1993, the World Health Organization (WHO) provided the following definition: "It is an individual's perception of their position in life, within the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns. It is a broad concept, complexly influenced by the individual's physical health, psychological state, level of autonomy, social relationships, and relationship with key aspects of their environment." (WHOQOL, 1993, p. 153).

According to this definition, quality of life is influenced by various factors, which vary depending on location, stage of life, and the specific components that determine it (family, social, socioeconomic, etc.). Monique Formarier, a former trainer of healthcare executives and editor-in-chief of the scientific journal *Recherche en soins infirmiers*, identifies the following domains as influencing a person's quality of life:

- **health status and level of disability,**
- **psychological and spiritual aspects,**
- **the family environment and the surrounding context,**
- **socioeconomic status.**

The concept emphasizes the notion of perception, or "the individual's overall satisfaction with the meaning they attribute to well-being." This focus on the individual's perspective adds complexity to the concept: quality of life is an evaluative criterion that, ideally, should be objective, but which is subject to subjective interpretation.

Similarly, according to the World Health Organization's Quality of Life Group (WHOQOL, 1993), "quality of life is defined as an individual's perception of their position in life, within the cultural context and value systems in which they live, in relation to their goals, expectations, priorities, and interests. It is a broad concept, influenced overall by a person's physical health, their psychological state, their degree of dependence, their social relationships, and their connection to the essential characteristics of the environment."

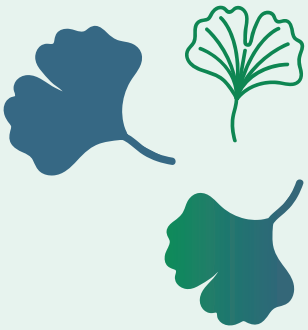
This emphasis on the individual perspective adds complexity to the concept: although quality of life is supposed to be an objective criterion by nature, it is open to subjective interpretation, varying according to each individual's own assessment of their norms and values and evolving over time and across different life stages.

According to Zribi and Poupée-Fontaine, quality of life is partly linked to individuals' opportunities to participate in decisions that affect them, both individually and collectively, as well as to their ability to express themselves, particularly with regard to their living environment, any care plans they may have, and their personal activities. Quality of life thus affirms the right to free choice, informed consent, access to all personal information, and participation in their personalized care plan.

This implies recognizing individuals as "subjects" to be supported rather than as "objects" to be cared for. Quality of life is also linked to the ability to express oneself at the collective, institutional, and societal levels: the individual is a subject of rights, with the right to express their views on issues that concern them, the groups to which they belong, institutions, and society. The goal is to enable individuals to exercise their role as citizens and not be confined to the role of passive recipients.

As Emanuela Lopez summarizes in the report **Qualità della vita in età evolutiva**, "in short, quality of life is a broad concept involving multiple dimensions of life, representing a subjective perception of how individuals feel about their health status. In other words, it encompasses an individual's feelings about their life, their healthrelated values, their emotional and social functioning, and their relationships with their family and friends. The emphasis on subjectivity and multidimensionality implies that a description of an individual's quality of life should not reflect the opinions of healthcare professionals or family members, nor should it be based on an objective measure of a person's condition or possessions, but rather should include a wide range of criteria." (Lopez, 2013, p. 9).

To learn more...



REFERENCES

- Formarier, M., & Jovic, L. (2012). *Concepts in Nursing Science.* Mallet conseil.
- Hervy*, M. P. (2013). Recommendations on Quality of Life in Long-Term Care Facilities: Why This Topic?. *Empan*, (4), 126-132.
- Lopez, D. S. E. (2013). Quality of life in childhood: http://www. salute. gov. it/imgs/C_17_notizie_1363_listaFile_itemName_2_file. pdf.
- Poupee-Fontaine, D., & ZRIBI, G. (2002). Dictionary of Disability. EHESP
- WHOQoL Group. (1993). Study protocol for the World Health Organization project to develop a Quality of Life assessment instrument (WHOQOL). *Quality of life Research*, 2, 153-159.

WEBSITES

http://www.who.int/healthinfo/survey/WHOQOL-BIBLIOGRAPHY.pdf

https://www.anffas.net/it/cosa-facciamo/supporto-alle-persone-con-disabilita/qualita-della-vita/

https://www.nucleodoconhecimento.com.br/psicologia-it/qualita-della-vita

https://www.pnrr.salute.gov.it/imgs/C_17_notizie_1363_listaFile_itemName_2_file.pdf

Empowerment

Empowerment is a crucial concept, both as a value-based orientation for social intervention and as a theoretical model for understanding the processes and outcomes associated with exercising control and influence over decisions affecting personal life, organizational effectiveness, and quality of life in the community (Perkins & Zimmerman, 1995; Rappaport, 1981; Zimmerman & Warschausky, 1998).

Despite conceptual advances, empowerment remains an ambiguous concept, still poorly articulated within the context of health promotion. Several authors have observed that the relevance and lasting significance of empowerment in this discipline could be threatened by the variable use of this term (Rissel, 1994; Wallerstein, 1992; Zimmerman, 2000). The World Health Organization (WHO) defines empowerment in mental health as the ability of service users to exercise choice, make decisions, exert influence, and control over events in their lives (2010). In line with this view, Rappaport (1984) describes empowerment as a process that enables individuals and organizations to take control of their lives. However, this definition lacks specificity regarding the specific processes at different levels of analysis. These definitions suggest that empowerment is linked to the exercise of control, participation in achieving shared goals, access to resources, and a critical understanding of the sociopolitical context.

A project aimed at developing individual empowerment and promoting autonomy must address several dimensions: individual, socio-relational, and institutional.

At the individual level, empowerment manifests itself in the development of skills such as self-esteem, selfconfidence, a sense of personal efficacy, and the ability to self-assess (Perkins & Zimmerman, 1995). In the sociorelational dimension, projects based on cooperative learning should promote skills such as communication, cooperation, and conflict management (Ninacs, 2008). At the institutional level, empowerment involves creating conditions that foster active participation, awareness of rights and responsibilities, and inclusion in decision-making processes.

Empowerment requires a set of knowledge, skills, and relational strategies that enable individuals and groups to set goals and develop effective strategies to achieve them, using available resources. From a practical standpoint, exercising empowerment means pursuing goals, striving to achieve them, recognizing one's capacity to influence events, managing change, and building positive and collaborative relationships (Zimmerman & Warschausky, 1998).

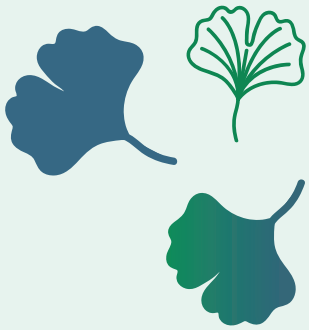
Although research has primarily focused on the individual level, there is a growing need to further explore empowerment at the organizational and territorial levels in order to better understand its implications and dynamics in different contexts.

At the organizational level, empowerment manifests itself through processes and structures that encourage member participation and improve effectiveness in achieving objectives. At the community level, it involves collective actions aimed at improving quality of life and strengthening ties between organizations and local stakeholders (Zimmerman & Warschausky, 1998). It is important to note that organizational and community empowerment is not limited to the sum of "empowered" individuals; it is a a broader and more complex collective process.

A key aspect of the conceptualization of territorial empowerment—one that is particularly discussed in the literature on health promotion—concerns the distinction between empowerment as a process and as an outcome. Rissel (1994) emphasizes that there is broad consensus that territorial empowerment is both a process and an outcome. However, measuring empowerment in either of these dimensions remains complex, as there is no consensus on which is more easily quantifiable or on the most appropriate methodological tools (Zimmerman, 2000; Wallerstein, 1992).

Some authors propose conceptualizing collective empowerment as a multi-level construct that develops in three stages: individual and psychological empowerment, collective empowerment, and, finally, social and/or political empowerment (Rissel, 1994; Zimmerman, 2000; Wallerstein, 1992).

To learn more...



REFERENCES

- Ninacs, W. A. (2008). *Empowerment et intervention.* Presses de l'Université du Québec.
- Perkins, D. D., & Zimmerman, M. A. (1995). Empowerment theory, research, and application. *American Journal of Community Psychology*, 23(5), 569–579. https://doi.org/10.1007/BF02506982
- Rappaport, J. (1981). In praise of paradox: A social policy of empowerment over prevention. American Journal of Community Psychology, 9(1), 1–25. https://doi.org/10.1007/BF00896357
- Rappaport, J. (1984). Studies in empowerment: Introduction to the issue. Prevention in Human Services, 3(2-3), 1–7. https://doi.org/10.1300/J293v03n02_02
- Rissel, C. (1994). Empowerment: The holy grail of health promotion? Health Promotion International, 9(1), 39–47. https://doi.org/10.1093/heapro/9.1.39
- Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. American Journal of Health Promotion, 6(3), 197–205. https://doi.org/10.4278/0890-1171-6.3.197
- Zimmerman, M. A. (2000). Empowerment theory: Psychological, organizational and community levels of analysis. In J. Rappaport & E. Seidman (Eds.), Handbook of community psychology (pp. 43–63). Springer. https://doi.org/10.1007/978-1-4615-4193-6_2
- Zimmerman, M. A., & Warschausky, S. (1998). Empowerment theory for rehabilitation research: Conceptual and methodological issues. Rehabilitation Psychology, 43(1), 3–16. https://doi.org/10.1037/0090-5550.43.1.3

WEBSITES

WHO (2010) *User empowerment in mental health – a statement by the WHO Regional Office for Europe.* https://iris.who.int/bitstream/handle/10665/107275/WHO-EURO-2010-8556-48328-71752-eng.pdf?sequence=3

Community-based Approach

In recent years, the territorial approach has gained prominence in public policies, regulations, and recommendations concerning care for older adults.

Unlike the traditional care model, this approach focuses on the realities of local communities. European institutions support this shift, advocating for a personcentered long-term care model based on proximity, rather than on traditional institutions. Principle 18 of the European Pillar of Social Rights (European Commission, 2017) emphasizes the right to affordable, high-quality long-term care services, particularly home care and community-based care. This model is based on the idea that community-based care improves the quality of life for people in need of long-term support by promoting their social inclusion, autonomy, and respect for their life choices.

The local environment refers to the social and territorial space where families interact, where social support networks are formed, and where public life primarily takes place. In general terms, the territorial approach can be understood as an intervention method that uses the local fabric and its components as active agents to promote quality of life, care, and protection for individuals—all of which are strongly influenced by social ties and their relationship with key elements of their environment.

Collective well-being within the local environment is the goal of this approach, achieved through the shared responsibility of stakeholders, who act cohesively while embracing local diversity (Sennett, 1999).

Territorial approaches rely on the collaboration and participation of the various actors present in local environments. To be effective, these interventions must be sustainable, designed for the medium or long term, and not limited to one-off, short-lived projects. Furthermore, the active and equal participation of all parties, particularly the most vulnerable groups, is essential (Chaskin et al., 2001; Bridger & Luloff, 1999).

A key element of the territorial approach is the mutual support generated through neighborhood relationships. Neighborhood solidarity, based on mutual support rather than charity, is indispensable for an effective intervention. Spade (2020) identifies three essential elements of mutual support: 1) meeting survival needs while understanding the root causes of inequalities; 2) encouraging solidarity among people from different backgrounds; and 3) promoting meaningful participation in autonomous and collective processes.

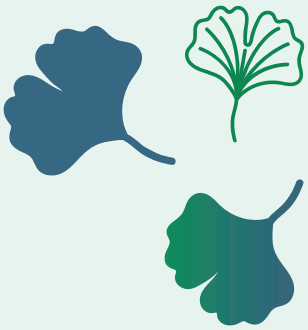
Networking is another central strategy of the territorial approach, facilitating shared responsibility.

This requires creating spaces for coordination and dialogue among institutions and groups working at the local level, such as: 1) organizing forums for local stakeholders to meet, reflect, and build cohesion; 2) implementing inclusive methods that respect and incorporate the diversity of ; and 3) the coordination of actions by local groups, collectives, and public entities to address the existing and emerging needs of the various stakeholders involved.

This approach seeks to align institutional perspectives with the values of the local community, viewing the territory as the driving force behind its own development. Local action is essential, as it allows for the adaptation of resources to local needs and ensuring their autonomy in managing conservation resources.

Brenner and Haaken (2000) argue that the lack of recognition of the is an obstacle to public policy. They suggest that effective care policies must support the rebuilding and strengthening of local, democratic structures.

To learn more...



REFERENCES

- Brenner, J. & Haaken, J. (2000). Utopian thought: Revisioning gender, family, and community. *Community, Work & Family*, 3(3), 333-347. https://doi.org/10.1080/13668800020006839
- Bridger, J.C. & Luloff, A.E. (1999). Toward an interactional approach to sustainable community development. Journal of Rural Studies, 15(4), 377-387. https://doi.org/10.1016/S0743-0167(98)00076-X
- Chaskin, R. J., P. Brown, S. A. Venkatesh, & A. Vidal. (2001). *Building community capacity*. New York: Aldine.
- European Comission (2017). The European Pillar of Social Rights. Publications Office of the European Union.
- Sennett, R. (1999): The Corrosion of Character: The Personal Consequences of Work in the New Capitalism, Nueva York, W.W. Norton.

Public Policies and Co-Responsability

The use of the term "shared responsibility" in the field of elder care refers to the need to view care resources as an integrated system, in which public policies, families, the private sector, and civil society must jointly engage in caregiving.

This concept emerged within the field of gender studies to draw attention to the limitations of work-family balance policies, which were primarily aimed at encouraging women to reduce their working hours and their presence in the workplace in order to continue fulfilling their role as the primary caregivers within the family (Leira, 2002). In contrast to this view, the perspective of shared responsibility goes further and considers caregiving to be a need that cannot be met exclusively within the family, but one that must be addressed collectively.

This perspective has its origins in the work of feminist theorists of the 1970s, who recognized that care is a fundamental issue for social, economic, and political life, one that transcends the private sphere. Traditionally, care was linked to the family and was perceived as a daily activity performed by women, without any for this work. Daly and Lewis (2003) coined the term "social care" to counter this essentialist view, highlighting the social dimension of caregiving activities and the multiplicity of actors who must be involved in this responsibility.

Thus, the state, families, the private sphere, and local actors must all participate in caregiving. The imbalance among these four actors—known as the four pillars of the "care diamond" (Razavi, 2007)—creates tensions, inequalities, and a risk of neglect for older adults.

The combined efforts of these actors are essential in the current context of the "care crisis" (Hochschild, 1995), where the growing need for care due to an aging population coincides with a time when the traditional resources for providing this care—women within the family—are no longer available or guaranteed. In light of this situation, it is necessary to implement strategies that, at the same time, provide additional resources to ensure care for the elderly. Within the family context, the involvement of men is essential. Although there has been progress in their involvement in caring for children, their participation in caring for the elderly remains limited, with male caregivers being more common when the person in need of care is their partner, whereas in the case of parents, the majority of the responsibility is delegated to other women.

The most immediate consequence is caregiver burnout, which negatively impacts the caregiver's physical, psychological, emotional, social, and economic well-being, with unequal effects on women and men (Mosquera et al., 2016).

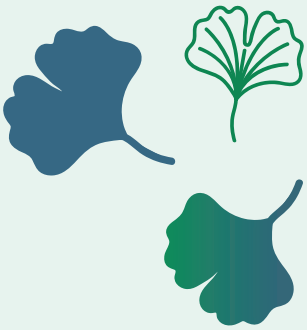
In the realm of public policy, it is necessary to move toward models that guarantee care as an individual right, placing it on the same level as other areas of well-being, such as health, education, or retirement. Institutions must ensure the promotion of a that involves all sectors and levels of government to address the challenges posed by caregiving. Similarly, institutions must refocus their attention on the needs of individuals and families and build on their active role. More specifically, improving coordination between families, social care services, and the health care system is key to making progress toward ensuring care.

The private sector is increasingly involved in the care sector, either through direct hiring by families or through participation in major competitive bidding processes managed by public administrations (residential care centers or care services (such as working from home). In both cases, there is a common profile for workers in this sector: a woman working under precarious conditions. It is therefore necessary to move toward regulating this sector to the same level as other sectors of activity and to improve labor inspections in this area.

Finally, the principle of shared responsibility calls for the mobilization of civil society in the development of care services to ensure that older adults can receive care in their local communities—a principle included in the Action Plan of the European Pillar of Social Rights (European Commission, 2017). Local action policies that foster collaboration among local stakeholders and a community-based approach to social services play an important role in the collective organization of care (Finch, 1983). Facilitating the development of local initiatives that promote care is an essential role for institutions. In this regard, initiatives such as mutual aid networks or the organization of respite activities for caregivers are valuable strategies that can be promoted at the local level.

In short, discussing Co-Responsability in elder care implies understanding that care is a right and that, to guarantee it, it is necessary to mobilize new resources that help reduce the gender and social class disparities that have traditionally shaped the organization of care.

To learn more...



REFERENCES

- Daly, M. & Lewis, J. (2000). The concept of social care and the analysis of contemporary welfare states, T*he British Journal of Sociology*, 51(2), 281-298.
- European Comission (2017). *The European Pillar of Social Rights.* Publications Office of the European Union.
- Finch, J. (1983). Community care: developing non-sexist alternatives. *Critical Social Policy*, 3(9), 6-18. https://doi.org/10.1177/026101838300300902
- Hochschild, A. R. (1995). The Culture of Politics: Traditional, Post-modern, Cold-modern, and Warm-modern Ideals of Care. *Social Politics* 2(3): 331–45.
- Leira, A. (2002). *Working Parents and the Welfare State: Family Change and Policy Reform in Scandinavia.* Ed: Cambridge University Press. Mosquera, I; Vergara, I; Larrañaga, I; Machón, M;del Río, M; Calderón, C. (2016). Measuring the impact of informal elderly caregiving: a systematic review of tools. *Qual Life Res*, 25(5): 1059-92. doi: 10.1007/s11136-015-1159-4
- Razavi, S. (2007). The political and social economy of care in the development context. Conceptual issue, research questions and policy options. *Gender and Development*, *3*, Ginebra, UNRISD.

Violence Against Older Adults

Violence against older adults is a major social and structural problem.

The World Health Organization (WHO) defines it as "a single or repeated act, or a failure to take appropriate action, occurring within any relationship where there is an expectation of trust, and which causes harm or distress to an older person." This violence can be physical, emotional, sexual, or financial, or result from neglect and abandonment, among other forms. Although its true extent is unknown, a 2017 literature review revealed that one in six people over the age of 60 had experienced some form of abuse (Yon et al., 2017).
The underreporting of these cases may be explained by the fact that these situations often occur within family settings, in relationships based on trust and dependence, or because victims find it difficult to report the incidents.
It is important to note that this type of violence is not limited to the domestic sphere but can also occur in institutional settings, such residential centers or other social and health care facilities. Perpetrators may include family members, friends, health and social care professionals, or even strangers. Furthermore, some researchers, such as Chang et al. (2021), highlight structural abuse as another form of violence against older adults, manifesting notably through discrimination in public policies.

Research agrees that, although any older adult can be a victim of violence, certain individual factors increase the likelihood of being victimized. In particular, people in situations of greater vulnerability—such as those with functional limitations, dependency, a disability, frailty, or cognitive impairments—who require assistance from others for daily activities, are at the highest risk. Similarly, there is a higher percentage of female victims compared to male victims, and one of the that increases the likelihood of experiencing violence is social isolation or a lack of social contacts.
Although more research is needed on its impact, ageism—that is, all negative attitudes and stereotypes toward older adults based on their age, is a social factor that can also contribute to the development of violent behavior. Furthermore, there are individual factors that increase the risk of abuse, such as caregivers with a history of substance abuse, mental health issues, economic dependence, or stress and burnout related to caring for an older adult, as well as a lack of knowledge about aging and caregiving processes, insufficient caregiving skills, and a scarcity or inadequacy of support resources.

Abuse of older adults, in its various forms, constitutes a violation of human rights, undermining equality, physical integrity, and the right to a life free from violence. Although there are references to the rights of older adults in international treaties and agreements, such as the European Charter on the Rights and Responsibilities of Older People in Need of Long-Term Care, which is based on the need to recognize and affirm the rights of the most vulnerable older adults, there is still no specific, legally binding international law dedicated exclusively to the protection of this group,

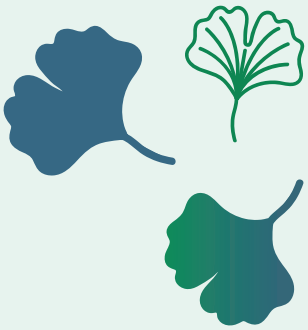
apart from the Charter of Fundamental Rights of the European Union, which recognizes, in Article 25, the right of older adults to a dignified and independent life. Organizations such as HelpAge International are advocating for the creation of a specific UN Convention on the Rights of Older Adults, which would serve as a protective instrument and promote global change to prevent and eliminate violence.

At the same time, EU institutions are also moving toward a human rights-based approach to aging. This approach promotes the development and the implementation of a model that places "human rights principles and standards at the center of all aspects of service planning, policies, and practices" (ENNHRI, 2017, p. 6).

This ensures that life in old age is characterized by choice, control, and autonomy, just as in other stages of life (FRA, 2018).

Ultimately, violence against older adults remains a low priority globally. That is why the World Health Organization (2022), as part of the United Nations Decade of Healthy Aging (2021–2030), has identified five priorities for preventing and responding to this type of violence: combating ageism, improving the quality and quantity of data on its prevalence as well as on risk and protective factors, develop cost-effective solutions, justify the necessary investments, and raise funds to meet this challenge.

To learn more...



REFERENCES

- Chang, E-S., Monin, J. K., Zelterman, D., & Levy, B. R. (2021). Impact of structural ageism on greater violence against older adults: A transnational study of 56 countries. *BMJ Open*, 11(5), -7. https://doi.org/10.1136/bmjopen-2020-042580
- European Network of National Human Rights Institutions (ENNHRI). (2017). *Respect my rights: An ENNHRI Toolkit on Applying a Human Rights-Based Approach to Long-term Care for Older Persons.* ENNHRI. https://ennhri.org/wp-content/uploads/2019/10/ennhri_17_005_toolkit_for_care_providers-03a-page.pdf
- European Union Agency for Fundamental Rights (FRA). (2018). *Shifting perceptions: towards a rights-based approach to ageing.* Publications Office of the European Union. https://fra.europa.eu/en/publication/2018/fundamental-rights-report-2018
- World Health Organization (2022). Tackling abuse of older people: five priorities for the United Nations Decade of Healthy Ageing (2021–2030). Geneva: World Health Organization. https://www.who.int/publications/i/item/9789240052550
- Yon, Y., Mikton, C. R., Gassoumis, Z. D., & Wilber, K. H. (2017). Elder abuse prevalence in community settings: A systematic review and meta-analysis. Lancet Global Health, 5(2), 147-156. doi: 10.1016/S2214-109X(17)30006-2

WEBSITES

https://www.who.int/ (World Health Organization)

https://www.helpage.org/ (HelpAge Internacional)

https://www.nia.nih.gov/health/elder-abuse (National Institute on Aging)

Bientraitance

According to the Haute Autorité de Santé (HAS) in France, "bientraitance" is defined as: "A comprehensive approach to the care of the patient or service user and the support provided to their loved ones, aimed at promoting respect for their rights and freedoms, attentive listening, and consideration of their needs, while preventing abuse" (HAS).

The HAS considers bientraitance to be:

- **A holistic approach that recognizes others in terms of their humanity, their rights, and their needs.**
- **A way of being, acting, and expressing oneself that is attentive to others, responsive to their needs, and respectful of their choices and refusals.**
- **An active approach that goes beyond simply preventing abuse.**

This definition highlights several essential aspects:

- Respect for the rights and freedoms of the individual.
- Attentive listening and consideration of individual needs.
- Prevention of all forms of abuse.
- A comprehensive, patient- or person-centered approach that includes their support network.

The ANESM (National Agency for the Evaluation and Quality of Social and Medical-Social Services) defines welltreatment as "a culture that inspires individual actions and collective relationships within an institution or service, aimed at promoting the wellbeing of the service user."

The ANESM's main recommendations include:

- A culture of respect for the individual, their history, their dignity, and their uniqueness.
- A way for professionals to be, speak, and act that is attentive to others and their needs.
- Recognizing the person receiving care as a co-creator of their care journey.
- A continuous effort to adapt to the situations encountered.

Well-being is a collaborative approach aimed at identifying the best possible support for the person receiving care, respecting their choices, and tailoring care as closely as possible to their needs. This recommendation serves as a reference framework for all ANESM guidelines and underpins best professional practices. The of "bientraitance" involves a continuous cycle of reflection and action. It requires both collective reflection on professional practices and rigorous implementation of the measures recommended by this reflection to foster continuous improvement. From this perspective, it consists of adopting a culture of continuous questioning (HAS). The HAS emphasizes that promoting wellbeing is a major priority for the healthcare system, by strengthening user engagement in their care, improving the quality of life for

healthcare professionals at work, and fostering continuous improvements in practices.

In social work, bientraitance is characterized by:

- A respectful and empathetic professional attitude involving active, attentive, and compassionate listening, transparent communication, and empowering the individual's personal expression.
- Taking into account the needs and choices of the person being supported, with tailored interventions.
- Respect for the individual's dignity and rights, prioritizing "care" over the mere "provision of care."
- An approach that promotes autonomy and well-being while actively combating all forms of abuse (physical, psychological, financial, and medical).

Well-being requires constantly adapting practices to meet the specific needs of each individual. This involves:

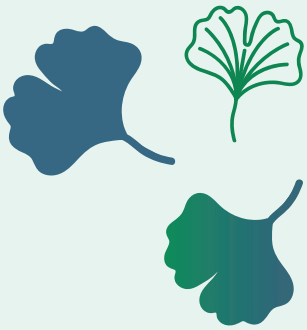
- The development of individualized care plans.
- Continuously adjusting interventions as needs change.
- Training and support for professionals.
- Supporting teams in their efforts to promote bientraitance.
- Encouraging reflective practice to continuously improve care.

Well-being is a dynamic process that requires:

- Regular evaluation of practices.
- Implementation of continuous improvement initiatives.
- An openness to internal and external contributions to enrich support.

In conclusion, well-being in practice involves a holistic and proactive approach focused on respecting and improving the well-being of the person receiving support, while supporting professionals in their mission and by continually adapting institutional practices.

To learn more...



REFERENCES

- Guillou, M-C. et Verlucco, M-J. (2022). Manuel de la bientraitance. Éditions Médiaspaul France.
- French National Authority for Health (HAS). (2012). La bientraitance : Definition and Guidelines for Implementation. Recommendations for Good Professional Practices.
- National Agency for the Evaluation and Quality of Social and Medical-Social Institutions and Services (ANESM). (2008). bientraitance : Definition and Guidelines for Implementation.
- Casagrande, A. (2016). La bientraitance : Definitions and Applications. Dunod.
- Moulias, R., Moulias, S., & Busby, F. (2010). “bientraitance”: What Is It? Gerontology and Society, 33(133), 10–21.
- Rapoport, D. (2006). La bientraitance in Child Care: Roots and Wings. Belin.
- Schmitt, M. (2013). “Bientraitance”: An Ethics of Care. Soins, 58(780), 31–33.
- Graz, B., Plancherel, F., Gervasoni, J. P., & Hofner, M. C. (2009). “Child-Centered Care”: An Exploration of the Concept and an Attempt at Its Application in Public Health. An Experience in Fribourg (Switzerland). Public Health, 21(1), 89–99.
- Delamarre, C. (2014). Dementia and Life Planning: Supporting People with Alzheimer’s Disease or Related Conditions. Dunod.
- Svandra, P. (2010). Is Care Compatible with “Bientraitance”? Gerontology and Society, 33(133), 23–31.

WEBSITES

https://www.has-sante.fr/

https://www.has-sante.fr/upload/docs/application/pdf/2018-03/reco_bientraitance.pdf

Nonviolent Communication

Nonviolent Communication (NVC), developed by Marshall Rosenberg (2003), is a communication method rooted in humanistic psychology.

Raised in Detroit during a period of racial and social unrest, Rosenberg studied clinical psychology and comparative religion, immersing himself in the lives of "peacemakers" to understand the dynamics of violence and ways to reduce it.

In 1984, he founded the Center for Nonviolent Communication, an international nonprofit organization promoting NVC in 30 countries, reaching a diverse audience— teachers, psychologists, parents, mediators, managers, inmates, law enforcement officers, military personnel, members of the clergy, and public administrators—through seminars designed to foster constructive interactions.

NVC emphasizes understanding the unmet needs underlying words and actions to reduce hostility, alleviate suffering, and build fulfilling relationships. It develops three fundamental communication skills:

- Self-empathy (a compassionate awareness of one's own inner experience),
- Empathy (understanding another person's perspective through attentive listening),
- Authentic self-expression (communicating clearly and sincerely).

The method shifts attention away from thoughts of right and wrong, duty, or guilt toward four essential elements:

1. Facts,
2. Feelings,,
3. Needs,
4. Possible ways to address to these needs (strategies/requests).

NVC encourages careful observation and prioritizes understanding based on facts rather than moral judgments. This approach involves expressing needs directly without criticism, leading to clear statements of desired outcomes. Through NVC, individuals gain a better understanding of the roots of their feelings, recognize shared human needs (from survival to respect and autonomy), and formulate specific, present-oriented requests.

The Listening component of NVC aims to understand others' needs beyond criticism, judgment, or aggression. It invites individuals to choose empathy over conflict by recognizing the basic elements—facts, feelings, needs, and strategies—even when they are masked by judgments or demands.

NVC suggests that conflicts arise from unmet needs and that alternative strategies exist to meet these shared needs. Although needs are universal and can foster mutual understanding, strategies are often subjective, varying by individual and cultures.

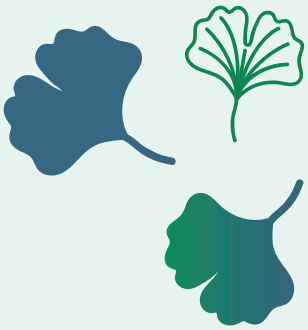
By focusing on shared needs, NVC helps bridge divides and supports collaborative problemsolving.

In mediation, the facilitator's role is to:

- Help each party identify their needs (regardless of initial expressions),
- Ensure that each party understands the other's needs,
- Encourage empathy to understand each person's perspective,
- Promote a clear recognition of personal and mutual needs,
- Help translate solutions into concrete steps.

Through NVC, Rosenberg has introduced peacebuilding programs in conflictaffected regions such as Rwanda, Burundi, Nigeria, Malaysia, Indonesia, Sri Lanka, Sierra Leone, the Middle East, Colombia, Serbia, Croatia, and Northern Ireland.

To learn more...



REFERENCES

- Rosenberg, Marshall (2003). Nonviolent Communication: A Language of Life. Puddledancer Press.
- Rosenberg, Marshall B. (2005). Speak Peace in a World of Conflict: What You Say Next Will Change Your World. Puddledancer Press. p. 240.
- Rosenberg, Marshall (2006). The Nonviolent Communication Training Course. Boulder, Colorado: Sounds True, Inc. pp. Disc Eight, "How Nonviolent Communication Supports Social Change".
- Rosenberg, Marshall (2005). The Heart of Social Change: How You Can Make a Difference in Your World. Encinitas, California: PuddleDancer Press. pp. 10-12.
- Rosenberg, Marshall (August 2002). Nonviolent Communication: A Language of Compassion (8th Printing ed.). Encinitas, California: PuddleDancer Press. pp. 155-163.

WEBSITES

https://www.cnvc.org

https://www.nonviolentcommunication.com/index.htm

Biopsychosocial Perspective

The Biopsychosocial (BPS) model provides a comprehensive framework for understanding aging, integrating biological, psychological, and social aspects. When combined with the principles of Active Aging and Successful Aging, this model offers a holistic approach to caring for older adults, addressing physical, mental, and social well-being, as well as living conditions.

Biological, Psychological, and Social Dimensions in Action

The biological, psychological, and social elements of aging continually interact, shaping the experiences of older adults.

Here are some examples of how these dimensions are integrated:

- Chronic diseases and mental health: Physical conditions such as heart disease or arthritis can affect an older adult's mental health. Chronic pain, for example, can lead to anxiety or depression. Conversely, mental health issues such as depression can worsen physical health by reducing self-care or adherence to treatment, thus illustrating the interaction between biological and psychological factors.
- Cognitive Decline and Social Engagement: Cognitive impairments often lead to social withdrawal, as individuals fear embarrassment. However, strong social networks and mental stimulation through social engagement can help preserve cognitive function, demonstrating how social connections mitigate the effects of cognitive decline and promote resilience.
- Physical activity and emotional resilience: Exercise benefits both physical and mental health by improving mood and reducing stress. Participating in group physical activities strengthens social bonds, contributing to emotional well-being. This example shows how biological practices such as exercise can have a positive impact on psychological health and social connectedness.

Holistic interventions based on the BPS model

Within the BPS model, interventions must simultaneously address biological, psychological, and social needs.

Here are some examples of integrated care:

- Comprehensive health assessments: Health checkups should include assessments of mental health and social environments. Screening for depression and asking about social support can help identify how mental health issues or social isolation may exacerbate physical conditions.
- Collaborative care planning: a team of healthcare professionals — doctors, psychologists, social workers, and occupational therapists — should work together to create personalized care plans.

By taking biological, mental, and social factors into account, these plans provide integrated solutions that combine medical treatments, counseling, and community engagement.

- Social Prescription: Instead of medication, some older adults may benefit from social activities that promote engagement. "Social prescription" involves connecting individuals to resources such as senior centers seniors or social clubs, thereby improving their physical and mental health.

Empowering Older Adults Through an Integrated Approach

The BPS model enables older adults to lead independent and fulfilling lives, even in the face of age-related challenges:

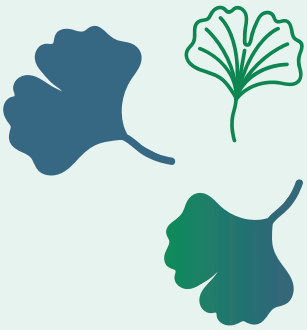
- Building resilience: Emotional resilience helps individuals cope with the challenges of aging. Support groups, therapy, or mindfulness practices can help you develop coping mechanisms and maintain a positive outlook.
- Strengthening social networks: Strong social connections with family and friends, along with involvement in the local community, promote emotional well-being.

Social engagement provides a support system that counteracts the negative effects of aging.

- Supporting caregivers: Caregivers play a vital role in the well-being of older adults. Providing them with training and resources to address not only physical needs but also emotional and social needs enables more balanced care.

The BPS model offers a holistic approach to supporting older adults, taking into account the interconnectedness of biological, psychological, and social factors. By promoting physical, mental, and emotional health, caregivers can help older adults maintain their independence and quality of life as they age.

To learn more...



REFERENCES

- Guillou, M-C. et Verlucco, M-J. (2022). Handbook of Well-Treatment. Éditions Médiaspaul France.
- Baltes, P. B., & Baltes, M. M. (1990). Successful aging: Perspectives from the behavioral sciences. Cambridge University Press.
- Borrell-Carrió, F.; Suchman, AL. & Epstein, RM. (2004). The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. *Annals of Family Medicine*, 2(6), 576-82. doi: 10.1370/afm.245.
- Ding, L., Dai, R., Qian, J., Zhang, H., Miao, J., Wang, J. Tan, X. & Li, Y. (2024). Psycho-social dimensions of cardiovascular risk: exploring the impact of social isolation and loneliness in middle-aged and older adults. *BMC Public Health*, *24*, 2355 (2024). https://doi.org/10.1186/s12889-024-19885-w
- Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. Science, 196(4286), 129-136.
- George, L. K., & Ferraro, K. F. (Eds.). (2015). Handbook of aging and the social sciences. Academic Press.

Training modules

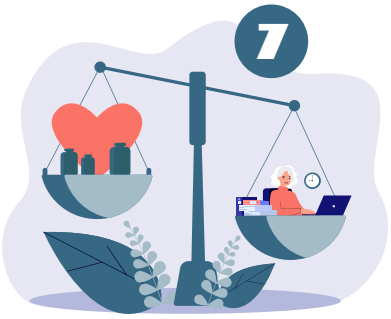
The Training Path: Modules and Connections

This visual representation provides a structured overview of the training program, highlighting the main modules and their interconnections.

The modules are designed to be fully flexible and adaptable.
All elements, including target groups, learning objectives, unit content, duration, learning environments, materials, references, and terminology, can be adapted to the participants' prior knowledge, skills, and learning needs.

In addition, the workshops—presented as cross-cutting elements—offer practical and interactive experiences that reinforce what has been learned and develop skills across a variety of topics.

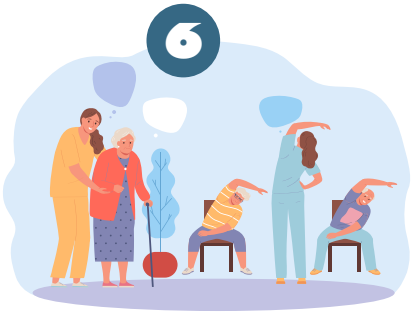
Network Building and Local Engagement



Promoting the quality of life and well-being of caregivers and healthcare professionals (prevention of burnout)

Workshop on narrative communication—telling stories through video

Workshop on Narrative Communication—Telling stories through photography



Biopsychosocial Perspective

Serving as a roadmap, this outline guides the training process by promoting a comprehensive, coherent, and integrated approach.

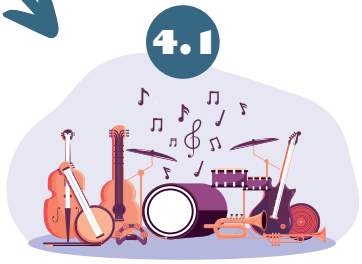
Aging, ageism, stereotypes and prejudices

Protective and risk factors for social isolation

Communication with Target Groups, a Person-Centered Approach

GINKGO
The social link factory

Socio-educational strategies



Participating in a cultural cooperation project and health

Intergenerational Relationships

Physical Activity and Sports

Structure of the training module

Each training module follows a structured format designed to ensure clarity, consistency, and practical applicability. The content is organized into key sections that define the target audience, describe the role of trainers, and establish learning objectives.

Each module presents the main topics, describes the proposed training activities, and offers methodological suggestions for assessment. In addition, references to relevant literature and examples of best practices are included where appropriate.

All sections are designed to be adaptable to the specific context, participants, and educational objectives. Trainers are encouraged to modify the content, duration, and methods based on the learners' needs and prior knowledge.

For clarity, the following section provides an overview of the various elements included in each module, explaining their purpose and how they contribute to the overall learning process.

Section 1 :
Target Audience

This section describes the module's intended target audience. The training team should assess whether this group matches the characteristics of its participants and, if necessary, adapt the content, objectives, and methods of the module.

TARGET AUDIENCE

- Students and trainees in vocational training, college, or early their careers
- Professionals in the health and social services
- Volunteers involved in supporting or supporting vulnerable individuals
- Untrained informal caregivers
- Family caregivers
- Older adults

Section 2 :
Instructional Team

This section describes the expected profile of the teaching team responsible delivering the module, highlighting the knowledge, experience, and skills necessary to ensure high-quality learning and foster participant engagement. It can be adapted to clarify the teaching team's role based on the learners' profile and the training context.

TRAINERS (ROLE)

Experts in the field of aging who take a social and health-care approach (social anthropology, social work, social education, nursing, etc.).

Section 3 :
Description of the Training Activity

This section provides a structured overview of the training activity, specifying the methods used, the tools used, and the logistical aspects that shape the learning journey. It highlights interactive approaches designed to foster participant engagement, resources that promote knowledge acquisition, and spaces conducive to a collaborative and dynamic atmosphere.

Recommendations regarding group size and session duration are also provided to ensure balanced and effective learning. All elements—activities, tools, schedules, and spaces—must be tailored to the specific needs of the learners and the context of the training, whether it is inperson, online, or hybrid.

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Development of based on concept sheets and readings.
- Group work to analyze this approach through case studies.
- Group discussion of theoretical aspects and readings.
- Video analysis and examples of best and worst practices.

Section 4 :
Objectives and Purposes

This section specifies the intended learning outcomes, highlighting the knowledge, skills, and competencies that participants are expected to develop. It provides a framework for understanding the module's instructional objectives and for effectively guiding the training. The objectives must be formulated with the learners' prior competencies and experience in mind.

LEARNING OBJECTIVES AND GOALS

- Understand the concept of ageism.
- Explore the implications of ageism in terms of stereotypes, social perceptions, and accurately identifying the needs of older adults.
- Propose activities that avoid ageist biases and take into account older adults in all their diversity, incorporating perspectives on gender, interculturalism, and social inequalities.

Section 5 : Content

This section details the instructional structure of each module, organized around central themes, key concepts, and areas of knowledge to be explored in depth. The content is divided into distinct learning units, ensuring logical progression and clear understanding throughout the course.

Each module begins with an introductory unit designed to welcome participants, foster engagement, encourage discussion, and identify their expectations and learning needs. It concludes with a final unit focused on consolidating what has been learned, individual and group reflection, and the assessment of knowledge, while guiding participants toward the next steps in their learning journey.

The consistent use of these opening and closing units ensures the pedagogical coherence of the entire program. The teaching team must select and adapt the modules based on the students' prior knowledge and skills.

CONTENTS

Learning Unit 1 : Introduction and Welcome
Get to know the other participants and identify their expectations.
Create a supportive training environment conducive to learning.
Present the training program and explain its objectives.

Learning Unit 2 : Ageism
Definition of ageism: an introduction to the fundamentals of this concept as an agerelated prejudice that impacts all stages of life. Highlight its most pronounced effects on young people and older adults, emphasizing its persistence within the older adult population (see the key concept of ageism).

Ageism in Different Areas of Society: analysis of how ageism manifests in various contexts, such as the labor market, the healthcare sector, the media, advertising, and digital design, among others.

Section 6:
Methodological Recommendations for Evaluation

This section describes the methodological approach adopted to assess participants' progress, engagement, and learning outcomes throughout the training. It specifies the key indicators used to measure knowledge acquisition, the application of skills, and the level of overall satisfaction. Evaluation is progressively integrated into the various stages of the program—initial, intermediate, and final— through various tools such as observation, group discussions, case studies and structured assessments. This approach ensures a comprehensive and nuanced assessment of learning outcomes.

Assessment methods must be selected and adapted by trainers based on the participants' learning profiles and objectives.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and expected outcomes

- Participants gain new knowledge after the training.
- Participants are able to apply what they have learned in practical exercises conducted during the training. Learners actively participate in the training.
- Participants are satisfied with the content and structure of the training they received.
- Application of theories to identify the needs of older adults.
- Analysis of case studies using an ageism-centered approach.
- Formulating intervention proposals that avoid ageist biases.

Section 7: References

This section lists the main bibliographic references that have contributed in developing the module's content. It serves as a starting point for exploring the topics covered in greater depth, providing reliable sources that enrich understanding and stimulate further reflection on the subjects addressed. Trainers are responsible for selecting appropriate and up-to-date references and terminology, taking into account the target group, specific learning needs, and the national or regional context.

To learn more...

REFERENCES

- Ayalon, L., & Tesch-Römer, C. (2017). Taking a closer look at ageism: Self- and other-directed ageist attitudes and discrimination. *European Journal of Ageing, 14(1)*, 1–4. https://doi.org/10.1007/s10433-016-0409-9

Section 8 :
Best Practices

This section highlights examples of best practices related to the module's themes, presenting proven approaches, relevant strategies, and concrete examples. These examples serve as inspiring benchmarks, enabling participants to better apply the knowledge they have acquired in real-world and operational contexts.

BEST PRACTICES

See Section 4:
Active Aging in the Practical Guide

Prerequisites

This section outlines the basic knowledge and skills required to fully benefit from the workshop. It recommends supplementary modules to help participants better prepare, ensuring a solid understanding of key concepts and active participation in the various activities offered.

PREREQUISITES

To successfully complete this activity, it is essential to have completed the following modules:
- **Module 1:** Aging (issues related to aging: diversity, violence, etc.).
- **Module 2:** Protective and Risk Factors for Social Isolation.
- **Module 3:** Communicating with the Intervention's Target Groups— A Person-Centered Approach..
- **Module 5:** Intergenerational Dynamics.

Workshops A and B

The workshops, presented as cross-cutting elements, offer practical and interactive opportunities to deepen understanding and improve skills in several areas.

They are designed to complement one or more modules rather than function as standalone units. Their structure follows the same sections as the modules, with the addition of a prerequisites section that suggests relevant modules with which they can be combined to maximize learning outcomes.

As with the modules, all workshop components are designed to be flexible and adaptable to participants' specific needs, prior knowledge, and skills, allowing trainers to tailor the experience accordingly.

Workshop A

Workshop on Narrative Communication: The Art of Telling a Story Through Video

Workshop B

Workshop on Narrative Communication: The Art of Telling a Story Through Photography

Module 1

Aging, Ageism, Stereotypes, and Prejudices

TARGET AUDIENCE

- Students and trainees in vocational training, college, or early their careers
- Professionals in the health and social services
- Volunteers involved in supporting or supporting vulnerable individuals
- Untrained informal caregivers
- Family caregivers
- Older adults

DURATION

2 to 20 hours, adjustable according to the group's needs.

SPACES

- Training room with movable chairs.

REQUIRED TOOLS

- Computer
- Video projector
- Slide presentations
- Case studies
- Internet

TEACHING APPROACH

- In-person learning
- Online learning
- Blended Learning

TRAINERS (ROLE)

Experts in the field of aging who take a social and health-care approach (social anthropology, social work, social education, nursing, etc.).

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Development of based on concept sheets and readings.
- Group work to analyze this approach through case studies.
- Group discussion of theoretical aspects and readings.
- Video analysis and examples of best and worst practices.

LEARNING OBJECTIVES AND GOALS

- Understand the concept of ageism.
- Explore the implications of ageism in terms of stereotypes, social perceptions, and accurately identifying the needs of older adults.
- Propose activities that avoid ageist biases and take into account older adults in all their diversity, incorporating perspectives on gender, interculturalism, and social inequalities.

CONTENTS

Learning Unit 1 : Introduction and Welcome

Get to know the other participants and identify their expectations.
Create a supportive training environment conducive to learning.
Present the training program and explain its objectives.

Learning Unit 2 : Ageism

Definition of ageism: an introduction to the fundamentals of this concept as an agerelated prejudice that impacts all stages of life. Highlight its most pronounced effects on young people and older adults, emphasizing its persistence within the older adult population (see the key concept of ageism).

Ageism in Different Areas of Society: analysis of how ageism manifests in various contexts, such as the labor market, the healthcare sector, the media, advertising, and digital design, among others.

Factors Increasing the Risk of Ageism: identification of factors that increase the likelihood of being a victim of age discrimination.

Impact of ageism: analysis of the negative repercussions on physical and mental health, overall well-being, and respect for the fundamental rights of those affected.

Learning Unit 3 : Stereotypes and Prejudices Related to Aging

Common stereotypes related to old age:
Explore the various forms of ageism and the often reductive image of older adults that results from it. Deconstruct representations that systematically associate old age with frailty, dependence, or a decline in abilities.

Negative Effects of Prejudice: analyze how stereotypes affect social inclusion, selfesteem, and older adults' access to appropriate services.

Deconstructing Prejudices: promote a more positive and diverse view of old age by highlighting the abilities and potential of older adults and encouraging active and healthy aging.

Identifying ageist practices: recognizing attitudes and behaviors that reflect ageism, such as disregarding the opinions of older adults, treating them as if they were children, or focusing solely on their physical or cognitive limitations.

Learning Unit 4 : Best Practices for Working with Older Adults

Addressing ageism: promoting respect, inclusion, and the empowerment of older adults; challenging stereotypes; and advocating for equal rights and opportunities. Adopting an inclusive approach that acknowledges their diversity, including gender, interculturality, and social equality.

Strategies to Reduce Ageism: proposals to combat ageism through (1) public policies and legal frameworks aimed at preventing age-related discrimination and inequalities, (2) educational interventions aimed at reducing prejudice and discrimination, particularly in schools and workplaces, (3) intergenerational outreach activities that encourage interaction between generations, (4) communication and information campaigns; Networks and media on ageism in order to promote positive attitudes toward aging and (5) recruitment policies that encourage the hiring and recognition of older workers. recrutement qui encouragent l'embauche et la valorisation des travailleurs âgés.

Identifying and promoting best practices for intervention:
identifying best practices related to the inclusion of older adults in the planning and delivery of services, the promotion of their autonomy, and their active participation in the community, among other areas.

Benefits of best practices: improved quality of life, enhanced self-esteem, and the guarantee of older adults' fundamental rights to a dignified and independent life.

Final Unit: Conclusion of the Training

- Summary of key content.
- Qualitative/quantitative evaluation of the training.
- Next steps: opportunities and possibilities for future studies or initiatives.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and expected outcomes

- Participants gain new knowledge after the training.
- Participants are able to apply what they have learned in practical exercises conducted during the training. Learners actively participate in the training.
- Participants are satisfied with the content and structure of the training they received.
- Application of theories to identify the needs of older adults.
- Analysis of case studies using an ageism-centered approach.
- Formulating intervention proposals that avoid ageist biases.

Initial Assessment

- Observation of prior knowledge during the training.

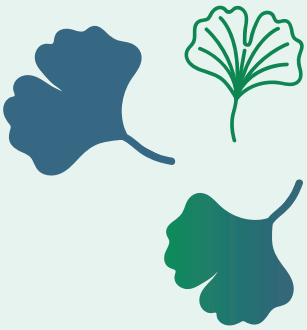
Midterm assessment

- Observation of activities during the training.
- Analysis of real-world examples of best and worst practices.
- Discussion of the materials and examples.

Final assessment

- Quiz on theoretical concepts.
- Proposals for solving case studies.
- Participation and level of engagement in training activities.

To learn more...



REFERENCES

- Ayalon, L., & Tesch-Römer, C. (2017). Taking a closer look at ageism: Self- and other-directed ageist attitudes and discrimination. *European Journal of Ageing*, *14(1)*, 1–4. https://doi.org/10.1007/s10433-016-0409-9
- Butler, R.N. (1975). Psychiatric and the elderly: An overview. *American Journal of Psichiatry*, *132*, 893-90
- World Health Organization. (2021). *The Global report on ageism.* Geneva: World Health Organization. https://iris.who.int/bitstream/handle/10665/340208/9789240016866-eng.pdf?sequence=1

Module 2

Protective and Risk Factors for Social Isolation

TARGET AUDIENCE

- Students and interns in vocational or university training, or those early in their careers
- Professionals in the health and social work sectors
- Volunteers involved in support or care work
- Informal caregivers without prior training
- Family caregivers supporting a loved one
- Older adults participating in the programs

DURATION

2 to 20 hours, adjustable based on the group's needs.

FACILITIES

- Training room with movable chairs.

REQUIRED TOOLS

- Computer
- Projector
- Slide presentations
- Case studies
- Internet

TEACHING APPROACH

- In-person learning
- Online learning
- Blended Learning

TRAINERS (ROLE)

Experts in education, psychology, social work, or geriatrics.

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Interactive theoretical sessions with group discussions.
- Case studies and best practices.
- Reflection on and analysis of real-life experiences.
- Exchange and analysis of best practices.

LEARNING OBJECTIVES AND GOALS

- To promote a comprehensive understanding of the factors influencing social isolation among older adults.
- Develop skills for the multidimensional assessment of older adults.
- Deepen knowledge of the causes and mechanisms contributing to social isolation.
- Strengthen the ability to identify risk factors associated with this isolation.
- Improve the ability to recognize and understand the protective factors that mitigate social isolation among older adults.

CONTENTS

Learning Unit 1 : Introduction and Welcome

Get to know the other participants and understand their expectations.
Create a supportive training environment conducive to learning.
Presentation of the training program.

Learning Unit 2 : Quality of Life for Older Adults

Aging from a demographic perspective: growth of the older population, increased life expectancy, and declining birth rates.

Concepts Related to Aging: various definitions of old age (third/fourth/fifth age, young/old elderly) and "new" categories of older adults (baby boomers, older migrants, LGBTQI+).

Multiple changes associated with aging:

- Psychophysical changes: intelligence, memory, attention, emotions, sensory abilities.
- Role changes and social transitions: retirement, becoming a grandparent, grief and death, the impact of COVID-19.

Learning Unit 3 : Loneliness and Social Isolation

Examine how economic and social changes are altering the living environments of older adults, including shifts in family size and composition.

Highlight how transitions and disruptive events in later life can lead to social isolation and loneliness, affecting relationships and social networks.

Understand the distinction between social isolation (lack of social contact) and loneliness (a subjective feeling of inadequate connections).

Understanding loneliness: explore the emotional and cognitive aspects of loneliness and its effects on physical and mental health.

Impact of social interactions: emphasize the importance of the quality and diversity of social connections rather than their quantity.

The paradox of connections: understand how loneliness can occur despite the presence of a social network, and conversely, how it can be absent even in the face of limited social interactions.

Impact of the Pandemic: exploring the impact of the pandemic on isolation and loneliness. Reflect on the effects of lockdowns and restrictive measures. Examine the ambivalent role of digital technology in both connecting older adults and creating barriers for them. Analyze how ageist stereotypes have contributed to social exclusion and limited access to healthcare and support (Ayalon et al., 2021).

Learning Unit 4 : Aging and Frailty

The concept of frailty in older adults: cognitive and functional decline, loss of independence.

Mild Cognitive Decline: Definition and Potential Link to Dementia.

Main Types of Dementia:
- Alzheimer's disease
- Frontotemporal dementia
- Lewy body dementia
- Vascular dementia

Learning Unit 5 : The Needs of Older Adults

Diverse Pathways of Aging Person-Centered Assessment:
- Maslow's Hierarchy of Needs.
- Kitwood's Perspective (1997).
- Multidimensional needs assessment (Poon et al., 2003).

Learning Unit 6 : Multidimensional Geriatric Assessment

Risk and protective factors: key concepts for identifying conditions that promote wellbeing or increase vulnerability.

Introduction to the Integrated Approach: An overview of the integrated approach, exploring the multidimensional assessment framework to explain the protective and risk factors that influence the well-being of older adults.

Physical Dimension
- Protective factors: cognitive stimulation, psychological support, social activities, and leisure

activities.- Facteurs de risque : fragilité, déclin cognitif, troubles de l'humeur.

Psychological Dimension
- Protective factors: stimulation cognitive, soutien psychologique, activités sociales et loisirs.
- Risk factors: frailty, cognitive decline, mood disorders.

Social dimension
- Protective factors: social support network, participation in social activities, access to services and resources.
- Risk factors: social isolation, limited access to services, poverty, and financial difficulties.

Functional dimension
- Protective factors: environmental adaptations, support for daily activities.
- Risk factors: loss of independence, mobility limitations

Final Unit: Conclusion of the Training

- Summary of key content.
- Qualitative/quantitative evaluation of the training.
- Next steps: opportunities and possibilities for future studies or initiatives.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and Expected Outcomes

- Feedback from participants during the training.
- Participation during the training.
- Risk factors and protective factors correctly identified during group discussions or practical exercises.
- Reflection on the risk factors and protective factors identified during group discussions or practical exercises.

Initial assessment

- Reflection on participants' current knowledge.

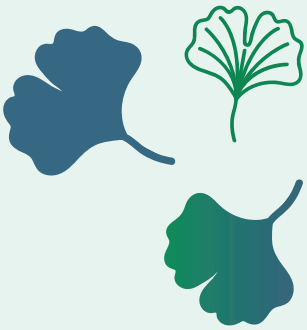
Mid-training assessment

- Observation of group activities.
- Discussion and reflection on what has been learned.
- Discussion and reflection on the case study.

Final assessment

- Quiz or test on theoretical concepts.
- Discussion and reflection on what was learned.
- Case Study: Analysis and Proposed Solutions for the Case Study.

To learn more...



REFERENCES

- Ayalon, L., Chasteen, A., Diehl, M., Levy, B. R., Neupert, S. D., Rothermund, K., Tesch-Römer, C., & Wahl, H.-W. (2021). Aging in Times of the COVID-19 Pandemic: Avoiding Ageism and Fostering Intergenerational Solidarity. *The Journals of Gerontology: Series B*, 76(2), e49–e52. https://doi.org/10.1093/geronb/gbaa051

- Masi, C. M., Chen, H.-Y., Hawkley, L. C., & Cacioppo, J. T. (2011). A Meta-Analysis of Interventions to Reduce Loneliness. *Personality and Social Psychology Review*, 15(3), 219–266. https://doi.org/10.1177/1088868310377394

- Kitwood, T. M. (1997). *Dementia reconsidered: The person comes first*. Open University Press.

- Poon, L. W., Gueldner, S. H., & Sprouse, B. M. (2003). *Successful aging and adaptation with chronic diseases*. Springer Publishing Company.

Module 3

Communication with Target Groups: A Person-Centered Approach

TARGET AUDIENCE

- Students and interns in vocational training, university programs, or early in their careers
- Professionals in the health and social work sectors
- Volunteers involved in support or care work
- Informal caregivers without prior training
- Family caregivers supporting a loved one

DURATION

2 to 20 hours, adjustable according to the group's needs.

SPACES

- Training room with movable chairs.

REQUIRED EQUIPMENT

- Computer
- Projector
- Slide presentations
- Case studies
- Internet

TEACHING APPROACH

- In-person learning
- Online learning
- Blended learning

TRAINERS (ROLE)

Communication experts and/or psychology and/or education and/or social work.

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Interactive theoretical sessions with group discussions
- Case studies and best practices
- Role-playing
- Brainstorming
- Awareness-raising exercises on nonverbal communication
- Sharing meaningful stories and reflecting on how to use them in interactions
- Guided discussions on personal experiences

LEARNING OBJECTIVES AND GOALS

- Develop skills in interpreting and analyzing communication, with an emphasis on the relationship between communication and needs.
- Improve understanding of communication dynamics.
- Strengthen the ability to identify key elements for effective interactions.
- Improve the ability to apply effective communication strategies that promote understanding and connection with older adults.
- Increase proficiency in applying communication techniques to foster dialogue and understanding in interactions.

CONTENTS

Learning Unit 1 : Introduction and Welcome

Get to know the other participants and understand their expectations.
Create a supportive training environment conducive to learning.
Presentation of the training program.

Learning Unit 2 : Communication

What is communication? Definition of communication as an exchange of messages and meanings; the role of communication in building relationships with others.

Focus on potential barriers and obstacles:

- Cognitive barriers (memory loss, slower information processing).
- Physical barriers (hearing and/or vision impairments).
- Emotional and psychological barriers (feelings of isolation or anxiety, mistrust, or discomfort).
- Environmental barriers (noisy or distracting environments, physical distance, or lack of eye contact).

Learning Unit 3 : Managing Communication

Verbal communication: understanding the role of clear and simple language in interactions with older adults (taking into account any cognitive or sensory changes that may affect comprehension).

Nonverbal Communication: Recognize the importance of gestures, posture, facial expressions, and eye contact in building trust and expressing respect (especially when verbal communication is limited).

Paraverbal Communication: explore how tone of voice, rhythm, volume, and pauses can be adjusted to convey a message with sensitivity and clarity.

Focus on the key elements for establishing communication with others (Rosenberg & Chopra, 2015)

- Nonjudgmental observation: observe the situation and behavior without judgment to better understand the older adult's needs. Distinguish factual observations from personal interpretations or assumptions.

- Identifying and expressing feelings: recognize and acknowledge the emotions of both the caregiver and the older adult. Encourage clear and respectful expression of feelings to promote emotional awareness.

- Recognizing needs: identify the underlying needs behind behaviors, both of the caregiver and the older adult, to strengthen the connection and improve communication.

- Managing dialogue and requests: formulate clear, specific, and respectful requests to meet the needs of both parties. Encourage open dialogue to foster mutual understanding and problem-solving.

Learning Unit 4 : Techniques for Promoting Dialogue and Understanding

- **Nonviolent Communication (NVC) (Rosenberg & Chopra, 2015):** examples, demonstrations, and practical exercises.
- **Communication in the Gentlecare Approach (Jones, 1999):** examples, demonstrations, and practical exercises.
- **Creative Conflict Management (Fisher et al., 2011; Sclavi, 2003):** examples, demonstrations, and practical exercises.
- **Well-being (Rapoport, 2015) :** examples, demonstrations, and practical exercises.

Final Unit: Conclusion of the Training

- Summary of key content.
- Qualitative/quantitative evaluation of the training.
- Next steps: opportunities and possibilities for future studies or actions.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and expected outcomes

- Participant feedback during the training.
- Participation during the training.
- Identifying the needs of older adults during practical exercises.
- Describing interactions without judgment.
- Use of key communication strategies.
- Using active listening techniques during practical exercises.

Initial Assessment

- Reflection on participants' current knowledge.

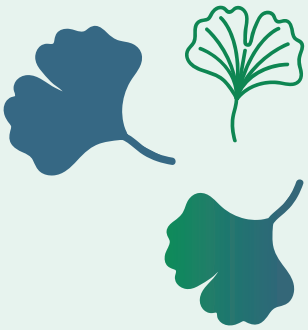
Mid-course assessment

- Observation of group activities.
- Discussion and reflection on what has been learned.
- Discussion and reflection on the case study.

Final assessment

- Quiz or test on theoretical concepts.
- Discussion and reflection on what was learned.
- Case study: analysis and proposed solutions for the case study.

To learn more...



REFERENCES

- Dynes, R. (2017). *Positive communication: Activities to reduce isolation and improve the wellbeing of older adults.* Jessica Kingsley Publishers.
- Fisher, R., Ury, W. L., & Patton, B. (2011). *Getting to yes: Negotiating agreement without giving in. Penguin.*
- Jones, M. (1999). *Gentlecare. Changing the experience of Alzheimer's Disease in a Positive Way.* Hartley & Marks.
- Rapoport, D. (2015). *Bien-traitance et management dans les lieux d'accueil: De la maternité au grand âge.* Belin.
- Rosenberg, M. B., & Chopra, D. (2015). *Nonviolent communication: A language of life: empathy, collaboration, authenticity, freedom* (3rd edition). PuddleDancer Press.
- Sclavi, M. (2003). *Arte di ascoltare e mondi possibili: Come si esce dalle cornici di cui siamo parte.* Mondadori.
- Storlie, T. (2015). *Person-Centered Communication with Older Adults: The Professional Provider's Guide.* Elsevier Science & Technology.

Module 4

Social and Educational Strategies

TARGET AUDIENCE

- Students and interns in vocational or university programs or at the beginning their careers
- Professionals in the health and social work sectors
- Volunteers involved in providing care or support
- Informal caregivers without prior training
- Family caregivers supporting a loved one

DURATION

2 to 20 hours, adjustable according to the group's needs.

SPACES

- Training room with movable chairs.

REQUIRED TOOLS

- Computer
- Projector
- Slide shows
- Case studies
- Internet

TEACHING APPROACH

- In-person learning
- Online learning
- Blended Learning

TRAINERS (ROLE)

Experts in socio-educational strategies, pedagogy, and innovative methodologies (music therapy, theater, etc.).

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Interactive theoretical sessions with group discussions
- Case Studies and Best Practices
- Role-playing
- Project work
- Reflection and analysis of real-world experiences
- Sharing and analysis of best practices
- Interactive workshops
- Multimedia/digital tools

LEARNING OBJECTIVES AND GOALS

- To improve the ability to recognize and value individuals from a multidimensional perspective.
- To enhance the ability to identify the underlying needs of older adults.
- Strengthen the ability to design personalized activities that meet individual needs and highlight the skills of older adults.
- Develop the ability to identify and implement modifications to the physical environment to promote safety, comfort and independence.

CONTENT

Learning Unit 1 : Introduction and Welcome

Get to know the other participants and identify their expectations.
Create a supportive training environment conducive to learning.
Present the training program and explain its objectives.

Learning Unit 2 : The Concept of Aging

Introduction: Learning does not stop with age. It is part of a lifelong development perspective, in which each stage—including old age—represents a continuation of previous phases. This approach helps us better understand that aging does not mean the end of development, but rather a new phase of personal enrichment and adaptation. To establish this framework, we will briefly introduce the life-span perspective as well as Erik Erikson's theory of psychosocial development, which help situate old age within a comprehensive and evolving view of the human life course.

Principles and Theory of Socio-Educational Strategies :

- **Person-centered approach (Kitwood, 1997):** emphasizing the individual needs and preferences of older adults to promote their autonomy and well-being.
- **Validation method (Feil, 1993):** techniques aimed at recognizing and validating the emotions and experiences of older adults, particularly those with cognitive impairments.

Learning Unit 3 : Cognitive Strategies

Presentation and explanation:

- **Sensory stimulation:** Techniques to engage and maintain cognitive functions, such as memory exercises and problem-solving tasks. Examples and demonstrations.
- **Recall:** Using past memories to stimulate cognitive engagement and improve. Examples and demonstrations.

Learning Unit 4 : Sensory Strategies

Presentation and Explanation:

- **Sensory stimulation:** Engaging the senses (touch, sight, smell, hearing) to stimulate cognitive and emotional responses. Examples and demonstrations.
- **Psychomotor Skills:** Using movement to improve motor skills and cognitive functions. Examples and demonstrations.
- **Physical Stimulation:** Activities that incorporate physical movement and touch to improve emotional and physical well-being. Examples and demonstrations.

Learning Unit 5 : Creative and Expressive Methods

Presentation and explanation:

- **Montessori Method (Judge et al., 2000):** Application of Montessori principles to promote independence and participation in daily life. Examples and demonstrations.
- **Practical Creative Workshops:** Arts-and-crafts activities to stimulate creativity, fine motor skills, and social interaction. Examples and demonstrations.
- **Theater Workshops:** Use of role-playing and improvisation to encourage communication and self-expression. Examples and demonstrations.

- **Writing Workshops:** Writing exercises to promote self-expression and reflection (e.g., journals, stories). Examples and demonstrations.

Learning Unit 6 : Technology and Social Interaction

Presentation and explanation:

- **Technologies for Social Interaction:** Using digital tools to encourage communication and reduce social isolation. Examples and demonstrations.
- **Technologies for Daily Life:** Tools for accessing health services, managing appointments, and performing other practical tasks. Examples and demonstrations.

Final Session: Conclusion of the Training

- Summary of key content.
- Qualitative/quantitative evaluation of the training.
- Next Steps: Opportunities and possibilities for future studies or initiatives.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and Expected Outcomes

- Feedback from participants during the training
- Participation during the training
- Description of situations without passing judgment
- Identification of older adults' needs during practical exercises
- Activities Designed During Practical Exercises

Initial assessment

- Trainees reflect on their current knowledge

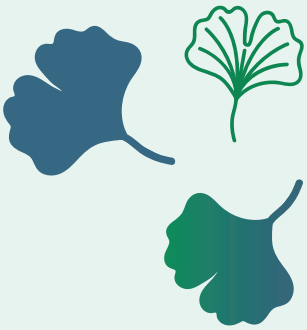
Midterm assessment

- Observation of group activities
- Discussions and reflections on what has been learned
- Discussions and reflections on case studies and practical exercises

Final assessment

- Questionnaire/test on theoretical concepts
- Project work
- Case study: analysis and proposed solutions for the practical exercises and case studies

To learn more...



REFERENCES

- Feil, N. (1993). The Validation breakthrough: *Simple techniques for communicating with people with "Alzheimer's-type dementia"*. Health Professions Press.
- Judge, K. S., Camp, C. J., & Orsulic-Jeras, S. (2000). Use of Montessori-based activities for clients with dementia in adult day care: Effects on engagement. *American Journal of Alzheimer's Disease*, 15(1), 42–46. https://doi.org/10.1177/153331750001500105
- Kitwood, T. M. (1997). Dementia reconsidered: The person comes first. Open University Press.

BEST PRACTICES

See Section 4:
Active Aging in the Practical Guide

Submodule 4.1

Participating in a cooperation project in culture and health

TARGET AUDIENCE

- Students and interns in vocational training, university programs, or early in their careers
- Professionals in the health and social work sectors
- Volunteers involved in support or care work
- Informal caregivers without prior training
- Family caregivers supporting a loved one

DURATION

2 to 20 hours, adjustable according to the group's needs.

SPACES

- Training room with movable chairs.

REQUIRED TOOLS

Each participant receives a resource kit containing:
- Videos featuring project stories;
- Project maps to visualize the initiatives;
- Examples of agreements or budgets.

TEACHING APPROACH

- In-person learning
- Online learning
- Blended learning

TRAINERS (ROLE)

Experts in socio-educational strategies, pedagogy, and collaborative methodologies, with knowledge of the cultural and arts sector.

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

The training is based on active, participantcentered pedagogy focused on participants' engagement in hands-on activities. The goal is to enable, through successive experiments, the gradual and guided development of knowledge and skills acquired by the participants themselves within a structured and supportive learning environment provided by the trainer.

The training approach is based on a balanced alternation of:

- **Practical exercises:** hands-on exploration of the concepts studied.
- **Case studies:** concrete examples of cultural projects related to health and education.
- **Reflective feedback:** analyzing experiences and drawing concrete lessons from them.
- **Targeted theoretical input:** structuring and deepen learning in line with the training objectives.

LEARNING OBJECTIVES AND GOALS

- Understand the intersection between culture and health to better support cooperation projects in these areas.
- Develop the ability to understand one's role and to contribute effectively and meaningfully to the success of a cooperation project.
- Define and incorporate the specific constraints and needs of cultural projects within a social or health context.
- Identify and articulate the essential conditions for establishing meaningful collaborations with arts and culture professionals.
- Analyze the dynamics of participants' engagement and involvement in a cultural project.

CONTENT

Learning Unit 1 : Introduction and Welcome for Participants
Get to know the other participants and understand their expectations.
Create a safe and supportive training environment.
Presentation of the training program.

Learning Unit 2 : Key Concepts
A brief introduction to key concepts: art therapy, facilitation, education, and cultural cooperation.

Learning Unit 3 : Frameworks and Methodologies
A comprehensive overview of the historical evolution, key milestones, and operational mechanisms of the public and institutional frameworks governing the implementation of cultural projects (Unit tailored for a professional audience).

Learning Unit 4 : Regional Initiatives
Exploration of local cultural initiatives, highlighting their objectives, impact, and dedicated resources.

Learning Unit 5 : Collaboration with the Cultural Sector
Prerequisites and essential criteria for fostering effective collaboration with arts and culture professionals.

Learning Unit 6 : Collaboration avec le secteur culturel
Conditions préalables et critères essentiels pour favoriser une collaboration efficace avec les professionnels des arts et de la culture.

Final Unit: Conclusion of the Training
- Summary of key content.
- Qualitative/quantitative evaluation of the training.
- Next steps: opportunities and possibilities for future studies or initiatives.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

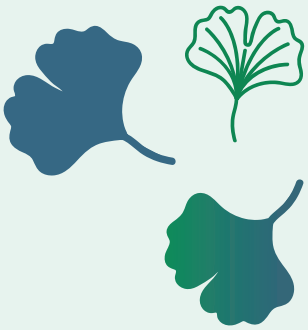
Indicators and Expected Outcomes
- Feedback from participants during the training
- Participation during the training
- Description of situations without passing judgment
- Identification of older adults' needs during practical exercises
- Activities designed during practical exercises

Initial Assessment
- Trainees reflect on their current knowledge

Midterm evaluation
- Observation of group activities
- Discussions and reflections on what has been learned
- Discussions and reflections on case studies and practical exercises

Final assessment
- Questionnaire/test on theoretical concepts.
- Project work
- Case study: analysis and proposed solutions for the practical exercises and case studies

To learn more...



REFERENCES

- https://culture-sante-na.com/ressources/bibliotheque-en-ligne/
- https://culture-sante-na.com/ressources-video/
- https://editions-attribut.com/product/culture-et-sante/
- https://culture-sante-na.com/nos-expertises/innovation-sociale/culture-health-platform/

BEST PRACTICES

See Part 3 of the Practical Guide: Cultural Life and the Arts as a Lever for Social Cohesion and Health

Submodule 4.2

Physical Activity and Sports

TARGET AUDIENCE

- Students and trainees in vocational or university programs or at the beginning their careers
- Healthcare and social work professionals
- Volunteers involved in providing care or support
- Informal caregivers without prior training
- Family caregivers supporting a loved one

DURATION

2 to 20 hours, adjustable according to the group's needs.

SPACES

- Training room with movable chairs.

REQUIRED EQUIPMENT

- Computer
- Projector
- Slide presentations
- Case studies
- Internet

EDUCATIONAL APPROACH

- In-Person Learning
- Online Learning
- Blended Learning

TRAINERS (ROLE)

Experts in socio-educational strategies, pedagogy, and innovative methodologies (music therapy, theater, experts in inclusive sports practices, etc.)

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Interactive theoretical sessions with group discussions
- Case studies and best practices
- Role-playing
- Project work
- Reflection and analysis of realworld experiences
- Sharing and analysis of best practices
- Interactive workshops
- Multimedia/digital tools

LEARNING OBJECTIVES AND GOALS

- Acquire knowledge about health promotion and active aging.
- To promote social inclusion and prevent isolation through sports.
- Raise awareness of the importance of physical activity for older adults.
- Provide practical tools for organizing sports activities tailored to older adults.
- Develop skills to engage older adults in sports activities.
- Developing local expertise in planning sports activities tailored to an aging population.
- Develop individualized plans based on specific needs (person-centered approach).

CONTENT

Learning Unit 1 : Introduction and Welcome for Participants

Get to know the other participants and identify their expectations.
Create a safe and supportive training environment.
Presentation of the training program.

Learning Unit 2 : Promoting Healthy Aging

The role of physical activity in improving mobility, well-being, and cognitive function:

- **Aging:** physical and functional factors to consider and barriers to physical activity.
- **The WHO Model for Active and Healthy Aging:** Physical activity as a key component of this strategy.
- **Physical benefits:** improved mobility, strength, and overall health.
- **Psychological benefits:** reduced stress, improved mood, reduced anxiety and depression, and enhanced self-esteem and social relationships.
- **Social benefits:** fostering social connections, establishing routines, and promoting a sense of belonging.
- **Cognitive benefits:** improved memory, learning, processing speed, and executive functions. Using sports to manage neurodegenerative diseases and cognitive disorders.

Learning Unit 3 : Adapting Sports for Everyone

Physical activities adapted to all ages and abilities

- Inclusive sports: adapting sports activities to different physical abilities.
- Adapted physical activities: low, moderate, and high intensity.
- Individual activities: stationary bike, walking, yoga, tai chi, etc.
- Group activities: Nordic walking, gentle exercise, Pilates, water aerobics, dance, team sports, boccia, etc.
- Adapted sports: baskin, gymnastics for all, chair yoga, swimming, tai chi, etc.

Learning Unit 4 : Technology and Physical Activity

From the use of portable electronic devices to Virtual Reality (VR) and Augmented Reality (AR), offering immersive sports experiences to people with physical limitations.

Learning Unit 5 : Engaging Older Adults in Sports

Strategies, community involvement, and inclusive activities:

- Techniques for Motivating Older Adults to Participate.
- The importance of communication and social support.
- Testimonials from participants and success stories.
- Involvement of local residents and stakeholders in sports activities.
    - The Toronto Charter for Physical Activity.
    - Creating an action plan to implement activities in your community.
    - Intergenerationality in Sports: An Example of an Inclusive Sports Activity such as Power Walking.

Final Unit: Conclusion of the Training

- Summary of key content.
- Qualitative/quantitative evaluation of the training.
- Next Steps: Opportunities and Possibilities for Future Studies or Actions.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and Expected Outcomes

- Participant feedback during the training
- Participation during the training
- Description of situations without passing judgment
- Identification of older adults' needs during practical exercises
- Activities designed during practical exercises

Initial Assessment

- Trainees reflect on their current knowledge

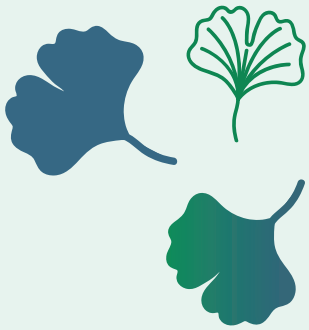
Midterm Assessment

- Observation of group activities
- Discussions and reflections on what has been learned
- Discussions and reflections on case studies and practical exercises

Final assessment

- Questionnaire/Test
- Project work
- Case study: analysis and proposed solutions for the practical exercises and case studies

To learn more...



REFERENCES

- Fassina M. (2022), *Sport e inclusione sociale - Esperienza etnografica di un giocatore di baskin.* Edizioni Epoké
- Javadzade N, Esmaeili SV, Omranifard V, Zargar F. Effect of mindfulness-based stress reduction (MBSR) program on depression, emotion regulation, and sleep problems: A randomized controlled trial study on depressed elderly. BMC Public Health. 2024 Jan 23;24(1):271. doi: 10.1186/s12889-024-17759-9. PMID: 38263131; PMCID: PMC10804770.
- *WHO guidelines on physical activity and sedentary behaviour.* https://www.who.int/publications-detail-redirect/9789240015128
- *Sport, Physical Activity, and Aging: Are We on the Right Track?* | SpringerLink. https://link.springer.com/chapter/10.1057/978-1-137-48562-5_17 https://www.happyageing.it/wp-content/uploads/2024/09/Libro-Bianco-attivita-fisica-invecchiamento-in-salute.pdf

BEST PRACTICES

See Section 4: Active Aging in the Practical Guide

Module 5

Intergenerationality

TARGET AUDIENCE

- Students and interns in vocational training, university programs, or early in their careers
- Professionals in the health and social work sectors
- Volunteers involved in support or care work
- Informal caregivers without prior training
- Family caregivers supporting a loved one
- Older adults participating in the programs

DURATION

2 to 20 hours, adjustable according to the group's needs.

SPACES

- Training room with movable chairs.

REQUIRED EQUIPMENT

- Computer
- Projector
- Slide presentations
- Case studies
- Internet

TEACHING APPROACH

- In-person learning
- Online learning
- Blended learning

TRAINERS (ROLE)

Experts in education and/or psychology and/or social work.

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Interactive theoretical sessions with group discussions.
- Case studies and sharing of best practices.
- Role-playing exercises.
- Reflection on and analysis of real-life experiences.
- Interactive workshops

LEARNING OBJECTIVES AND GOALS

To promote understanding and dialogue between generations:

- To deepen knowledge of the characteristics of different generations.
- Develop the ability to identify and analyze stereotypes associated with different life stages.
- Strengthen observational skills to better understand the perspectives and needs of other generations.
- Improve the ability to adopt the perspective of another generation.
- Acquire skills to design and implement intergenerational projects and initiatives.

CONTENTS

Learning Unit 1 : Introduction and Welcome

Get to know the other participants and understand their expectations.
Create a safe and supportive training environment.
Presentation of the training program.

Learning Unit 2 : Defining Intergenerationality

Development as a Lifelong Process (Baltes, 1987): analysis of development throughout the life span, with a particular focus on old age as a continuous phase of previous stages, highlighting the life-cycle perspective and lifelong learning as key elements for fostering intergenerationality.

Deconstructing stereotypes related to life stages and reconstructing intergenerational roles: Challenging rigid views that associate specific roles with life stages, emphasizing the continuity of personal development. Fostering mutual discovery between generations, driven by a sincere desire to learn from one another.

Learning Unit 3 : Solidarity Between Generations

Explore how intergenerational dialogue creates spaces for inclusion and renewal, supporting the aging process and promoting social empowerment (Nussbaum & Levmore, 2019).

Focus on how individuals and communities develop the skills needed to actively contribute to meaningful relationships.

Highlight the power of collective thinking to share and amplify resources and opportunities, while acknowledging vulnerabilities and challenges.

Learning Unit 4 : Intergenerational Strategies and Interventions

Impact on Social Isolation and Loneliness: Demonstrate how intergenerational interventions can reduce social isolation and improve outcomes related to loneliness by fostering stronger connections between generations.

How to Design and Structure Intergenerational Interventions:
Design interventions centered on shared learning experiences, mentoring relationships, and collaborative projects to facilitate interactions and relationship-building across generations.

Adapt strategies to the specific needs of different groups, such as isolated individuals, long-term care residents, and people living independently.

Develop skills to balance short-term programs that address immediate social needs with long-term programs that foster lasting connections and mutual understanding.

Final Unit: Conclusion of the Training

- Summary of key content.
- Qualitative/quantitative evaluation of the training.
- Next Steps: Opportunities and possibilities for future studies or initiatives.

SUGGESTIONS MÉTHODOLOGIQUES POUR L'ÉVALUATION

Indicators and expected outcomes

- Participant feedback during the training.
- Participation during the training.

Initial assessment

- Participants' reflections on their current knowledge

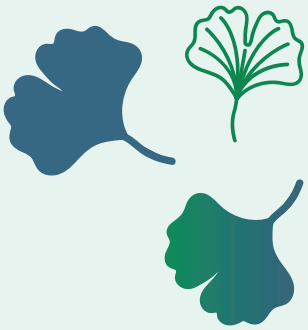
Mid-training assessment

- Observation of group activities.
- Discussions and reflections on what has been learned.
- Discussions and reflections on case studies and practical exercises.

Final assessment

- Quiz/test on theoretical concepts.
- Discussion and reflection on what has been learned.
- Case study: analysis and proposed solutions for the practical case study.

To learn more...



REFERENCES

- Baltes, P. B. (1987). Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline. *Developmental Psychology*, 23(5), 611–626. https://doi.org/10.1037/0012-1649.23.5.611
- Kaplan, M., Sanchez, M., & Hoffman, J. (2017). Intergenerational Approaches for Sustaining Individual Health and Well-being. In M. Kaplan, M. Sanchez, & J. Hoffman, *Intergenerational Pathways to a Sustainable Society* (pp. 29–64). Springer International Publishing. https://doi.org/10.1007/978-3-319-47019-1_3
- Nussbaum, M. C., & Levmore, S. (2019). *Invecchiare con saggezza: Dialoghi sulla vita, l'amore ei rimpianti. Il mulino.*

BEST PRACTICES

See Part 1 of the practical guide: Intergenerational Relations

Module 6

Biopsychosocial Perspective

TARGET AUDIENCE

- Students and trainees in vocational or university programs or at the beginning their careers
- Healthcare and social work professionals
- Volunteers involved in providing care or support
- Informal caregivers without prior training
- Family caregivers supporting a loved one

DURATION

2 to 20 hours, adjustable according to the group's needs.

SPACES

- Training room with movable chairs.

REQUIRED EQUIPMENT

- Computer
- Projector
- Slide presentations
- Case studies
- Internet

EDUCATIONAL APPROACH

- In-Person Learning
- Online Learning
- Blended Learning

TRAINERS (ROLE)

Experts in social intervention, social and educational professionals, and healthcare professionals (nurses, social workers, social educators, teachers, etc.).
Experience and knowledge in social intervention projects, in the health sector, and in innovative methodologies and/or approaches (social-health coordination, citizen participation, community action, new technologies, music therapy, theater, etc.) are a plus.

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Development of content for the training program based on concept sheets, readings, and case studies.
- Group work to solve case studies.
- Group discussions on theoretical concepts and readings.
- Video analysis.

LEARNING OBJECTIVES AND GOALS

- To know and understand the theoretical foundations of the biopsychosocial approach to improving people's well-being, particularly that of older adults.
- Develop attitudes that support the biopsychosocial care of older adults.
- To learn about and acquire biopsychosocial intervention approaches and methods, and to know how to apply them appropriately to specific contexts.
- Acquire the skills to create supportive environments, with atmospheres and resources conducive to biopsychosocial intervention with older adults.
- Acquire the skills to conduct an assessment and implement a biopsychosocial approach in the care of older adults, based on active aging with a regional, integrated approach coordinated with environmental agencies and stakeholders.
- Develop interventions that promote active aging through a holistic approach, incorporating a gender and equity perspective, and based on networking.
- Acquire tools to design evaluations of interventions using a biopsychosocial approach.

CONTENT

Learning Unit 1 : Introduction and welcome for participants

Get to know the other participants and identify their expectations.
Create a safe and supportive training environment.
Presentation of the training program.

Learning Unit 2 : The biopsychosocial perspective on health and well-being for Older Adults

Introduction to the biopsychosocial perspective (see key concept): definition and basic principles (Engel's biopsychosocial model)

Comparison and contributions (added value) relative to other models, such as the biomedical model: advantages of a holistic approach.

Other related approaches or theoretical models: social determinants of health, the active aging perspective and the life-course approach, person-centered care for health and wellbeing.

Learning Unit 3 : Interaction between biological, psychological, and social aspects

Biological, psychological, and social variables influencing the well-being and health of the population: genetics, physiological functioning, health, lifestyle habits, emotional stability, personal and family interactions, socioeconomic status, cultural context, etc.

Intrinsic interaction among the various variables affecting people's quality of life (e.g., psychosomatic illnesses, possible links between chronic diseases and mental health, cognitive decline and progressive social isolation, or insufficient economic resources and physical and mental health).

The role of social determinants of health in the onset and management of diseases from a perspective of social inequalities.

Learning Unit 4: Biopsychosocial and health interventions based on an approach

Interventions aimed at health promotion and disease prevention: use of local resources to foster socialization and social participation that have a positive impact on health and well-being.

Interventions based on an integrated and holistic approach:

- A comprehensive approach to social and health assessments.
- Collaborative planning and care coordination with other stakeholders, and the involvement of the person concerned.
- Multidisciplinary coordination and networking among the entities or individuals involved in the care process.
- Support for caregivers.

Identification of examples of best practices in psychosocial interventions or integrated care programs.

Final Session: Conclusion of the Training

- Summary of key content.
- Qualitative/quantitative evaluation of the training.
- Next steps: opportunities and possibilities for future studies or initiatives.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and expected outcomes

- Participants increase their knowledge after completing the training.
- Participants are able to apply what they learned in the training to practical exercises.
- Participants are actively engaged in the training.
- Participants are satisfied with the training they received.
- Application of theories to the resolution of practical cases.
- Analysis of case studies using a biopsychosocial approach.
- Proposing interventions using a biopsychosocial approach.

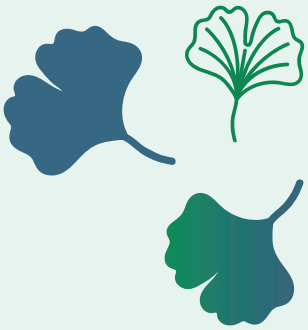
Initial assessment

- Assessment of prior knowledge during the training.

Midterm Evaluation
- Observation of activities.
- Analysis of case studies.
- Discussions.

Final Assessment
- Quiz on theoretical concepts.
- Proposed resolution on case studies.
- Participation in activities.

To learn more...



REFERENCES

- Baltes, P. B., & Baltes, M. M. (1990). Successful aging: Perspectives from the behavioral sciences. Cambridge University Press.
- Ding, L., Dai, R., Qian, J., Zhang, H., Miao, J., Wang, J. Tan, X. & Li, Y. (2024). Psycho-social dimensions of cardiovascular risk: exploring the impact of social isolation and loneliness in middle-aged and older adults. *BMC Public Health*, 24, 2355 (2024). https://doi.org/10.1186/s12889-024-19885-w
- George, L. K., & Ferraro, K. F. (Eds.). (2015). Handbook of aging and the social sciences. Academic Press.

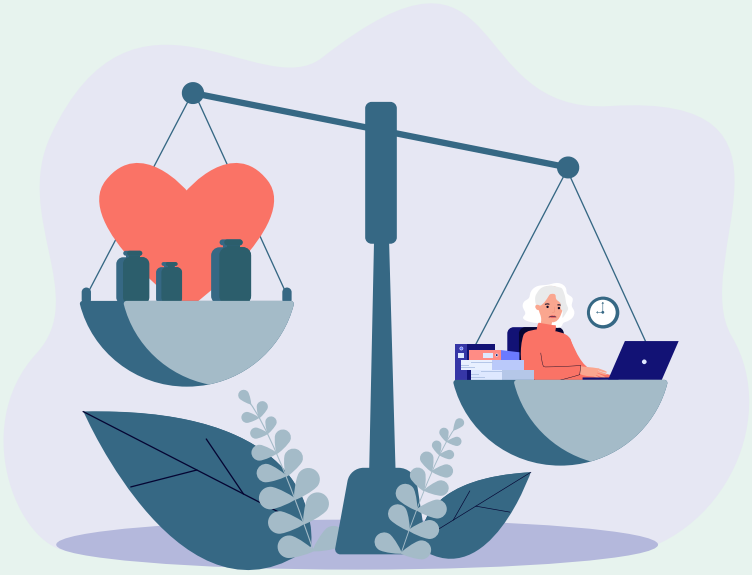
BEST PRACTICES

See Part 2 of the Practical Guide: Social, Health, and Community Coordination in the Care and Support of Older Adults

Module 7

Promoting the Quality of Life and Well-Being of Caregivers and Professionals

(Prevention of Burnout)



TARGET AUDIENCE

- Students and trainees in vocational or university programs or at the beginning their careers
- Healthcare and social work professionals
- Volunteers involved in providing care or support
- Informal caregivers without prior training
- Family caregivers supporting a loved one

DURATION

2 to 20 hours, adjustable according to the group's needs.

SPACES

- Training room with movable chairs.

REQUIRED EQUIPMENT

- Projector
- Internet

EDUCATIONAL APPROACH

- In-Person Learning
- Online Learning
- Blended Learning

TRAINERS (ROLE)

Psychologists, department heads/directors with managerial experience and in-depth knowledge of the sector, as well as the stakeholders involved in combating and preventing isolation. Knowledge of The burnout process and preventive measures.

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Theoretical input.
- Small-group work.
- Active learning.
- Communication role-plays.
- Role-playing with breathing and relaxation exercises.

LEARNING OBJECTIVES AND GOALS

- Be able to identify risk factors and warning signs of burnout.
- Propose individual and collective prevention measures.
- Implement managerial practices that promote quality of life at work.

CONTENTS

Learning Unit 1 : Introduction and Welcome

Get to know the other participants and identify their expectations.
Create a safe and supportive training environment.
Presentation of the training program.

Learning Unit 2 : The 3 Dimensions of Burnout

Definitions of the causes and symptoms of burnout, bore-out, and brown-out.

Differences between stress, depression, and burnout.

Dimensions of burnout according to Maslach: emotional exhaustion, depersonalization, and personal accomplishment.

The Development of Burnout: psychological and Physiological Mechanisms.

Risk factors specific to "helping" professions: emotional strain, exposure to suffering and death, the gap between ideal aspirations and reality, responsibilities, and a lack of recognition and support.

Learning Unit 3 : Stress in Daily Professional Life

Definition and warning signs:

- **Physical symptoms:** fatigue, sleep disturbances, tension, pain, digestive problems weight fluctuations.
- **Emotional symptoms:** irritability, cynicism, detachment, anxiety, loss of motivation.
- **Behavioral symptoms:** social isolation, avoidance, absenteeism, tardiness, substance abuse (coffee, alcohol, medications).

Burnout assessment tools: Maslach Burnout Inventory (MBI), Karasek questionnaire, Copenhagen Burnout Inventory (CBI).

Prevention initiatives for professionals: stress management, emotional intelligence, assertiveness, communication, healthy lifestyle.

Preventive measures for managers: regular assessment of psychosocial risks, stress management training, forums for analyzing work situations, recognition, and collaborative relationships.

Learning Unit 4 : Quality of Life at Work

Employer Responsibilities: Duty to ensure safety and prevent occupational hazards (psychosocial risks, ergonomics). Social dialogue, quality of life, and working conditions.

Employee Responsibilities: Compliance with safety guidelines and procedures. Reporting risky situations and proposing improvements to working conditions.

Management strategies: surveys, interviews, HR metrics, organizational adjustments (flexibility, remote work, workspaces), shared governance.

The team as a driver of quality of life: cohesion, mutual support, sharing of knowledge and best practices, conflict management.

Meaning and recognition at work: values, organizational vision, career prospects, empowerment, contribution to projects.

Learning Unit 5 : Specific focus on quality of life at work

Combating Gender Stereotypes:

- Challenging Prejudices About "Feminine Qualities" in the Healthcare Professions.
- Gender-neutral communication in recruitment and human resources management.
- Promoting diversity of skills beyond gender.
- Combating self-censorship among men in so-called "feminine" professions.
- Analyzing the impact of gender stereotypes on career paths and professional development.

Impact of digital technologies and artificial intelligence:

- Benefits (optimization of schedules, information sharing).
- Areas of concern: the right to disconnect, diversity of professional skills.

Final Session: Conclusion of the training

- Summary of the main content.
- Qualitative/quantitative evaluation of the training.
- Next steps: opportunities and possibilities for future studies or initiatives.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and expected outcomes

- Application of what was learned in the workplace.
- Impact on the team's collective practices.
- Understanding of key concepts related to quality of life at work.
- Knowledge of factors influencing workplace well-being.
- Proficiency in tools and methods for improving quality of life at work.
- Understanding of legal and regulatory issues related to workplace well-being.
- Identify sources of stress and discomfort at work.
- Take concrete steps to improve the work environment.
- Communicate effectively with colleagues and supervisors about well-being issues.

Initial Assessment

- Observation during the training to assess prior knowledge.

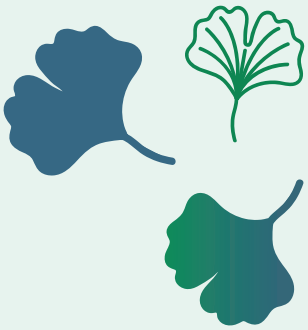
Midterm Assessment

- Observation of activities.
- Analysis of case studies.
- Discussions.

Final assessment

- Quiz on theoretical concepts.
- Proposals for resolving case studies.
- Participation in activities.

To learn more...



REFERENCES

- WHOQoL Group. (1993). Study protocol for the World Health Organization project to develop a Quality of Life assessment instrument (WHOQOL). *Quality of life Research*, 2, 153-159.
- PROJET I-MANO — Innovation managériale et organisationnelle dans les services à la personne, Gérontopole, https://gerontopole-na.fr/projets/i-mano/.

BEST PRACTICES

See Section 6 of the practical guide: Quality of Life and Well-being of Caregivers

Module 8

Networking and Community-Based Interventions

TARGET AUDIENCE

- Students and trainees in vocational or university programs or at the beginning their careers
- Professionals in the health and social work sectors
- Volunteers involved in providing care or support

DURATION

2 to 20 hours, adjustable according to the group's needs.

SPACES

- Training room with movable chairs.

REQUIRED EQUIPMENT

- Computer
- Projector
- Slide presentations
- Case studies
- Internet

EDUCATIONAL APPROACH

- In-Person Learning
- Online Learning
- Blended Learning

TRAINERS (ROLE)

Experts in social, community, and health interventions (social work, social education, nursing, etc.). Practical experience and knowledge of community development projects, social action, and networking with various local stakeholders are major assets.

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Analysis of best practices.
- Contributions using multimedia resources.
- Simulation of the operational environment.
- Case studies.
- Group work for project planning.
- Development of analytical tools: SWOT (Strengths, Weaknesses, Opportunities, Threats, Potential) and sociogram.
- Project implementation and impact assessment.

LEARNING OBJECTIVES AND GOALS

- Adopt a local approach, drawing on networking, to promote active citizenship based on and local opportunities.
- Learn the principles of assessment, planning, implementation, and evaluation of a community-based intervention project.
- Acquire methodologies and tools for intergenerational and community-based interventions.
- Develop a community-based intervention project based on the needs identified in the community.
- Contextualize and evaluate the implications of an intervention project.

CONTENTS

Learning Unit 1 : Introduction and Welcome for Participants

Get to know the other participants and identify their expectations.
Create a safe and supportive training environment.
Presentation of the training program.

Learning Unit 2 : The Community-Based Approach in New Models of Care

Introduction to the territorial approach: definition and main characteristics.
The evolution of political and institutional policies toward community-based and shared-responsibility care models, which help prevent the institutionalization of people in need of support or care.

Learning Unit 3 : Benefits of the regional model and networking

Benefits of community-based care, for example:

- The local community and proximity as a context for preventive intervention and the reduction of social inequalities.
- Local resources and services to prevent isolation and unwanted loneliness among older adults.
- Availability of care resources in the person's immediate environment to support their life plans, promote their independence, and foster their social inclusion.
- Community-based initiatives to create supportive care environments (e.g., age-friendly cities).

Benefits of collaboration among healthcare providers, for example:

- Integrated and continuous care through collaboration among local stakeholders.
- More efficient use of resources through coordinated services.
- Strengthening of the social support network in local communities.

Learning Unit : Regional Projects and Interventions

Principles of networking: participation, collaboration, shared responsibility, etc.
Strategies, processes, and methodological tools for community-based interventions.

- Assessment, planning, implementation, and evaluation of community-based projects.
- Building partnerships and fostering cross-sector collaboration.
- Intergenerational intervention strategies.
- Intercultural sensitivity in managing networks and projects in diverse regions.

Identification of best practices at the European level for preventive projects carried out in local contexts.

Final Session: Conclusion of the Training

- Summary of key content.
- Qualitative/quantitative evaluation of the training.
- Next steps: opportunities and possibilities for future studies or initiatives.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and Expected Outcomes

- Participants apply what they have learned in the training to the practical exercises during the course.
- Participants are actively engaged in the training.
- Participants are satisfied with the training they received.
- Understanding, interpretation, and application of basic concepts related to the project.
- Knowledge of the project area and its resources.
- Skills in applying methodological tools.
- Ability to develop the various phases of a territorial project: assessment, planning, implementation, and evaluation.

Initial Assessment

- Observation during training to assess prior knowledge.

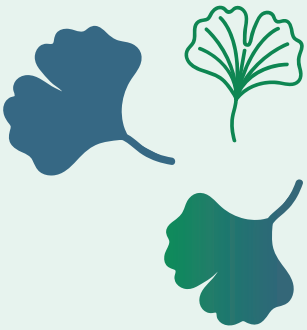
Midterm evaluation

- Observation of activities.
- Analysis of case studies.
- Discussions.

Final assessment

- Quiz on theoretical concepts.
- Proposed solutions to case studies.
- Participation in activities.

To learn more...



REFERENCES

- Brenner, J. & Haaken, J. (2000). Utopian thought: Revisioning gender, family, and community. *Community, Work & Family*, 3(3), 333-347. https://doi.org/10.1080/13668800020006839
- European Comission (2017). The European Pillar of Social Rights. Publications Office of the European Union.
- Spade, D. (2020). Mutual Aid: Building Solidarity during This Crisis (and the Next), London: Verso.

BEST PRATICES

See Section 5: Housing (p. 76) in the Practical Guide

Workshop A

Workshop on Narrative Communication: The Art of Telling a Story Through Video

TARGET AUDIENCE

- Students and interns in vocational training, university programs, or early in their careers
- Healthcare and social work professionals
- Volunteers involved in support or care
- Informal caregivers without prior training
- Family caregivers supporting a loved one
- Older adults

DURATION

2 hours for the activity presentation and instructions.
4 hours for conducting the interview and video editing.

SPACES

- Training room.
- Comfortable environment for recording interviews

REQUIRED TOOLS

- Computer
- Video Projector
- Slideshows
- Case Studies
- Internet
- Smartphone or camera

TEACHING APPROACH

- In-person learning
- Online learning
- Blended learning

TRAINERS (ROLE)

- Students and interns in vocational or university training programs, or those early in their careers
- Professionals in the health and social work sectors
- Volunteers involved in support or care
- Informal caregivers without prior training
- Family caregivers supporting a loved one
- Older adults

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Interactive lecture.
- Focus groups.
- Brainstorming.
- Role-playing.
- Practical exercises/simulations.
- Hands-on practice with technical tools.

LEARNING OBJECTIVES AND GOALS

- To understand the concepts of social isolation and loneliness among older adults, as well as the importance of intergenerational solidarity, social inclusion, and intercultural dialogue in addressing these issues.
- Develop skills to connect with older adults and understand their needs through video interviews, focusing on creating an empathetic environment, asking open-ended questions, and managing technical aspects.
- Promote an empathetic and respectful approach when working with older adults, ensuring sensitivity to their experiences while upholding the values of social inclusion.

PREREQUISITES

To successfully complete this activity, it is essential to have completed the following modules:
- **Module 1:** Aging (issues related to aging: diversity, violence, etc.).
- **Module 2:** Protective and Risk Factors for Social Isolation.
- **Module 3:** Communicating with the Intervention's Target Groups —A Person-Centered Approach..
- **Module 5:** Intergenerational Dynamics.

CONTENTS

Learning Unit 1 : Introduction and Welcome
Introduction of participants and discussion of expectations.
Creating a supportive training environment.
Overview of the training program.

Learning Unit 2 : Interview Planning
Identifying a meaningful local practice or project.
Gather detailed information and contact the project leaders.
Define and communicate the purpose of the interview.
Obtain the necessary consents.

Learning Unit 3 : Preparing the Interview Framework
Creating an outline or storyboard for the interview.
Setup of technical equipment (microphone, lighting, location).

Learning Unit 4 : Conducting the video interview
Create a welcoming and supportive atmosphere.
Apply the principles of active and empathetic listening, following the interview structure and respecting the interviewee's time and needs.
Conclude thoughtfully, ensuring an appropriate and considerate ending.

Learning Unit 5 : Editing
Available editing tools: trimming clips, inserting slides, managing multiple languages, adding subtitles, adding transitions, finalizing the render.

Final Unit: Conclusion of the Training
- Summary of key content.
- Qualitative/Quantitative Evaluation of the Training.
- Next steps: opportunities and possibilities for future studies or initiatives.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and Expected Outcomes

- Feedback from participants during the activity.
- Active participation by learners.
- Ability to identify the needs of older adults during practical exercises.
- Use of active listening techniques during the exercises.

Initial assessment

- Participants' reflections on their current knowledge

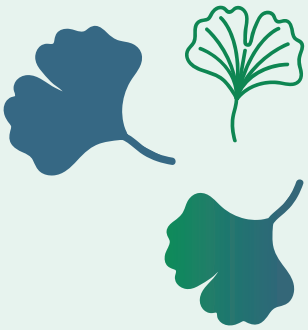
Midterm evaluation

- Observation of group activities.
- Discussions and reflections on what has been learned.
- Discussions and reflections on case studies and practical exercises.

Final assessment

- Questionnaire/test on the theoretical content of the activity.
- Qualitative tool to assess participant satisfaction.
- Discussions and reflections on what was learned.
- Case studies: analysis and proposals for appropriate solutions.

To learn more...



REFERENCE

- Naughton-Doe, R., Barke, J., Manchester, H., Willis, P., & Wigfield, A. (2024). Ethical issues when interviewing older people about loneliness: reflections and recommendations for an effective methodological approach. *Ageing and Society*, 44(7), 1681–1699. https://doi.org/10.1017/S0144686X2200099X

Workshop B

Workshop on Narrative Communication: The Art of Telling a Story Through Photography

TARGET AUDIENCE

- Students and interns in vocational training, university programs, or early in their careers
- Professionals in the health and social work sectors
- Volunteers involved in support or care work
- Informal caregivers without prior training
- Family caregivers supporting a loved one
- Older adults

DURATION

2 hours for the activity presentation and briefing
4 hours for conducting the interview and taking photos

SPACES

- Training room
- Comfortable environment for recording interviews

REQUIRED TOOLS

- Computer
- Projector
- Slide presentations
- Case studies
- Internet
- Smartphone or camera.

TEACHING APPROACH

- In-person learning
- Online learning
- Blended learning

TRAINERS (ROLE)

Experts in communication and/or psychology and/or education and/or social work.

DESCRIPTION OF THE TRAINING ACTIVITY

METHODS

- Interactive lectures.
- Discussion groups.
- Brainstorming.
- Role-playing exercises.
- Practical exercises/simulations.
- Hands-on practice with technical tools.

LEARNING OBJECTIVES AND GOALS

- To understand the main issues related to social isolation and its impact on older adults, particularly the role of stories and visual narratives in combating stereotypes and promoting social inclusion.
- Develop the ability to conduct empathetic interviews, collect compelling stories and images, and design a photo book that effectively communicates complex social issues through innovative and sensitive approaches.
- Cultivate an empathetic, respectful, and person-centered person-centered approach when working with older adults, prioritizing their dignity, comfort, and autonomy.

PREREQUISITES

To successfully complete this activity, you must have completed the following modules:

- **Module 1:** Aging (issues related to aging: diversity, violence, etc.).
- **Module 2:** Protective and risk factors for social isolation.
- **Module 3:** Communication with the Intervention's Target Groups —A Person-Centered Approach.
- **Module 5:** Intergenerationality

CONTENTS

Learning Unit 1 : Introduction and Welcome

Introduction of participants and discussion of expectations.
Creating a supportive training environment.
Overview of the training program.

Learning Unit 2 : Interview Planning

Identify a meaningful story, gather detailed information, define and communicate the interview's objective, address legal and confidentiality issues, prepare logistics, and set narrative and stylistic goals.

Learning Unit 3 : Preparing the Environment

Preparation for filming focuses on selecting impactful photos that reflect key themes such as aging and isolation, and offers practical advice on how to take high-quality photos with smartphones. This includes techniques for optimal lighting, composition, and stability.

Learning Unit 4 : Conducting the Interview and Taking Photos

Create a welcoming and caring atmosphere.
Apply the principles of active and empathetic listening, following the interview structure and respecting the interviewee's time and needs.
Take meaningful photos.
Conclude thoughtfully, ensuring an appropriate and respectful ending.

Learning Unit 5 : Graphic Design

Using the available editing tools. Photo editing. Laying out photos and text. Harmonization.

Final Unit: Conclusion of the Training

- Summary of key content.
- Qualitative/quantitative evaluation of the training.
- Next steps: opportunities and possibilities for future studies or initiatives.

METHODOLOGICAL SUGGESTIONS FOR EVALUATION

Indicators and expected outcomes

- Feedback from participants during the activity.
- Active participation by learners.
- Ability to identify the needs of older adults during practical exercises.
- Use of active listening techniques during exercises.

Initial Assessment

- Participants' reflection on their current knowledge.

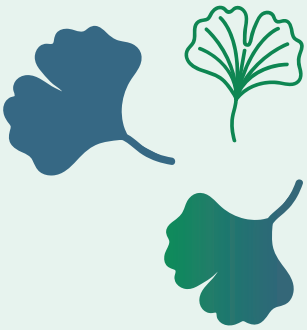
Mid-course assessment

- Observation of group activities.
- Discussions and reflections on what has been learned.
- Analysis of case studies and practical exercises.

Final assessment

- Questionnaire/test on the theoretical content of the activity.
- Qualitative tool to assess participant satisfaction.
- Discussions and reflections on what was learned.
- Case Studies: Analysis and Proposed Solutions.

To learn more...



REFERENCE

• Naughton-Doe, R., Barke, J., Manchester, H., Willis, P., & Wigfield, A. (2024). Ethical issues when interviewing older people about loneliness: reflections and recommendations for an effective methodological approach. *Ageing and Society*, 44(7), 1681–1699. https://doi.org/10.1017/S0144686X2200099X

The GINKGO project partners:

- Etcharry Formation Développement, Ustaritz, France
- Centre communal d'action sociale, Urruña, France
- Pôle Culture & Santé en Nouvelle-Aquitaine, Bordeaux, France
- Universidad Pública de Navarra, Pampelune, Spain
- Bortzirietako Gizarte Zerbitzuen Mankomunitatea, Etxalar, Spain
- Università di Bologna, Bologne, Italy
- Cefal Emilia Romagna, Bologne, italy
- Anziani e non solo, Carpi, Italy

GINKGO

The social link factory

www.ginkgo-project.eu