Of the attendees, 1089 were alive and still living in the Oslo area in 2003, and were re-invited to follow-up assessments. Of these, 755 (69.3%) attended and 616 (56.6%) provided follow-up data on outcome variables from Q2. Of these, 603 answered at least one question from Q3, and were included in the analyses of the present study, representing an attrition rate from baseline of 44.6%.

**Intervention**

The theory-based intervention aimed at generating a forward transition in stages of change in physical activity by favourably influencing the potential psychosocial mediators; social support, self-efficacy, attitudes, perceived control, and physical activity identity. The multi-component population-based intervention (Figure 1) comprised four main strategies:

1) **Communication strategies**

A range of communication efforts were developed and implemented throughout the intervention period to: 1) communicate information about physical activity and health, and to 2) promote the physical activity programs of the project [25]. A number of channels and settings were employed: local television, radio, newspapers, posters, stage-based and ordinary brochures, direct mailings, stands, lectures etc. "Walk the stairs"-posters [1] were placed at block entrances and in public buildings to encourage people to climb the stairs in stead of using escalators and elevators. Late in the intervention period, the local General Practitioners also prescribed physical activity (Green prescription). As about 20% of the target population were of non-Western origin [20], efforts were made to reduce language and cultural barriers by translating some of the information material into the most common foreign languages and by offering a special program to the attendants at Norwegian classes.

2) **Physical activity programs**

Low-threshold physical activity programs were developed in close collaboration with representatives of the inhabitants of the community [3]. The activities comprised a number of weekly sessions of outdoor walking groups and indoor aerobic exercise programs conducted by exercise leaders, a dance course, as well as a test of physical fitness twice a year.

3) **Environmental strategies**

In accordance with social-ecological models [12] several initiatives were implemented to increase the accessibility to physical activity arenas in the local environment; labelling of walking paths and improved street lighting, snow clearing and gritting of pavements and walking paths during winter season. To increase the motivation to use the walking paths, a walk diary was distributed to every household in the community, and could be returned to project staff after registration of weekly walking distance for participation in local competitions.

4) **Participatory strategies**

The intervention was based on participatory approaches [26], including local political and lay leaders as well as local health and welfare workers in the planning and implementation of intervention strategies. Furthermore, the project was incorporated in the strategic plans of the community, stating the councils' commitment to and involvement in the project.

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**Intervention components**

<table>
<thead>
<tr>
<th>General information (i.a. brochures)</th>
<th>Stands</th>
<th>Lectures</th>
<th>Walks the stairs'-posters</th>
<th>Green prescription</th>
<th>Walking groups</th>
<th>Aerobic exercise groups</th>
<th>Physical fitness test</th>
<th>Labelling of walking path</th>
<th>Walk diary</th>
<th>Health surveys</th>
</tr>
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<tbody>
<tr>
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**Year**

<table>
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<tr>
<th>2000</th>
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<th>2002</th>
<th>2003</th>
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**Figure 1**

Intervention components and time of exposure in relation to the health surveys.