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INTERREG ITALY-CROATIA PROJECT ADRINCLUSIVE

D.1.6.1 LOCAL WORK SESSIONS REPORT

(Version 1.0 –31/07/2025)



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Project Title	Innovative and sustainable tourism offer for equal access and social inclusion of people with dementia and cognitive decline to tourist destinations in the Adriatic sea
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Deliverable	D.1.6.1 - Local Work Sessions Report
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1. Introduction

Deliverable 1.6 aims to consolidate the knowledge, insights, and feedback gathered from local activities involving stakeholders and key experts. Its primary purpose is to support the definition of the ADRINCLUSIVE Strategy and Pilot Actions by providing a structured report of each partner's local working group. This deliverable includes a template for partners to systematically document the outcomes of their local work sessions, ensuring that the experiences and innovative solutions identified at the local level can inform the broader project objectives.

Inclusive tourism for people with dementia addresses both social and practical challenges, ensuring that individuals with cognitive impairments can participate in cultural, recreational, and leisure activities in a safe and supportive environment. Focusing on this segment of the population allows local authorities, service providers, and tourism operators to develop tailored solutions that respond to specific needs, fostering a more equitable and accessible tourism sector. Local work sessions, guided by experts, are essential to identify innovative approaches, share experiences, and build the capacity of stakeholders to deliver high-quality, inclusive tourism services.

2. Shared Methodological Approach

The elaboration of Deliverable 1.6 was carried out through a shared and participatory methodology, agreed upon by all project partners. The approach combined local engagement with a common analytical framework, ensuring that the outcomes reflect both territorial specificities and transnational coherence.

2.1 Participatory and Inclusive Process

Each partner organized work sessions in their local area, bringing together a wide and diverse group of stakeholders. Tourism operators, socio-health professionals, representatives of associations and NGOs, public authorities, and academic institutions were all involved. This multiplicity of voices guaranteed that the findings were rooted in practical experience and reflected the actual needs of people with dementia and their families. The participatory nature of the process also ensured that stakeholders were not only consulted but actively engaged in shaping the recommendations, thereby building shared ownership of the results.

The local work sessions were structured as moderated discussions, often complemented by focus groups and round tables. These meetings created spaces for collective reflection and exchange of experiences, with the aim of co-designing feasible solutions. Two main thematic areas guided the debate: first, the



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preparation of tourism workers through training on inclusive practices; second, the practical organization of pilot holidays designed to be accessible to people with dementia and their caregivers. This structure made it possible to align conversations across different territories while leaving room for local adaptations and creativity.

To ensure comparability of results, partners agreed on a common set of guiding questions that oriented the discussions. These questions explored issues such as the integration of dementia-related modules into existing training programs, the identification of stakeholders to be involved in content design, the type of pilot inclusive holiday that could be implemented, the adaptations required in facilities, and the most appropriate ways to evaluate impact. By relying on this shared framework, local discussions remained anchored to the overall objectives of the ADRINCLUSIVE project, while still capturing the nuances of each territorial context.

After the sessions, each partner produced a local report summarizing findings, priorities, and proposals. These reports were then brought together into a comparative analysis that identified common patterns and needs, as well as innovative practices emerging in specific contexts. The cross-reading of results made it possible to distinguish elements that are locally specific from those that can inform a more general and transferable model for the Adriatic region. This comparative step was essential to transform fragmented experiences into a coherent and shared framework.

The overall methodology thus combined local participation, thematic guidance, and transnational synthesis, and it was conceived as a process of building consensus and preparing for future action. Through this shared approach, partners have laid the groundwork for the definition of a common training pathway for tourism operators, the design of replicable models of inclusive holiday experiences, and the creation of stakeholder networks capable of supporting the sustainability and scaling up of inclusive tourism initiatives.

3. Key Findings from Local Work Sessions

The analysis of the local work sessions carried out by the different partners revealed a series of recurring themes and priorities, which, despite being rooted in specific territorial contexts, converge towards a coherent vision of inclusive tourism for people with dementia. The following synthesis presents the most significant findings emerging from the comparison of reports.



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3.1 Training and Education

One of the most evident gaps identified across all territories concerns education and training. Universities, vocational schools, and professional training programs rarely include modules on dementia, inclusivity, or accessible tourism.

“There is a clearly identified lack of educational content preparing tourism workers to work with people with dementia. University and secondary school programs in Italy and Croatia rarely, if at all, include topics such as recognizing dementia symptoms, understanding the behavior of people affected, or adapting communication.” (PP4 – Zdravi Grad)

This absence has created a workforce that is technically prepared for hospitality but largely untrained in dealing with the specific needs of people with cognitive impairments.

To address this gap, partners agreed on the importance of defining a set of core competencies for tourism workers, including basic knowledge about dementia, awareness of the challenges faced by families, and the ability to provide empathetic and respectful services. Communication emerged as a central skill: tourism workers must be trained in simple, inclusive techniques that facilitate interaction with people who may experience disorientation or memory difficulties.

In Brindisi, for instance, the local working group designed a concise yet practice-oriented training pathway (approximately 30–40 hours) combining e-learning and on-the-job shadowing. The course emphasizes empathy, crisis management, and environmental adaptation, with 80% of the time devoted to practice. This approach directly responds to the gap identified across partners concerning the lack of dementia-related content in vocational tourism programs. A participant noted, *“Technical skills alone are not enough without empathy and understanding” (LP - Municipality of Brindisi)*, summarising the spirit of the blended pathway. The integration of such blended models directly responds to the transnational recommendation that training “must not be purely theoretical but experiential,” while also contributing to the proposed European framework of progressive levels, from basic to specialized, for inclusive tourism competence development. The integration of such blended models directly responds to the transnational recommendation that training should not be purely theoretical for inclusive tourism competence development.

The stakeholders agreed that experiential methodologies such as simulations, role-playing exercises, and workshops are crucial in helping workers acquire practical confidence.

“Everyone suggests summarizing the content, for the training 2–3 hours, for the shorter workshop around 45–60 minutes. Because of the different backgrounds and education levels of the participants, the level of interest in the subject will likely be different, as well as their capability to concentrate.” (PP2 – City of Novigrad)



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Moreover, certification systems, such as badges for trained facilities or labels designating dementia-friendly services, were proposed as tools to recognize efforts and encourage widespread participation in training initiatives.

3.2 Adaptation of Tourism Services

Beyond training, partners emphasized that the physical and organizational environment of tourism services must be adapted to the needs of people with dementia.

Tourist facilities (hotels, restaurants, museums, etc.) are mostly not adapted for people with cognitive difficulties. The issue is not only physical access, but also atmosphere, approach, scheduling of activities, and staff support.” (PP4 – Zdravi Grad)

Environmental adjustments, such as clear signage, appropriate lighting, and safe rest areas, were frequently cited as essential elements for creating accessible spaces. On this topic, it’s interesting to note the Brindisi workshop experience, as the stakeholder further operationalized these principles through the conceptual idea of “dementia-friendly environment toolkit,” focusing on lighting contrasts, noise reduction, and simplified signage along visitor routes such as the Castello Alfonsino and Torre Guaceto sites. This practical translation of the ADRINCLUSIVE guidelines helped local stakeholders visualize how existing assets could evolve into inclusive settings.

Similarly, service-related adaptations, for instance, in the scheduling of meals, the design of daily activities, or the availability of personalized assistance, are necessary to reduce anxiety and enhance well-being.

Some reports suggested the development of specialized tourism packages designed around the needs of people with dementia and their caregivers. These packages would combine environmental and service adaptations with tailored cultural, recreational, and leisure activities. Integration with existing accessibility frameworks, such as the Italian “Bandiera Lilla” model, was also recommended as a way to ensure coherence and sustainability.

3.3 Pilot Actions (Inclusive Holidays)

A central innovation of the project lies in the conception and testing of inclusive holiday models. Across all contexts, the shared objective was clear: *holidays should be recognized as a right, not as a privilege reserved for the few.*

"The project ‘An Unforgettable Holiday’ was born with a deeply innovative purpose: it does not have a clinical or healthcare aim, but places normality at the center, understood as a right and a condition of shared well-being." (PP5 – AFAM Marche)



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This vision was illustrated through pilot initiatives that placed the person with dementia and their families at the center of the tourism experience.

"The origin of the experience is deeply human: it arose from the simple but powerful request of Mrs. Lina, who expressed the desire to be able to go on holiday again." (PP5 – AFAM Marche)

The AFAM initiative “Una vacanza indimenticabile” emphasized normality and dignity, allowing participants to experience a holiday free from stigma. In Novigrad, activities such as creative reading, art workshops, and music evenings were designed to combine enjoyment with therapeutic value.

“The conclusion after a brainstorming of possible activities was that the goal of the pilot action is to create a comfortable vacation for the people with dementia and for the caregivers, which means that we need to provide ‘light’ activities, which are not mandatory and are adaptable to some participants if needed.” (PP2 – City of Novigrad)

Despite differences in format, both experiences highlighted common success factors: activities had to be light and adaptable, the presence of a multidisciplinary team was indispensable, and the involvement of the local community proved essential in creating a welcoming and inclusive atmosphere.

For the future of ADRINCLUSIVE and more broadly of inclusive tourism, the sustainability of such initiatives will depend on the capacity to mobilize EU, national, and regional funding streams, ensuring that inclusive holidays are not isolated experiments but replicable practices.

Furthermore, pilot initiatives across partner territories will be testing dementia-friendly tourism packages integrating cultural, natural, and leisure experiences into short stays of two to three nights (as inspired by the previously discussed experiences). Each pilot reinforces the principle of equal access to leisure as a component of social inclusion.

Typical itineraries combine slow-paced cultural visits, accessible outdoor activities, and sensory workshops or shared meals, supported by trained guides and educators. Programs are designed with flexible scheduling, regular rest breaks, and low-complexity transport to minimize fatigue or disorientation. These models serve as prototypes for replicable, community-based, inclusive tourism products.

3.4 Stakeholder Involvement

A key finding concerns the broad range of stakeholders required to make inclusive tourism a reality. NGOs, health institutions, local authorities, hospitality providers, and families each play a distinct yet complementary role. The reports emphasize that tourism alone cannot meet the complex needs of



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people with dementia; effective action depends on cross-sectoral cooperation linking tourism with healthcare, social services, education, and civil society.

The establishment of local networks capable of coordinating resources and fostering synergies emerged as a decisive success factor. Bringing together municipalities, social cooperatives, training bodies, tourism operators, cultural site managers, and caregivers ensures that every component, from education to logistics, contributes coherently to the same inclusive goal.

Partnerships between public authorities, educational institutions, and hospitality providers have proven especially effective in embedding dementia awareness into the wider tourism ecosystem. Such collaboration reflects the project's guiding principle that sustainable inclusion stems from shared ownership, not isolated initiatives, and ultimately helps integrate inclusive tourism into the everyday life of local communities.

3.5 Communication and Awareness

Despite the availability of some inclusive initiatives, their visibility remains extremely limited. Many families are unaware that such offers even exist, which severely restricts their impact. Raising awareness and improving communication, therefore, emerged as urgent priorities.

Direct communication channels with families and caregivers were recommended, alongside stronger partnerships with tourism boards, professional associations, and digital platforms. Moreover, awareness-raising campaigns should aim not only at promoting services but also at combating stigma, thereby transforming perceptions of dementia in society and normalizing the idea that people with cognitive impairments are full participants in community and tourism life.

3.6 Monitoring and Evaluation

Finally, the partners stressed the importance of robust systems for monitoring and evaluation. The effectiveness of training and inclusive holidays must be demonstrated through evidence, not only to improve practices but also to justify continued investment. Indicators should combine qualitative and quantitative dimensions, measuring improvements in participants' well-being, reductions in medication or behavioral symptoms, satisfaction among caregivers and families, and the extent of stakeholder engagement.

Various tools were proposed to support this process, ranging from surveys and structured observation sheets to focus groups, diaries, and reflective reports. When applied systematically, these tools can



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generate valuable knowledge, facilitate continuous improvement, and demonstrate the replicability of inclusive tourism models across different territories and support their enhancement by providing data about important indicators, including safety (number of incidents), satisfaction on a Likert Scale, and environmental compliance (checklist items meeting expectations and needs).

4. Recommendations and Proposed Framework

Building on the findings from the local work sessions and the comparative analysis of partner contributions, a shared framework has been developed to guide the implementation and upscaling of inclusive tourism practices for people living with dementia. The framework rests on five interrelated pillars that together form the foundation of the ADRINCLUSIVE model.

4.1 Training pathway: basic, advanced, specialization

Partners agreed that the development of a structured training pathway is a prerequisite for sustainable capacity-building in inclusive tourism. The proposed model envisages a progressive structure, basic, advanced, and specialization levels, allowing workers from diverse professional backgrounds to gradually acquire and deepen relevant competencies.

The basic level introduces fundamental concepts of dementia, communication, and safety; the advanced level focuses on applied practices, scenario-based learning, and teamwork with caregivers; and the specialization level prepares “inclusion focal points” capable of mentoring colleagues and coordinating site-level implementation. Training should remain practice-oriented and experiential, combining e-learning micro-modules with on-the-job observation and role-play simulations. Certification mechanisms should be tied to demonstrable competence rather than attendance alone.

4.2 Service adaptation guidelines

Creating a genuinely dementia-friendly tourism experience requires more than staff training; it demands an environment designed with accessibility, safety, and comfort in mind. Partners recommend adopting service adaptation guidelines to ensure consistent quality across destinations.

These guidelines include: simplified and well-contrasted signage; calm and adequately lit spaces; safe and clearly defined routes; sufficient rest areas; and activity schedules that respect a slower pace and regular breaks. Toolkits and checklists developed during local sessions should be harmonized into a shared transnational reference document, enabling sites to assess their “dementia-friendliness” using objective indicators.



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4.3 Certification and recognition mechanisms

To encourage participation and acknowledge professional commitment, partners propose the introduction of certification systems at both individual and institutional levels.

For individuals, short micro-credentials could validate specific skills acquired through ADRINCLUSIVE training modules and serve as a basis for regional qualification frameworks. For institutions, a “dementia-friendly” or “inclusive tourism” label could recognize compliance with established environmental and service standards. These recognition tools would not only reward achievement but also raise public awareness and increase the visibility of inclusive tourism destinations.

4.4 Pilot models for inclusive holidays

The pilot initiatives carried out by project partners demonstrate that inclusive holidays are not a niche product but a replicable form of community-based tourism promoting well-being, dignity, and participation. The proposed model is a short-stay (2–3 days) format integrating cultural, natural, and leisure experiences, supported by trained staff and flexible logistics.

Each pilot acts as a living laboratory, testing protocols for accessibility, safety, and service coordination. Data collected through monitoring and evaluation should inform the refinement of operational guidelines and provide evidence for future scaling across the Adriatic area.

4.5 Policy integration and scalability (regional/national level)

Finally, the long-term success of ADRINCLUSIVE depends on embedding inclusive tourism within existing regional and national policy frameworks. This includes aligning the training pathway with recognized skill registries, incorporating inclusive tourism standards into tourism certification schemes, and promoting synergies with health and social care strategies.

Partners emphasize that policy integration will ensure continuity beyond the project’s lifespan, allowing inclusive tourism to become a permanent feature of destination management rather than an experimental initiative. Scalability should rely on documented results, stakeholder networks, and adaptable models capable of responding to local specificities while preserving a shared European vision.

5. Conclusions and Next Steps

The collective work carried out within ADRINCLUSIVE has produced a solid basis for advancing a common European framework for inclusive tourism and dementia-friendly destinations. The findings



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confirm that inclusive tourism requires an integrated approach combining human training, environmental adaptation, intersectoral cooperation, and systematic evaluation.

The comparative analysis shows that, across territories, the same priorities emerge: practical training, clear service guidelines, collaborative governance, and recognition systems that make inclusion visible and measurable. These elements now converge into a coherent transnational strategy aimed at ensuring that people with dementia and their families can participate fully in cultural and leisure life.

In the coming months, project partners will translate this framework into action through pilot testing and targeted training initiatives. The next pilot activities, scheduled for June and September 2025, will validate the training modules, assess the effectiveness of environmental adaptations, and refine monitoring tools.

Following these pilots, results will be consolidated into regional and cross-border guidelines, feeding into the final ADRINCLUSIVE Strategy. By building local capacity and establishing transferable standards, the project contributes to a broader European movement toward tourism that is equitable, empathetic, and accessible to all.



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Appendix

Template for local activities report

1. General information

- Report title:
- Date:
- Location:
- Participants: (List of participants and involved organizations)
- Partner name:

2. Training proposals for tourism workers in inclusive tourism

2.1 Training content

- Main topics: (List of topics covered)
- Learning objectives: (What is intended to be achieved with each topic)

2.2 Access methods

- When and where (in which context) are they taught?: (apprenticeship, schools, etc.)
- Teaching methodology: (E-learning, face-to-face lessons, workshops, etc.)
- Tools used: (Online platforms, teaching materials, etc.)

2.3 Training type

- Course type: (Basic course, advanced, specialization, who is the target of the courses?, etc.)
- Certifications: (If any, specify which ones)
- Expected results: (What is expected to be achieved at the end of the course)

2.4 Course duration

- Total duration: (Number of hours or days)
- Session breakdown: (Number of sessions and duration of each)

3. Organization of pilot actions (inclusive holidays)

3.1 Description of pilot actions

- Objectives of pilot actions: (What is intended to be achieved)
- Activity description: (Details of planned activities)

3.2 Stakeholders involved

- List of stakeholders: (Who they are and their role)
- Roles and responsibilities: (Who is in charge of what)



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3.3 Planning and coordination

- Timeline: (Calendar of activities)
- Required resources: (Materials, personnel, funding, etc.)

3.4 Monitoring and evaluation

- Success indicators: (How the success of pilot actions will be measured)
- Monitoring tools: (Which tools will be used)

4. Conclusions and next steps

- Summary of results: (Summary of collected information)
- Next actions: (What is planned to be done next)

5. Attachments

- Supporting documents: (Any additional documents)
- Reference contacts: (Useful contacts for further information; e.g. email of interested stakeholders for pilot actions)

