World Health Organization

Centre for Health Development

Appendix C

Chile: Geropolis

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Preface

The World Health Organization Centre for Health Development Kobe has contracted RAND Europe to serve as a research hub for conducting a systematic review and gathering evidence of middle- and high-income countries' community-based social innovations (CBSIs) for healthy ageing. RAND Europe has undertaken two main strands of research: (1) a systematic review of CBSIs for healthy ageing in middle- and high-income countries, and (2) a series of ten case studies of CBSIs for healthy ageing in middle-income countries.

This report presents the findings from one of our ten case studies, the Geropolis programme in Chile.

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Summary of the community-based social innovation (CBSI)

Background

Chile

Locations
Valparaíso, Chile

Type of intervention
Adaptive

Year established
2015

The intervention

Establishing the CBSI

- Geropolis is an institution improvement programme created by the University of Valparaíso in 2015.
- The programme is financed by the Ministry of Education in Chile and aims to develop an integral and replicable model of education, health activities and urban planning that can improve the quality of life of older people.
- There were three main factors in the creation of Geropolis: (i) the demographic situation in Chile and in particular in Valparaíso, (ii) the 2014 fire in Valparaíso, which destroyed 2,000 homes and dramatically affected the older population, and (iii) the geographical setting of Valparaíso which has steep roads.
- Geropolis has four major objectives relating to the following programmatic areas: Associativity, Intervention, Education, and Knowledge development.

Activities of the CBSI

- The target population comprises older adults (60+) in the city of Valparaíso. Across integrated programmes, the programme is currently benefiting around 50,000 senior citizens from the Valparaíso Municipality.
- There are four main projects under the Intervention objective:
  - The *Health Multiplication Agents programme (AMS)*, which aims to form or recognise leaders in their communities and give them more tools so that they can contribute to the health and well-being of older people.
  - The *Mobile Health Platform (PMS)*, which delivers patient medical appointment reminders and healthy habits and self-care information through text and voice messages. This pilot project is undertaken in direct collaboration with the primary care centre.
  - The *Urban Appropriation Programme (PAU)*, which is mapping parts of Valparaíso in order to identify important features of the surrounding environment in terms of accessibility and mobility for older people.
  - *Geromovil* – a modified truck that will provide various medical or social services as well as cultural activities.

Results and impact of the CBSI to date

- The number of older people engaged in Geropolis-related activities varies according to each programme – for example, 118 persons attended training generated through AMS and 2,072 benefited from the PMS.
- At the micro level, Geropolis is having an impact predominantly on the well-being of beneficiaries through increased peer interaction and equipping participants with knowledge that benefits them, as well as by giving participants a sense of pride in their contribution.
- At the meso level the programme has brought benefits for the local primary care clinic by helping attain the clinic's coverage goals (population reached with targeted messages) and increase efficiencies in delivering healthcare by reducing the rate of non-attendance at health appointments.
- At the macro level the programme has managed to bring together a series of actors from various fields (health, social care, education, civil society, international health organisations) to work on the problems of older persons in Chile.

Ageing in Chile

- The percentage of the population aged 60 and over was 15.2 per cent in 2015 and it is expected to reach 17.4 per cent by 2020.
- Valparaíso has the greatest share of older adults in Chile, with 20 per cent of its population over 60.
- In 2015, through a collective effort with other countries in the Americas, the Inter-American Convention on Protecting the Human Rights of Older Persons was developed. This is the world's first binding convention referring to the rights of older persons and Chile was one of the countries that spearheaded its development.

Reflections on the CBSI

- The programme is being transformed in order to increase its sustainability beyond the guaranteed funding period.
- The beneficiaries interviewed were very positive about the programmes they have been involved in. The Geromovil truck (inaugurated in August 2017) will travel across Valparaíso, presenting an innovative way of bringing services to a wider population and facilitating greater access to health services for older people.
- The programme contributes to linking capital as the openness of the University to the community is seen by older adults as a means of validating their human capital – they enter the University and attend courses, and can then go out and further distribute their knowledge.
- Several beneficiaries enjoy the AMS courses not only for the peer-to-peer interaction but also for the opportunity to interact with young people, increasing their understanding of and respect for older adults.
- Geropolis maintains good linkages with the local health system in Valparaíso. In articulating its objectives, the programme considers the needs not only of the local populations but also the wider ecosystem involved in issues related to older people, as reflected in the numerous partnerships it has established.
- The programme is regularly monitored and evaluation data is reported to several key stakeholders. As it develops, a consideration of indicators that capture the wider impact of activities may be beneficial, as these might help to attract additional sources of funding.

Aims of the research

This report presents the findings from one of our ten case studies, the Geropolis programme in Chile. The overall aim of the research is to describe within a pool of rapidly ageing countries, and from those with high proportions of older people, a) the core roles, services and functioning (including feasibility of scale-up) of community-based social innovations (CBSIs) for healthy ageing that seek to support older people becoming a resource for their own health and well-being; b) their linkages with and sustainable partnerships to deliver health services, strengthen social systems; and c) the nature of enabling policies, programmes, financing and interactions with the health/social care delivery system.

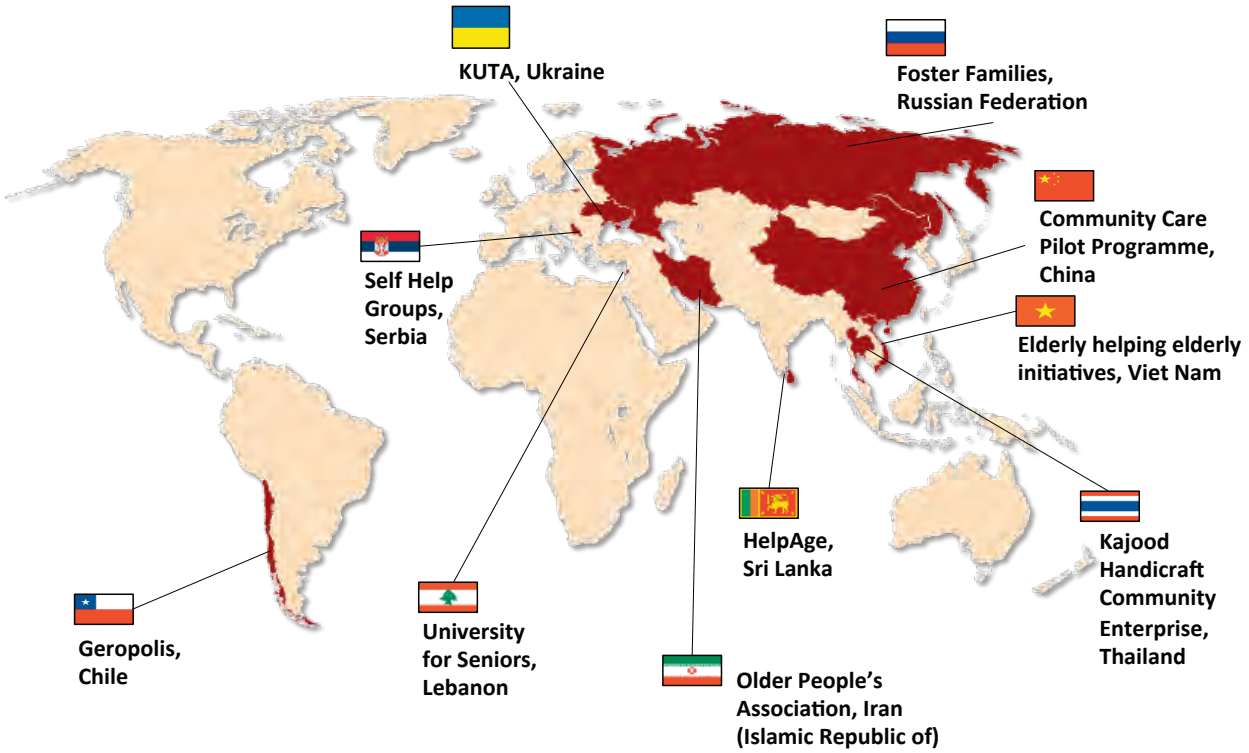
A recent WHO study conceptualised CBSIs as initiatives that seek to empower older people to improve their self-efficacy in caring for themselves and their peers, maintain their well-being and promote social cohesion and inclusiveness. They can also help older people to access, understand and navigate health and social care systems (Ong et al. 2016).

While CBSIs may hold the potential to transform health and social care provision for older people, more evidence is needed to improve our understanding of what types of initiatives and service delivery models are pursued in practice that engage communities and span a spectrum of health and social services.

Aiming to develop a typology of CBSI, this research consisted of three main parts: (i) a systematic review of CBSIs for healthy ageing in upper middle- and high-income countries; (ii) a series of ten case studies to examine the effectiveness of ongoing CBSI interventions in middle-income countries; and (iii) an expert consultation at the World Health Organization's Centre for Health Development (WHO-WKC) in Kobe, Japan, to validate and refine the typology.

Given the relative lack of evidence on CBSIs in middle-income countries in academic literature, the ten case studies were identified through an open call for Expressions of Interest (EOIs). Figure 1 below shows the location of the ten case study countries.

Figure 1 Ten case study countries



The data gathered in this case study will serve to better conceptualise what a CBSI is and to present typologies and functions of CBSIs for older populations.

Each individual case study will seek to explore:

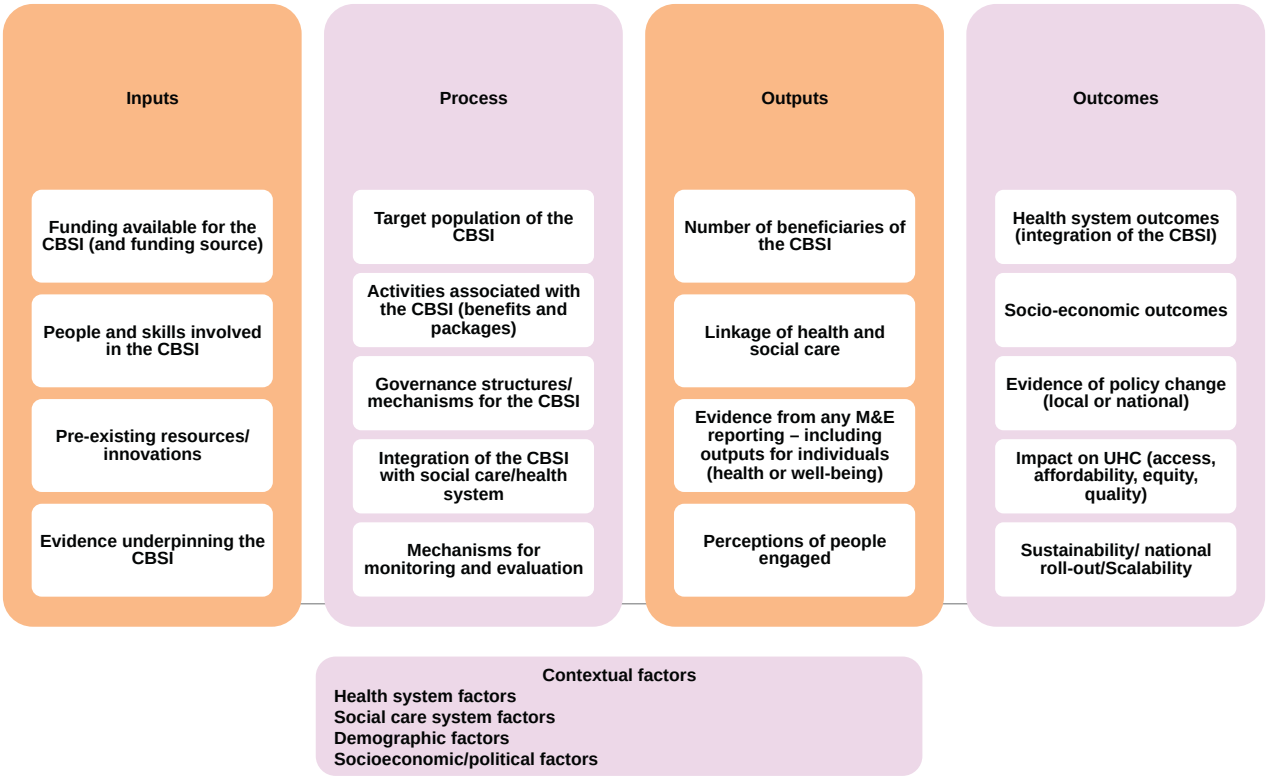
- The role and function of older people as resources for themselves and for others (peers, family, community).
- Health and social services delivered by those initiatives, and referral processes when they exist.
- Links made within these communities of support between health interventions and social health protection interventions (e.g. help with transportation, livelihoods, pensions, cash or in-kind transfers).
- Coordination mechanisms with formal health and social sectors, including any formal connections with the health and social care system.
- Coordination and engagement with a variety of health/social-service workers and community-based services.
- Types of metrics (indicators, monitoring tools) implemented to assess impact on health[1] and the concept of health that is being measured.
- Measures to understand and respond to health inequities in the population served.

We have used a logic model approach to examine the effectiveness of selected CBSIs. This helps us assess the intervention logic for CBSIs and track the progress, impacts and evolutionary dynamics of CBSIs at core levels of analysis. As illustrated in Figure 2 below:

- **Inputs** will help us understand the resource environment of each CBSI and provide a foundation for exploring the linkages between resources, outputs and impacts. This resource input environment is likely to capture aspects such as resources for implementation (funding, infrastructure and skills/capabilities). We will also aim to capture the reasoning and evidence base leading to the establishment of the CBSI.
- The **process** dimension will help us examine both the diversity of CBSIs, in terms of activities/services offered, population groups targeted and geographies projects covered, and mechanisms for designing, managing and evaluating the CBSI if present. We will also examine the integration of the CBSI within the wider health and social care services offered to older people.
- The **output** dimension will help us assess the relative progress of CBSIs since they have been established and capture the diversity of outputs and associated achievements. This will involve capturing outputs such as the number of beneficiaries involved in the CBSI and any initial health and well-being outputs for beneficiaries reported.
- The **outcomes** dimension will help us capture a wider range of benefits, including those relating to impact on resources for achieving universal health coverage (UHC), policy-level impacts and other (including unintended) consequences which may affect the health and well-being of older people in a particular country. In particular, we will not only consider impacts at an individual level (e.g. beneficiaries engaged in the CBSI) but also look to examine any potential impacts on the wider community and the overall health/social care system.

1 We used the term ‘health’ very broadly at this stage in anticipation that it could incorporate physical and mental health and broader wellbeing. As the case studies were exploratory, we did not seek to further define or restrict at this stage as we were interested in understanding of the CBSIs themselves conceptualised and measured these types of outcomes, if at all.

Figure 2 Framework for gathering data on CBSIs and the contexts they operate in



- The **contextual factors** will guide us to consider the influence of both health and social care system factors and demographic, socioeconomic and political factors which may help or hinder progress of the CBSI. A greater understanding of the contextual factors underpinning the CBSI will also help to inform reflections on its transferability/ scalability by offering a rich understanding of the setting.

Structure of the case study

The next section of the report begins with a brief overview of the methodology used for the case study. The report then highlights some of the key contextual factors affecting the CBSI, related to the country's ageing population and its health and social care system.

The main section of the report focuses on how the four areas of the logic model (outlined in Figure 2) related to the CBSI, in the following four areas: (i) establishing the CBSI (inputs); (ii) activities of the CBSI (processes); (iii) results of the CBSI (outputs); and (iv) impact of the CBSI (outcomes). Within each subsection the perspectives of interviewees are presented alongside findings from the desk review. Finally, the report concludes with some overall reflections on the CBSI and draws out key themes and experiences to better conceptualise CBSIs and their role and functions for older populations.

Methodology

Case studies have been used to collect descriptive data on CBSIs through a mix of methods including semi-structured interviews and a review of administrative data and documentation. Each case study follows the same design in order to provide in-depth understanding of each CBSI and allow comparisons to be made between different actors

within a single case, between cases and between groups across cases, taking into account relevant contextual factors. Key-informant interviews were conducted with key stakeholder groups involved in the CBSI, as well as with wider health and social care system actors.

Desk-based document review

Building on any documentation identified in consultation with the CBSI, the literature review draws on academic and grey literature to provide an overview of the health and social services delivered by the CBSI in Chile and the wider context in which these interventions are taking place. In addition, any available evaluative documentation was reviewed to collect evidence on the metrics, indicators and monitoring tools used to assess the effectiveness of the identified initiatives. Key documents included journal articles and policy documents, such as commissioned discussion documents and government strategies. Academic literature was identified through PubMed, focusing on the years 2000 to the present. The literature search was conducted between July and September 2017.

Stakeholder interviews

In addition to the document review described above, key-informant interviews were also used as a key means of gaining an insight into the ongoing activities of the CBSI and the wider contextual factors affecting its functioning in Chile. The interviews followed a common topic guide, with the main topics discussed including: resources that support the CBSI, engagement with older people and functioning of the CBSI, outputs and linkages with the health and social care systems and impact of the CBSI. Emphasis, however, was placed on allowing participants to talk from their own perspective.

In order to explore different perceptions of impact associated with the CBSI, and to identify any linkages and interactions between stakeholders, the project team in coordination with the CBSI staff identified suitable interviewees from three major stakeholder groups (as outlined in Table 1 below). A total of 15 interviews were conducted in Chile between 28 July and 2 August 2017.

Prior to being interviewed, written consent to participate was sought from all participants.

Table 1 Overview of the interviewees

Stakeholder group	Profile of the interviewees
Beneficiaries of the programme	Five interviews with beneficiaries of the programme– two men and three women – were carried out. The age of the participants varied between 65 and 73. Four of the interviewees lived in the neighbourhood that is in the area of care of the medical practice that has particular good connections with the CBSI and one interviewee lived in the neighbourhood most affected by the Valparaíso fire, having lost his house in this event. With the exception of one participant, all the others had not attended university and were educated to high-school level.
CBSI staff	Five interviews with CBSI staff were conducted. The interviewees were involved in several areas of the CBSI – engineering, urbanistic or medical – or had various roles in the management and governance of the project.
Policymakers, academia and civil society	Five interviews were conducted with this group of stakeholders with the following distribution: local policymakers responsible for state-run programmes for older people in Valparaíso (two representatives), academia (two university academics familiar with the ageing agenda in Chile) and international organisation representatives (one UN technical agency representative). All these stakeholders had a very good understanding of the programme.

Interviews were conducted face-to-face in Valparaíso and Santiago de Chile, in various locations. The interviews with the beneficiaries were conducted at Geropolis headquarters, with one exception, which took place in the neighbourhood affected by the fire, in the upper hills of Valparaíso.

The interviews typically lasted between 30 and 60 minutes and were semi-structured in style, to enable participants to raise concerns that may not have been anticipated by the research team or were specific to the practice; this provided a flexible approach which allowed respondents to offer their own perspective and raise issues most salient to them, while covering the same topic areas in each interview.

The interview data was analysed and coded by the project team, and then grouped into the categories and sub-categories outlined in the logic model. In analysing the categories, the team also identified emerging themes, which are presented at the end of this report.

Overview of the context in Chile

Chile is an upper middle-income country with a per capita Gross Domestic Product (GDP) of $23,960, the highest GDP per capita in Latin America (World Bank 2016). In 2010 Chile became a member of the Organization for Economic Co-ordination and Development (OECD 2016). The country has managed to reduce the proportion of the population living in poverty by a third in the past ten years (World Bank 2017a). While reductions in the Gini index, which measures inequalities, have also been registered (from 0.55 in 2000 to 0.45 in 2015), the value is still above the OECD's average of 0.32 in 2014 (OECD 2017). The richest quintile of the population in Chile has an average income 17.5 times higher than that of the poorest one; furthermore, '*the richest 20% of Chileans are earning 58% of the GDP*' (Bossert and Leisewitz 2016). This signals that while tremendous progress has taken place, increases in wealth are poorly distributed.

Demographic factors

Chile has a total population of 17,910,000, with a rate of population growth decreasing from 1.6 per cent in 1990 to 0.8 per cent in 2016. In the last 25 years the life expectancy rose from 73 (1990) to 80 (2015) (World Bank 2017b). This is the second-highest life expectancy (for both sexes) on the American continent, being surpassed only by Canada's 82.2 (World Bank 2017b). The percentage of the 60+ population is 15.2 (2015), expected to reach 17.4 by 2020 (UN World Population Prospects 2017).

Overview of the Chilean health system

In 2005 Chile introduced a system of universal healthcare coverage known as the *Plan de Acceso Universal con Garantías Explícitas*, which includes a standard package of health treatments that all healthcare structures must provide (WHO 2011). While this is an important step towards achieving UHC, there is also criticism regarding the amount of out-of-pocket expenditure that is still being registered. As reported by Bossert and Leisewitz (2016), 33 per cent of health expenditure is covered by out-of-pocket payments, with a total of 54 per cent covered by private insurances. Chile has the third highest out-of-pocket health expenditure of any OECD country.

The provision of health services is decentralised. The Ministry of Health coordinates a network of Health Care Districts, which in turn oversee public hospitals and municipal primary healthcare facilities. The number of physicians and nurses is reported to be well below the OECD average per 1,000 inhabitants. In addition, they are unevenly distributed across the country, causing regional differences in both quality of care and access to services (WHO 2011).

Overview of the Chilean social care system

In 2008 the Chilean government introduced a social security reform aimed to guarantee a minimum pension for all, improving the balance between direct and indirect contributions. The reform was based on three pillars: a mandatory salary-related contribution, introduced to support older persons, persons with disabilities and those with low income; a Voluntary Social Security Savings scheme; and the government-lead Solidarity Pension System (International Policy Centre for Inclusive Growth 2015). However, according to the International Labour Organization, the three pillars are inefficiently organised. The private system is reported to be inefficient and characterised by a lack of solidarity, resulting in an over-burden for the state, '*which therefore has to fund non-contributory and minimum pensions*' (Mesa-Lago 2008, 391). Moreover, the private system is reported to exacerbate inequalities because it relies heavily on workers self-funding (Ibid.).

Overview of the CBSI

Establishing the CBSI (Inputs)

Establishing the CBSI

Geropolis is an institution improvement programme[2] created by the University of Valparaíso in 2015. Financed by the Ministry of Education in Chile, the programme aims to develop a replicable model of education, health activities and urban planning to improve the quality of life of older persons. There were three contributing factors that led to the development of the Geropolis programme:

(i) **The population of Valparaíso has the greatest share of older adults in Chile, with 20 per cent being over 60**. This demographic shift over the last 20 years has put significant pressure on the local health and social services, which have had to deal with increasing and age-specific demands.

(ii) **Valparaíso experienced a devastating fire in 2014 which destroyed approximately 2,000 homes and left around 11,000 people homeless**. The most affected area, located in the upper hills, represents the poorest region of the city. As several generations of families lived in houses located on the same plot, entire generations of families lost all their life savings and livelihoods. For older people the situation was particularly acute. As described by one of the interviewees, many older people were forced to sleep rough, relying on emergency services for food and drink.

(iii) **Valparaíso is built on a series of steep hillsides, with many of the poorest inhabitants living at higher altitudes, where infrastructure is limited**. The upper hills area (*Ceros*) in the city is home to many older inhabitants. Interviews with beneficiaries of the programme highlighted the difficulties in accessing other parts of the city from the *Ceros*, due to the high cost and limitations in transport infrastructure.

Against this background the University of Valparaíso was keen to develop an initiative to improve the quality of life of older people in Valparaíso, involving the University, the community and several other local, national and international actors. The initiative allowed for the continuation of the voluntary programmes that were being introduced as a response to the fire and began developing a new model of education, improving health services and urban planning in Valparaíso. The Geropolis programme was initiated by a small group of academics working at the University, who decided to apply for a grant from the Ministry of Education of Chile under the stream of Institutional Improvements Programmes.

2 A programme run with funds from the Ministry of Education aimed at improving Chilean universities.

Figure 3 Training course at Geropolis

The programme builds on the pre-existing interests of various academics working at the University on ageing-related issues. The opportunity to access funds from the Ministry of Education was seen by the University as a means to institutionalise and consolidate its work with older people, and to scale up certain activities.

Aims and objectives of the initiative

Geropolis has four major objectives, in the following programmatic areas:

- **Associativity**: The programme aims to build permanent strategic alliances between public, private, social and academic organisations and institutions. This includes establishing, maintaining and expanding the University's network of internal and external stakeholders involved in ageing-related issues and service provision to older people.
- **Intervention**: Geropolis also aims to implement a range of integrated health and education programmes for and with older people in Valparaíso. The programmes currently being implemented are: Health Multiplication Agents (AMS), the Mobile Health Platform (PMS), the Urban Appropriation Programme (PAU) and the Geromovil programme.
- **Education**: Geropolis aims to strengthen the incorporation of ageing-related topics at all levels of the University's educational processes, from undergraduate- and postgraduate-level education through to specific courses. This has the aim of sensitising different professions to the problems associated with ageing. It can be achieved through different means – such as modules within existing curricula (for example in law studies), exchange programmes (abroad) for both students and professors, and graduate programmes specialising in ageing (gerontology, neuropsychology, etc.). The programme also promotes internships and visits by international experts in ageing-related issues.
- **Knowledge development**: Geropolis also aims to promote and develop new transdisciplinary knowledge in the subjects of gerontology and geriatrics more broadly. It achieves this objective through providing a number of grants to academics for interdisciplinary work on ageing-related issues.

  Also, connections have been established with the Pan-American World Health Organization (PAHO) and the Ministry of Health and Service for the Older Person (*Servicio por el adulto mayor* – SENAMA) in Chile, which has resulted in a yearly event in the country called the International Ageing Forum. This is a space where several stakeholders meet to discuss topics relevant to healthy ageing, such as supporting environments or the needs of carers. It is now in its third edition.

Due to the focus of the case study on better understanding the involvement of older persons in various activities, we will be discussing primarily the programmes run under the *Intervention* programmatic area. This area

is aligned with the national Positive Ageing Policy, adopted in May 2012, which determines state orientations and actions to be performed by different ministries and public services, in collaboration with other institutions. The challenges proposed by the Positive Ageing Policy are: (i) to protect the functional health of older adults, (ii) to improve integration and participation of older adults in all aspects of society, and (iii) to transversally increase the subjective well-being of older adults. These objectives match the objectives of Geropolis, allowing for an important synergy with local institutions willing to engage in the implementation of its projects.

Funding for the CBSI

The Geropolis programme obtained funding from the Ministry of Education which ensures the programme is able to function for three years (based on the planning submitted by the applicants). This was a $1.9 million grant. In the initiation stage it was negotiated that the University has the obligation to keep the programme going for three more years. Thus, Geropolis has secured funding from the Ministry until 2018 and the University will maintain its functioning until 2021. From 2021 the Geropolis programme will need to identify other sources of funding to continue its activities.

Other initiatives in the region

There are several other state-funded initiatives in the region that try to address problems that older people are facing. According to two interviewees these reflect the importance the Chilean government grants to the theme of ageing, which in recent years has been gaining greater prominence on the Chilean political agenda.

Through SENAMA, several programmes for older people have been developed. For example, SENAMA launched a housing programme for older people (*Viviendas Tuteladas*), through which they are offered housing subsidies, and in some cases has built special housing facilities for older people who can take care of themselves but are in need of housing. SENAMA has also launched a nutritional programme, through which nutritional supplements are provided to older adults.

In 2015, the countries of the Americas developed the Inter-American Convention on Protecting the Human Rights of Older Persons[3]. This is the world's first binding convention referring to the rights of older persons and Chile was one of the countries that spearheaded its development. In the past four months the declaration was ratified by the Chilean Congress and is now waiting promulgation. This Convention lists 26 rights of older persons (e.g. right to health, right to education, right to receive long-term care, right to housing) and also sets forth the monitoring mechanism to track implementation of the country's commitments under the Convention.

Activities of the CBSI (Process)

Target population and eligibility criteria

The target population for the programme is any older person aged 60 or over who resides in the city of Valparaíso. In general there are no major inclusion or exclusion criteria for benefiting from Geropolis activities. However, there are nuances; for example, for participation in AMS courses there is a 'referral' system to identify persons that already have leadership capacities.

Also, many of the activities run by the programme are open to people of all ages. Students at the University were mentioned by several interviewees as a group that consistently participate in Geropolis activities, for example providing support to older people in increasing their computer literacy. The intergenerational element is seen by Geropolis as important in sensitising the community and future and current professionals in respect to the needs of older people.

3 OAS (N.d.).

Figure 4 Training course at Geropolis

For some of the programme's activities, Geropolis works with local partners or healthcare providers to identify participants. For example, one interviewee noted that participants in the AMS programme are identified through a family health centre located in one of Valparaíso's neighbourhoods (CESFAM MENA).

Activities associated with the CBSI

As outlined in the section above, the Geropolis programme undertakes activities across four different areas. In particular, the *Intervention* programmatic area has focused on four projects that specifically aim to promote active and healthy ageing for older people in Valparaíso.

These four projects draw on the premise that older people want to continue living and grow old in the environments in which they spent their active lives. To grow old in a familiar social and physical territory is considered a positive factor regarding identity, physical health and functionality, privacy, skills and social bounds, which contribute to the general well-being of senior citizens. Geropolis uses the 'Ageing in Place' concept and through its projects aims to facilitate access to the health and social care system, to strengthen health self-care abilities and to improve the social and environmental conditions relating to older people's needs.

The four projects are:

The Health Multiplication Agents programme (Agente Multiplicatores de Salud – AMS)
AMS is a programme comprising four training modules, which aims to empower people in local communities to become health leaders, giving older people the knowledge and tools they need to contribute to their own health and well-being. The participants include older people, community members and university students.

The four modules are:

- *Management of Rights and Advocacy* – which includes a submodule on the rights of older people, including their health rights.
- *Self-care and First Aid* – which provides tools to identify risk situations and to respond rapidly to them.
- *Taking Control of Your Health* (*Tomando Control de su Salud*) – a series of community workshops which give community leaders the skills to deliver workshops in their communities on the management of chronic conditions. This programme was developed by Stanford University and implemented in Chile with the help of the PAHO.
- *Social and cultural interventions* – this provides community leaders with training and tools for them to undertake social or cultural activities with older people in their community to improve social participation (e.g. theatre).

Given the modular nature of the programme, participants are not expected to complete all modules at once, instead usually completing the programme within three years. In 2017, Geropolis offered three modules and registered between 20 and 25 participants per module. After completing the training, participants return to their communities and with the programme's support they start community workshops.

Another stakeholder group is represented by academics, who can expand their knowledge in ageing and then further distribute this knowledge (the multiplier effect). The programme's

activities are intergenerational and transversal. Intergenerational interaction has been recognised by beneficiaries as a very pleasant activity. The intergenerational element is seen by Geropolis as important in sensitising the community and future and current professionals in respect to the needs of older persons. The CBSI staff stressed the importance of building a community that has solidarity and that permits that these persons live in the places they have always lived (their neighbourhoods).

AMS's older participants were identified through Geropolis contacts in the community and through partners such as health staff of CEFAM MENA – a family centre located in one of Valparaíso's neighbourhoods. After receiving the training the participants return to their communities and with Geropolis's support they start community workshops. Students (from different career tracks) also participate, taking on the role of evaluators. Geropolis estimates that after two years, AMS participants should do refresher courses. Contact with the programme is maintained telephonically, which also involves students – either paid or volunteers.

Mobile Health Platform – PMS (Plataforma Mobil de Salud)

The PMS is an innovative method for reminding patients about their medical appointments through either text or voice messages. This pilot project was undertaken in direct collaboration with CESFAM MENA and aims to generate a replicable intervention model that can be used by all health centres in Valparaíso Municipality. In addition to the medical appointments, it is also planned to use the platform to provide healthcare information to older people, for example on healthy habits and self-care.

Urban Appropriation Programme – PAU (Apropriation Urbana)

The PAU is mapping parts of the territory of Valparaíso in order to identify important features of the surrounding environment in terms of accessibility and mobility for older people. This programme is meant to inform further interventions, including targeted health visits in collaboration with CESFAM MENA's employees.

Figure 5 Geromovil

Geromovil

Geromovil, a modified truck that will provide various medical or social services as well as cultural activities, was inaugurated at the beginning of August 2017. The truck will travel around Valparaíso, bringing services to older people in areas of the city that are hard to reach.

Governance and management of the CBSI

The Geropolis team initially comprised four employees in 2014 and has now expanded to 12 staff members, all from varied backgrounds, including anthropologists, social workers, geographers, engineers, administrators, journalists and architects.

Geropolis has a core executive team formed by the staff involved in the management of the programme, which meets weekly to discuss operational activities.

The programme also has a Directive team, which is made up of the Rector of the University, the Vice-Rectors and the Deans of the three faculties that put together the initial proposal to obtain the educational grant for Geropolis, namely engineering, medicine and architecture. The Directive team monitors the development of Geropolis' actions and gives guidance on strategic directions.

Geropolis also has a wider consultative committee (also referred to as the joint executive committee), which includes representatives of public and private organisations and civil society, including older people.

Geropolis is required to submit monitoring reports to the Ministry of Education every six months, as well as an annual monitoring report. Each of the annual reports contains information on all of Geropolis' activities outlined above. In addition to the formal monitoring and evaluation requirements, each programme also has its own processes to monitor progress, such as internal registers which contain further information.

Results of the CBSI (Outputs)

Enrolment of older people

The number of older people engaged in Geropolis-related activities varies according to each programme. Table 2 presents an overview of the number of older people involved in each of the programmes outlined above, as reported in the most recent Geropolis monitoring report (Jan–Jun 2017) (Geropolis 2017). Most of the targets have been reached for the current year, or are in the process of being reached with the Geromovil activities having started after the publication.

Data on the characteristics of participants, such as their gender or socio-economic status, was unavailable, although interviewees noted that most participants belonged to low-or middle-income socio-economic groups, given that many are from the same area of Valparaíso.

Self-reported health gains among beneficiaries

Beneficiaries reported a sense of integration in the society as a result of their participation in Geropolis, which contributed to their well-being. All participants expressed their satisfaction with the fact that they interacted with various peers, including younger people, which they saw as an important element in combating ageism. The opportunity to form friendships and engage in activities was also reported by interviewees as important for alleviating loneliness. Furthermore, beneficiaries who attended the AMS courses also reported personal health gains such as losing weight or quitting smoking. In terms of the AMS programme's impact on well-being, two participants expressed that the courses enhanced self-confidence and led to their increased engagement in social activities. Beneficiaries felt that the way in which the courses were being delivered, with an emphasis on empathy and conveying messages in a personalised way, was key in the training programme's success.

Overall, the beneficiaries interviewed were very positive about the programmes they have been involved in under Geropolis. This seems to be in accordance with various process and performance indicators that Geropolis monitors. For example, according to the recent annual report over 80 per cent of participants are satisfied with the activities they have been involved in at Geropolis.

Table 2 Number of beneficiaries of activities run under Geropolis (cumulative data gathered up to June 2017)

Name of activity	Number of participants
Trainers formed through Health Multiplication Agents (AMS)	118
Beneficiaries of the Mobile Health Platform – PMS	2,072
Beneficiaries who participated in the Urban Appropriation Programme (PAU)	350
Geromovil	0

Linkages to the health and social care system

Through the collaboration with CESFAM MENA, Geropolis is directly linked to local primary health services in Valparaíso. CESFAM MENA is providing services to a population of approximately 26,200 people and of these 19 per cent are older than 60. The clinic is involved in a number of Geropolis' activities, including:

- AMS – CESFAM MENA is involved in referring community leaders to Geropolis, who then undertake courses.
- PMS – the text and voice messages sent through the mobile health platform are in relation to CESFAM MENA appointments and health campaigns.
- PAU – the mapping and geo-referencing is done in CESFAM MENA's catchment area and will help CESFAM health personnel ensure that home visits are done in an efficient manner.
- The clinic will also become involved with Geromovil by potentially delivering certain types of medical interventions; further details were not available at the time of writing.

The results of the evaluation of the PMS, conducted by CESFAM, reveal a very high level of satisfaction with the service among patients.[4] The CESFAM representatives interviewed for this case study also considered the programme beneficial, as it helped them achieve regional health goals such as participation in seasonal health campaigns (e.g. cardiovascular health programmes or diabetic foot check-ups).

In regard to the social care system, Geropolis connects various social care actors as part of its overall remit on promoting associativity. This includes fostering relationships with several representatives of state structures, such as the Municipal Office for the Older Person and SENAMA, which are also involved in the governance structures of Geropolis.

Impact of the CBSI (Outcomes)

Wider impacts of the programme

The programme has brought benefits for CESFAM, helping it reach particular populations with health services and information and allowing it to attain its health coverage goals. Involvement in Geropolis was also reported to have increased CESFAM's efficiencies in delivering healthcare by reducing the rate of non-attendance at health appointments through the PMS. However, interviewees also noted that more research was needed to determine the extent of the cost-savings here. Geropolis has also had an impact at the University, helping to create a model of interdisciplinary cooperation across departments, which could be replicated in other areas (e.g. childcare).

Geropolis has managed to bring together a series of actors from various fields including health, social care, education, civil society and international health organisations, to work together on ageing-related issues in Chile. This has been achieved not only through the inclusive governance structure of Geropolis but also through the International Ageing Forum, which brings together a wide array of stakeholders to discuss ageing-relevant topics and which is now in its third edition. According to interviewees, inclusivity in the programme's decision-making processes has enabled it to respond to older people's needs and change activities accordingly, for example the proposed Geromovil project.

At the community level, the PAU and AMS have contributed to greater social awareness of ageing-related issues (e.g. inaccessibility of certain areas of Valparaíso for older adults) and greater civic engagement.

One area where future impact may be achieved by the programme is the future workforce's attitude towards older people and their

4 The evaluation consisted of a randomised telephone survey with 447 respondents.

knowledge of ageing-related issues. While interviewees stressed the need for a health workforce, in particular, that is knowledgeable of and empathetic to particularities of older adults, and while there is recognition of the potential of Geropolis' courses to contribute to the desired change, data on this outcome remains unavailable at this stage of the programme.

Sustainability of the programme

The greatest challenge for Geropolis will be to become financially sustainable, especially once its funding from the Ministry of Education and the University finishes in 2021. Leadership at Geropolis reported that steps are being taken to transform Geropolis into an Interdisciplinary Centre for the Development of the Older Person (*Centre Interdisciplinario del Desarolio del Adulto Mayor* – CIDAM). This will enable the programme to apply for additional research funds and undertake other initiatives – both inside and outside the University.

Through establishing and maintaining a network of key actors in ageing-related issues, Geropolis has the opportunity to explore various different funding sources, including both traditional partners such as health and social care organisations and private entities and other government authorities. For example, the Geromovil project will represent a collaboration with the Ministry of Culture, as the truck will also deliver cultural activities.

Reflections on the CBSI

The experience of the Geropolis programme in Chile raises some important themes relevant to the analysis of CBSIs.

Universities have a new role in facilitating community action and engagement of older people

Geropolis is an example of a CBSI started through a university and aimed at attaining community benefits. The openness to the community was seen by the beneficiaries as a means of acknowledging and valuing the skills and experience of older people – as they are allowed to enter the University and attend courses, after which they can go out and further distribute their knowledge. This is particularly valued by those older adults that did not have the opportunity to attend university when they were young.

Intergenerational activities as a means to prevent ageism

The university approach also exemplifies a new way in which universities can open up to the wider public, different from that of the Universities of the Third Age, as not only are university doors opened to older adults, but students' ability to engage with this target population is fostered. This engagement may bring about a new type of professionals by integrating the theme of older adults into university curricula. Students will be able to gain necessary skills for their future career (such as interacting with older adults and understanding their needs) from the formative stage. Furthermore, several beneficiaries interviewed noted that they particularly enjoyed the opportunity to interact with younger people through the AMS courses. The beneficiaries consider that this approach will lead to a better understanding between different generations, a reduction in ageism and more respect for older generations.

Partnerships can play a great role in programmes' expansion and sustainability

As articulated in its objectives, Geropolis not only considers the needs of local older populations but also the wider ecosystem involved in ageing-related issues.

In addition to engaging with national and local government, a key partnership highlighted by several interviewees is that with the PAHO. This was considered to be the source of great advice in regard to programme strategy and resources to establish sustainable partnerships. All this is grounded in a cooperation agreement between PAHO, SENAMA, the University of Valparaíso

and City Hall – a legal instrument, therefore giving more weight and enabling various activities.

There is a need to streamline indicators in order to reduce administrative burden

One challenge that came through in several interviews with CBSI staff was the existing bureaucracy, which leads to administrative reporting burdens. The fact that the programme has evolved while staying true to its original objectives requires additional monitoring and evaluation, to report to various entities. While the Ministry of Education requires a set of indicators, those used to track in-house progress can differ. Ideally CBSIs would be able to find a set of indicators that would respond to funders' requirements but also capture the wider impact of CBSIs to help attract additional sources of funding, enabling programme sustainability.

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World Health Organization

Centre for Health Development

China: Care Coordinators programme in Shaanxi, China

RAND Europe researcher: Ioana Ghiga

In-country collaborating partner: Deng Xueyi

Preface

The World Health Organization Centre for Health Development Kobe has contracted RAND Europe to serve as a research hub for conducting a systematic review and gathering evidence of middle- and high-income countries' community-based social innovations (CBSIs) for healthy ageing. RAND Europe has undertaken two main strains of research consisting of: (1) a systematic review of CBSIs for healthy ageing in middle- and high-income countries, and (2) a series of ten case studies of CBSIs for healthy ageing in middle-income countries.

This report presents the findings from one of our ten case studies, the Care Coordinators programme in Shaanxi, China.

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Summary of the community-based social innovation (CBSI)

Background

China

Locations
Shaanxi Province, China

Type of intervention
Foundational

Year established
2016

The intervention

Establishing the CBSI

- The Community Care Pilot Programme is a CBSI started by the Ageing China Development Centre (ACDC).
- The project was financed and run as a pilot between January 2016 and April 2017, aiming to develop a care model that will address the growing needs of disabled and semi-disabled older people in rural areas.
- The project relies on the involvement of Older Peoples' Associations (OPAs) and of the local County Committees on Ageing (CCAs), which were both involved in the initial set-up of the programme.
- The OPAs manage the activities and distribution of funds and the CCAs provide advice and oversight.
- Each village receives around USD 700 to buy basic equipment for running community care activities, or to buy products (basic facilities to support care activities, gifts for the older persons). Each OPA/village is also provided with USD 90 per month to compensate care coordinators for their time and work.

Activities of the CBSI

- The main activities of care coordinators include :
  - (i) Support in daily life tasks such as laundry, hairdressing, nail trimming and other hygienic activities, household chores and domestic assistance (water fetching, cooking, indoor and outdoor cleaning, etc.), shopping assistance and aiding walking.
  - (ii) Health management such as signs monitoring, blood pressure and blood sugar measuring, emergency treatment/first aid, diet.
  - (iii) Social visits and conflict mediation if needed.
- Care coordinators receive training in areas such as recording care services provided to older people by care coordinators, managing physiological and psychological changes of older people, effective communication and psychological counselling, provision of certain basic healthcare services such as emergency treatment/first aid and monitoring of various parameters such as diet compliance.

Results and impact of the CBSI to date

- There are 34 rural community volunteers looking after 180 beneficiaries.
- Beneficiaries are disabled and semi-disabled older people, usually persons that do not have family and are located in rural areas.
- The care coordinators and the beneficiaries are usually neighbours and have been acquainted with each other since before the start of the project.
- Beneficiaries appreciate in particular the help they receive and the human connection that they have with the care coordinator.
- Care coordinators benefited from the knowledge they acquired and expressed a desire to learn more about both the management of certain diseases and older persons' rights.
- Wider impact of the project may consist in contributions to stabilising the rural society's needs, which currently are affected by an economic migration of youth towards cities, and ensuring targeted care for older people.

Ageing in China

- The percentage of the population aged 60 and over was 15.4 per cent in 2015 and it is expected to reach 17.6 per cent by 2020.
- The Chinese social care system consists primarily of home-based care, which accounts for around 90 per cent of all social care, with community care and residential care only accounting for 7 per cent and 3 per cent, respectively.
- 18.3 per cent (40 million) of the total Chinese older people (222 million) need constant care services.
- Based on this demand, China needs at least ten million caregivers, yet the total number of the caregivers is less than 600,000. Elderly care in rural China is much less developed.

Reflections on the CBSI

- Currently the project is not receiving financial support from ACDC; however, the local ownership of the model has led to its continuation.
- The programme focuses on a very specific segment of the older population, located in rural settings, and may have the potential to bridge several gaps in the provision of health and social care for this vulnerable population.
- The pre-existing social networks of OPAs have been instrumental in running the programme and obtaining further benefits for the elderly.
- There are no formal linkages with the health and social care system, but through training older people to care for their peers and be agents of their own health, the CBSI raises interesting questions around meeting healthcare workforce needs.
- The programme has undergone regular monitoring and evaluation in the pilot stage and important efforts have been made to develop a monitoring culture. The inclusive governance model of the Care Coordinators programme contributes to adoption and dissemination of the innovation.

Aims of the research

This report presents the findings from one of our ten case studies, the Care Coordinators programme in Shaanxi, China. The overall aim of the research is to describe within a pool of rapidly ageing countries, and from those with high proportions of older people, a) the core roles, services and functioning (including feasibility of scale-up) of community-based social innovations for healthy ageing that seek to support older people becoming a resource for their own health and well-being; b) their linkages with and sustainable partnerships to deliver health services, strengthen social systems; and c) the nature of enabling policies, programmes, financing and interactions with the health/social care delivery system.

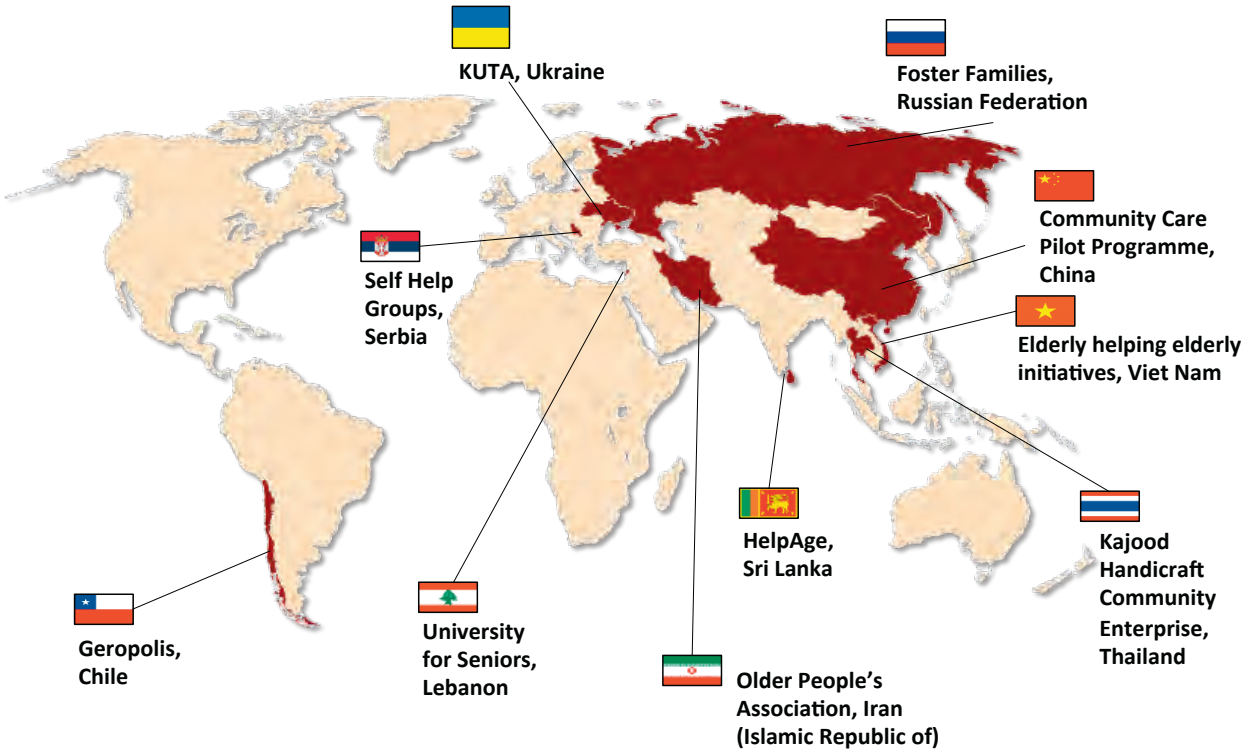
A recent WHO study conceptualised CBSIs as initiatives that seek to empower older people to improve their self-efficacy in caring for themselves and their peers, maintain their well-being and promote social cohesion and inclusiveness. They can also help older people to access, understand and navigate health and social care systems (Ong et al. 2016).

While CBSIs may hold the potential to transform health and social care provision for older people, more evidence is needed to improve our understanding of what types of initiatives and service delivery models are pursued in practice that engage communities and span a spectrum of health and social services.

Aiming to develop a typology of CBSI, this research consisted of three main parts: (i) a systematic review of CBSIs for healthy ageing in upper middle- and high-income countries; (ii) a series of ten case studies to examine the effectiveness of ongoing CBSI interventions in middle-income countries; and (iii) an expert consultation at the World Health Organization's Centre for Health Development (WHO-WKC) in Kobe, Japan, to validate and refine the typology.

Given the relative lack of evidence on CBSIs in middle-income countries in academic literature, the ten case studies were identified through an open call for Expressions of Interest (EOIs). Figure 1 below shows the location of the ten case study countries.

Figure 1 Ten case study countries



The data gathered in this case study will serve to better conceptualise what a CBSI is and to present typologies and functions of CBSIs for older populations.

Each individual case study will seek to explore:

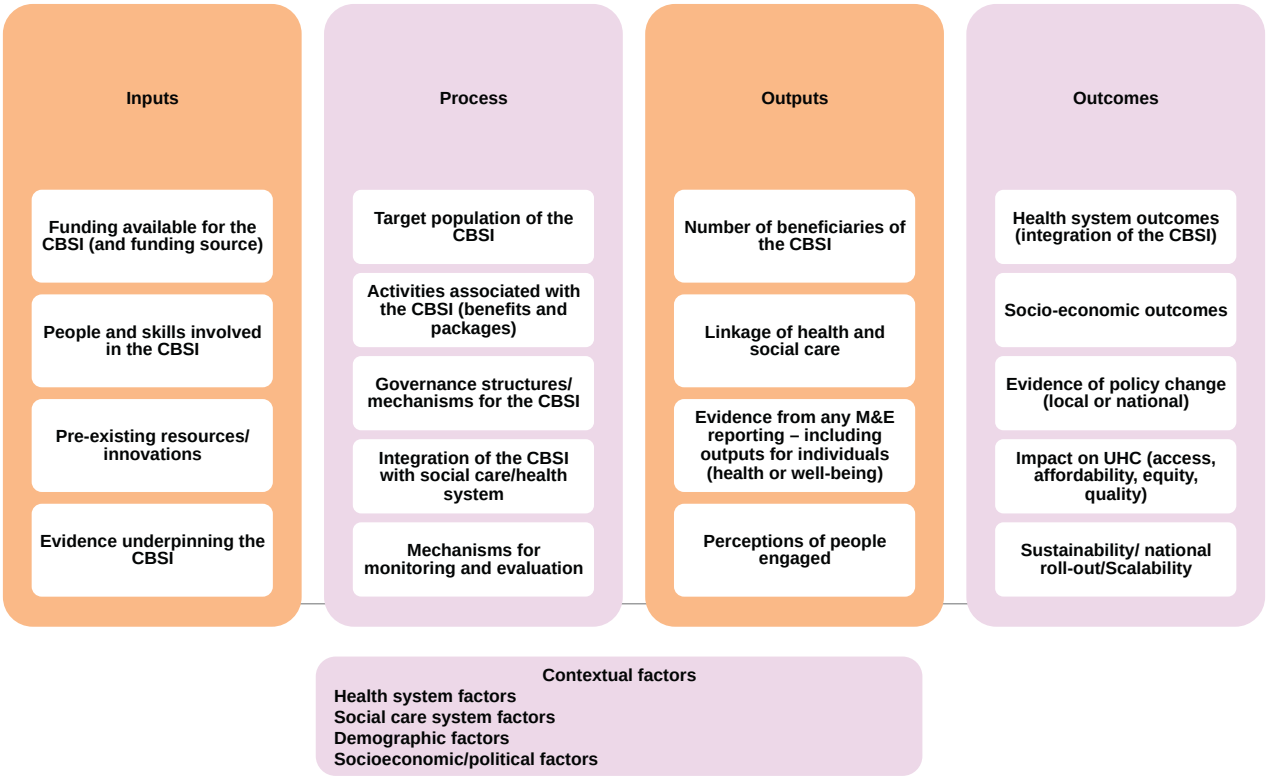
- The role and function of older people as resources for themselves and for others (peers, family, community).
- Health and social services delivered by those initiatives, and referral processes when they exist.
- Links made within these communities of support between health interventions and social health protection interventions (e.g. help with transportation, livelihoods, pensions, cash or in-kind transfers).
- Coordination mechanisms with formal health and social sectors, including any formal connections with the health and social care system.
- Coordination and engagement with a variety of health/social-service workers and community-based services.
- Types of metrics (indicators, monitoring tools) implemented to assess impact on health[1] and the concept of health that is being measured.
- Measures to understand and respond to health inequities in the population served.

We have used a logic model approach to examine the effectiveness of selected CBSIs. This helps us assess the intervention logic for CBSIs and track the progress, impacts and evolutionary dynamics of CBSIs at core levels of analysis. As illustrated in Figure 2 below:

- **Inputs** will help us understand the resource environment of each CBSI, and provide a foundation for exploring the linkages between resources, outputs and impacts. This resource input environment is likely to capture aspects such as resources for implementation (funding, infrastructure and skills/capabilities). We will also aim to capture the reasoning and evidence base leading to the establishment of the CBSI.
- The **process** dimension will help us examine both the diversity of CBSIs, in terms of activities/services offered, population groups targeted and geographies projects covered, and mechanisms for designing, managing and evaluating the CBSI if present. We will also examine the integration of the CBSI within the wider health and social care services offered to older people.
- The **output** dimension will help us assess the relative progress of CBSIs since they have been established and capture the diversity of outputs and associated achievements. This will involve capturing outputs such as the number of beneficiaries involved in the CBSI and any initial health and well-being outputs for beneficiaries reported.
- The **outcomes** dimension will help us capture a wider range of benefits, including those relating to impact on resources for achieving universal health coverage (UHC), policy-level impacts and other (including unintended) consequences which may affect the health and well-being of older people in a particular country. In particular we will not only consider impacts at an individual level (e.g. beneficiaries engaged in the CBSI) but also look to examine the impact on the wider community and the overall health/social care system.

1 We used the term ‘health’ very broadly at this stage in anticipation that it could incorporate physical and mental health and broader wellbeing. As the case studies were exploratory, we did not seek to further define or restrict at this stage as we were interested in understanding of the CBSIs themselves conceptualised and measured these types of outcomes, if at all.

Figure 2 Framework for gathering data on CBSIs and the contexts they operate in



- The **contextual factors** will guide us to consider the influence of both health and social care system factors and demographic, socioeconomic and political factors which may help or hinder progress of the CBSI. A greater understanding of the contextual factors underpinning the CBSI will also help to inform reflections on its transferability/ scalability by offering a richer understanding of the setting.

Structure of the case study

The next section of the report begins with a brief overview of the methodology used for the case study. The report then highlights some of the key contextual factors affecting the CBSI, related to the country's ageing population and its health and social care system.

The main section of the report focuses on how the four areas of the logic model (outlined in Figure 2) related to the CBSI, in the following four areas: (i) establishing the CBSI (inputs); (ii) activities of the CBSI (processes); (iii) results of the CBSI (outputs); and (iv) impact of the CBSI (outcomes). Within each sub-section the perspectives of interviewees are presented alongside findings from the desk review. Finally, the report concludes with some overall reflections on the CBSI and draws out key themes and experiences to better conceptualise CBSIs and their role and functions for older populations.

Methodology

Case studies have been used to collect descriptive data on CBSIs through a mix of methods including semi-structured interviews and a review of administrative data and documentation. Each case study follows the same design in order to provide in-depth understanding of each CBSI and allow comparisons to be made between different

actors within a single case, between cases and between groups across cases, taking into account relevant contextual factors. Key-informant interviews were conducted with key stakeholder groups involved in the CBSI, as well as with wider health and social care system actors.

Desk-based document review

Building on any documentation identified in consultation with the CBSI, the literature review draws on academic and grey literature to provide an overview of the health and social services delivered by the CBSI in China and the wider context in which these interventions are taking place. In addition, any available evaluative documentation was reviewed to collect evidence on the metrics, indicators and monitoring tools used to assess the effectiveness of the CBSIs identified. Key documents included journal articles and policy documents, such as commissioned discussion documents and government strategies. Academic literature was identified through PubMed, focusing on the years 2000 to the present. The literature search was conducted between July and September 2017.

Stakeholder interviews

In addition to the document review described above, key-informant interviews were also used as a key means of gaining an insight into the ongoing activities of the CBSI and the wider contextual factors affecting its functioning in China. The interviews followed a common topic guide, with the main topics discussed including: resources that support the CBSI, engagement with older people and functioning of the CBSI, outputs and linkages with the health and social care systems and impact of the CBSI. Emphasis, however, was placed on allowing participants to talk from their own perspective.

In order to explore different perceptions of impact associated with the CBSI, and to identify any linkages and interaction between stakeholders, the project team in coordination with the CBSI staff identified suitable interviewees from three major stakeholder groups (as outlined in Table 1 below). A total of 16 interviews were conducted in China between 29 and 30 September 2017.

Prior to being interviewed, written consent to participate was sought from all participants and they were each asked to sign an informed consent form. Interviews were conducted face-to-face in various locations in Dongjie and Gouershang Villages, Jingyang County, Shaanxi Province.

The interviews typically lasted between 30 and 60 minutes and were semi-structured in style, to enable participants to raise concerns that may not have been anticipated by the research team or were specific to the practice; this provided a flexible approach which allowed respondents to

Table 1 Overview of the interviewees

Stakeholder group	Profile of the interviewees
Beneficiaries of the programme	Three interviews with beneficiaries of the programmes were carried out – all for them were women aged between 60 and 70. Three interviews were conducted with care coordinators.
CBSI staff	Two interviews with Ageing China Development Centre (ACDC) staff were conducted. These had both managerial and operational duties and had been involved with the programme since its design phase.
Policymakers, academia and civil society	Two interviews were conducted with this group of stakeholders, with both participants working for the local authorities – the County Committee on Ageing (CCA). Four interviews with Older Peoples' Association (OPA) leaders took place, all of them also being care coordinators.

offer their own perspective and raise issues most salient to them, while covering the same topic areas in each interview.

The interview data was analysed and coded by the project team, and then grouped into the categories and sub-categories outlined in the logic model. In analysing the categories, the team also identified emerging themes, which are presented at the end of this report.

Overview of the context in China

China is the world's most populated country and one of the planet's most dynamic economies, having enjoyed a doubling of its GDP in the past 30 years (World Bank 2016). Through the social, organisational and economic reforms of the past 20 years, China managed to improve the standard of living for its population (UNDP 2014). This was demonstrated by the country's success in achieving years in advance the Millennium Development Goals on poverty reduction. Currently China is faced with addressing geographical inequalities that translate to a poverty rate of 11.8 per cent (UNDP 2014).

Demographic factors

China has a total population of 1,409,517,000 (United Nations 2017), with a rate of population growth of 0.5 per cent in 2016 (World Bank 2017). Today, the average life expectancy is 76, with an average healthy life expectancy at birth of 68.5 (WHO 2015). By the end of 2016, the percentage of the population aged 60 years and above was 16.7 per cent (Ministry of Civil Affairs China 2016a) and it is expected to reach 17.6 per cent in 2020 (United Nations 2017).

Overview of the Chinese health system

China's healthcare system has gone through significant changes in the past 20 years which have led to better health delivery services and improved health outcomes (China Joint Study Partnership 2016). The 'barefoot doctors' programme, which originated in the 1950s and consisted of training agricultural workers to meet the needs of populations living in rural areas, represented an important historical innovation in China. Workers were trained in providing health education to rural populations, immunisations, first aid and some basic primary care and post-illness follow-up services (Sidel 1972). The programme underwent significant transformations in the 1980s and 1990s, with the government withdrawing support, meaning farmers now had to pay for healthcare. While the quality of the programme is hard to assess, the 'barefoot doctors' that remain in the primary health community in China represent an important legacy when it comes to ensuring health services for rural populations (WHO 2008).

Building on the legacy of the 'barefoot doctors' and the recent Chinese reforms, successes have been registered in reducing child and maternal mortality rates, as well as those of mortality from infectious diseases. Similarly to a lot of countries, China is now having to address the needs of an ageing population in addition to the burden of non-communicable diseases (China Joint Study Partnership 2016).

Progresses in healthcare in China have been attributed to investments in expanding health infrastructure and ensuring near-universal health insurance coverage. The most recent reforms to the healthcare system took place in 2003 and 2008 (Bairoliya et al. 2017). Specifically, in 2003 the New Rural Cooperative Medical Scheme was introduced to offer minimal health protection for all rural workers. Following this, in 2008 a new form of insurance was implemented – Urban Residence Basic Medical Insurance, an extension of the 1998 Employee Basic Medical Insurance, which further extended medical coverage to urban residents (Bairoliya et al. 2017). In 2012 China provided comprehensive healthcare coverage to 95 per cent of its population, and aims to provide affordable basic healthcare for all Chinese people by 2020 (Blumenthal and Hsiao 2015).

Nevertheless, several and significant geographical inequalities persist in the provision of healthcare in China. Community health workers in rural China are a key feature of the Chinese healthcare system, providing basic public and personal health services at village level (Blumenthal and Hsiao 2015). By the end of 2016, there were 639,000 village clinics in rural China with 1.43 million village health workers (Ministry of Health 2016). This is important, as most of the older adults in China live in villages.

China has a hierarchical governance system in regard to ageing, with the National Working Commission on Ageing representing the highest forum of decision making. However, it is important to note the role of the Older People's Associations (OPAs) here, emphasising the role of communities in the Chinese ageing framework.

Overview of the Chinese social care system

Following a period of public demonstrations, especially in rural areas, in 2006 China announced a series of social reforms aimed to increase social equality, promoting a harmonious society. The first step was to recentralise the provision of retirement pensions, which had been delegated to regional authorities during the 1980s. Like healthcare insurance, pensions schemes are divided between urban and rural, with the former enjoying more benefits. The current pension systems consist of a basic state-provided social pension and a pay-as-you-go individual account. The latter – the Basic Old-Age Insurance System for Employees – is funded primarily by workers with a small contribution from their employers; in the case of rural workers, this contribution is made by local governments – this scheme is called the New Rural Social Pension Scheme. In addition, a basic pension is guaranteed to scheme participants independently of their individual contributions (Bairoliya et al. 2017).

In regard to organisation, the Chinese social care system consists of home-based care (90 per cent), community care (7 per cent) and residential care (3 per cent), as established during the 2010–2015 period of China's 12-year plan. Many care facilities were developed in the past few years to meet the growing care needs of China's ageing population. There is a trend shifting the focus of care towards more community-based and home-based care. Based on recent national data from the China Research Centre on Ageing, 18.3 per cent (40 million) of the total older people in China (222 million) need constant care services (Ministry of Civil Affairs China 2016b). China needs at least about

Figure 3 Governmental institutional structures with responsibility for ageing-related issues in China

ten million caregivers, yet the total number of caregivers in China is less than 600,000. Care systems are not well developed in rural areas where there is a lack of good public services, although the needs of older people are much greater.

Overview of the CBSI

Establishing the CBSI (Inputs)

Establishing the CBSI

The Care Coordinators' Pilot Project is a CBSI started by the Ageing China Development Centre (ACDC). ACDC is a Chinese NGO registered in 2014 which works in close collaboration with HelpAge International. ACDC's mission is:

> *to cooperate and collaborate with relevant government agencies such as ageing authorities, civil society organizations, donors and development partners, with additional support from individuals to facilitate older people's contribution and participation in development, rights and access to healthcare, social services and economic and physical security.*

This mission translates into five core operational areas: (i) develop OPAs to achieve sustainable community development; (ii) reduce old-age poverty; (iii) explore community-based care models; (iv) conduct population ageing-related training, surveys and studies; and (v) promote sharing and learning.

The Care Coordinators' Pilot Project, which was established in 2016, falls mainly within the third operational area: exploring community-based care models. It includes training activities and support for older people that are providing and organising care for peers in their community. The involvement of OPAs and the local County Committees for Ageing (CCAs) from the beginning was instrumental in identifying six project villages and their corresponding OPAs. The OPAs in turn mobilised 34 rural community volunteers (five to seven people per village, a total of 16 men and 18 women: three volunteers aged 40–49, six volunteers aged 50–59, 15 volunteers aged 60–69 and ten volunteers aged 70–79) to act as coordinators within this project.

From the interviews with CBSI staff, an initial needs assessment revealed a sample of 280 potential beneficiaries. However, given the financial restraints of the project, a total of 180 beneficiaries were finally selected with the help of the OPAs and ACDC. The baseline needs assessment also found the following distribution of co-morbidities among older people: hypertension (54 per cent), experienced a heart attack (37 per cent), experienced a stroke (34 per cent), osteoporosis (29 per cent), chronic gastritis (18 per cent), chronic bronchitis (14 per cent) and diabetes (10 per cent).

Aims and objectives of the initiative

This Care Coordinators' Pilot Project aims to develop a care model that will address the growing needs of disabled and semi-disabled older people in rural areas. Relying on the involvement of OPAs, the project seeks to establish care coordinators who are older persons and members of local communities.

Funding the CBSI

The project ran in six rural villages located in Shaanxi Province between January 2016 and April 2017, with funding provided by HelpAge International through ACDC. HelpAge International provided roughly USD 30,000, intended to cover also ACDC's operating costs. Currently, the project is not receiving financial support; however, the local ownership of the model has led to its continuation.

For their services the care coordinators receive a monthly subsidy, which is no longer being funded through ACDC but in some cases is still being continued through OPA funds.

Other initiatives in the region

The Care Coordinators' Pilot Project builds on a previous European Union-sponsored project undertaken by ACDC. This previous project

Figure 4 Older person in China engaging in community activities

involved identifying community volunteers that would provide a limited amount of services to older people. The EU-funded project was run in 30 villages in Shaanxi Province and recruited 540 volunteers that provided services to 570 beneficiaries.

The main difference between the volunteer programme and the Care Coordinators' Pilot Project is that the latter's role involves a coordination function whereby village doctors, health practitioners and other key stakeholders are included in the care of the older people, in addition to care provided by volunteers. The networks established in this first EU project – with both OPAs and county officials – have been highlighted in the interviews as valuable in setting up the Care Coordinators' Pilot Project. One of the villages that participated in the EU-funded project was also included in the Care Coordinators' Pilot Project.

An important aspect of the Chinese context is the existence of OPAs. According to interviewees, these are instrumental in ensuring psychosocial support and well-being for their members, through encouraging participation in various social activities and promoting healthy ageing practices such as physical exercise, training courses, management of non-communicable diseases or self-care practices, or ensuring the delivery of certain medical services such as health check-ups. Furthermore, OPAs engage in activities aimed at ensuring income security, such as organisation of livelihood training and sharing sessions, running micro-credit projects or providing social assistance. OPAs are also active in advocacy activities in the area of protection of rights and interests of older people. They are in direct communication with the local authorities both at village level (village committees) and at county level (CCAs). ACDC was recognised by the Shaanxi Provincial Committee on Ageing as the Shaanxi Provincial Incubator for OPAs, with the responsibility to further develop the network of OPAs to meet the needs of the ageing population in the region.

The OPA representatives interviewed mentioned several projects that are run by the OPAs, including intergenerational activities such as setting up and running a kindergarten, which over the past 16 years has housed over 2,000 children. Other activities highlighted were organising a Pavilion for Older People, which organises activities involving direct service provision to older people (e.g. fetching water), or recreational activities such as playing mah-jong, ping-pong and chess. The Pavilion was also seen as a monument that would be a symbol for younger generations, reminding them of their duty to look after older people.

Activities of the CBSI (Process)

Target population and eligibility criteria

The Care Coordinators' Pilot Project focuses on disabled and semi-disabled older people. The beneficiaries are usually older people that do not have a family, are completely bedridden or incapable of looking after themselves, are very old or exceptionally poor and are located in rural areas.

The six project villages were selected with guidance from the CCA, which considered these villages representative of the province, both geographically and from a needs perspective. In Shaanxi Province, the number of older people over 60 reached six million by the end of 2016, amounting to 16.1 per cent of the total population of the province (Li Xuan Ke, 2017). In rural

areas of the province, there were four million older persons, representing 70 per cent of the province's rural population (Shaanxi Provincial Civil Affairs Department, 2016[2]).

Figure 5 Older person participating in ACDC activities

This was then followed by identification and selection of beneficiaries. In this step ACDC worked closely with the OPAs familiar with each candidate. The selection was guided by several criteria such as whether the older people considered were bedridden, dependent, disabled, psychosocially lonely, living in extreme poverty or living alone.

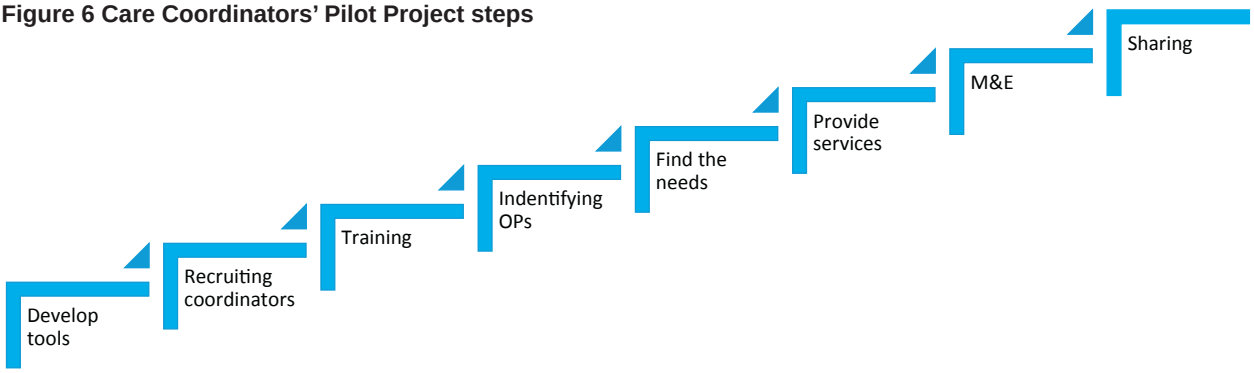
After identification of care coordinators and beneficiaries, supported by the CCA, ACDC together with the OPAs and the care coordinators jointly articulated a detailed tailored service plan drawing on results from a needs assessment exercise. This included further identification of skills needs and decisions on how to tailor an appropriate monitoring and evaluation plan.

Activities associated with the CBSI

After securing funding from HelpAge International, ACDC proceeded to development and implementation of the programme. The project steps are described in Figure 6.

The care coordinators received training in areas such as managing physiological and psychological changes experienced by the elderly, effective communication and psychological counselling, provision of certain basic healthcare services such as emergency treatment/first aid and monitoring of various parameters such as diet compliance.

Figure 6 Care Coordinators' Pilot Project steps



2 This data was supplied by an in-country partner who identified it as coming from the Shaanxi Department of Civil Affairs, but no further reference could be provided at this time.

The main activities that care coordinators offer to the beneficiaries are:

(i) Support in daily life tasks such as laundry, hairdressing and nail trimming and other hygienic activities, household chores and domestic assistance (water fetching, cooking, indoor and outdoor cleaning, etc.), shopping assistance and aiding walking.

(ii) Health management such as signs monitoring, blood pressure and blood sugar measuring, emergency treatment/first aid, diet.

(iii) Social visits and conflict mediation if needed.

Governance and management of the CBSI

The programme has an inclusive governance mechanism involving three main actors: ACDC, OPAs and CCAs. While the financial support and the formal monitoring and evaluation are the responsibility of ACDC, the decision-making process is participatory, starting from project inception, in selecting coordinators and beneficiaries and conducting needs assessment. The OPAs are also responsible for supervising some activities and distribution of subsidies. Each village receives RMB 5,000 (approximately USD 753), which is used to buy basic equipment for running community care activities, or to buy products (gifts for the older persons). OPAs are also provided with RMB 600 (approximately USD 90) per month for each OPA/village to compensate care coordinators for their time and work. On average there are five to six care coordinators per village, meaning a total of approximately RMB 100 per month (approximately USD 15).

The interviews with the OPAs revealed a high level of ownership of the programme, with OPA leadership serving as champions for both the programme and other, complementary activities. In both villages that were visited for the purposes of this research, the OPA heads and deputy heads were also care coordinators, showing investment in this pilot project. Furthermore, when asked about decisions on how to spend the bulk sum of money the OPA receives, members highlighted the participatory nature of decision-making processes.

The main monitoring and evaluation activities of the programme are undertaken by ACDC; however, the OPAs and the CCA are also involved in monitoring the programme by obtaining verbal testimonials in regard to beneficiary and coordinator satisfaction.

Results of the CBSI (Outputs)

Enrolment of older people

The care coordinators are serving 180 beneficiaries located as follows:

Village	Township	Number of beneficiaries
Ruining	Jinggan	26
Kangying	Yongle	24
Sunjiabao	Taiping	29
Chayang	Taiping	53
Dongjie	Wangqiao	34
Gouershang	Qiaodi	14

These are 75 men and 105 women, with the following age distribution: 21 beneficiaries aged 60–69, 91 beneficiaries aged 70–79, 52 beneficiaries aged 80–89 and 16 beneficiaries aged 90 and above.

The driver for selecting both the care coordinators and the beneficiaries is represented by the OPAs. In both villages that were visited the enrolment rate in OPAs reached approximately 90 per cent of the total eligible population (persons over 50). The most quoted reason for the 10 per cent non-participation was inability to pay the membership fee.

The care coordinators and the beneficiaries are usually neighbours and have been acquainted with each other since before the start of the project. When it comes to the care coordinators' motivations to participate in the project, a predominant theme that emerged from the

interviews was around their duty to help and be kind to their (older) peers, and to serve as an example for younger generations in this respect.

Self-reported health gains from beneficiaries

All beneficiaries interviewed were able to list several activities for which they receive help from their coordinators, such as receiving haircuts, fetching water, buying goods, washing clothes or cooking. Beneficiaries appreciated the 'human warmth' that they receive from their care coordinators, with one interviewee saying that if it had not been for her coordinator she would not have been alive today.

The interviews also suggest benefits in accessing care as a result of the care coordinators' help. One beneficiary, who has trouble moving, mentioned that she tells her coordinator when she wants to see the doctor and receives help with her medication intake and compliance.

The theme of mediation also emerged in the interviews with the care coordinators. In one situation one of the participants was benefiting from the help of a paid helper hired by her family, but she did not get along with this person. The care coordinator described how she had to take up a mediator role to ensure a good relationship.

In regard to the effect on care coordinators, these reported that they benefited from the knowledge they acquired and expressed the desire to learn more on both the management of certain diseases and older persons' rights. One care coordinator also reported elevated mood as a result of having to visit two older people more frequently.

Overall the beneficiaries interviewed were very positive about their involvement in the project, praising and expressing gratitude to their care coordinators, and said they would recommend it to peers.

Linkages to health and social care system

The project is benefiting from the advice of the CCAs; however, there are no formal links with either the health or the social care system.

Throughout the interviews with the OPA heads an interesting theme emerged. The participants from different villages explained that as a result of their personal networks, through informal ties they have been able convince private and public providers to offer free check-ups and even subsidies to the OPAs. In one case this involved doctors in both private and public hospitals, whereas in another only the private doctors agreed to provide services for free while the public doctors had to be paid. This approach is routed in the 'Guanxi' concept, which implies a network of personal relationships relying on trust, in which different kinds of support can be provided between members.

Impact of the CBSI (Outcomes)

Wider impacts of the programme

It is difficult to assess the wider impacts of the project, as this represented a pilot stage running in parallel to other community initiatives. Therefore, issues of attribution are problematic in this case. ACDC shared the project model

Figure 7 Peer support activities

and reported findings to the local authorities to gain their attention and support. This project was one of two in Shaanxi Province, which were recognised at national level by the National Development and Reform Commission, the Ministry of Civil Affairs and the China National Committee on Ageing as an example of providing care services for older people (National Development and Reform Commission for Social Development Department et al. 2017). The care pilot project was also recently reported in local media channels.

One CCA representative highlighted two important potential impacts of the project. The first is in terms of stabilising the rural society's needs in regard to social care, which currently are affected by an economic migration of youth towards cities. The other impact, which builds on the previous point, is in regard to the potential of the programme to ensure targeted care for older persons, as care coordinators are able to become intimately aware of individual needs in a more holistic way (so including social and economic determinants).

Another possible area of impact is in further strengthening and developing the role of OPAs and increasing community ties. By providing an opportunity to engage in social visits and events and build more intimate ties between neighbours, the programme could lead to greater community cohesion. ACDC aims to prove that supported and trained OPAs can provide elderly care services to bridge the current gap of care provision in rural areas in China. The leading role that OPAs are taking in the running of the project, and the exposure to ACDC's practices of monitoring and evaluation, could potentially further transform these associations into organisations that are capable of demonstrating impact though their own monitoring and evaluation system.

Sustainability of the programme

The project represented a pilot and is no longer receiving ACDC financial support. This was seen as detrimental to the programme's sustainability by the OPAs, who praised the financial help. However, despite this limitation, the project is still ongoing in a transformed form – with care coordinators continuing their roles without remuneration. While not explicitly mentioned in the interviews, this could raise questions of sustainability, in particular for coordinator–beneficiary pairs that are not very well acquainted with each other. In addition, the current care coordinators have benefited from a series of training courses that it would be problematic to realise at the same scale and pace, given the lack of ACDC support; success would be very much dependent on each OPA head's Guanxi.

Reflections on the CBSI

The experience of the Care Coordinators Pilot Project in China raises some important themes relevant to the analysis of CBSIs.

The inclusive governance model of the Care Coordinators programme contributes to adoption and dissemination of the innovation.

The OPAs are not the only critical component that enables diffusion of innovation. While horizontal networks of peers facilitate exchanges, the inclusion of CCAs in the pilot project has enlarged its potential for scale-up and replicability. In terms of power structures the CCAs can connect, encourage and transfer information vertically and potentially attract more resources for these types of initiatives.

The Care Coordinators programme is answering contextual needs in an evolving Chinese society.

Chinese society is witnessing an economic migration of young people towards cities, while still managing to maintain valuable traditions such as respect and care for older people. However, this can create tensions, as often the limited resources and great physical distances impede children's ability to provide for their parents.

Networks of OPAs have been instrumental in running the programme and obtaining further benefits for older people.

The instrumental support of OPAs in the development and running of the Care Coordinators programme is evident. The way these networks are organised provides valuable examples of inclusion of older people in decision making and in the diffusion of innovation. The OPAs' success in China is however dependent on the availability of key people to lead change and the richness of their social network, making some individuals more important than others in accessing services.

Building on China's legacy and valuable lessons learned from the 'barefoot doctors' programme, the Care Coordinators Pilot Project raises interesting questions for meeting healthcare workforce needs.

China has a history of innovating in the health workforce to meet the needs of its population. The 'barefoot doctors' are seen by many as an inspiration for greater focus on primary healthcare and addressing the health concerns of populations in rural areas, bringing a focus on prevention and drawing on both Western and traditional practices. That programme exemplifies a successful practice of training up a particular segment of the population to deliver services in rural areas. In this respect the Care Coordinators programme shows similarities and great potential. It could provide a model for addressing the Chinese healthcare workforce needs. Further research could determine the optimal balance of care coordinators/beneficiaries, the right skills mix and a viable incentive structure.

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World Health Organization

Centre for Health Development

Iran (Islamic Republic of): Tehran's Older People's Association *(Jahandidegan)*

RAND Europe researcher: Gavin Cochrane

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Preface

The World Health Organization Centre for Health Development Kobe has contracted RAND Europe to serve as a research hub for conducting a systematic review and gathering evidence of middle- and high-income countries' community-based social innovations (CBSIs) for healthy ageing. RAND Europe has undertaken two main strands of research: (1) a systematic review of CBSIs for healthy ageing in middle- and high-income countries, and (2) a series of ten case studies of CBSIs for healthy ageing in middle-income countries.

This report presents the findings from one of our ten case studies, the Older People's Association (*Jahandidegan*) in Iran (Islamic Republic of).

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Summary of the community-based social innovation (CBSI)

Background

Iran (Islamic Republic of)

Locations
Tehran Municipality, Iran (Islamic Republic of)

Type of intervention
Adaptive

Year established
2006

The intervention

Establishing the CBSI

- Tehran Municipality established the Older People's Association programme in 2006, as a network of Older People's clubs aimed to promote the health status and social participation of older people in Tehran and to increase voluntary participation of people in community-based activities.
- The Older People's Association programme is a non-governmental, non-commercial, non-political and non-profit organisation working within a framework of laws and regulations of Tehran.
- The aims and objectives of the programme have evolved over time from initially promoting social presence and participation to comprising a social intervention which older people are involved in managing and running.
- The CBSI has no specific budget and is reliant on the skills and capabilities of its members to run its activities.

Activities of the CBSI

- All citizens of the Tehran metropolitan area who are aged 60 and over are eligible to participate in the Older People's clubs and membership is free of charge.
- The main activities of the CBSI include: (1) training courses in various health-related and sociocultural areas; (2) leisure activities, sports events and music performances; (3) bi-weekly health check-ups; (4) fundraising activities; (5) intergenerational activities; and (6) an honorary card providing discounts and benefits.
- Each Older People's club has a managing board and a Secretary General elected by members of that neighbourhood.
- All activities are coordinated and managed by the older people who are members of each club. The municipality has the responsibility of policymaking and financing and monitoring of the programme.

Results and impact of the CBSI to date

- Over the last ten years the CBSI has enrolled a total of 61,548 members across 22 districts and 374 neighbourhoods in Tehran, who are aged over 60.
- Beneficiaries noted a range of physical and social health gains, including psychosocial benefits and improved health literacy, mental health and well-being.
- Beneficiaries also noted that they felt as a result of their participation a sense of empowerment to care for themselves and their peers, and to act as health ambassadors in their local community.
- Beneficiaries noted that the wider impacts of the programme were related to their standing in society, with participation having improved their civic engagement and helped persuade society that older people were a valuable resource.

Ageing in Iran (Islamic Republic of)

- Iran (Islamic Republic of) is a middle-income country with a rapidly ageing population.
- The percentage of the population aged 60 and over was 8.2 per cent in 2015 and is projected to reach 10 per cent by 2021.
- The Iranian health system has made significant improvements over the last 30 years and has been able to extend preventive services throughout the country, developing an extensive primary healthcare network.
- The government is mandated to protect all older people, although studies suggest that social care is provided in a non-coherent manner.

Reflections on the CBSI

- The programme's reliance on members' capabilities presents a sustainable model which has the potential to be replicated in other cities across Iran (Islamic Republic of).
- The programme has successfully managed to enrol a large number of older people in the city and reduce their social isolation, although members are primarily female.
- The participatory, bottom-up approach of the programme has allowed members to be involved directly in civic activities to help improve the status of older people in their communities.
- The programme has pursued formal steps to encourage intergenerational activities, although the increasing divide between older and younger generations was seen as a challenge to programme sustainability.
- Through its affiliation with Tehran Municipality, the programme has good linkages with other parts of the local health and social care system, although lack of oversight and coordination between services may cause duplication of effort and inefficiencies.
- The programme has benefited from extensive monitoring and evaluation activities, which have allowed the programme to improve over time and demonstrate its impact at a national level.

Aims of the research

This report presents the findings from one of our ten case studies, the Older People's Association (*Jahandidegan*) in Iran (Islamic Republic of). The overall aim of the research is to describe within a pool of rapidly ageing countries, and from those with high proportions of older people, a) the core roles, services and functioning (including feasibility of scale-up) of community-based social innovations (CBSIs) for healthy ageing that seek to support older people becoming a resource for their own health and well-being, b) their linkages with and sustainable partnerships to deliver health services, strengthen social systems; and c) the nature of enabling policies, programmes, financing and interactions with the health/social care delivery system.

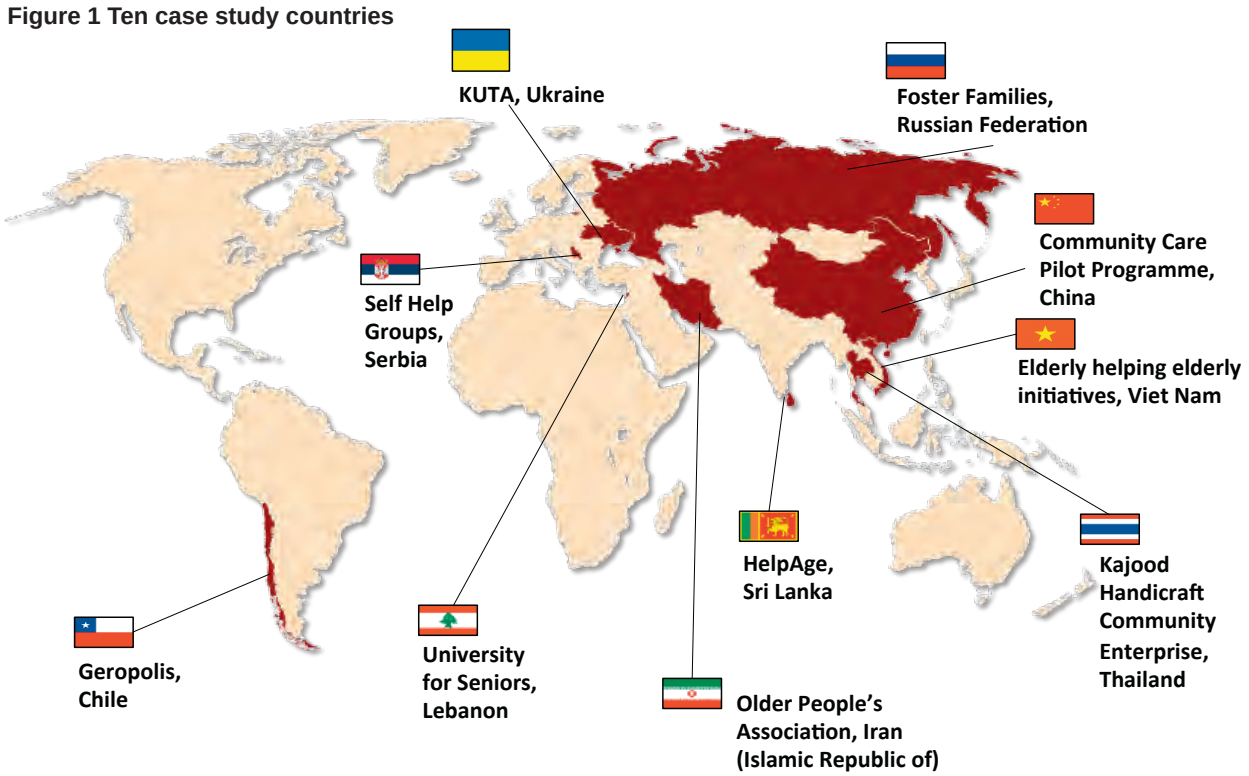
A recent WHO study (2016) conceptualised CBSIs as initiatives that seek to empower older people to improve their self-efficacy in caring for themselves and their peers, maintain their well-being and promote social cohesion and inclusiveness. They can also help older people to access, understand and navigate health and social care systems (Ong et al. 2016).

While CBSIs may hold the potential to transform health and social care provision for older people, more evidence is needed to improve our understanding of what types of initiatives and service delivery models are pursued in practice that engage communities and span a spectrum of health and social services.

Aiming to develop a typology of CBSI, this research consisted of three main parts: (i) a systematic review of CBSIs for healthy ageing in upper middle- and high-income countries; (ii) a series of ten case studies to examine the effectiveness of ongoing CBSI interventions in middle-income countries, and (iii) an expert consultation at the World Health Organization's Centre for Health Development (WHO-WKC) in Kobe, Japan, to validate and refine the typology.

Given the relative lack of evidence on CBSIs in middle-income countries in academic literature, the ten case studies were identified through an open call for Expressions of Interest (EOIs). Figure 1 below shows the location of the ten case study countries.

Figure 1 Ten case study countries



The data gathered in this case study will serve to better conceptualise what a CBSI is and to present typologies and functions of CBSIs for older populations.

Each individual case study will seek to explore:

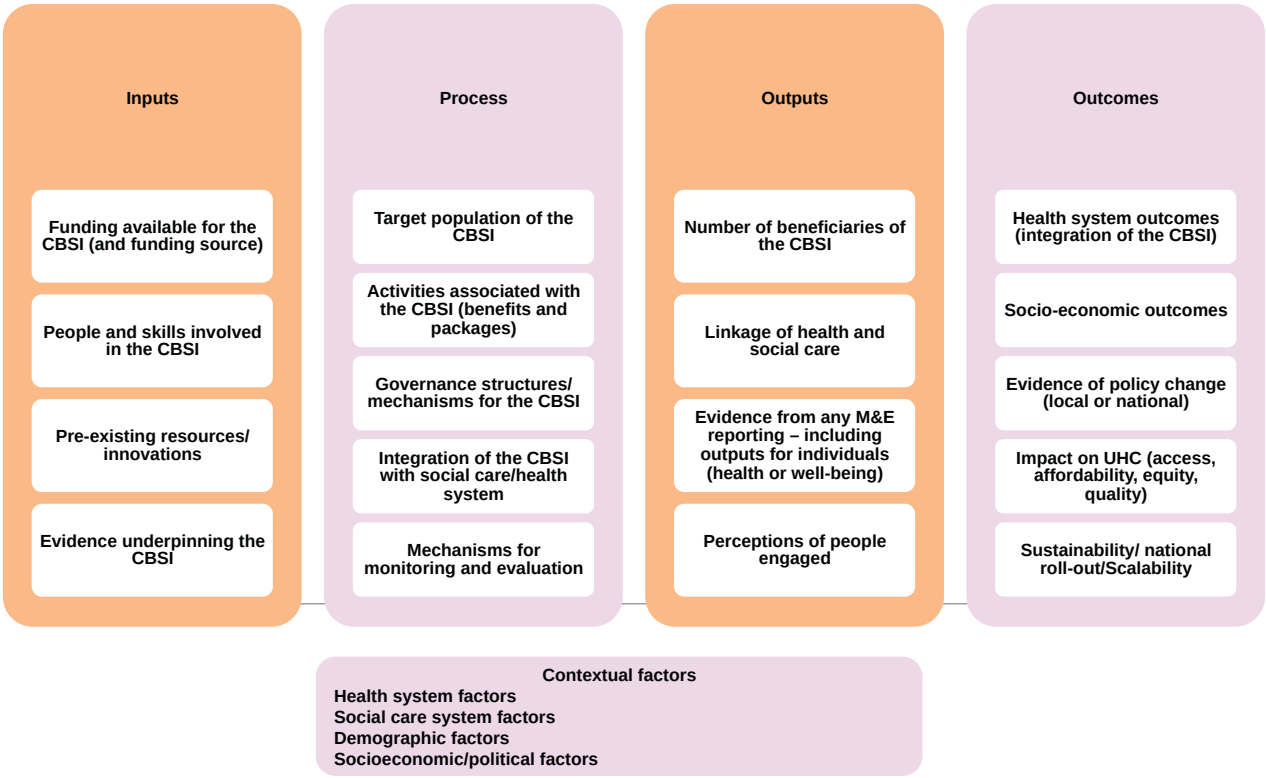
- The role and function of older people as resources for themselves and for others (peers, family, community).
- Health and social services delivered by those initiatives and referral processes when they exist.
- Links made within these communities of support between health interventions and social health protection interventions (e.g. help with transportation, livelihoods, pensions, cash or in-kind transfers).
- Coordination mechanisms with formal health and social sector, including any formal connections with the health and social care system.
- Coordination and engagement with a variety of health/social-service workers and community-based services.
- Type of metrics (indicators, monitoring tools) implemented to assess impact on health[1] and the concept of health that is being measured.
- Measures to understand and respond to health inequities in the population served.

We have used a logic model approach to examine the effectiveness of selected CBSIs. This helps us assess the intervention logic for CBSIs and track the progress, impacts and evolutionary dynamics of CBSIs at core levels of analysis. As illustrated in Figure 2 below:

- **Inputs** will help us understand the resource environment of each CBSI, and provide a foundation for exploring the linkages between resources, outputs and impacts. This resource input environment is likely to capture aspects such as resources for implementation (funding, infrastructure and skills/capabilities). We will also aim to capture the reasoning and evidence base leading to the establishment of the CBSI.
- The **process** dimension will help us examine both the diversity of CBSIs, in terms of activities/services offered, population groups targeted and geographies projects covered, and mechanisms for designing, managing and evaluating the CBSI if present. We will also examine the integration of the CBSI within the wider health and social care services offered to older people.
- The **output** dimension will help us assess the relative progress of CBSIs since they have been established and capture the diversity of outputs and associated achievements. This will involve capturing outputs such as the number of beneficiaries involved in the CBSI and any initial health and well-being outputs for beneficiaries reported.
- The **outcomes** dimension will help us capture a wider range of benefits, including those relating to impact on resources for achieving universal health coverage (UHC), policy-level impacts and other (including unintended) consequences which may affect the health and well-being of older people in a particular country. In particular we will not only consider impacts at an individual level (e.g. beneficiaries engaged in the CBSI) but also look to examine the impact on the wider community and the overall health/social care system.

1 We used the term 'health' very broadly at this stage in anticipation that it could incorporate physical and mental health and broader wellbeing. As the case studies were exploratory, we did not seek to further define or restrict at this stage as we were interested in understanding of the CBSIs themselves conceptualised and measured these types of outcomes, if at all.

Figure 2 Framework for gathering data on CBSIs and the contexts they operate in



- The **contextual factors** will guide us to consider the influence of both health and social care system factors and demographic, socioeconomic and political factors which may help or hinder progress of the CBSI. A greater understanding of the contextual factors underpinning the CBSI will also help to inform reflections on its transferability/ scalability by offering a richer understanding of the setting.

Structure of the case study

The next section of the report begins with a brief overview of the methodology used for the case study. The report then highlights some of the key contextual factors affecting the CBSI, related to the country's ageing population and its health and social care system.

The main section of the report focuses on how the four areas of the logic model (outlined in Figure 1) related to the CBSI, in the following four areas: (i) establishing the CBSI (inputs); (ii) activities of the CBSI (processes); (iii) results of the CBSI (outputs); and (iv) impact of the CBSI (outcomes). Within each sub-section the perspectives of interviewees are presented alongside findings from the desk review. Finally, the report concludes with some overall reflections on the CBSI and draws out key themes and experiences to better conceptualise CBSIs and their role and functions for older populations.

Methodology

Case studies have been used to collect descriptive data on CBSIs through a mix of methods including semi-structured interviews and a review of administrative data and documentation. Each case study follows the same design in order to provide in-depth understanding of each CBSI and allow comparisons to be made between different actors

within a single case, between cases and between groups across cases, taking into account relevant contextual factors. Key-informant interviews were conducted with key stakeholder groups involved in the CBSI, as well as with wider health and social care system actors.

Desk-based document review

Building on any documentation identified in consultation with the CBSI, the literature review draws on academic and grey literature to provide an overview of the health and social services delivered by the CBSI in Iran (Islamic Republic of) and the wider context in which these interventions are taking place. In addition, any available evaluative documentation was reviewed to collect evidence on the metrics, indicators and monitoring tools used to assess the effectiveness of the CBSIs identified initiatives. Key documents included journal articles and policy documents, such as commissioned discussion documents and government strategies. Academic literature was identified through PubMed, focusing on the years 2000 to the present. The literature search was conducted between August and September 2017.

Stakeholder interviews

In addition to the document review described above, key-informant interviews were also used as a key means of gaining an insight into the ongoing activities of the CBSI and the wider contextual factors affecting its functioning in Iran (Islamic Republic of). The interviews followed a common topic guide, with the main topics discussed including: resources that support the CBSI, engagement with older people and functioning of the CBSI, outputs and linkages with the health and social care systems and impact of the CBSI. Emphasis, however, was placed on allowing participants to talk from their own perspective.

In order to explore different perceptions of impact associated with the CBSI, and to identify any linkages and interaction between stakeholders, the project team in coordination with the CBSI staff identified suitable interviewees from three major stakeholder groups (as outlined in Table 1 below). A total of 14 interviews were conducted in Iran (Islamic Republic of) between 23 and 27 September 2017.

Table 1 Overview of the interviewees

Stakeholder group	Profile of the interviewees
Beneficiaries of the programme	Five beneficiaries were interviewed: • Secretary General of the Older People's Association, female, 66 years old. • Three female secretaries of districts, 62, 78 and 61 years old. • A male district secretary, 66 years old.
CBSI staff	Five CBSI staff were interviewed: • Head of health department (Tehran Municipality), female, 37 years old. • Deputy manager of health department, male, 39 years old. • Former head of health department, male, 49 years old. • Two heads of district health offices, a 47-year-old male and 51-year-old female.
Policymakers, academia and civil society	• Social deputy from Ministry of Health, 55-year-old male. • Head of welfare organisation in Tehran, 51-year-old male. • General manager of Secretariat of Ageing, male (age unknown). • Head of Ageing Research Centre, 48-year-old male.

Prior to being interviewed, written consent to participate was sought from all participants. Interviews were conducted face-to-face in Tehran. The interviews typically lasted between 30 and 60 minutes and were semi-structured in style, to enable participants to raise concerns that may not have been anticipated by the research team or were specific to the practice; this provided a flexible approach which allowed respondents to offer their own perspective and raise issues most salient to them, while covering the same topic areas in each interview.

The interview data was analysed and coded by the project team, and then grouped into the categories and sub-categories outlined in the logic model. In analysing the categories, the team also identified emerging themes, which are presented at the end of this report.

Overview of the context in Iran (Islamic Republic of)

Iran (Islamic Republic of) is a middle-income economy with one of the largest populations in the Middle East, over 80 million (UN World Population Prospects 2017). Not only is the country one of the largest in the region, it is fast becoming one of the oldest, with a rapidly ageing population. Nevertheless, Iran (Islamic Republic of) faces major challenges with respect to care of older people in the country, particularly with regard to policymaking and access to social and health-based care services and technical infrastructure (Goharinezhad et al. 2016).

Demographic factors

Due to a fall in the fertility rate and an increasing life expectancy, Iran (Islamic Republic of) rate of population growth was around 1.1 per cent in 2016 (World Bank, 2017). The proportion of the population aged 60 and over was 8.2 per cent in 2015 and is projected to reach 10 per cent and 20 per cent in the years 2021 and 2050, respectively (Mousavi et al. 2015). Today, the average life expectancy is 76, with an average healthy life expectancy at birth of 66.5 (WHO 2015).

Overview of the Iranian health system

In the last 30 years Iran (Islamic Republic of) has significantly improved its healthcare system (UNICEF 2017). Its rural Primary Health Care network, created in 1979, includes more than 17,000 health houses, which are run by either physicians or trained generic health workers. A key role is played by Medical Universities, one per province, both as education centres and as bodies responsible for organising the local health centres and hospitals (UNICEF 2017). Nevertheless, while having a modern system in place, urban areas are not fully covered by secondary and tertiary healthcare facilities, the cost of the state-led healthcare system is raising major concerns in terms of its sustainability, and a chronic lack of healthcare managers is reported – a role usually covered by senior doctors (Lankarani et al. 2013).

Overview of the Iranian social care system

The Iranian Constitution mandates the government to protect all older people. Iran (Islamic Republic of) has therefore developed an extensive pension system that is composed of contributory and non-contributory schemes, regulated by a 1975 Social Security Law and a 1986 law on self-employment. Together the two schemes cover 50 per cent of the labour force and close to 60 per cent of the population aged 60 and over (World Bank 2003). However, Goharinezhad et al. (2016) conclude that social care in Iran (Islamic Republic of) is provided in a sporadic, non-coherent manner due to particular challenges, including the stewardship and governance of social care, unequitable access to services and resource constraints faced by older people in Iran (Islamic Republic of).

According to the World Bank (2003; 2005), the Iranian government will soon need to face two main issues with respect to the country's social care system. Firstly, a structural reform of the pension system is needed to prevent bankruptcy. Secondly, there is a need to increase access to social care services for older people living in rural areas.

Due to the rapid ageing of the Iranian population and the subsequent decrease in the labour force, the social care system is underfunded and few pension funds have a reasonable potential support ratio – that is, the number of people aged 15–64 per person aged 65 or above (World Bank 2003; 2005).

Overview of the CBSI

Establishing the CBSI (Inputs)

Establishing the CBSI

Over the last 15 years, Tehran Municipality (the city council) has begun to widen its remit, from initially providing only urban services to providing more social services. One of the social services the municipality began to provide about 15 years ago comprised 'neighbourhood houses' in each of the 354 neighbourhoods of Tehran. Each neighbourhood house consisted of 14 sub-houses, focusing on various social services, for example health, culture, art and sport. Within each sub-house a number of clubs are established to address specific social services. Health houses are health facilities in each neighbourhood of Tehran that provide people with medical check-ups and preventative medicine training. Each health house contains 11 clubs, which focus on particular issues such as diabetes and maternal health.

Tehran Municipality's Older People's Association programme, known as *Jahandidegan*[2], was established in 2006, as a network of Older People clubs within the health houses in each neighbourhood of Tehran. Through support from the municipality's Department of Health, the Older People's Association aims to improve the health status and social participation of older people in Tehran and to increase voluntary participation in community-based activities.

The decision to establish the network of Older People's Association came from the necessity to raise older people's participation in society and improve the social aspect of health among the city's ageing population. According to interviewees who were involved in the establishment of the programme, it also built on evidence from previous projects run in the city, such as the Tehran Healthy Cities project (WHO, 2003), a pilot run in some neighbourhoods of Tehran in 1997 that demonstrated the importance of local participation and the potential for older people to participate in successful urban management. The Older People Association was also introduced to the WHO through the Age-friendly City (WHO, 2017) project. Prior to the establishment of the Older People Association, interviewees noted, there were some cultural centres for older people in a few districts but nothing comprehensive. Another motivation to establish a network of clubs for older people was the great socioeconomic diversity in Tehran, which would make implementing a unified programme for the whole of the city challenging.

The Older People's Association programme is a non-governmental, non-commercial, non-political, non-profit and community-based organisation working within a framework of laws and regulations of Tehran.

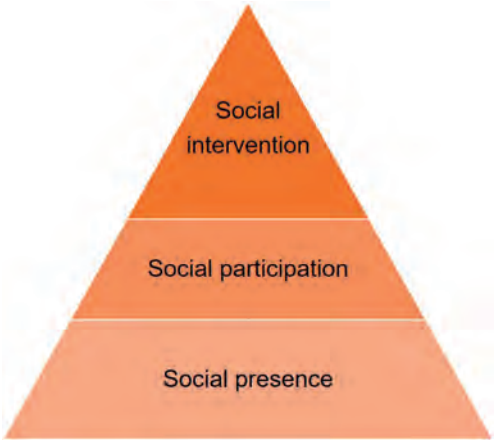
Aims and objectives of the initiative

The Older People's Association were initially established to encourage peer-to-peer support among older people in order to create a local network which would improve their health status, facilitate voluntary activities for them and raise their visibility in the society. A core component of the programme has been to build on the capacities and capabilities of older people to provide training and peer support for members.

One of the interviewees involved in the establishment of the CBSI noted the changing role of older people in the programme over time. When the programme was initially established, it aimed only to improve older people's visibility in society through holding events and running

2 The name is derived from the plural form of '*Jahandide*', which means 'a worldly-wise person' in Farsi.

Figure 3 Pyramid of older people's function in the Older People Association



training courses. Gradually, older people have become increasingly involved in the management of the clubs and are running their own programmes. Now, after ten years, older people are the primary decision makers in the clubs, involved in coordinating a wide range of activities, and the Secretary-General of the Association is included in national-level meetings concerning ageing and older people's rights. In this respect, the interviewees felt that the aims and objectives of the programme had evolved over time from initially promoting social presence and participation to comprising a social intervention (Figure 3).

Funding for the CBSI

While the programme was established by Tehran Municipality, interviewees noted that it does not have a specific budget. Instead, different local government departments have general budgets for training activities which contribute to the Older People's Association activities and the municipality provides resources such as infrastructure and transportation. The majority of activities offered through the CBSI are provided free of charge to members, although there is a small user fee for certain activities and training courses beyond the designated training schedules. Members of the Older People's Association also play an active role in generating funding for their activities, through raising money from local NGOs and charities and local government bodies such as the Assembly of Health Donors, part of the Ministry of Health.

Other initiatives in the region

Iran (Islamic Republic of) has sought to address the challenges posed by its rapidly ageing population through a number of laws and regulations, through various organisations across different levels of government. These organisations include the Ministry of Health, the Ministry of Welfare and Social Affairs, welfare organisations and insurance bodies, medical universities and research centres, NGOs and charities.

Interviewees noted that among the relevant institutions that have responsibility for promoting healthy ageing in Iran (Islamic Republic of), Tehran Municipality is one of the main stakeholders, which has implemented various activities in order to improve the lives of older people.

Among the additional initiatives mentioned by interviewees, two mentioned the Farzanegan NGO, which provides consultancy on a range of issues relating to healthy ageing via physicians, professors, donors and older people. Another NGO mentioned was Line of Life[3], which provides incapacitated older people with home care and help with their daily activities. Charities and NGOs for older people are supported financially by the local administration and entitled to tax deductions.

Beneficiaries interviewed also mentioned other clubs within the health houses that benefit older people, such as those for diabetes patients and physicians' clubs, but it was noted that these tend to be much less active than the Older People's Association.

Despite the large number of clubs and activities for older people in Iran (Islamic Republic of), some interviewees noted that there was weak coordination between these clubs at the

3 Iranian Students' News Agency (N.d.).

departmental level, which often resulted in duplication of effort and inefficiencies. To address this problem, it was noted that the Farzanegan NGO planned to merge with the Older People's Association in Tehran, in order to build on their experience and reduce inefficiencies.

Activities of the CBSI (Process)

Target population and eligibility criteria

All citizens of the Tehran metropolitan area who are aged 60 and over are eligible to participate in the Older People's Association and membership is free of charge. All that members need to enrol in the programme is a copy of their national ID card to confirm their age and address. Membership is initially given for one year but can be extended for as long as the members wish to be involved in the programme. Given the decentralised structure of the Older People's Association, each neighbourhood's club has a strong local identity. One of the CBSI staff interviewed noted that she developed an IT system in her own district to identify the skills and education of the members, so that they could be approached as potential teachers or experts for training courses.

The programme is advertised widely across the city through billboards at local festivals and in public places (e.g. mosques and parks), as well as online and through mobile technology. However, interviewees noted that the members of the clubs often comprise the best channel for advertising the programme, through word of mouth. When the clubs were initially established, municipality staff were more involved in the recruitment process, but now most of the activities, including registration for workshops and tours and publicity, are managed by the older people themselves. Interviewees from the CBSI felt that the bottom-up structure of the clubs was functioning well. However, one interviewee noted that awareness of the programme remained limited, guessing that only around 10 per cent of the general population in Tehran knew about the activities within the health houses. Nevertheless, they noted that improvements had been made by using mobile technologies and online media.

Figure 4 Training course with older residents

Activities associated with the CBSI

The Older People's Association organise different programmes and activities based on the needs and characteristics of the members in that district or neighbourhood (e.g. age, gender, health status, education level and occupation). There are many services and activities within the clubs, but most fit into the following six categories:

1. **Training courses and workshops** – these are broadly categorised into two groups: (1) health-related training, for example on specific diseases such as Alzheimer's and diabetes, or provision of more general information on preventative medicine, health promotion, nutrition and mental health; (2) sociocultural/education-related topics such as language, filmmaking, sports, music and IT skills.

2. **Leisure activities** – in addition to the training courses the clubs also run tours to places of interest, sports events, food festivals and games. Sometimes these sport or music performances attract additional financial resources for the club.

3. **Health station** – twice a week the clubs host a health station where members can check their blood pressure, body-mass index (BMI), blood glucose and mental health.

4. **Fundraising activities** – activities aimed at raising funds for low-income members; these are then made available to members in need through special loans and financial aid schemes.

5. **Intergenerational activities** – the association recently signed a Memorandum of Understanding (MoU) with the youth clubs to try to facilitate more intergenerational activities for older people (e.g. IT workshops or traditional sports) and exchange ideas and experience on hosting events and sharing resources.

6. **Honorary card** – each member receives a card designed by the municipality to provide older people with free access to public transportation, cultural activities (e.g. cinemas, museums) and sport facilities.

Some of the specialist training courses are designed by the municipality (e.g. disease-specific courses), but there is also the opportunity for members to propose their own topics, participate in designing and conducting workshops and courses and be involved in train-the-trainer programmes. Building on the capabilities and skills of the older people involved is a core component of all activities in the programme.

Governance and management of the CBSI

Each Older People's Association has a managing board and a secretary, elected by members of that neighbourhood. Members also vote, through an internal election, on one secretary to represent the Older People's Association at a district level. One of the 22 district secretaries is then elected as Secretary-General for the Association and acts as the coordinator between the municipality and the clubs, as well as taking part in national-level meetings on ageing policies and older people's rights in Iran (Islamic Republic of).

All activities are coordinated and managed by the older people who are members of each club. The municipality has the responsibility for policymaking, financing and monitoring the programme, based on the reports from regional

Figure 5 Honorary card for members

centres. The municipality's Department of Health, welfare organisation and medical universities are all involved in assessing the effectiveness of the programme and providing advice.

The governance approach of the programme is therefore bottom-up, with the municipality only being responsible for monitoring progress and ensuring the democratic process of the elections.

Results of the CBSI (Outputs)

Enrolment of older people

Over the last ten years since the Older People's Association was established they have enrolled a total of 61,548 members aged over 60 across 22 districts and 374 neighbourhoods in Tehran. It was noted by one interviewee from the CBSI that around 70 per cent of members remain in the club after their first annual membership. The vast majority of members in the Older People's Association are female, 82 per cent compared to only 18 per cent of male older people enrolled. Interviewees felt that the nature of the training courses, focused on care and health promotion, was more appealing to women.

The primary motivation cited by beneficiaries of the programme was to be involved in activities by which they could help their peers, particularly those unable to care for themselves or physically weaker. These activities consisted of raising funds or providing care and helping to empower older people in their locality. Additionally, beneficiaries noted that the programme offered

Figure 6 Older People Association Event

opportunities to learn new skills, such as health training and language skills.

Self-reported health gains from beneficiaries

Beneficiaries interviewed noted a range of physical and social health gains as a result of their membership in the programme. The most frequently reported benefit was in the psychosocial aspect, with beneficiaries reporting that the programme helped reduce social isolation in their neighbourhood. This was seen as particularly important for improving older people's mental health and well-being.

Physical health gains were noted by interviewees through participation in sports and leisure activities, and through improved health literacy and awareness to help manage diseases such as diabetes. Beneficiaries also noted that they felt a sense of empowerment to care for themselves and their peers as a result of their participation, and to act as health ambassadors in their local community.

The honorary card provided to members was also seen as an important factor in facilitating older people's access to healthcare services, through providing them with free transportation.

Linkages to health and social care system

Given the role of Tehran Municipality and local government organisations in the programme's establishment and its financial and operational support, the Older People's Association has always been able to rely on good links with both the health and social care system.

There is a close collaboration between the Older People's Association and the Ministry of Health, the Ageing Council of Iran (Islamic Republic of) and welfare organisations which provide support for training courses and activities. One interviewee from the CBSI noted that the clubs try to work within the broad framework of health and social services provision at the national level, but that formal communication with the Ministry of Health or the welfare organisations is carried out through the district health office.

The Secretary-General of the programme is also officially involved in national-level government meetings, which allows the experiences of the CBSI to be incorporated directly into national policies on ageing, and provides it with the opportunity to gain additional funding.

The clubs have also actively pursued MoUs with several key organisations and clubs, such as youth clubs and NGOs, to share knowledge, resources and experiences and enable the joint hosting of events and courses. Personal and informal linkages of the members to different associations and NGOs are also an important factor in the networking of the CBSI, with one interviewee noting that her involvement in a centre for people with disabilities helped to link potential beneficiaries with the Older People's Association.

Impact of the CBSI (Outcomes)

Wider impacts of the programme

Many studies have been done to evaluate the performance of the Older People's Association since they were established over a decade ago (e.g. Bagheri Yazdi et al. 2010; Kasraei 2016; Moradi et al. 2011). Qualitative feedback on programme activities is gathered regularly through surveys specifically designed for the activities and courses, and through quantitative data on number of participants and courses. The

effectiveness of the programme overall is also assessed on a regular basis by the research centre of the municipality. Some of these studies have shown a significant difference in the mental health of members of the Older People's Association compared with older people who are not involved in the programme.

For example, in 2010 one study by the Bureau of Municipal Social Studies evaluated the programme in regard to its outcomes on the mental health of older people enrolled. The study assessed the mental health status of members compared to non-members. Findings showed that the rate of depression among members is about 36.8 per cent and 41.6 per cent among non-members, but this difference was not statistically significant. In addition, T-testing of the mean mental health and satisfaction scores of the older people in the two groups showed that the psychosocial support services provided by the clubs made a significant positive difference on the mental health and life satisfaction of older people in the programme (Bagheri Yazdi et al. 2010).

In addition to the formal evaluation of the programme, students in Iran (Islamic Republic of) have also completed studies on it, analysing the satisfaction and mental health of participants. Moradi et al. (2011) explored the relationship between quality of life dimensions and social participation among members of the clubs, finding a significant positive correlation between their participation and quality of life.

The most recent study, conducted by the Bureau of Municipal Social Studies in 2016, assessed participants' satisfaction with service delivery and the role of clubs in reinforcing social participation. The main findings include:

- 53.8 per cent of older people stated that they have accepted a lot of new responsibilities and roles as a result of their participation.
- 59.9 per cent of respondents reported improvements in their happiness and well-being as a result of their participation.
- 52.2 per cent of the respondents said that their living skills have increased significantly.
- 67.4 per cent of participants believed that their social interaction has been greatly strengthened as a result of their participation (Kasraei, 2016).

Beneficiaries noted that the wider impacts of the programme were related to their standing in society, with participation having improved their civic engagement and helped persuade society that older people were a valuable resource. In particular, one beneficiary has set up a charity to raise funds for older people and children as a result of her participation in the programme. Some interviewees also noted that the clubs may provide the opportunity for older people to set up small businesses, which would provide participants with additional income or help to finance other activities.

Some interviewees also noted that the long-term impact of the improved health of older people enrolled in the programme may improve the socioeconomic status of their families and wider society, in terms of creating cost savings by reducing demand for nursing homes and residential care, although there is no evidence to confirm this opinion.

Based on the learning from the above-cited studies, the municipality intends to make the case for country-wide roll-out of the Older People's Association, based on the participatory bottom-up approach adopted in Tehran, whereby older people are involved in the management and organisation of the programme.

Sustainability of the programme

The key success factor of the programme, which was mentioned by almost all of the interviewees, was the participatory bottom-up approach of the Older People's Association, which allowed them to remain relevant in responding to older people's needs. The reliance on the capabilities of members was considered as an important factor in the sustainability of the programme.

Nevertheless, interviewees also mentioned factors which may challenge the sustainability or further scale-up of the programme to include other cities. These included:

- The challenge of meeting the increasing demand for the programme without having a specific budget for activities.
- Lack of skills in managing group working in some districts was seen as a limiting factor, as were the challenges posed by an increasing skills gap between generations.
- Lack of unified strategic goals in the programme was seen as a challenge that may result in duplication of effort between different clubs.
- Bureaucratic limitations of Tehran Municipality and other government organisations was seen as a barrier to scale-up of activities.

Reflections on the CBSI

The experience of the Older People's Association in Iran (Islamic Republic of) raises some important themes relevant to the analysis of CBSIs.

The programme's reliance on members' capabilities presents a sustainable model which has the potential to be replicated in other cities across Iran (Islamic Republic of).

Through creating a model in which members are involved in all aspects of decision making around the management and running of the CBSI, the Older People's Association provides a sustainable model of a social innovation, as older people themselves are the main resource in the programme's day-to-day activities. With the support of local administrations in other cities, the model of a strong network of Older People's Association could be replicated, building on the experiences of the CBSI in Tehran.

The programme has successfully managed to enrol a large number of older people in the city, which may contribute to reductions in the social isolation of older people in Tehran, although members are primarily female.

The programme has managed to reach a significant number of older people in Tehran, despite the challenges reported in advertising the CBSI. Beneficiaries report that the programme has made a valued contribution to reducing social isolation for older people in their neighbourhoods, providing them with the opportunity to help each other and socialise on a regular basis. However, there is a significant imbalance in the gender of members, with older women making up 82 per cent of all participants. More research is needed to establish the reasons behind the unequal gender balance in the participation of the Older People's Association and understand what factors and activities may improve the participation of older men in the programme.

The participatory bottom-up approach of the programme has allowed members to be involved directly in civic activities to help improve the status of older people in their communities.

A factor in the success of the programme is its participatory bottom-up approach, which has allowed the clubs to remain relevant in responding to older people's needs. The model was considered as important for improving the self-confidence and independence of members. This in turn was perceived to improve their civic engagement and the status of older people in their communities, becoming health ambassadors for their families and communities.

The programme has pursued formal steps to encourage intergenerational activities, although the increasing divide between older and younger generations was seen as a challenge to programme sustainability.

While intergenerational activities were not a core component of the CBSI's activities, some were mentioned by members, such as sports events and IT classes. In addition to coordinating some activities, the programme has actively pursued collaborations with youth clubs in Tehran, signing an MoU to not only collaborate on activities but

share experiences, knowledge and resources for managing community events and courses. This presents an interesting model for other CBSIs, as there is benefit in conducting intergenerational activities not only in terms of knowledge transfer but because other community groups may have valuable experience in running similar activities. Some interviewees noted that the increasing divide between older and younger generations was a particular challenge to the sustainability of the programme, and promoting more activities that included older and younger generations was seen as beneficial.

Through its affiliation with Tehran Municipality, the programme has good linkages with other parts of the local health and social care system, although lack of oversight and coordination between services may cause duplication of effort and inefficiencies.

The establishment of the Older People Association by the local city authority, namely Tehran Municipality, was crucial for its integration into the broader health and social care system in the city and means that it has direct links to the Ministry of Health and welfare organisations, and representation at the national level on ageing-related policies and agendas. However, the large array of clubs within the neighbourhood health houses structure providing services to older people in Tehran, and the several local NGOs and charities, means that there are challenges in coordinating activities across all 354 neighbourhoods, and this may result in inefficiencies. It was felt that the Older People Association should look for more opportunities to pool resources and experiences with other clubs and NGOs working with older people to reduce the duplication of effort.

The programme has engaged in a number of monitoring and evaluation activities, which have allowed the programme to improve over time and make a case for itself at a national level.

The programme has a number of processes in place for monitoring its activities through feedback surveys with course participants and regular reporting to the municipality. The programme’s effectiveness has also been studied externally by academics in Iran (Islamic Republic of) and learning from the evaluations has been used to identify needs and improve services provided.

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World Health Organization

Centre for Health Development

Lebanon: University for Seniors

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Preface

The World Health Organization Centre for Health Development Kobe has contracted RAND Europe to serve as a research hub for conducting a systematic review and gathering of evidence of middle- and high-income countries' community-based social innovations (CBSIs) for healthy ageing. RAND Europe has undertaken two main strains of research consisting of: (1) a systematic review of CBSIs for healthy ageing in middle- and high-income countries and (2) a series of ten case studies of CBSIs for healthy ageing in middle-income countries.

This report presents the findings from one of our ten case studies, the University for Seniors in Lebanon.

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Summary of the community-based social innovation (CBSI)

Background

Lebanon

Locations
Beirut, Lebanon

Type of intervention
User-driven

Year established
2010

The intervention

Establishing the CBSI

- The University for Seniors (UfS) programme is a lifelong learning initiative run through the American University of Beirut (AUB). It was launched in the spring of 2010 on an experimental basis and then in full in 2011.
- The programme targets adults aged 50 years and over and aims to provide a lifelong learning experience for older people. Over time it has become increasingly framed as a public health intervention.
- The American University of Beirut provides facilities and 'moral support' to the programme. Funding to support a programme manager and administrator comes from membership fees and fundraising.
- The programme has three guiding principles that have underpinned its development: (1) peer learning; (2) community building; (3) intergenerational connections.
- All lectures are provided on a voluntary basis. The governance structure allows members to take an active role in planning the content of the programme.

Activities of the CBSI

- The only eligibility criterion is that members are over 50 years of age. Members typically come from the area surrounding the AUB campus in Beirut.
- Membership is USD 200 per term, with a discount when joining for two terms, or free for 'golden members' – members aged over 85 years having been members for six consecutive terms.
- The main activities of the CBSI include (1) lectures; (2) study groups; (3) book clubs; (4) cultural travel activities; and (5) social activities.
- Intergenerational connections are promoted on a formal (e.g. regular students taking study groups on IT) and informal basis (e.g. through interactions on campus).
- Lectures are not repeated from one term to the next and cover a diverse range of subjects. They typically include lectures on health and well-being delivered by physicians or nurses who volunteer to lecture on the programme.

Results and impact of the CBSI to date

- Membership has grown from 50 in 2010 to close to 300 per term in 2017. Most members are middle/upper middle class in background and are predominantly women (~85 per cent).
- Beneficiaries noted a range of benefits including increased self-esteem, confidence and happiness. The setting of the campus seemed significant, providing a tranquil environment and some escape from problems or divisions that may be more apparent outside of the University.
- Benefits were also noted for lecturers and younger students, who appreciated the challenge of teaching and interacting with the older people.
- The programme is responsive to feedback and collects this systematically.
- Evaluations of the wider impact of the programme are limited, although a range of stakeholders felt it could be contributing to changing attitudes towards older people.

Ageing in Lebanon

- Lebanon is an upper middle-income country with an ageing population.
- The percentage of the population aged 65 and over was 7.3 per cent in 2014 and is projected to reach 12 per cent in 2030 and 21 per cent in 2050.
- Other changes such as migration, increasing life expectancy and reduced fertility mean that traditional family support structures are changing.
- The Lebanese health system is fragmented. Insurance is often linked to employment and private schemes can be prohibitively expensive for older people.

Reflections on the CBSI

- The programme is sustainable in its current form but faces interesting questions about scaling up and replication.
- The programme is widely considered to be successful for the community it serves. This is a restricted population however and there is encouragement for the programme to expand in order to increase coverage.
- The programme draws on community and the spreading of knowledge through word-of-mouth, and further encourages community building through its activities.
- Intergenerational connections form one of the three guiding principles of the programme and are promoted in a more formal sense as part of the CBSI's activities and through more informal interactions on campus.
- There is no formal linkage with health or social care services, although there are examples of healthcare professionals recommending the programme to older people. NGOs are important providers of social care in the Lebanese context and play an important role in advocating for a positive ageing agenda.
- The programme has regular evaluation of course content and member experience. The course is receiving international attention and is a focus of postgraduate studies. There is an understanding of benefits for members but no systematic measurement of outcomes and limited evaluation of wider impacts.

Aims of the research

This report presents the findings from one of our ten case studies, the University for Seniors (UfS) in Lebanon. The overall aim of the research is to describe within a pool of rapidly ageing countries, and from those with high proportions of older people, a) the core roles, services and functioning (including feasibility of scale-up) of community-based social innovations (CBSIs) for healthy ageing that seek to support older people becoming a resource for their own health and well-being; b) their linkages with and sustainable partnerships to deliver health services, strengthen social systems; and c) the nature of enabling policies, programmes, financing and interactions with the health/social care delivery system.

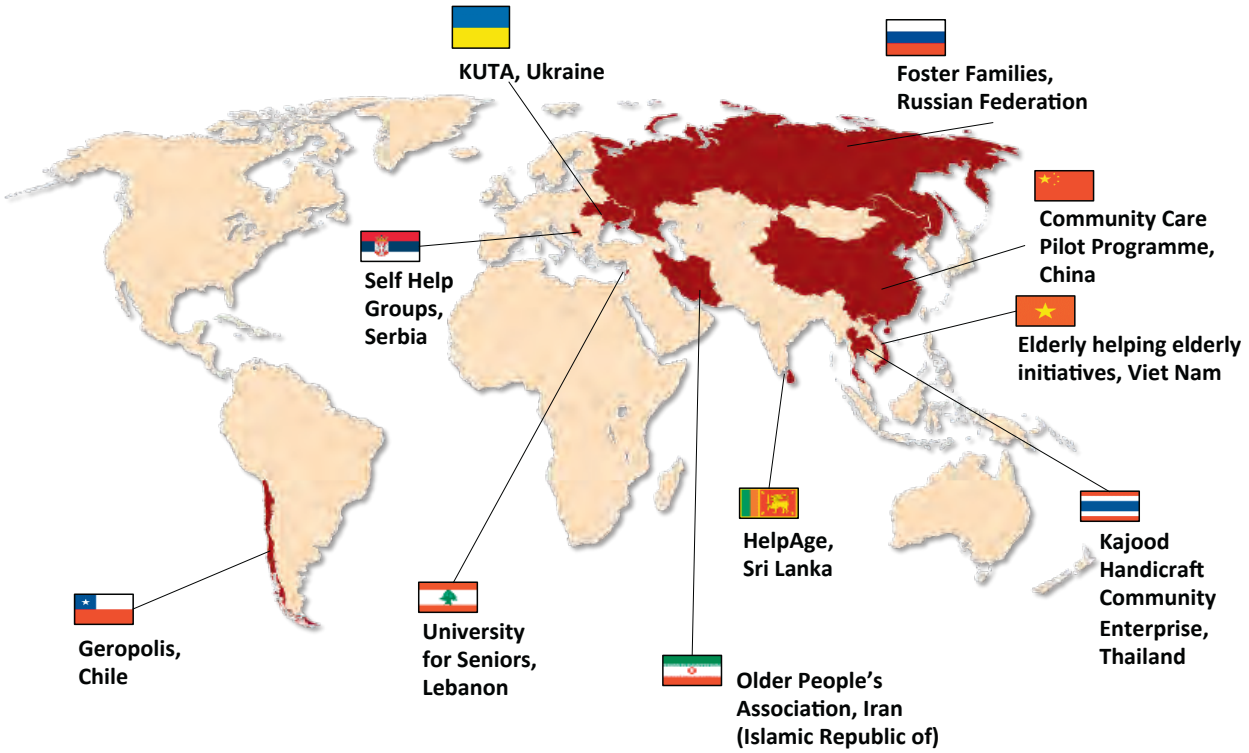
A recent WHO study (2016) conceptualised CBSIs as initiatives that seek to empower older people to improve their self-efficacy in caring for themselves and their peers, maintain their well-being and promote social cohesion and inclusiveness. They can also help older people to access, understand and navigate health and social care systems (Ong et al. 2016).

While CBSIs may hold the potential to transform health and social care provision for older people, more evidence is needed to improve our understanding of what types of initiatives and service delivery models are pursued in practice that engage communities and span a spectrum of health and social services.

Aiming to develop a typology of CBSI, this research consisted of three main parts: (i) a systematic review of CBSIs for healthy ageing in upper middle- and high-income countries; (ii) a series of ten case studies to examine the effectiveness of ongoing CBSI interventions in middle-income countries; and (iii) an expert consultation at the World Health Organization's Centre for Health Development (WHO-WKC) in Kobe, Japan, to validate and refine the typology.

Given the relative lack of evidence on CBSIs in middle-income countries in academic literature, the ten case studies were identified through an open call for Expressions of Interest (EOIs). Figure 1 below shows the location of the ten case study countries.

Figure 1 Ten case study countries



The data gathered in this case study will serve to better conceptualise what a CBSI is and present typologies and functions of CBSIs for older populations.

Each individual case study will seek to explore:

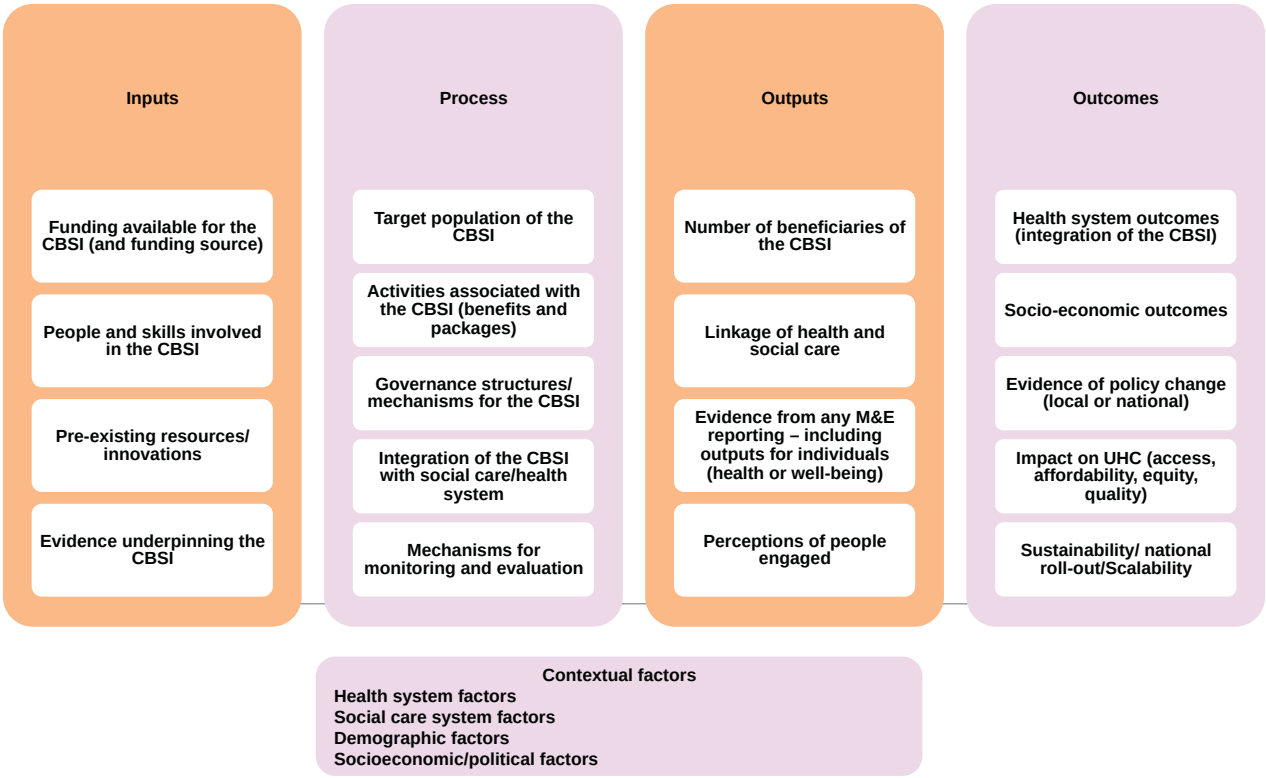
- The role and function of older people as resources for themselves and for others (peers, family, community).
- Health and social services delivered by those initiatives, and referral processes when they exist.
- Links made within these communities of support between health interventions and social health protection interventions (e.g. help with transportation, livelihoods, pensions, cash or in-kind transfers).
- Coordination mechanisms with formal health and social sector, including any formal connections with the health and social care system.
- Coordination and engagement with a variety of health/social-service workers and community-based services.
- Type of metrics (indicators, monitoring tools) implemented to assess impact on health[1] and the concept of health that is being measured.
- Measures to understand and respond to health inequities in the population served.

We have used a logic model approach to examine the effectiveness of selected CBSIs. This helps us assess the intervention logic for CBSIs and track the progress, impacts and evolutionary dynamics of CBSIs at core levels of analysis. As illustrated in Figure 2 below:

- **Inputs** will help us understand the resource environment of each CBSI, and provide a foundation for exploring the linkages between resources, outputs and impacts. This resource input environment is likely to capture aspects such as resources for implementation (funding, infrastructure and skills/capabilities). We will also aim to capture the reasoning and evidence base leading to the establishment of the CBSI.
- The **process** dimension will help us examine both the diversity of CBSIs, in terms of activities/services offered, population groups targeted and geographies projects covered, and mechanisms for designing, managing and evaluating the CBSI if present. We will also examine the integration of the CBSI within the wider health and social care services offered to older people.
- The **output** dimension will help us assess the relative progress of CBSIs since they have been established and capture the diversity of outputs and associated achievements. This will involve capturing outputs such as the number of beneficiaries involved in the CBSI and any initial health and well-being outputs for beneficiaries reported.
- The **outcomes** dimension will help us capture a wider range of benefits, including those relating to impact on resources for achieving universal health coverage (UHC), policy-level impacts and other (including unintended) consequences which may affect the health and well-being of older people in a particular country. In particular we will not only consider impacts at an individual-level (e.g. beneficiaries engaged in the CBSI) but also look to examine the impact on the wider community and the overall health/social care system.

1 We used the term ‘health’ very broadly at this stage in anticipation that it could incorporate physical and mental health and broader wellbeing. As the case studies were exploratory, we did not seek to further define or restrict at this stage as we were interested in understanding of the CBSIs themselves conceptualised and measured these types of outcomes, if at all.

Figure 2 Framework for gathering data on CBSIs and the contexts they operate in



- The **contextual factors** will guide us to consider the influence of both health and social care system factors and demographic, socioeconomic and political factors which may help or hinder progress of the CBSI. A greater understanding of the contextual factors underpinning the CBSI will also help to inform reflections on its transferability/ scalability by offering a rich understanding of the setting.

Structure of the case study

The next section of the report begins with a brief overview of the methodology used for the case study. The report then highlights some of the key contextual factors affecting the CBSI, related to the country's ageing population and its health and social care system.

The main section of the report focuses on how the four areas of the logic model (outlined in Figure 2) related to the CBSI, in the following four areas: (i) establishing the CBSI (inputs); (ii) activities of the CBSI (processes); (iii) results of the CBSI (outputs); and (iv) impact of the CBSI (outcomes). Within each sub-section the perspectives of interviewees are presented alongside findings from the desk review. Finally, the report concludes with some overall reflections on the CBSI and draws out key themes and experiences to better conceptualise CBSIs and their role and functions for older populations.

Methodology

Case studies have been used to collect descriptive data on CBSIs through a mix of methods including semi-structured interviews and a review of administrative data and documentation. Each case study follows the same design in order to provide in-depth understanding of each CBSI and allow comparisons to be made between different

actors within a single case, between cases, and between groups across cases taking into account relevant contextual factors. Key-informant interviews were conducted with key stakeholder groups involved in the CBSI, as well as with wider health and social care system actors.

Desk-based document review

Building on any documentation identified in consultation with the CBSI, the literature review draws on academic and grey literature to provide an overview of the health and social services delivered by the CBSI in Lebanon and the wider context in which these interventions are taking place. In addition, any available evaluative documentation was reviewed to collect evidence on the metrics, indicators and monitoring tools used to assess the effectiveness of the identified CBSIs. Key documents included journal articles and policy documents, such as commissioned discussion documents and government strategies. Academic literature was identified through PubMed, focusing on the years 2000 to the present. The literature search was conducted between August and September 2017.

Stakeholder interviews

In addition to the document review described above, key-informant interviews were also used as a key means of gaining an insight into the ongoing activities of the CBSI, as well as the wider contextual factors affecting its functioning in Lebanon. The interviews followed a common topic guide, with the main topics discussed including: resources that support the CBSI, engagement with older people and functioning of the CBSI, outputs and linkages with the health and social care systems and impact of the CBSI. Emphasis, however, was placed on allowing participants to talk from their own perspective.

In order to explore different perceptions of impact associated with the CBSI, and to identify any linkages and interactions between stakeholders, the project team in coordination with the CBSI staff identified suitable interviewees from three major stakeholder groups (as outlined in Table 1 below). A total of 12 interviews with 13 participants were conducted in Lebanon between 20 and 28 August 2017.

Written consent to participate was obtained from all participants after sharing information about the project. Interviews were conducted face-to-face in Beirut where possible (n=8) and otherwise via Skype (n=4). The interviews typically lasted between 30 and 60 minutes and were semi-structured in style, to enable participants to raise concerns that may not have been anticipated by the research team or were specific to the practice; this provided a flexible approach which allowed respondents to offer their own perspective and raise issues most salient to them, while covering the same topic areas in each interview. Interviews were audio-recorded with permission.

The interview data was analysed and coded by the project team, and then grouped into the categories and sub-categories outlined in the logic model. In analysing the categories, the team also identified emerging themes, which are presented at the end of this report.

Overview of the context in Lebanon

Lebanon is a middle-income country with an estimated population of just over six million people (World Bank 2017a). The country has the fastest-ageing population in the Arab region (Abdulrahim et al. 2015). This ageing of the population has been accompanied by periods of instability and civil war, significant out-migration, decreasing fertility rate and significant incoming refugee populations, which have contributed to social change in Lebanon and an inadequate ability of the health and social care system to support a healthy-ageing agenda.

Table 1 Overview of the interviewees

Stakeholder group	Profile of the interviewees
Beneficiaries of the programme	Five interviews with members of the UfS programme: • 62-year-old female, member for nine terms, very active member and volunteers at the office and on trips. Retired. Cancer survivor. • 68-year-old female, member for two terms. Never worked. Husband has advanced Parkinson's disease and she has no children. • 89-year-old male, member for three terms, very active member participating in trips as well as courses. Retired, spent much of working life abroad. • 59-year-old female, member for four terms. Returned to Lebanon after living in the United Kingdom. She is in good health but attends with her mother who is a member and has significant health problems. • 80-year-old male, member for six terms. Retired, spent working life in the United States. Cancer survivor and history of heart attacks.
CBSI management and voluntary lecturers*	One interview with the co-founder and current manager of the UfS programme. One interview with a lecturer on the UfS programme.
Policymakers, academia and civil society	There were five interviews with this group of stakeholders. One interview was with a representative of the Ministry of Social Affairs at a national level, and four further interviews were with participants bringing expertise on ageing from different perspectives: • Expert and activist on ageing, academic and consultant to the Ministry of Public Health. • HelpAge International representative. • Expert on ageing with knowledge of government and non-government responses. • Geriatrician (one of 15 in the country). All of the stakeholders had some familiarity with the programme. Three were employees of AUB, although they held wider roles with respect to ageing too.

*There are a limited number of 'staff' associated with the programme – one manager and one administrator. Lectures are provided on a voluntary basis.

Demographic factors

Statistics and data concerning population structure have been somewhat unreliable for Lebanon over time, and reliant on indirect estimates, because of significant periods of turmoil in the country and the lack of vital registration systems (Sibai et al. 2004). Analysis of trends in the Arab region published in 2014 (Sibai et al. 2014) showed that 7.3 per cent of the population in Lebanon are aged 65 or over, which was projected to increase to 12 per cent in 2030 and 21 per cent in 2050. In the same period it was projected that the proportion of those aged over 80 will increase from 1.1 to 4.6 per cent of the population.

Patterns of migration (out, in and return) are important to understand in the context of Lebanon because of the implications on care and support structures for older people. Multigenerational living has been the norm in Lebanon. Older generations rely on financial and social support of younger generations, particularly given the lack of government support beyond retirement age. Lebanon has long

been marked by high rates of emigration and immigration. Out-migration is often of young skilled people, which brings benefits to older generations through remittances but results in a growing proportion of older people living alone. More than one in ten adults (12 per cent) over 65 live alone in Lebanon, with this proportion increasing for women (18 per cent) (Abdulrahim et al. 2015). This is compounded by so-called waves of 'return migration', whereby older adults return to Lebanon in retirement (Sibai et al. 2015). Lebanon has traditionally also been a place of immigration. The recent crisis in Syria has seen this exacerbated, with Lebanon taking in over one million refugees.

As in many countries, demographic trends have been accompanied by a transition from infectious to non-communicable diseases as the main burden of ill health and cause of death in Lebanon. A national survey has shown that three-quarters of older people in Lebanon have at least one co-morbid condition and a quarter perceive their health status to be poor (Sibai et al. 2015). Hypertension, cardiac conditions, diabetes and musculoskeletal diseases are leading causes of ill health among those aged over 65. Obesity is also a growing problem, particularly for older women, as over half are classified as obese (BMI $\geq$ 30). Mental health problems such as depression and dementia are also a significant burden (Sibai et al. 2015). The rates of physical and mental health problems and physical disabilities are higher still among older refugees (Ibid.).

Overview of the Lebanese health system

The health system in Lebanon is fragmented, with many different actors. As a proportion of GDP, Lebanon spent 6.4 per cent on health in 2012. Public spending accounts for around half of all healthcare spending (World Bank 2017b). Of private expenditure, around 70 per cent is out-of-pocket (World Bank 2017c). Older people in Lebanon consume over 60 per cent of the country's health resources (Sibai et al. 2015) in a system that is characterised by high pharmaceutical spending and hospital use. Public healthcare services are organised under the Ministry of Public Health. Insurance schemes are typically linked to employment in Lebanon and many older people are left vulnerable, with around 70 per cent having no health insurance (Sibai et al. 2016). Access to private health insurance after retirement is expensive and restrictive, for example, due to pre-existing conditions, while public insurance is considered inadequate and fragmented. Certain groups, such as women and the self-employed, or workers in the informal sector, are disadvantaged through public schemes. Primary healthcare centres are in place to cater for low-income poorer people, but in general great concern was raised by participants in our research that the current system was not able to meet the needs of older people, with the exception of those able to pay out-of-pocket. As such, the system is characterised by inequalities.

In terms of human resources, the number of geriatricians in Lebanon has been increasing but there are still only 15 to cover the whole of the country. This is equivalent to around 1 geriatrician per 20,000 people aged over 60 (Sibai et al. 2015). There are also a growing number of nurses and allied healthcare professionals specialising in geriatrics but most have to go abroad for training. One geriatrician we spoke to said that the priority was as much about ensuring other specialists and generalists are trained in the care of older people as about growing geriatrics as a specialism, and that interdisciplinary care was key in the development of models of care. The model of healthcare in Lebanon is perceived to be focused on curative models, which does not necessarily fit with the needs of older people (Sibai et al. 2015).

Overview of the Lebanese social care system

Social care and policies for older people fall under the remit of the Ministry for Social Affairs. Lebanon does not have a universal old-age pension and citizens who work in the public

sector lose rights to the National Social Security Fund (NSSF) on retirement. Private-sector workers typically receive a lump sum upon retirement and no ongoing pension (Abdulrahim et al. 2015). Older people are thus often reliant on family, but, as mentioned, the number living with family is decreasing. The presence of an active private sector in health and social care has meant that there has been an increase in the number of nursing homes, but culturally nursing homes are seen as a last resort for families. As such there have been calls for improved models of support to be provided for older people in-home. Higher-income families are increasingly drawing on the relatively low-cost labour of immigrants from Asia. Over 100 NGOs also provide outpatient nursing-home services for older people in the community, but there are no coordinated models of care (Abdulrahim et al. 2015; Sibai et al. 2015). Examples in Lebanon may include meals-on-wheels provision to older people as part of a commitment to 'Ageing in Place' policies (Sibai et al. 2014). The Ministry for Social Affairs provides day centres, primarily in more deprived or remote areas of Lebanon. More broadly, a review of policies on ageing across different countries has shown that the Ministry of Social Affairs has initiated policies around disability, neglect and abuse and literacy and education for older people, but is still at the planning stage in respect to other areas, including promoting a positive image of ageing and housing (Sibai et al. 2014). There has been criticism of the weak policy environment with respect to the ageing population in Lebanon but there is a sense that this may be changing, partly through the work and advocacy of NGOs.

Overview of the CBSI

Establishing the CBSI (Inputs)

Establishing the CBSI

The University for Seniors (UfS) programme is a lifelong learning initiative run through the American University of Beirut (AUB). It was launched in the spring of 2010 on an experimental basis and then in full in 2011. The programme targets adults aged 50 years and over and aims to provide a lifelong learning experience for older people. It offers lectures, study groups, cultural travel opportunities and social cultural activities to its members.

It is based somewhat on international models such as the University of the Third Age; however, as the co-founders explained, it is designed specifically for the Beirut context and the needs of older people in the community surrounding AUB. The idea for the programme came in 2008 as part of a wider AUB neighbourhood initiative. A survey as part of this initiative had shown that a high proportion of older people in the area surrounding AUB were lonely but physically able and looking for something in life, having finished their previous roles in a work or family context. The two co-founders, Professor Cynthia Myntti and Professor Abla Sibai (both from the Faculty of Health Science, AUB), are experts in ageing and health and were aware of international programmes in these areas; they were keen to see if a lifelong learning programme might work in the context of AUB. A further feasibility study, including a survey of AUB alumni aged 50 and over and focus group discussions with wider stakeholders, explored what potential members would want from such a programme and how much they would be willing to pay for it. Professors Myntti and Sibai also had the opportunity to visit similar programmes in the United States to learn what may or may not be applicable and appropriate for the context of Lebanon. The programme, according to case study participants, was not conceived as a public health intervention at the outset but rather as an outreach programme that could bring older people out of their loneliness. With time though the programme has been increasingly framed as a public health programme with the potential to impact on physical, mental and social well-being.

Aims and objectives of the initiative

The overall aim of the UfS is to 'create a new and positive face of ageing in Beirut, Lebanon and the Middle East Region', promoting a

context where older adults 'remain intellectually and socially engaged, energised to learn new things, and active contributors to their communities' (University for Seniors 2017a).

The programme has three guiding principles:

- **Peer learning**: Participants share what they know and learn from each other. There are no paid teachers. Seniors with a passion and expertise for a certain subject volunteer to facilitate a study group or give a lecture.
- **Community building**: The UfS adopts a membership concept whereby one joins for a term rather than enrols in a specific course. This reinforces the idea that members are part of the community of the UfS. Social events are also organised during the terms to strengthen this principle.
- **Intergenerational connections**: Seniors are connected to the regular AUB student body. These intergenerational connections are created through multiple academic and extra-curricular activities on and off campus.

There was evidence from the interviews that these were actively implemented in decision making around the course. For example, in the rare case where lecturers (volunteers from within or outside of AUB) challenged the lack of payment, the management had made an explicit decision to maintain the principle of peer learning and not to make any exception. Stakeholders and beneficiaries reported that the principle of older people facilitating study or giving lectures had not been applied as much as had been intended at outset. One member who had been asked to give a lecture reported that he had declined because he did not want to stand out from fellow members by claiming particular expertise in a subject. The intergenerational connections were reported to be an important part of the programme and are discussed further below.

Funding for the CBSI

The UfS was supported in the initial stage through money from the aforementioned AUB neighbourhood initiative, which enabled some part-time support to organise the programme. This was somewhat limited, however, and the co-founders devoted a lot of time to the programme. There was no revenue generated from membership fees during the experimental phase. In moving to launch the programme in full form, funds were raised from AUB Trustees and 'friends' of the programme who could see the value of it. This funding supported the appointment of a programme manager and full-time administrator. AUB supports the programme on an ongoing basis through provision of space and estates costs. The UfS is an independent programme of the Continuing Education Centre (CEC) at AUB. The Director of the CEC is a member of the steering committee for the UfS, but otherwise the UfS management reported that this positioning within the University afforded them significant autonomy; they were able to foster the support of key departments and centres within the University, such as the Centre for Studies on Ageing, without being beholden to them. There was a sense of a trade-off between freedom and financial instability. Importantly, participants reported that AUB had strengthened its 'moral support' for the programme, even if this did not come with increased financial support. This had been demonstrated recently when the AUB President highlighted the UfS in his fortnightly communication to the AUB community (University for Seniors 2017b).

The costs of running the programme, primarily the salaries of the UfS manager and administrator, are partly covered on an ongoing basis through the fees paid by members. A limited amount is raised through small fundraising activities which also serve as promotional opportunities for the programme. Membership fees are currently USD 200 per term (half academic year) with a USD 50 discount if members join for two terms at once or couples join together. A free 'golden membership' is also awarded for life to those members of 85 years of age and over who have been members for six consecutive terms.

Members can join as many activities as they want as part of membership. There are no limits to the number of members attending lectures but numbers are limited for the study groups, requiring members to sign up in advance. Members spoke of the need to register quickly for these as demand was high. In addition to the UfS programme, members require an AUB ID card (valid for one year at the cost of LL 10,000 – approx. USD 6) which gives them access to the AUB campus and library, discounted rates on campus cafés and access to other facilities such as the university gym, pool and beach.

The UfS management explained that at the outset of the programme they had been hopeful of securing more substantial funding through philanthropists or endowments and that this would offer the programme more security. On reflection, the UfS management felt that it may have been hard for potential donors to see the value of the programme at that time, particularly as it was not targeting what would be perceived as a typically needy community. Convincing donors to give money towards a primary prevention programme in public health to support a healthy population is challenging. The management interviewees reported however that they felt they would now have a much stronger case to make as the programme had shown its value. It was anticipated that this approach would be returned to as a strategy in about a year's time.[2]

Other initiatives in the region

In general, the UfS was reported by stakeholders and beneficiaries to offer something unique in Lebanon. There were examples of other university programmes catering to older people but these were reported to be more academic in focus by some, more expensive to access, and focused on particular courses rather than membership of a wider programme with cultural activities. It was reported too that other programmes did not have the same focus on community building.

In the broader context in Beirut there was felt to be a lack of opportunities for older people and a lack of understanding of older people as active and productive members of society. Government provision was reportedly mainly through day clubs for older people run by the Ministry of Social Affairs. These provide recreational activities for older people and are primarily focused on poorer and more remote neighbourhoods. Stakeholders working with older people more broadly in the city and in the country at large did feel that there were some other isolated examples of social engagement programmes for older people. They highlighted that currently there was a lack of coordination between such programmes, one participant referring to a tendency of each to be protective of its own initiative. The beneficiaries we spoke to did not perceive that other similar opportunities existed for them and certainly not in that area of Beirut; this was important, as travelling in the city is very challenging with poor infrastructure and heavy congestion.

Activities of the CBSI (Process)

Target population and eligibility criteria

The target population for the UfS is people aged over 50 years. This age was chosen as consistent with a lifelong learning ethos and the idea that healthy ageing starts at a young age. There are no other eligibility criteria. Members tend to be drawn from areas close to AUB, although some members reported travelling further in order to attend and the number doing so was reported to be increasing.

The main way that members tended to hear about the programme was through word of mouth and all beneficiaries we spoke to reported

2 At the time of the case study (August 2017) the UfS programme manager was about to go on study leave for 12 months to pursue a postgraduate qualification in relation to ageing. As such some decisions about the direction of the programme were reportedly on hold until her return.

that they had recommended it to others. The UfS spoke of referrals coming from doctors and healthcare professionals, and one geriatrician with AUB said it was one thing he told many of his patients about in clinical settings as social engagement was very important for them.

The UfS management also reported that word of mouth was commonly the way that people learn about the programme, although advertising through other means had increased recently and the programme has an online and social media presence. The UfS manager reported undertaking an average of 15 media interviews a year and that there were nearly a quarter of a million Facebook interactions in 2016. A more innovative means of promotion and increasing memberships was a programme of gift vouchers redeemable for a term of membership (Figure 3).

Beneficiaries' motivations for being involved were variable. For some the programme filled a gap in life following the cessation of another role, such as employment or a caring role in the family. For one beneficiary it was something she could do for herself while maintaining her role as a carer for her husband, who had advanced Parkinson's disease. For some it offered an opportunity to attend university which they had not had before, or specifically to attend AUB, which they may not have been able to do in earlier stages of life because circumstances took them overseas. Three of the beneficiaries had returned to Lebanon after extended periods abroad and the UfS was part of building a life again in Beirut. One member attended with her mother and saw the UfS very much as an active part of her mother's rehabilitation following significant medical treatment. The extent to which members reported being driven by the social or educational opportunities offered through the programme varied, but all were motivated by a mixture of the two.

Figure 3 Gift voucher promoting the UfS as beneficial for mind and spirit

Activities associated with the CBSI

The UfS offers a range of activities to members:

- **Lectures** – covering a wide range of topics under education, psychology, politics, heritage, literature, arts, music and health and well-being.
- **Study groups** – each covering a specific topic where members meet once or more per week for four to six weeks. A broad range of topics have been covered. Examples from autumn 2017 include French, mastering the art of public speaking, online shopping and an introduction to the iPad. Mini study groups are also offered on the same principle but for fewer weeks.
- **Book clubs** – held for English and Arabic books.
- **Special interest groups** – focused around non-academic subjects, for example, yoga and food.
- **Educational travel programmes** – to visit historical and cultural sites of interest in Lebanon and abroad.
- **Social and cultural activities** – held once or twice a term and out of term-time to foster community building.

With the exception of some lectures that may be open to the public, these activities are restricted to members only. Members are also actively encouraged to suggest further activities; some reported for example that they arrange their own social gatherings. Most of the programme is delivered in English but up to around a third is in Arabic, in part following feedback from

Figure 4 A cultural travel programme at the UfS

beneficiaries expressing a desire to make the programme more inclusive.

To give an indication of the number of activities, in the spring term of 2017 58 lectures, 13 study groups, four trips within Lebanon and one international trip (a 14-day trip to Italy) were offered to 286 members.

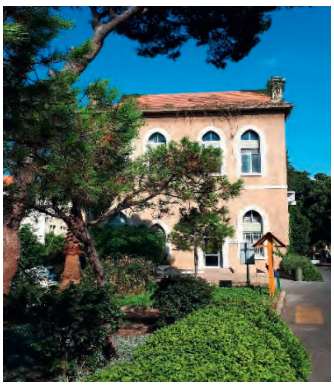
All of the lectures, study groups and cultural programmes are provided on a voluntary basis and there is no repetition of topics from one term to the next. This means that the programme has to maintain a bank of volunteers that it can call on.

Health and well-being is included as a topic area within lectures and healthcare professionals were reportedly keen to volunteer for these. Physicians and nurses who had themselves been graduates of AUB saw it as a way of giving back. Beneficiaries reported that these could be particularly interesting lectures, highlighting topics such as exercise for older people and continence which had been of value. Beneficiaries varied however in terms of how important they saw these lectures as part of the overall programme. One member reported that her behaviour had definitely changed as a result and that understanding these topics could have important consequences for different generations within her family; but others were more indifferent.

Members can choose how many lectures they want to attend and beneficiaries varied in how they selected them. Some chose to attend routinely, even daily, irrespective of the topic, because of the routine and social interaction that this provided and also because they could be surprised about which topics were of interest. Others were more selective about the lectures that they attended. Members spoke highly about the study groups, book clubs and cultural programmes in allowing more sustained or alternative opportunities to study a topic. It was appreciated that the programme provided entirely new lectures each year but for some there was a sense that it would be good to explore topics in more depth rather than as a one-off.

The UfS also enabled members to access the AUB campus which was significant for all of the beneficiaries. AUB represented a relatively tranquil and green setting (see Figure 5) in an otherwise very urban, noisy and congested

Figure 5 The AUB campus



environment. Beyond this, beneficiaries reported that it provided a space and environment that was inclusive rather than divisive and as such contrasted to the wider social and political environment in the country. Members spoke of an environment where it did not matter what religion or background you were from, and welcomed this. The campus also enabled interaction with younger students, which is explored below as part of the intergenerational aspects of the programme.

Intergenerational activities associated with the CBSI

Intergenerational connections form one of the guiding principles underpinning the UfS and were achieved through different means involving a variety of generations. The age eligibility criteria for the UfS mean that intergenerational connections can emerge within the membership group. Two of the beneficiaries we spoke to also had a parent or a child who had attended the programme. For one beneficiary, supporting her elderly mother to attend was an attraction of the programme, as both could gain from it. Further intergenerational connections were promoted between younger, standard AUB students and members of the UfS. This was achieved through informal and more formal means:

- **Formal** attempts within the programme to promote intergenerational activities include standard AUB students running study groups, often around IT issues. The programme had also introduced ‘senior to senior’ interviewing schemes, where senior-year undergraduate AUB students have mock interviews with members of the UfS. This was reportedly welcomed by both groups. Many of the UfS members have held senior positions during their professional life and therefore it was a good opportunity for students to benefit from their experience and make important contacts. The UfS members were reported to find the experience similarly stimulating.
- **Informal** means of making connections are also available on campus. Beneficiaries spoke of having the opportunity to speak to younger students as part of being on campus or joining them in the canteen. The extent to which members did interact with standard AUB students varied but those who did reported benefits or being inspired by the work younger students were doing and hoping that they might have in return have benefited from hearing about their experiences, and formed a different view of older people.

Governance and management of the CBSI

As mentioned, the UfS is an independent programme of AUB’s Continuing Education Centre (CEC). The following governance structures are in place:

- **Steering committee** – composed of the CEC’s Director and two AUB faculty, founders of the programme. The committee has responsibility for overseeing daily operations of the project and its strategic development. On a day-to-day basis this work is implemented by the UfS manager, who is supported by an administrator. Where needed, the manager can refer to other members of the steering group and generally issues are resolved very quickly, with meetings convened for more significant issues.
- **Curriculum committee** – this committee has active involvement of members and has the following remit:
  - Plans, organises and schedules the terms.
  - Ensures a balance in variety of offerings.
  - Actively reaches out to prospective leaders and lecturers and encourages them to submit a proposal.
  - Works with the UfS programme manager in monitoring the implementation and evaluation of the term’s programme as well as monitoring any complaints that may arise in classes and the required problem solving.

  - Offers intellectual and practical support to study group leaders and lecturers, as requested.

  One of the beneficiaries we spoke to had been an active member of the curriculum committee, a role she had welcomed as it enabled her to draw on skills she had developed in her professional life.

- **Social committee** – is focused around the guiding principle of community building and works to help foster a community spirit among members through organising events and social functions. Specifically, the committee:
  - Prepares the quarterly calendar of functions/events/off-term trips
  - Plans and coordinates approved functions/events/off-term trips.
- **Institutional committee** – has responsibility to develop and maintain the by-laws and procedures for the programme. The committee has overseen the development of by-laws, policies and a handbook of procedures and now has responsibility for reviewing these every two years. The UfS management reported that the systems and processes for the programme are now very well developed, so that the programme runs very systematically.

In relation to the day-to-day management of the programme, stakeholders and members were consistent in their high praise of the manager and administrator. They argued that the commitment of these staff and the personal attention to members and lecturers was very important. They were reported to be available at all times and one member of the UfS organisation was present at every lecture or event to ensure it ran smoothly and to receive feedback. Examples were given of the programme ensuring that the needs of individual members were met, for example, in helping with accessibility for members with poor mobility. The close relationship between some members and the management was observed during the research: members would frequently call into the office even though it was out of term time.

Results of the CBSI (Outputs)

Enrolment of older people

Membership has grown from 50 in 2010 to 286 in spring 2017. Table 2 gives a breakdown of members' characteristics in terms of age and gender for the last two completed terms.

This breakdown shows that the majority of members are women. In exploring why this was the case, participants offered several possible explanations:

- At the younger end of the spectrum, women may be less likely to be in employment and therefore more able to attend.
- Women may have been more likely to have missed out on a university education and the UfS offers a way of fulfilling this dream.
- Women may be more likely to be looking to fill a gap in social or family life, for example, if children have grown up or moved away.

Table 2 Characteristics of members by age and gender (fall 2016 and spring 2017)

	Gender n (%)		Age n (%)			
	Female	Male	50–59	60–69	70–79	80+
Fall 2016 (n=289)	246 (85)	43 (25)	90 (31)	112 (39)	75 (26)	12 (4)
Spring 2017 (n=286)	240 (84)	46 (16)	81 (28)	110 (39)	77 (27)	18 (6)

- Women tend to be more social than men and more likely to seek opportunity.

The gender balance was not expressed as a problem by participants, with some thinking that the proportion of men may increase gradually over time. One male beneficiary commented that it did create a particular environment within lectures and small groups, and that groups of women were somewhat dominant but not enough to put him off.

Around three-quarters of members registering in these terms had been members previously. Approximately half of members registering in spring 2017 had been members for two or more terms.

Data on socioeconomic status of members is not collected as part of enrolment on the programme but all participants reported in interviews that members are typically of higher socioeconomic status and well educated, which is reflective of the community in which AUB is situated. As such there was a feeling that the UfS served a restricted population very well but that similar opportunities were not yet available to older people outside of this socioeconomic and geographical grouping. Within the membership it was reported that there was diversity in other characteristics such as religion and nationality.

Self-reported health gains among beneficiaries

The UfS members we spoke to were overwhelmingly positive about the programme. Although this may be a bias in the people we spoke to, their enthusiasm for it was palpable during conversations.

The benefits to health and well-being were most often expressed in terms of social or psychosocial benefits, including self-esteem, confidence and enjoyment, and educational benefits. Phrases such as ‘I can’t tell you how alive it makes me feel. It gives me life’ and ‘I can’t tell you how much I have enjoyed it, it has really helped me a lot’ were used by members. One member said that it has specifically helped

Figure 6 IT classes at the UfS

in her mother’s rehabilitation after illness and treatment, both through giving her something to look forward to and because the setting provided an environment where she could safely build up her ability to walk again. There was a sense that mental well-being was improved among members, through the social interaction experienced and through the skills and knowledge gained through the programme. A few members we spoke to referred also to a sense of belonging or peace brought by the programme, in contrast to life elsewhere in Lebanon: ‘It makes me think we are one’, one member said. Those involved in the UfS management felt that as a form of primary prevention, the programme brought older people out of their loneliness and led to improved physical, mental and social well-being.

It was hoped that indirect health benefits would be gained through lectures about health and well-being, but although these were enjoyed by members there were mixed views as to whether they made a difference, for example, to health behaviours. One member said that it did make a difference in terms of the exercise she was doing. Other members and wider stakeholders felt that sufficient sources of information about health and well-being were available elsewhere and that this was not really a main benefit or should not necessarily be a main focus of the UfS programme.

A further benefit that was reported was that experienced by lecturers and those involved in delivering the programme. The enjoyment and benefit that lecturers experienced was relayed through the UfS management and evidenced by lecturers volunteering repeatedly and the size of the pool of over 400 volunteers. The management reported that teaching on the programme presented a fresh challenge for lecturers. One lecturer we spoke to was also an AUB lecturer but spoke of the freedom in being able to teach topics outside the normal areas and the fresh challenge of preparing for and being able to engage an older audience. He also enjoyed the opportunities to attend social events as part of life at the UfS. It was a considerable time commitment for him but he felt that the benefits justified this.

The UfS programme has a system of evaluation relating to the programme organisation and content, but does not currently have one related to outcomes for members. This was felt by some stakeholders to be an important next step in order to inform how the programme could be expanded. The programme has been receiving increasing external interest and is currently the subject of research being undertaken by two Master's students from European universities, which may enrich understanding of outcomes for older people. However, no information is currently collected on enrolment, so any study would need to be retrospective in design. In terms of monitoring implementation, written and verbal feedback is sought on every lecture. Members reported that they felt free to make suggestions at any stage and that feedback was actively sought and acted on.

Linkages to health and social care system

There is no formal linkage between the UfS and the health and social care system. There were examples of physicians recommending the programme to members but this was based on their personal knowledge of the programme rather than any formal or systematic referral effort.

There were no formal links to the social care system, which is largely lacking for pension-aged people in Lebanon, but stakeholders who had knowledge of the programme felt that there was some potential to increase the reach of the UfS by, for example, linking into day-care centres run by the Ministry of Social Affairs. It was generally considered that there was poor coordination between different types of services trying to meet the needs of older people.

Some participants raised concerns about linking more closely with the health and social care system, explaining that one of the attractions of the UfS was that it offered something that represented a choice and was not something that you 'should or must do'. Similarly, concern was expressed that linking it to health more explicitly may risk the UfS being perceived as a treatment rather than a form of primary prevention.

The UfS was well known among the wider stakeholders we spoke to, including among international NGOs and government.

Impact of the CBSI (Outcomes)

Wider impacts of the programme

Given the lack of data, it is difficult to assess the long-term impact of the UfS.

Members, management and wider stakeholders felt that the UfS had the potential to contribute to a more positive view of ageing within the community because of the interaction with younger students and staff on campus. As yet such contributions took place only within a restricted community, but it was felt that it was an important start to providing opportunities to older people. The programme was also receiving increasing media attention and prominence, which could help to affect attitudes more widely.

Some stakeholders mentioned that the programme could have a greater role in advocacy for rights of older people, with members taking a lead on this. The programme

team were active and committed to working on ageing issues more generally in Lebanon and the wider region. It was not clear that members wished to pursue this commitment through the programme, although two members said that there was greater potential within the programme to cover social, political and economic issues facing the country.

Sustainability of the programme

The UfS has grown steadily since its inception and it was felt that it would be sustainable in its current form. The management spoke of a deliberate process of steady but sure growth through learning from experience and, with hindsight, reflected that perhaps the restriction on available resources had prevented them from trying to do too much too soon. There was evidence that the UfS was seen as a valued programme within AUB and a confidence that this would help its continuance.

It seemed though that the programme has reached a point where it must decide either to continue as it is or to expand. One participant spoke of the trajectory of the programme as being upward but now plateauing. A particular desire, especially for those outside the programme, was to extend the reach of the UfS to include a wider socioeconomic group and greater geographical areas. They saw that there would be benefit in doing this, even if only components of the programme could be outreached.

The management of the UfS reported that lots of ideas and potential options were open to them and that they were in part holding off until the programme manager returned from study leave to make decisions around the future direction(s) of the programme. Potential examples of growth included introducing satellite sites elsewhere in Lebanon or the region and making the programme available online to enable remote access. The latter option was met with some scepticism among current members and stakeholders, who commented that the programme had perhaps already restricted access through introducing online-only registration. The management expressed several dilemmas in terms of how to expand. For example, they would be keen to maintain AUB ownership and fidelity to the model but knew that local adaptation had been very important in developing the UfS to date. The participants we spoke to indicated somewhat mixed views in terms of whether they felt it was the responsibility of AUB and the UfS to extend access or whether it was for others to take the lead in other areas.

Reflections on the CBSI

The experience of the UfS programme raises some important themes relevant to the analysis of CBSIs.

The UfS is widely perceived as being successful and beneficial and faces interesting questions in terms of whether and how to scale up.

The UfS is very highly regarded by members and wider stakeholders involved in the care of older people or advocating for older people's rights at a policy level. There is an expectation that the UfS could and should extend its reach. It is less clear whether this is the responsibility of the programme or of AUB, which has a strong community focus but primarily relating to the community in one geographical area of Beirut. The stage of development that UfS is at raises interesting issues for similar CBSIs more broadly. Is there a responsibility for a private initiative to address equity and inclusion? Is it possible for programmes to be scaled up in a locally appropriate way while enabling the founding organisation to retain some ownership of the model? Social franchising may offer some solutions in terms of identifying what is important to replicate and recognising that a one-size-fits-all approach is unlikely to be appropriate for an intervention that has developed organically and in response to local conditions (Paren 2017).

The profile of participants is predominantly upper middle class and female.

The UfS fulfils its remit of providing a lifelong learning opportunity for older people in the surrounding and increasingly the greater Beirut community. There is no restriction on membership beyond age but the membership tends to be biased towards a middle-class and relatively educated population. The membership is predominantly female. This raises questions about the equity of this type of CBSI. Research elsewhere has also shown that members of University of the Third Age-type programmes tend to be more educated and intrinsically in better health than populations of non-members (Zielińska-Więczkowska et al. 2011). This needs to be borne in mind in terms of evaluating the health gains from such programmes, but also raises important questions as to the extent to which these types of CBSIs can include less healthy and relatively mobile older people of lower socioeconomic status. The gender imbalance in the programme also seems to fit with the experiences of University of the Third Age interventions in high-income countries. For example, Williamson (2000) notes that 'gender differences in U3A membership reflect a variety of issues centering on retirement interests, marital status, social group membership, and the feminization of U3A'.

Intergenerational connections form a guiding principle underpinning the UfS and have been achieved through different means involving a variety of generations.

The age eligibility criteria for the UfS mean that intergenerational connections can emerge within the membership group. Further intergenerational connections were promoted between younger, standard AUB students and members of the UfS through informal and more formal means. The intergenerational activities were seen as beneficial by the participants interviewed.

Coordination with other private or NGO initiatives should be considered in addition to linkages with the healthcare system.

In Lebanon the health and social care system is fragmented, particularly for older people for whom social security and employment-based health insurance ends with retirement. Despite this fragmentation there were indications of some informal linkage between UfS and the health system. The potential for more formal linkages(particularly with healthcare services external to AUB) may be limited by the capacity of the health system. Whether it is desirable for a model such as the UfS to link more formally with the health and social care system may be debatable, but, in light of the fragmentation within the system, it may be particularly important for CBSIs such as the UfS to ensure that they are coordinating across non-government and government actors.

CBSI has the potential to impact on health and well-being, even when health improvement is not a primary objective.

Although the UfS is now increasingly framed as a primary prevention public health intervention, it is an education-based programme that seeks to promote social interaction and lifelong learning for older people. Although there is not sufficient data available to demonstrate impact, it was evident speaking to the members that the programme improves well-being and social and psychological health. These findings have also been highlighted in other studies on Universities of the Third Age (Patterson et al. 2016) and are often given as a rationale for starting such a programme (University of Plymouth. N.d.). In considering expansion it may be important for the programme to be able to demonstrate such benefits, for example to secure further funding. Developing a low-burden mechanism for monitoring and evaluating CBSIs may help interventions such as the UfS to demonstrate associated health (physical and mental) health gains. The UfS is relatively well situated within AUB to access appropriate expertise to support such activities.

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World Health Organization

Centre for Health Development

Russian Federation: Foster families for older people in remote northern Russian territories

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Preface

The World Health Organization Centre for Health Development Kobe has contracted RAND Europe to serve as a research hub for conducting a systematic review and gathering evidence of middle- and high-income countries' community-based social innovations (CBSIs) for healthy ageing. RAND Europe has undertaken two main strands of research consisting of: (1) a systematic review of CBSIs for healthy ageing in middle- and high-income countries, and (2) a series of ten case studies of CBSIs for healthy ageing in middle-income countries.

This report presents the findings from one of our ten case studies, the foster families programme for older people in remote Russian territories.

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Summary of the community-based social innovation (CBSI)

Background

Russian Federation

Locations
Arkhangelsk, Russian Federation

Type of intervention
State-supported, Networked

Year established
2011 (Arkhangelsk region)

The intervention

Establishing the CBSI

- The foster families programme is a community intervention established across several regions from 2010, which pairs older people with adoptive foster families who are responsible for providing care to them
- The programme aims to provide older people with a better quality of life by offering social services in a home environment as opposed to residential facilities (e.g. nursing homes).
- The establishment of the foster family relies on a tripartite agreement between the foster family, the older person and the Complex Centre of Social Service (in each district of Arkhangelsk region) under the regional Ministry of Labour and Social Development.

Activities of the CBSI

- The only requirement for a person who wishes to become involved in the programme as a foster family organiser is (i) to be an adult legal citizen who resides in the Arkhangelsk region, and (ii) to commit themselves to living together with or in close proximity to an older adult in need of social services, and provide services in accordance with the foster family contract.
- A foster family organiser assists an older person in basic life tasks such as cooking and serving food, helping the person in maintaining daily hygiene, shopping, keeping appointments at medical centres and government agencies, etc.
- The Complex Centre of Social Service is in charge of monitoring compliance with the terms of the contract and paying the organiser remuneration in the form of a monthly salary of around RUB 5,000 (approximately USD 75).

Results and impact of the CBSI to date

- In total, since 2012, 148 foster families have been established in the region, mainly in remote rural areas.
- Benefits of the programme reported by the older people included the opportunity to continue living in a family environment, feeling less lonely or bored and increased opportunities for social interaction.
- Benefits of the programme reported by the foster families included companionship, mutual moral support, personal satisfaction from being of use to a peer, and support of intragenerational social cohesion.

Ageing in Russian Federation

- In 2015, the percentage of the Russian population aged 60 and over was 20.1 per cent and it is projected to reach 22.4 per cent by 2020.
- A low level of investments in the healthcare system from the central state since the fall of the Soviet Union has caused a general deterioration of the system's infrastructures and of the quality of care provided.
- The former social care system is formally still working although in practice, due to chronic underfunding, informal payments and personal connections are often necessary to access supposedly free services. Provision of services significantly varies between urban and rural areas.

Reflections on the CBSI

- The programme could represent a more cost-effective way of providing care to older persons than residential care, although more research is needed to establish value for money and cost-effectiveness.
- The elderly beneficiaries and the foster families can become resources for one another through mutual moral support and the personal satisfaction that one gains from being of use to peers.
- The implementation and sustainability of a programme such as the foster families is dependent on a very good understanding of the social and cultural country context. This requires a particular attention due to the intimacy of the family structures involved in the programme.
- The programme has direct health benefits in regard to reduced social isolation and loneliness in rural areas and increased access to social care services.
- The programme is directly connected to the Russian social care services through direct funding and monitoring activities, although there are no formal linkages to the health system.
- The programme has experienced difficulties in finding comprehensive monitoring and evaluation metrics.

Aims of the research

This report presents the findings from one of our ten case studies, the foster families for older people programme in remote Russian territories. The overall aim of the research is to describe within a pool of rapidly ageing countries, and from those with high proportions of older people, a) the core roles, services and functioning (including feasibility of scale-up) of community-based social innovations (CBSI) for healthy ageing that seek to support older people becoming a resource for their own health and well-being; b) their linkages with and sustainable partnerships to deliver health services, strengthen social systems; and, c) the nature of enabling policies, programmes, financing and interactions with the health/social care delivery system.

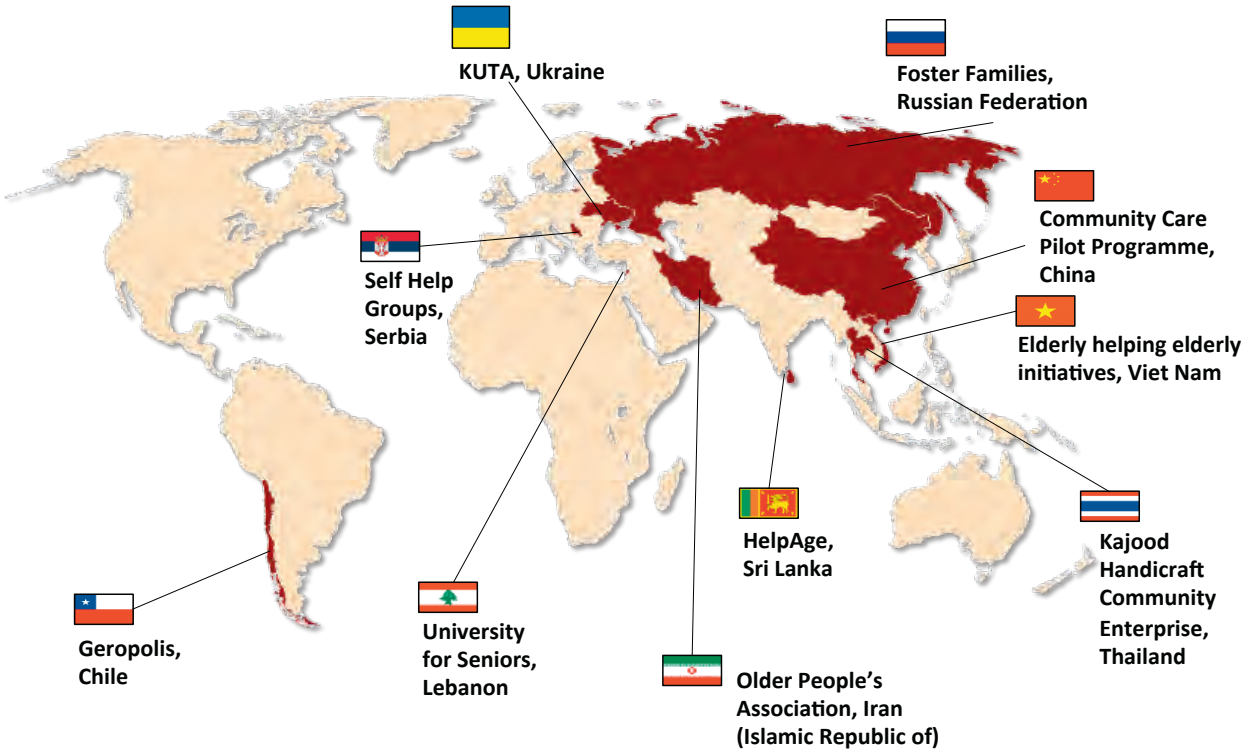
A recent WHO study conceptualised CBSIs as initiatives that seek to empower older people to improve their self-efficacy in caring for themselves and their peers, maintain their well-being and promote social cohesion and inclusiveness. They can also help older people to access, understand and navigate health and social care systems (Ong et al. 2016).

While CBSIs may hold the potential to transform health and social care provision for older people, more evidence is needed to improve our understanding of what types of initiatives and service delivery models are pursued in practice that engage communities and span a spectrum of health and social services.

Aiming to develop a typology of CBSIs, this research consisted of three main parts: (i) a systematic review of CBSIs for healthy ageing in upper middle- and high-income countries; (ii) a series of ten case studies to examine the effectiveness of ongoing CBSI interventions in middle-income countries; and (iii) an expert consultation at the World Health Organization's Centre for Health Development (WHO-WKC) in Kobe, Japan, to validate and refine the typology.

Given the relative lack of evidence on CBSIs in middle-income countries in academic literature, the ten case studies were identified through an open call for Expressions of Interest (EOIs). Figure 1 below shows the location of the ten case study countries.

Figure 1 Ten case study countries



The data gathered in this case study will serve to better conceptualise what a CBSI is and to present typologies and functions of CBSIs for older populations.

Each individual case study will seek to explore:

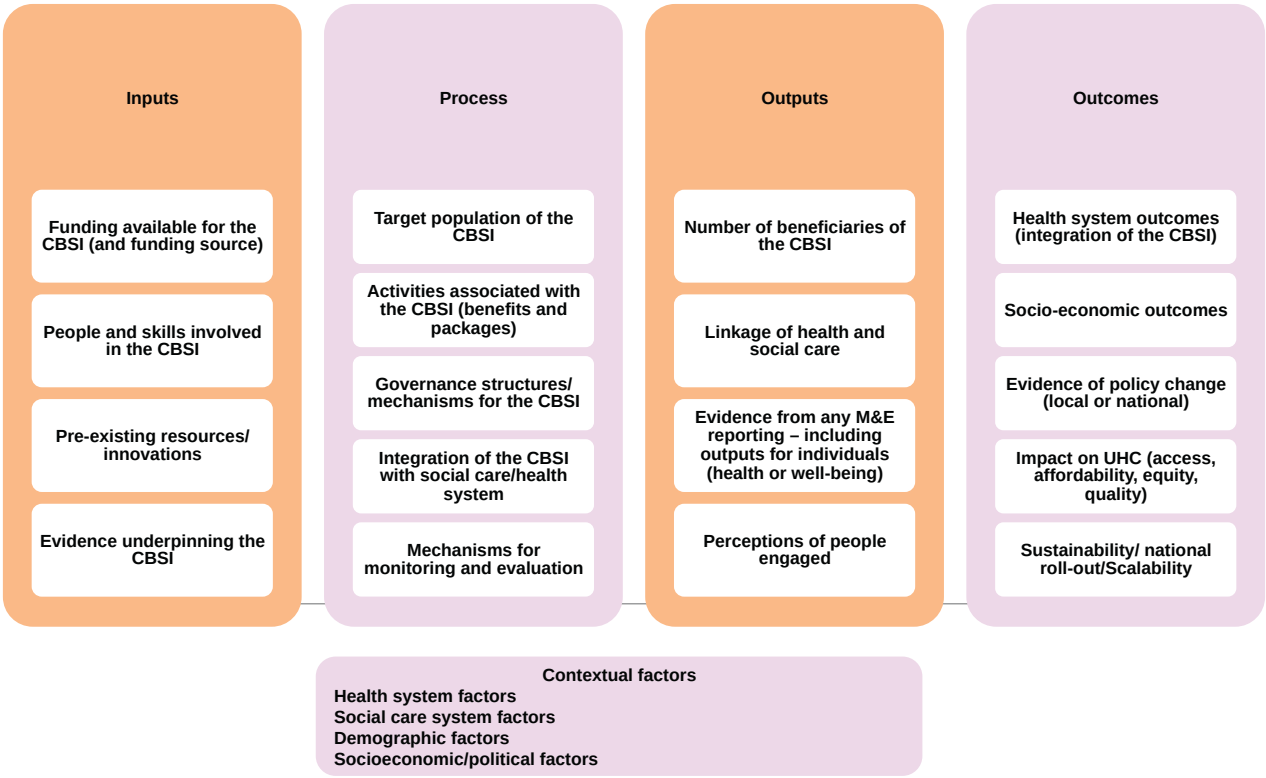
- The role and function of older people as resources for themselves and for others (peers, family, community).
- Health and social services delivered by those initiatives and referral processes when they exist.
- Links made within these communities of support between health interventions and social health protection interventions (e.g. help with transportation, livelihoods, pensions, cash or in-kind transfers).
- Coordination mechanisms with formal health and social sectors, including any formal connections with the health and social care system.
- Coordination and engagement with a variety of health/social-service workers and community-based services.
- Types of metrics (indicators, monitoring tools) implemented to assess impact on health[1] and the concept of health that is being measured.
- Measures to understand and respond to health inequities in the population served.

We have used a logic model approach to examine the effectiveness of selected CBSIs. This will help us assess the intervention logic for CBSIs and track the progress, impacts and evolutionary dynamics of CBSIs at core levels of analysis. As illustrated in Figure 2 below:

- **Inputs** will help us understand the resource environment of each CBSI and provide a foundation for exploring the linkages between resources, outputs and impacts. This resource input environment is likely to capture aspects such as resources for implementation (funding, infrastructure and skills/capabilities). We will also aim to capture the reasoning and evidence base leading to the establishment of the CBSI.
- The **process** dimension will help us examine both the diversity of CBSIs, in terms of activities/services offered, population groups targeted and geographies projects covered and mechanisms for designing, managing and evaluating the CBSI if present. We will also examine the integration of the CBSI within the wider health and social care services offered to older people.
- The **output** dimension will help us assess the relative progress of CBSIs since they have been established and capture the diversity of outputs and associated achievements. This will involve capturing outputs such as the number of beneficiaries involved in the CBSI and any initial health and well-being outputs for beneficiaries reported.
- The **outcomes** dimension will help us capture a wider range of benefits, including those relating to impact on resources for achieving universal health coverage (UHC), policy-level impacts and other (including unintended) consequences which may affect the health and well-being of older people in a particular country. In particular we will not only consider impacts at an individual level (e.g. beneficiaries engaged in the CBSI) but also look to examine the impact on the wider community and the overall health/social care system.

1 We used the term ‘health’ very broadly at this stage in anticipation that it could incorporate physical and mental health and broader wellbeing. As the case studies were exploratory, we did not seek to further define or restrict at this stage as we were interested in understanding of the CBSIs themselves conceptualised and measured these types of outcomes, if at all.

Figure 2 Framework for gathering data on CBSIs and the contexts they operate in



- The **contextual factors** dimension will guide us to consider the influence of both health and social care system factors and demographic, socioeconomic and political factors which may help or hinder progress of the CBSI. A greater understanding of the contextual factors underpinning the CBSI will also help to inform reflections on its transferability/scalability by offering a rich understanding of the setting.

Structure of the case study

The next section of the report begins with a brief overview of the methodology used for the case study. The report then highlights some of the key contextual factors affecting the CBSI, related to the country's ageing population and its health and social care system.

The main section of the report focuses on how the four areas of the logic model (outlined in Figure 2) related to the CBSI, in the following four areas: (i) establishing the CBSI (inputs); (ii) activities of the CBSI (processes); (iii) results of the CBSI (outputs); and (iv) impact of the CBSI (outcomes). Within each sub-section the perspectives of interviewees are presented alongside findings from the desk review. Finally, the report concludes with some overall reflections on the CBSI and draws out key themes and experiences to better conceptualise CBSIs and their role and functions for older populations.

Methodology

Case studies have been used to collect descriptive data on CBSIs through a mix of methods including semi-structured interviews and a review of administrative data and documentation. Each case study follows the same design in order to provide in-depth understanding of each CBSI and allow comparisons to be made between different actors

within a single case, between cases and between groups across cases, taking into account relevant contextual factors. Key-informant interviews were conducted with key stakeholder groups involved in the CBSI, as well as with wider health and social care system actors.

Desk-based document review

Building on any documentation identified in consultation with the CBSI, the literature review draws on academic and grey literature to provide an overview of the health and social services delivered by the CBSI in Russian Federation and the wider context in which these interventions are taking place. In addition, any available evaluative documentation was reviewed to collect evidence on the metrics, indicators and monitoring tools used to assess the effectiveness of the CBSIs identified initiatives. Key documents included journal articles and policy documents, such as commissioned discussion documents and government strategies. Academic literature was identified through PubMed (Medline, Scopus), focusing on the years 2000 to the present. The literature search was conducted between August and September 2017.

Stakeholder interviews

In addition to the document review described above, key-informant interviews were also used as a key means of gaining an insight into the ongoing activities of the CBSI and the wider contextual factors affecting its functioning in Russian Federation. The interviews followed a common topic guide, with the main topics discussed including: resources that support the CBSI, engagement with older people and functioning of the CBSI, outputs and linkages with the health and social care systems and impact of the CBSI. Emphasis, however, was placed on allowing participants to talk from their own perspective.

In order to explore different perceptions of impact associated with the CBSI, and to identify any linkages and interaction between stakeholders, the project team in coordination with the CBSI staff identified suitable interviewees from three major stakeholder groups (as outlined in Table 1 below). From a total of 14 interviews conducted in Russian Federation, 13 were performed between 7 and 11 August 2017 and one was conducted on 15 September 2017.

Prior to being interviewed, written consent to participate was sought from all participants and they were each asked to sign an informed consent form. Interviews were conducted face-to-face in various locations in Arkhangelsk and Onega. The interviews with the foster families were conducted in the family homes and researchers were able to observe the living conditions of the beneficiaries.

Table 1 Overview of the interviewees

Stakeholder group	Profile of the interviewees
Beneficiaries of the programme	In total the researchers visited four foster families – three were located in Onega and one in the suburbs of Arkhangelsk. Six interviews were conducted with members of four foster families.
CBSI staff	Three interviews with CBSI staff were conducted. Two were social workers working directly with the foster families and one was an official involved in the management of the social workers that work in the field and visit the foster families.
Policymakers, academia and civil society	Five interviews were conducted with this group of stakeholders, with the following distribution: three policymakers (high-level leadership, including minister level), academia (one – university professor working on ageing) and civil society (one – NGO representative). All these stakeholders had a very good understanding of the programme.

The interviews typically lasted between 30 and 60 minutes and were semi-structured in style, to enable participants to raise concerns that may not have been anticipated by the research team or were specific to the practice. This ensured a flexible approach which allowed respondents to offer their own perspective and raise issues most salient to them, while covering the same topic areas in each interview.

Interviews were audio-recorded, with permission of the participants. The interview data was analysed and coded by the project team, and then grouped into the categories and sub-categories outlined in the logic model. In analysing the categories, the team also identified emerging themes, which are presented at the end of this report.

While initially it was planned that the researchers would conduct eight separate interviews with beneficiaries and their foster family organisers (carers), this was not possible due to the physical and emotional state of some of the older persons. In three cases the older persons preferred to be part of the conversation with their foster family organiser rather than be interviewed separately. However, in two of these three cases the beneficiaries engaged only minimally and therefore are not counted as separate interviews. In total, six interviews were conducted with the four foster families – out of which four were with the organisers (the family representative that took in the older person) and two with the beneficiaries.

Overview of the context in Russian Federation

Ageing is a major concern in the Russian Federation (WHO 2017). The country's population registered a peak in 1992 (148.3 million); however, it was shrinking until 2009, following the dissolution of the USSR and the severe economic crisis, which were accompanied by relatively low birth and high mortality rates. Since 2009 the population numbers have been close to the 1992 peak (Popovich et al. 2011).

Due to socioeconomic differences between regions it is difficult to draw an 'average' picture of Russian Federation and its citizens. Ageing trajectories can differ substantially based on nationality, religion, political beliefs, social and economic status and region of residency. Moreover, although ageing is well researched in Russian Federation, the Siberian, Far East and circumpolar regions are often underrepresented (Strizhitskaya 2016).

Demographic factors

The Russian Federation has a total population of 143,990,000 (UN 2017), with a rate of population growth of 0.2 per cent in 2016 (World Bank, 2016). Today, the average life expectancy is 71 (World Bank 2016), with an average healthy life expectancy at birth of 63.4 (WHO 2015). As discussed by Popovich and colleagues (2011, 12), significant demographic differences are observable between genders. Male mortality is significantly higher due to alcohol and tobacco consumption and road traffic mortality, which is considered very high by international standards (21.1 per 100,000 population in 2008).

The percentage of the population aged 60 and above is 20.1 per cent (2015) and it is expected to reach 22.4 per cent by 2020 (UN 2017).

The trend of increasing life expectancy in Russian Federation results in about 86 per cent of 80-year-olds needing personal assistance (Golubeva 2016). This is particularly problematic in isolated and sparsely populated rural areas (which comprise 70 per cent of Russian territory). Independent living for older persons in these regions is difficult as a result of limited access to the social protection system and the traditional forms of social services. However, historically, Russian society has enabled positive social and psychological mechanisms that affect the interaction of the population. These draw on a close link to nature and owning farmsteads, promoting a society that maintains its traditions, thus offering a feeling of stability and tight family links which form a supportive network (Troshina 2016). Rural areas in particular register a

high level of integration of older people, which often helps to overcome the lack, absence or inadequacy of formal care services (Golubeva et al. 2005; Volkova and Durasanova 2003).

Overall the main causes of death at a population level are: ischaemic heart disease (35.1 per cent); stroke (21.3 per cent); HIV/AIDS (2.9 per cent); trachea, bronchus, lung cancers (2.8 per cent); cirrhosis of the liver (2.4 per cent); colon and rectal cancers (2.2 per cent); stomach cancer (1.8 per cent); lower respiratory infections (1.6 per cent); chronic obstructive pulmonary disease (1.5 per cent); and self-harm (1.5 per cent) (WHO 2012).

Overview of the Russian health system

After the dissolution of the Soviet Union the Russian healthcare system became less centralised, being partially delegated to regional agencies. This process was characterised by minor investments in the healthcare system from the central state, causing a general deterioration of the system's infrastructures and of the quality of care provided. This caused a general decline in all the main indicators of public health (Popovich et al. 2011). Starting in 2000, supported by a general economic recovery, Russian Federation made significant efforts to improve its healthcare system, although chronic organisational inefficiencies and the state's poor infrastructure limited the impact of the reforms. These challenges were further exacerbated by the 2008 global economic crisis (Popovich et al. 2011).

Every citizen is covered by the state's Mandatory Health Insurance and, formally, every citizen has access to a minimum standard of free healthcare services: the Government Guaranteed Package. Workers enjoy an additional private insurance paid by their employers to the scheme/company employees are enrolled in (OECD 2012, 21). Citizens often prefer to buy extra services, both formally – from private facilities – and informally – extra payments are often demanded by public medical personnel. According to the OECD, in 2007 'half of the patients admitted to a hospital paid something' (OECD 2012, 17).

The Russian healthcare system is affected by a significant urban/rural divide, with rural areas being poorly and discontinuously served. In addition the OECD identifies as a key problem the lack of prevention policies and the low level of health literacy among the population (OECD 2012, 15–16).

Overview of the Russian social care system

Following the collapse of the Soviet Union Russian Federation social care provision changed radically. The former 'cradle to grave' welfare system is formally still working, although due to chronic underfunding informal payments and personal connections are often necessary to access supposedly free services. Similar to healthcare, the provision of services varies significantly between urban and rural areas.

Despite recent improvement in the country's economy, salaries and pensions are often insufficient to cover standard living costs. This gap in services and resources is often filled by NGOs and religious associations, with a prominent role taken by the Russian Orthodox Church (Kuznetsova and Round 2014), which, for example, organises centres for lonely elderly people.

Russian Federation pensions system was reformed in 2002, moving from the Soviet public distributive system to a mandatory, privately managed contributory system. This pay-as-you-go mechanism, which aims to provide a basic source of income, is supported by additional voluntary occupational and personal pension funds (OECD 2013, 1).

Overview of the CBSI

Establishing the CBSI (Inputs)

Establishing the CBSI

Foster families programme in Russian Federation

The foster families programme is one of the Russian government's responses to ensuring that older people, particularly those living in rural and remote areas, are being offered an efficient form of social support in the context of increasing demands on state capacities and resources. It is based on the understanding of the needs of the older populations located in rural Russian Federation and an acknowledgement of the benefits of an 'ageing in place' approach.[2] The programme tries to pair older persons with adoptive foster families, which take on the responsibility of caring for these older citizens.

The programme is aligned with the National Strategy of Action in the Interests of Elderly Citizens until 2025. This identifies promising areas of action in the spheres of healthcare and social services, employment, education, leisure, culture and education with the aim to increase the quality of life of older people (Government of the Russian Federation 2016). The Strategy outlines approaches to rational exploitation of available opportunities and suggests ways of implementing actions to improve quality of life, recognising the value of the contribution of older people to the social, economic and cultural life of the country and harmonising the interests of different age groups of the population. There has been a shift in strategic planning from a needs-based approach that suggests that older people are passive participants in social interaction to an approach based on equality of opportunities and social inclusion in all aspects of life.
One approach comprises residential ways of providing services for older people, in particular the foster families concept. Following the issuing of the National Strategy of Action in the Interests of Elderly Citizens, several regions of the Russian Federation decided to implement a foster families programme, regulated by regional law. Currently such programmes are running in five regions of the Russian Federation.

Foster families programme in Arkhangelsk

This case study explores the foster families programme in the Arkhangelsk region in the northern Russian Federation.

Northern Russian Federation is prone to isolation due to its geographical setting. The population in the Arkhangelsk region is steadily decreasing, totalling 1,122,300 people as of 1 January 2017, with a working-age population of up to 56 per cent. Currently, every eighth inhabitant (13.3 per cent) is aged 65 or above (Statistics of Arkhangelsk Region 2017).

A study on the quality of life of older people in the Arkhangelsk region, conducted between 2006 and 2012, showed that elderly people living in sparsely populated rural areas rely in their daily activities (such as fetching water, cooking and cleaning) mainly on the help of families and neighbours (Golubeva 2012). The degradation or dissolution of social ties leads to loneliness, lack of purpose and feelings of uselessness, ultimately contributing to a lower quality of life. Therefore, as the ageing process brings about limitations of functional abilities, it becomes increasingly important to foster a microenvironment for ensuring a good quality of life: in rural areas, satisfaction with life is most dependent on having a family or living within one (Golubeva 2012).

The Arkhangelsk region was not among the first regions to introduce the foster families programme, and therefore was able to learn from previous implementations in other settings. As a result, as expressed during the interviews, the Arkhangelsk authorities were concerned to reduce the bureaucratic burden of the

2 The concept of 'ageing in place' (remaining in one's own home and in the local environment) is beneficial for many older people, as it avoids the potential isolation that could occur with moving to a new environment.

Figure 3 Foster family members

programme and find the best balance between reducing supervision pressure and preventing any opportunity for abuse.

As described by one interviewee, the development of the programme and of the corresponding legislation in Arkhangelsk was also informed by a preceding survey which gathered information on the willingness and desire of social workers and citizens who receive social care at home or live in residential homes to switch to foster families. Results from the survey seemed to have highlighted a willingness among respondents to leave the residential homes, and therefore a working group was created towards the development of legislation to support the foster families programme. The group comprised representatives from various ministries, politicians, representatives of public associations of veterans and invalids, social workers and representatives of the municipality. The consultative process and development of the legislation took eight months. Following this step, the law was submitted for public consultation on the local government's website. The public feedback was accounted for in the final form of the legislation. The main law is accompanied by corresponding normative documents (ten additional documents providing clarifications on the implementation of the law). The foster families programme was then initiated for senior citizens and disabled people in Arkhangelsk in 2012.[3]

Aims and objectives of the initiative

The overall aim of the programme is to provide older people with a better quality of life by offering social services in a home environment, not in residential facilities (nursing homes). The organisation and implementation of the activities of foster families in the Arkhangelsk region are carried out in accordance with the following principles:

1. The obligation to respect the rights of persons in need of social services.
2. The programme is under the supervision of the state social services authorities and organisations in the Arkhangelsk region.
3. The programme is concerned with ensuring equal opportunities in obtaining social services and their accessibility for persons in need.
4. The programme should focus on the individual needs of people requiring social services.
5. There should be voluntary acceptance of responsibilities by the person who organises the foster family and this person should have the right to withdraw from fulfilling these duties at any point.

Figure 4 Northern Russian Arctic territory

3 In accordance with the regional law of 21 November 2011, No. 382-26-OZ.

6. A person in need of social services should provide voluntary consent to live and receive social services in a foster family, and has the right to refuse this form of rendering social services.

Other initiatives in the region

Interviewees noted that in addition to the foster families programme, other initiatives aimed at older people were in place, with most focusing on social benefits rather than provision of health services.

Some of the initiatives offer cultural, educational or entertainment activities. For example, interviewees mentioned that cultural activities include visits to monuments, museums or the cinema. When it comes to educational activities, the local authorities organised computer literacy classes; in 2016 the Arkhangelsk region's pensioners became the Russian champions in the national computer literacy competition for older people. In the sphere of literacy, one project that is currently being developed is aiming to enhance the financial literacy of older people.

In the sphere of entertainment there are programmes that provide 'gardening therapy', whereby a designated space is offered to older persons to plant flowers. There is also a collaboration between the local social state agency and an equestrian school in the region that provides hippotherapy for older persons.

Other projects involve provision of social services. Interviewees mentioned the 'social taxi' project, which provides transport to disabled persons upon their request and is run through the local state-funded social centre.

Another programme is the 'Grandmother and Grandfather for the Weekend' initiative. This allows children from remote territories to attend a weekly boarding school programme while receiving help and care from older people, who participate on a part-time basis.

Activities of the CBSI (Process)

Target population

The beneficiary of a foster family is described in the legislation as a single adult of older age (women over 55, men over 60) and/or a disabled person (including disabled from childhood) who has a residence in the Arkhangelsk region and who needs social services in connection with a partial or complete loss of the ability to satisfy their own needs independently.

The family organiser must be (i) an adult legal citizen who resides in the Arkhangelsk region, and (ii) willing to commit themselves to living together with or in close proximity to an older adult in need of social services, and provide these in accordance with the foster family contract.

The organisation of a foster family is not allowed between close relatives (relatives on a straight ascending and descending line, such as parents and children, grandparents and grandchildren), including between half-parents and step-children and between adoptive parents and adopted children. A previous study into foster families generalised the profile of a foster family organiser, who tends to be female (82 per cent) with incomplete higher education (52 per cent), aged 55 and older (62 per cent) and with their own family (74 per cent) (Golubeva et al., forthcoming). This study, relying on surveys of 50 foster families, found that the main motivation for the organiser is the desire to help the older person. This also came through in the interviews conducted during this case study. The level of education, age and marital status of the organisers did not seem to influence the motives for creating the foster family (Golubeva et al. 2017). Interviews both with organisers and CBSI staff highlighted that the organisers should be persons with a good degree of patience, kindness and courage to take on this responsibility.

Activities associated with the CBSI

The foster family is formed by an 'adoptive' family/person (the foster family organiser), who takes into their care the beneficiary – the older person. However, the term beneficiary is artificially used here, as the foster family can bring benefits for the foster family organiser as well, who is often an older person themselves.

The older person can choose whether to move into the house of the foster family organiser or continue living in his/her own home, with the foster family organiser making frequent visits.

The establishment of a foster family relies on a tripartite agreement between the foster family organiser, the older person and the Complex Centre of Social Service (in each district of the Arkhangelsk region) under the regional Ministry of Labour and Social Development. Under this agreement, a foster family organiser assists an older person in basic necessities of life such as cooking and serving food, helping the person in maintaining daily hygiene, shopping, keeping appointments at medical centres and government agencies, etc.

Governance of foster families

The Complex Centre of Social Service is charged with monitoring compliance with the terms of the contract and paying the organiser remuneration in the form of a salary, the size of which varies significantly in different regions. In Arkhangelsk this is currently RUB 5,000 per month (approximately USD 75), having increased from RUB 4,358 in 2012. Compared with other regions this is a fairly good compensation, the range being from RUB 2,500 to 16,742.85 per month (Ministry of Labour and Social Development 2017). The organiser's salary is paid monthly on the basis of the foster family contract and the act of social services provided during that month representing a list of services provided. The act of rendered social services is compiled monthly and signed off by the organiser of the foster family, the person in need of social services and the state representatives.

The official formation of a foster family requires the state organisation of social services in the Arkhangelsk region to fill in the 'passport' of the foster family, which contains data on both the beneficiary and the family organiser. This is approved based on several documents, including medical consultations attesting to the physical and mental fitness of the family organiser. The criteria for creating a foster family for senior citizens are described in detail in Table 2. While these criteria are clearly set out, interviews with family organisers described this process as bureaucratic and slightly cumbersome.

An important aspect of the development of this form of living is the professional accompaniment of the foster family by a state social worker in the period of adaptation. The foster families are accompanied by professional carers from the social service centre in the beginning, on a case-by-case basis, to help the adoptee and foster family organisers adapt to their surroundings. The social service centre assists in overcoming crisis situations in interpersonal relationships, aiming to contribute to the emotional well-being of the family.

Results of the CBSI (Outputs)

Enrolment of older people

In total, between 2012 and 2017, 231 foster families were established in the region, mainly in remote rural areas: 10 were created in 2012, 23 in 2013, 59 in 2014, 75 in 2015, 64 in 2016. Out of these, approximately 65 per cent of families remain operational, with the following distribution of families that did not continue: 6 families did not continue in 2012, 21 in 2013, 28 in 2014, 19 in 2015 and 8 in 2016. The majority (96 per cent) of families were created by female organiser, and 72 per cent of elderly people in a family are female.

There is no publicly available data on the profiles of the families and no further information was obtainable for the purposes of this research. The main reasons why some of the families no longer exist include death of an elderly person, illness

Table 2 The criteria for creating a foster family for the elderly

Who can create a foster family for older persons?	An adoptive family can be organised by an adult legal citizen who has a place of residence in the Arkhangelsk region and who wishes to assume the obligations of living together and managing a joint household with a person (persons) in need of social services in order to provide the mentioned person with social services in accordance with the foster family contract.
Who can be a member of the foster family for older persons?	A single adult of older age (women over 55, men over 60) and/or a disabled person (including disabled from childhood) who has a residence in the Arkhangelsk region and who needs social services in connection with a partial or complete loss of the ability to satisfy their own needs independently,
Where to apply to organise a foster family for an older person?	A citizen who has expressed a desire to create a foster family should apply to the Complex Social Services Centre at the place of residence.
What documents need to be provided to create a foster family for an older person?	1. Written application.Copies of the passport of a citizen of the Russian Federation or other document proving the identity and confirming residence in the territory of the Arkhangelsk region.Copies of documents confirming the family composition (birth certificate, marriage certificate, court decision on recognition as a family member, a document from a house (apartment) book from the place of residence. 2. A copy of the financial account from the place of residence (residence). 3. Information on family income for the last three calendar months preceding the month of application; medical certificate of the absence of chronic alcoholism, drug addiction, substance abuse, quarantine infectious diseases, active forms of tuberculosis, severe psychiatric disorders, venereal and other diseases requiring treatment in specialised medical organisations, as well as a certificate of the fact that the person who has expressed a desire to organise a foster family is not a bacteria or virus carrier. 4. Copies of documents confirming the legal grounds for ownership or use of a dwelling in which the person who has expressed the desire to organise a foster family lives, containing information on the total area of the dwelling. 5. Written consent of all adult family members, including temporarily absent family members, to live together with a person in need of social services. 6. If requested the characteristics of the place of work of the person who wishes to organise a foster family.
Interaction with the specialists of the Complex Social Services Centre	All documents are accepted and registered by specialists at the Complex Social Services Centre. The specialist examines and verifies the completeness and reliability of the documents received from the person who has expressed a desire to organise a foster family and a person in need of social services. The specialists at the Centre carry out a survey of the social and living conditions of people in need of social services and those who have expressed a desire to organise a foster family. The employee of the Centre entrusted with organising foster families for elderly citizens and invalids, with the involvement of a psychologist, conducts psychological training for those who have expressed a desire to organise a foster family.
Documents regulating the creation of a foster family for an older person	A decision is made on the possibility of concluding a foster family contract after receiving written consent from a citizen in need of social services and a person who has expressed a desire to organise an adoptive family. The parties to such an agreement shall be notified of the decision taken within five working days of the date of the decision. The foster family agreement is concluded between the Complex Social Services Centre, the person who has expressed a desire to organise a foster family, and a person in need of social services no later than five days from the decision on the possibility of concluding a foster family contract. The foster family contract can be terminated on the grounds provided for by civil law or foster family contract.
Remuneration of social services	The Complex Social Services Centre provides for the remuneration of social services provided by the person who organises the foster family on the basis of the foster family contract and the social services act in terms of the procedure and procedures specified in the contract. Currently, the payment to the person who organises the foster family is RUB 4,358 per month.

of an organiser, change of place of residence, deprivation of legal capacity or reasons connected with difficulties of adaptation and lack of mutual understanding in the foster family.

Foster family members' self-reported and perceived gains

The older people interviewed unanimously praised the opportunity to continue living in a family environment and not having to move into a residential home. One interviewee compared her experience of living in the residential home to that of living in the foster family and concluded that, while she was treated well in the nursing home environment, in the foster family she receives more care and attention. Furthermore, she feels loved and, in participating in daily conversations on developments in the family, she also feels integrated. The friendship she shares with her family organiser is also built on common hobbies such as handicraft activities. Overall, she reported improved quality of life as a result of getting the care she needs. This same sentiment was reported by another beneficiary, who also praised the help she was receiving from her organiser. All older persons that were interviewed reported they felt less lonely or bored as a result of living in the foster families. The benefit of increased social interaction was also stressed by CBSI staff interviewees. The perceptions of these stakeholders highlight the contribution the foster families programme is making to the well-being of the older persons. This is due mostly to the psychological effect of living in a familial environment, with the possibility of continuing to live in their own home and maintain a degree of independence.

Foster family organisers can help deliver some medical services directly, which results in alleviation of pain and less stress for older persons. For example, in our sample, two organisers were able to give injections to the older persons – thus removing the necessity for visits by a medical professional or travelling to a health facility. In all cases the organisers were collecting prescriptions and contacting medical authorities if needed. This is particularly important in remote areas where, due to geographical isolation, lack of infrastructure (such as bridges, necessitating the use of boats) and hard climatic conditions, access to social and healthcare services is severely restricted. All these factors contribute to substantial health disparities among Russian regions (Nordic Council of Ministers 2014).

The organisers of the foster families also reported gains from the programme in terms of companionship, mutual moral support and the personal satisfaction of being of use to a peer. All of them highlighted that the remuneration is limited and cannot be the motivation for taking on such a responsibility. In two cases the organisers and their adopted beneficiaries were distant relatives and mentioned that they probably would have undertaken similar activities regardless of the programme.

Linkages to health and social care system

The programme is directly connected to the Russian social care services. Through the monitoring of the foster family by the social service centre both the organisers and the older persons can communicate their concerns and be aware of existing resources offered by the social care system (e.g. provision of wheelchairs and nappies/incontinence pants). This was seen as beneficial by the foster family interviewees. The CBSI staff noted that normally a social worker is responsible for overseeing 10–12 older persons and therefore has a divided attention. However, through the foster family organiser the older person can benefit from increased support and still receive the normal services the social worker would provide.

The foster families programme is not directly linked to the health system. However, throughout all the interviews mention was made of the 'navigator' function of the family organiser. This person can set up regular medical appointments or monitor health status, and alert medical authorities when there is a need to intervene to the benefit of the older person. As interviewees mentioned, the organiser can help with collecting

prescriptions from the pharmacy and ensuring taking of daily doses, as well as deliver basic medical services such as injections or monitoring blood pressure and glycaemia.

For both medical and non-medical issues the foster families can access a 'social taxi', which allows a low-mobility person to reach needed locations (e.g. tax office, hospital, dentist).

Impact of the CBSI (Outcomes)

Wider impacts of the programme

The monitoring and evaluation of the programme falls within the responsibility of the social centre. While attempts are being made to measure process indicators of the programme (such as whether participants are compliant with their contractual obligations), the monitoring controls performed by the social do not seem to capture long-term impacts.

Nevertheless, the policy interviewees expressed positive outlooks on the programme's long-term effects. At a system level the programme could help solve the problem of long waiting lists for getting into residential homes. The foster families seem to be a viable economic option: monthly spending for the programme is approximately RUB 5,000, while a place in a residential home costs RUB 30,000. Considering these cost savings and the benefits that the interviewees found in the foster family setting compared to the residential homes, the foster families could represent a more cost-effective way of providing care to older persons. However, more research is needed to establish value for money and cost-effectiveness. It was also noted that in the event that the condition of the beneficiary deteriorates to the point that additional care is required that cannot be provided within the foster family set-up, then the beneficiary would most likely be placed in a residential home.

Sustainability of the programme

As a state programme the foster families benefit from a legal status and state funding, which contributes to their sustainability. However, as stressed by several interviewees, the compensation for the organisers is small. The authorities are considering introducing a tiered compensation mechanism, with greater remuneration packages for organisers that are providing services to older persons with a higher degree of disability.

Another factor affecting the sustainability of the programme is the bureaucracy involved in setting up the foster family. This could act as a disincentive to persons that want to form a foster family. The state structures could investigate whether a simplified path could be designed for the organisers to obtain the required medical certificates – for example by establishing polyclinics that deal with these procedures and are familiar with the programme's requirements. Some family organisers commented that they are viewed with suspicion when trying to complete this paperwork; however, the reasons for this were not clearly explained. Designated channels for obtaining the medical clearances that are needed for setting up the foster families, involving people familiar with the programme, could improve the overall application experience. Another concern that could affect the way the programme continues to evolve is the dissemination strategy. Some interviewees expressed that less information is available about the programme now than when it was launched, which might result in fewer persons knowing about the initiative. Initially the programme had been advertised on TV, which seemed to have been a good dissemination channel.

Further considerations that could affect the sustainability of the programme pertain to the support given to the organisers in difficult periods. CBSI staff and policymakers stressed that as this is a long-term (often lifelong) commitment it is important to offer periods of respite (e.g. paid vacations) to allow organisers to recuperate after challenging emotional periods.

Reflections on the CBSI

Several themes that are relevant to the analysis of CBSIs have emerged and are presented below.

Understanding the relation between the foster families programme and social capital contributes to programme implementation and sustainability.

The implementation and sustainability of a programme such as the foster families are dependent on a very good understanding of the social and cultural country context. This requires a particular attention due to the intimacy of the family structures involved in the programme. It is expected that this sort of programme is best suited in contexts where there is a high degree of bonding social capital[4] with good family and neighbourhood networks. Previous research has shown that rural depopulation in northern Russian Federation leads to erosion of social capital and the supportive networks that this entails (Moran 2001). It is important to consider the potential of the foster family programme to preserve these community connections and increase social capital.

Older adults can maintain their desired social role through programmes such as the foster families.

One of the key themes that emerged from the case study pertains to the identity of older persons. The importance not only of 'ageing-in-place' but of having a 'family identity' came through strongly, with beneficiaries expressing their gratitude for being able to interact with family members.

Foster families can be seen as a means of promoting 'ageing-in-place'. However, in some situations the older person moves into the foster family's home (thus leaving their own). The present research had a very small sample size of older-person beneficiaries, which cannot provide conclusive information on whether the foster families are always seen as 'homes' or can also be 'liminal homes' (in-between places before being placed in a nursing home [Leibing et al. 2016]). However, research would seem to indicate that older people still consider a liminal home as a home, as they reside in that space based on their decision to do so and still have the option of making autonomous decisions in daily life, including on whom they wish to interact with (Leibing et al. 2016).

Difficulties in monitoring and evaluation metrics for programmes such as foster families.

Initiatives such as the foster families programme raise important points of consideration when it comes to monitoring and evaluation. Firstly, the spread of foster families in rural territories makes monitoring and evaluation activities difficult. Making use of innovative technologies could help with collecting some relevant indicators. For example, using mobile phones or other devices to register certain health outcomes could help with capturing a greater variety of impacts.

Secondly, foster families can be quite different from each other. For example, a foster family that is formed between persons that are very familiar with each other (such as nieces and aunts who always lived in close proximity) will have a different 'accommodation period' compared to two individuals that are meeting for the first time as a result of this initiative. The authorities are therefore challenged to find a balance between ensuring the safety of this programme for the participants, providing support in a way that is not burdening the participants and collecting data in the face of resource constraints. This will require a tailored monitoring and evaluation package for various foster family typologies.

Thirdly, in assessing the success of this initiative it is important to consider the weight that should be placed on numbers and spread. When asked whether they would recommend this programme

4 Described as 'trusting and cooperative relations between members of a network who see themselves as being similar, in terms of their shared social identity' in Szreter and Woolcock (2004).

to someone else, the organisers stressed that this is a personal commitment that should be addressed on a case-by-case basis because of the dedication entailed. Several interviewees from the policy field mentioned that such a programme cannot replace completely other forms of social care, and therefore its success should not be measured in big numbers of participants.

Ensuring the right skills for running a CBSI such as a foster family needs to consider organisers' training needs.

CBSIs that rely on a certain form of peer support need to consider the skillsets that are required of peers delivering the help to older persons. These skills need to ensure that appropriate services can be provided to the beneficiaries but also that peers have the knowledge to manage difficult situations or recognise moments when it would be better to solicit professional support.

There are several types of challenges that come with trying to ensure a good cohabitation in a foster family environment. These can be connected to the need to provide the older person with certain services, temperamental differences or the emergence of new illnesses during the cohabitation. Therefore, it is important for the foster family organiser to be helped in acquiring certain skills – on a case-by-case basis. Previous research found that members of the foster family require knowledge on the psychology of older person (78 per cent of respondents); however, the majority (56 per cent) did not see a need to receive psychological counselling training. Similar responses were given in the case of developing communication skills, with the majority (54 per cent) not seeing the need for such training. However, after accepting the older person into the family, the organisers reported the greatest concern was ensuring the health of the older person (58 per cent), suggesting a need to develop organisers' skills in providing basic medical support. The interviews with the foster family organisers seem to reinforce these findings, with one respondent mentioning she would like to receive training on performing massages while another would appreciate training on understanding a specific eye disease and the associated medications.

However, due to the limited sample size and heterogeneity of respondents, we do not want to suggest that psychological training should not be offered. One interviewee from academia stressed the importance of being able to recognise signs of early mental deviations, which could lead to earlier treatment and better health outcomes. Foster family organisers are in a good position to recognise such signs and could benefit from guidance in this respect. Furthermore, one of the reasons foster families disintegrate is a psychological mismatch between organisers and older persons, which perhaps could be uncovered earlier on with increased psychological evaluations.

To sum up, one further development of the programme could consist of offering the foster family organisers the opportunity to undertake specific training courses. However, this should be done on a case-by-case basis, with organisers able to choose between various courses.

One interviewee suggested the possibility of offering a certification course, similar to that offered for families that wish to adopt children, which would prepare organisers to become a foster family. Those putting together the certification curricula would need to consider the varying degree of understanding of the organisers and the ways these accumulate knowledge and are receptive to information, which are unlike those of people who adopt children.

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World Health Organization

Centre for Health Development

Serbia: Self-Help Groups for Older People

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Preface

The World Health Organization Centre for Health Development Kobe has contracted RAND Europe to serve as a research hub for conducting a systematic review and gathering evidence of middle- and high-income countries' community-based social innovations (CBSIs) for healthy ageing. RAND Europe has undertaken two main strands of research consisting of: (1) a systematic review of CBSIs for healthy ageing in middle- and high-income countries, and (2) a series of ten case studies of CBSIs for healthy ageing in middle-income countries.

This report presents the findings from one of our ten case studies, the Self-Help Groups for Older People in Serbia.

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Summary of the community-based social innovation (CBSI)

Background

Serbia

Locations
Paraćin, Bor

Type of intervention
Foundational

Year established
2010

The intervention

Establishing the CBSI

- Self-Help Groups (SHGs) for Older People were initially established in Serbia between 2010 and 2012, under the Instrument for Pre-accession Assistance Project: 'Dialog of Civil Society Organizations in Western Balkans' implemented in Serbia, Albania, Bosnia and Herzegovina.
- SHGs provide participants with a space to discuss issues of concern for their well-being and together to try come up with solutions, whether on their own (as a peer community) or through initiatives advocating for and mobilising action by other local or national stakeholders.
- In Serbia, several SHGs were organised in multiple locations, through the engagement of key NGOs such as Amity, Red Cross, Hleb Zivota (Bread of Life), Viktorija and the HumanaS network. This case study focuses specifically on the SHGs in Bor (convened by Amity and historically funded through EU sources) and Paraćin (convened by the local Red Cross and supported now also by the local authority).

Activities of the CBSI

- SHGs in Serbia consist of two main types of activities:
  i. Meetings between peers, creating a social network and support community.
  ii. Practical peer support in daily activities such as assistance with preparing meals and buying food, hygiene-related and other supplies; helping with efforts to organise house repairs or medical visits; and enabling social activities.
- From December 2013 to December 2015, 54 groups were functional (financed by the EU Delegation to Serbia) involving 572 older persons.

Results and impact of the CBSI to date

- Beneficiaries found that SHGs help alleviate loneliness and provide a platform for peer support.
- Beneficiaries expressed that SHGs bring significant benefits for their well-being through elevating their mood and serving as a source of comfort, as well as through practical peer assistance with activities of daily living.
- Opportunities to attend lectures on topics such as measuring hypertension and glycaemia were also seen as positive offerings of SHGs: though these are on a small scale, there is interest in their scale-up.
- SHGs have fostered advocacy activities which have led to small but meaningful changes in the everyday life of older participants.

Ageing in Serbia

- Serbia is an upper middle-income country with a rapidly ageing population.
- The percentage of the population aged 60 and over was 23.8 per cent in 2015 and it is expected to reach 25.2 per cent by 2020.
- Serbia's healthcare system grants universal health coverage through a state-run compulsory health insurance scheme financed via work-related taxes.
- Pensions in Serbia are low in comparison to European standards – in 2007 the average monthly pension was EUR 200 – leading to chronic poverty among older people.

Reflections on the CBSI

- The SHGs are dependent on their initiators, which makes the support of the NGO sector (Red Cross, Amity) very important in the initiation stage as well as in their continued functioning. The lack of sustainable financing of SHGs was presented as the greatest challenge to sustainability and scale-up of the programmes.
- SHGs manage to attend to a vulnerable segment of the population. The beneficiaries are usually older people that live alone, often unable to fully provide for themselves.
- Several participants raised concerns about diminishing levels of social capital limiting the potential and threatening the sustainability of SHGs. However, the findings highlight several opportunities to build relationships that can ensure the SHGs provide both individual and collective value simultaneously through stronger vertical and horizontal networks between various groups (between different SHGs and other initiatives related to healthy ageing, with local authorities, with national stakeholders).
- While this did not come through as a major theme, SHG members were also able to engage in intergenerational activities and activities with refugees, indicating potential for wider reach in social integration and community well-being, beyond only older people.
- There do not seem to be many formal linkages to either the health or social care system except for the financial support that some local governments provide to SHGs.
- Sustaining SHGs is relatively low-cost and interviewees widely perceived the initiatives to be of value, but no formal assessment of value for money exists. SHGs are difficult to evaluate due to a lack of a universal theory of change and intervention logic and an equal lack of data collection. The former issue is easier to address through theory-driven realist approaches which can accommodate sensitivity to adaptiveness and to local contexts. The latter would require resources to sustain data collection and working with local actors to enhance the existing evidence base.

Aims of the research

This report presents the findings from one of our ten case studies, the Self-Help Groups for Older People (SHGs) in Serbia. The overall aim of the research is to describe within a pool of rapidly ageing countries, and from those with high proportions of older people; a) the core roles, services and functioning (including feasibility of scale-up) of community-based social innovations (CBSIs) for healthy ageing that seek to support older people becoming a resource for their own health and well-being; b) their linkages with and sustainable partnerships to deliver health services, strengthen social systems; and c) the nature of enabling policies, programmes, financing and interactions with the health/social care delivery system.

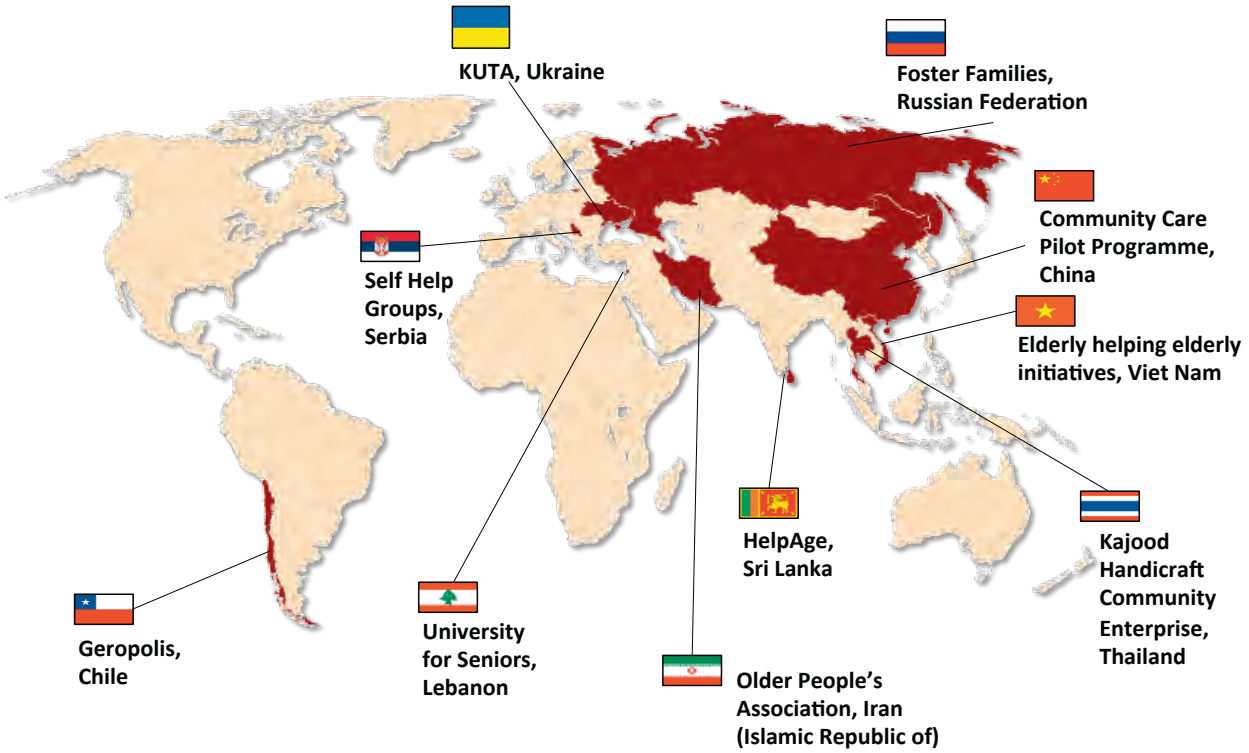
A recent WHO study conceptualised CBSIs as initiatives that seek to empower older people to improve their self-efficacy in caring for themselves and their peers, maintain their well-being and promote social cohesion and inclusiveness. They can also help older people to access, understand and navigate health and social care systems (Ong et al. 2016).

While CBSIs may hold the potential to transform health and social care provision for older people, more evidence is needed to improve our understanding of what types of initiatives and service delivery models are pursued in practice that engage communities and span a spectrum of health and social services.

Aiming to develop a typology of CBSIs, this research consisted of three main parts: (i) a systematic review of CBSIs for healthy ageing in upper middle- and high-income countries; (ii) a series of ten case studies to examine the effectiveness of ongoing CBSI interventions in middle-income countries; and (iii) an expert consultation at the World Health Organization's Centre for Health Development (WHO-WKC) in Kobe, Japan, to validate and refine the typology.

Given the relative lack of evidence on CBSIs in middle-income countries in academic literature, the ten case studies were identified through an open call for Expressions of Interest (EOIs). Figure 1 below shows the location of the ten case study countries.

Figure 1 Ten case study countries



The data gathered in this case study will serve to better conceptualise what a CBSI is and to present typologies and functions of CBSIs for older populations.

Each individual case study will seek to explore:

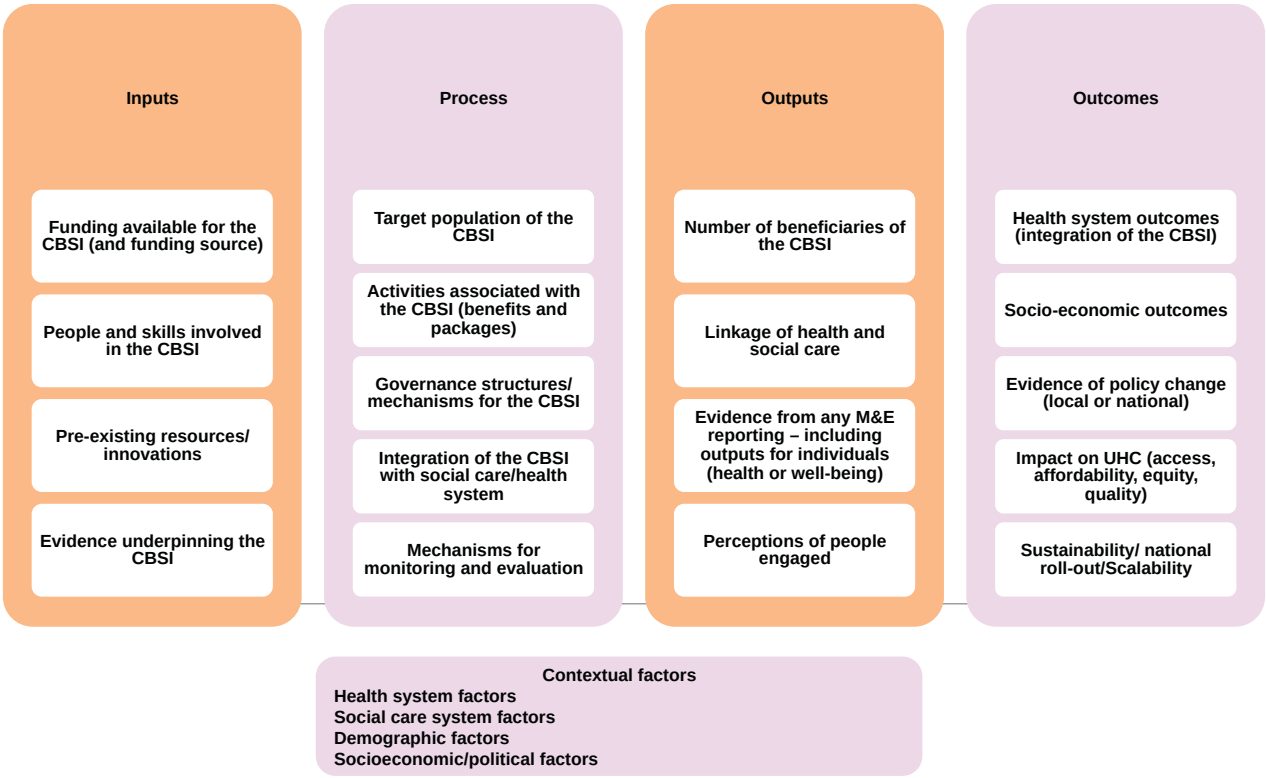
- The role and function of older people as resources for themselves and for others (peers, family, community).
- Health and social services delivered by those initiatives, and referral processes when they exist.
- Links made within these communities of support between health interventions and social health protection interventions (e.g. help with transportation, livelihoods, pensions, cash or in-kind transfers).
- Coordination mechanisms with formal health and social sectors, including any formal connections with the health and social care system.
- Coordination and engagement with a variety of health/social-service workers and community-based services.
- Types of metrics (indicators, monitoring tools) implemented to assess impact on health[1] and the concept of health that is being measured.
- Measures to understand and respond to health inequities in the population served.

In order to explore each of these factors, we have used a logic model approach to examine the effectiveness of selected CBSIs. This helps us assess the intervention logic for CBSIs and track the progress, impacts and evolutionary dynamics of CBSIs at core levels of analysis. As illustrated in Figure 2 below:

- **Inputs** will help us understand the resource environment of each CBSI and provide a foundation for exploring the linkages between resources, outputs and impacts. This resource input environment is likely to capture aspects such as resources for implementation (funding, infrastructure and skills/capabilities). We will also aim to capture the reasoning and evidence base leading to the establishment of the CBSI.
- The **process** dimension will help us examine both the diversity of CBSIs, in terms of activities/services offered, population groups targeted and geographies projects covered and mechanisms for designing, managing and evaluating the CBSI if present. We will also examine the integration of the CBSI within the wider health and social care services offered to older people.
- The **output** dimension will help us assess the relative progress of CBSIs since they have been established and capture the diversity of outputs and associated achievements. This will involve capturing outputs such as the number of beneficiaries involved in the CBSI and any initial health and well-being outputs for beneficiaries reported.
- The **outcomes** dimension will help us capture a wider range of benefits, including those relating to impact on resources for achieving universal health coverage (UHC), policy-level impacts and other (including unintended) consequences which may affect the health and well-being of older people in a particular country. In particular we will not only consider impacts at an individual level (e.g. beneficiaries engaged in the CBSI) but also look to examine the impact on the wider community and the overall health/social care system.

1 We used the term ‘health’ very broadly at this stage in anticipation that it could incorporate physical and mental health and broader wellbeing. As the case studies were exploratory, we did not seek to further define or restrict at this stage as we were interested in understanding of the CBSIs themselves conceptualised and measured these types of outcomes, if at all.

Figure 2 Framework for gathering data on CBSIs and the contexts they operate in



- The **contextual factors** will guide us to consider the influence of both health and social care system factors and demographic, socioeconomic and political factors which may help or hinder progress of the CBSI. A greater understanding of the contextual factors underpinning the CBSI will also help to inform reflections on its transferability/ scalability by offering a rich understanding of the setting.

Structure of the case study

The next section of the report begins with a brief overview of the methodology used for the case study. The report then highlights some of the key contextual factors affecting the CBSI, related to the country's ageing population and its health and social care system.

The main section of the report focuses on how the four areas of the logic model (outlined in Figure 2) related to the CBSI, in the following four areas: (i) establishing the CBSI (inputs); (ii) activities of the CBSI (processes); (iii) results of the CBSI (outputs); and (iv) impact of the CBSI (outcomes). Within each sub-section the perspectives of interviewees are presented alongside findings from the desk review. Finally, the report concludes with some overall reflections on the CBSI and draws out key themes and experiences to better conceptualise CBSIs and their role and functions for older populations.

Methodology

Case studies have been used to collect descriptive data on CBSIs through a mix of methods including semi-structured interviews and a review of administrative data and documentation. Each case study follows the same design in order to provide in-depth understanding of each CBSI and allow comparisons to be made between different actors

within a single case, between cases and between groups across cases, taking into account relevant contextual factors. Key-informant interviews were conducted with key stakeholder groups involved in the CBSI, as well as with wider health and social care system actors.

Desk-based document review

Building on any documentation identified in consultation with the CBSI, the literature review draws on academic and grey literature to provide an overview of the health and social services delivered by the CBSI in Serbia and the wider context in which these interventions are taking place. In addition, any available evaluative documentation was reviewed to collect evidence on the metrics, indicators and monitoring tools used to assess the effectiveness of the CBSIs identified. Key documents included journal articles and policy documents, such as commissioned discussion documents and government strategies. Academic literature was identified through PubMed, focusing on the years 2000 to the present. The literature search was conducted between July and September 2017.

Stakeholder interviews

In addition to the document review described above, key-informant interviews were also used as a key means of gaining an insight into the ongoing activities of the CBSI and the wider contextual factors affecting its functioning in Serbia (for the case study presented below). The interviews followed a common topic guide, with the main topics discussed including: resources that support the CBSI, engagement with older people and functioning of the CBSI, outputs and linkages with the health and social care systems and impact of the CBSI. Emphasis, however, was placed on allowing participants to talk from their own perspective.

In order to explore different perceptions of impact associated with the CBSI, and to identify any linkages and interaction between stakeholders, the project team in coordination with the CBSI staff identified suitable interviewees from three major stakeholder groups (as outlined in Table 1 below). A total of 17 interviews were conducted in Serbia between 1 and 4 August 2017.

Prior to being interviewed, written consent to participate was sought from all participants and they were each asked to sign an informed consent form. Interviews were conducted face-to-face in various locations throughout Serbia.

The interviews typically lasted between 30 and 60 minutes and were semi-structured in style, to enable participants to raise relevant issues of interest that may not have been anticipated

Table 1 Overview of the interviewees

Stakeholder group	Profile of the interviewees
Beneficiaries of the programme	Six interviews with beneficiaries of the programmes were carried out – with two men[2] and four women. Most of the participants seemed to help at and participate in SHG meetings and delivery of support services to peers, rather than only to receive benefits from others.
CBSI staff	Five interviews with CBSI staff were conducted. These did not belong to one single NGO but to the whole network of NGOs involved with the project.
Policymakers, academia and civil society	Six interviews were conducted with this group of stakeholders, with the following distribution: local policymakers (two representatives), academia (three university academics) and government representative (one). All these stakeholders had a very good understanding of the programme.

2 One of the men accompanied his wife to the interview and occasionally commented during the discussion.

by the research team or were specific to the practice. This ensured a flexible approach which allowed respondents to offer their own perspective and raise issues most salient to them, while covering the same overarching topic areas in each interview.

The interview data was analysed and coded by the project team, and then grouped into the categories and sub-categories outlined in the logic model (to the extent to which they applied to the case in question). In analysing the categories, the team also identified emerging themes, which are presented at the end of this report.

Overview of the context in Serbia

A former member of the Yugoslav Republic, Serbia has been a separate country since 2006. Overcoming periods of political and economic crisis, Serbia is now an upper middle-income country (at the lower end of the World Bank threshold),[3] with its economy making important progress, having reduced its public debt from 7 per cent in 2014 to 1.4 per cent in 2016 (Goldstein 2017).

The country has one of the highest percentages of older adults in the region due to below-replacement fertility, increasing life expectancy at birth and high permanent emigration (Rasevic 2012). This results in a dependency ration of 1.1 to 1, which puts a strain on health and social welfare sustainability (WHO 2014). Unemployment in Serbia is at 13 per cent – the lowest level for ten years (Goldstein 2017). As in other European countries, big cities attract most of the high-qualified job seekers. In Serbia this results in less populated rural regions in the south and east (Berlin Institute for Population and Development 2017). The remaining populations in these regions usually comprise older adults, who, as a result of living in less economically developed areas, are facing several challenges when it comes to accessing health and social benefits. In rural areas in 2014, it was estimated that 18 per cent of older people were living in poverty and only 3 per cent received social benefits (WHO 2014).

Demographic factors

Serbia has a total population of approximately 7.1 million (Penev and Marinkovic 2012), with a rate of population growth of -0.54 per cent in 2016 (World Bank, 2016). Data from 2012 showed the average life expectancy is 75, with an average healthy life expectancy at birth of 66.7 (WHO 2015). The percentage of the population aged 60 and above is 23.8 per cent (WHO, 2015) and it is expected to reach 25.2 per cent by 2020 (UN 2017).

The main causes of death are: stroke (14.3 per cent); cardiomyopathy, myocarditis (13.9 per cent); ischaemic heart disease (13.6 per cent); trachea, bronchus and lung cancers (5.6 per cent); hypertensive heart disease (4 per cent); diabetes mellitus (3.4 per cent); colon and rectal cancers (2.9 per cent); chronic obstructive pulmonary disease (2.5 per cent); kidney diseases (2.1 per cent); and breast cancer (1.9 per cent) (WHO 2012).

Overview of the Serbian health system

Serbia's healthcare system grants universal health coverage through a state-run compulsory health insurance scheme financed via work-related taxes (Health Policy Institute 2014). However, due to changes in the state of the economy, the healthcare system has been severely under-funded for many years, and there has also been an emergence of private health insurances which operate as a supplement to the national system, offering faster access and enhancing consumers' choice (Health Policy

3 According to the World Bank, upper middle-income economies are those with a GNI per capita of between USD 4,036 and USD 12,475. GNI per capita for 2016 in Serbia was EUR 4,821 (approx. USD 5,082) (Ministry of Finance of the Republic of Serbia 2016).

Institute 2014). However, due to the country's economic situation these private practices are not affordable to many.

At a health system level, despite medical staff being well trained, the standard of available healthcare merits improvements as the system lacks adequate resources and facilities, and regulation of fair practice is still an area of development.

Overview of the Serbian social care system

Social care of the citizens most in need is regulated by the Social Welfare Law adopted in 2011 (Republic of Serbia 2011). The law introduces earmarked transfers from central level (Art 207) to support the development of community-based social services in underdeveloped areas, financial benefit schemes, poverty-related financial social assistance and carer allowance. The active inclusion of the beneficiaries of financial social assistance is one of the innovations into the social system (Republic of Serbia 2011).

The Serbian pension system is regulated by the Law on Pension and Disability Insurance (2007) and works on a pay-as-you-go basis. Nevertheless, due to the increased longevity of the population, the low fertility rate and the impossibility for many workers to contribute sufficiently to their future pension, a reform of the system is widely seen as needed (Jovanović et al. 2015). Pensions in Serbia are low in comparison to European standards – in 2007 the average monthly pension was EUR 200 – leading to chronic poverty among older people (Sataric et al. 2009).

Overview of the CBSI

Establishing the CBSI (Inputs)

Establishing the CBSI

Self-Help groups (SHGs) for Older People were initially established in Serbia in November 2010, through financing from a European Union Instrument for Pre-Accession Assistance project implemented in Serbia, Albania and Bosnia and Herzegovina called 'Dialog of Civil Society Organisations in Western Balkans' (Age UK 2012).

According to information given by the CBSI staff, in the first instance, the SHGs were initiated by the Red Cross of Serbia and the HumanaS network[4] (HumanaS 2017). The first 48 groups were organised during the period November 2010 to November 2012, in 25 municipalities of Serbia. Overall the groups enrolled 462 persons aged 60 and above. Age UK (Great Britain) was the implementer, with one Civil Society Organisation (CSO) per country as a partner. In Serbia, the project was implemented by the CSOs and members of the HumanaS network. The main project implementer in Serbia was the Red Cross of Serbia (due to the fact that the HumanaS network is not registered as a legal entity). Out of the members of the HumanaS network, four SHGs were formed by Victorija of Kragujevac (municipalities of Kragujevac and Knić), four by Hleb zivota (Bread of Life) of Belgrade (municipalities of Vračar and Starigrad), and two by Amity (one in Bor and one in Smederevo). The remaining 38 groups were formed by municipal organisations of the Red Cross in the following municipalities: Trstenik, Velika Plana, Paraćin, Jagodina, Požarevac, Pirot, Palilula, Negotin, Boljevac, Loznica, Mionica, Vladimirci, Savski Venac, Kovin, Kikinda, Kanjiža, Bačka Topola, Ruma and Vrbas.

4 Established in 2004, HumanaS is a network of 15 NGOs (HumanaS 2017): the Red Cross of Serbia, the Society of Gerontology of Serbia, Caritas, Amity, Victorija, Lastavica, the Circle of Serbian Sisters, the Charity Foundation of the Serbian Orthodox Church Philanthropy, the Society for the Care of the Elderly, the National Foundation for Dignified Ageing, the Pensioners Union of Serbia, the University of the Third Age Network, the Christian Humanitarian Association, The Bread of Life, Moka and Rosa.

The CBSI staff mentioned that in 2013, a second wave of forming and supporting SHGs in Serbia took place. This time further financing was made available to the same 48 SHGs and also to another six that had been newly formed. In total 54 SHGs were supported, these registering 572 beneficiaries (persons of 60 and above) in the same 25 municipalities as in the first cycle. The SHGs were financially supported from December 2013 to December 2015, under the project 'Improvement of Human Rights of Older Persons in the Republic of Serbia', with the British HelpAge International as the umbrella organisation and the Red Cross of Serbia as the partner acting on behalf of the HumanaS network. Financial support to this project was provided by the EU Delegation to the Republic of Serbia.

This case study focuses specifically on the SHGs in Bor (convened by Amity and historically funded through EU sources, and now largely self-sustaining but with diminished scale, scope and reach) and Paraćin (convened by the local Red Cross and supported now also by the local authority).

Aims and objectives of the initiative

The overarching goal of the SHGs is to create a peer-support community and provide participants with a space to discuss issues of concern and together to come up with solutions, whether on their own or in the context of initiatives targeted at mobilising action by relevant – predominantly local – stakeholders.

As described by the CBSI staff, one of the main characteristics of the groups is their flexibility in terms of implementing activities (within an overarching common goal, as described above). This ensures that each group has its own dynamics and can pursue specific discussions and objectives aligned to members' needs and priorities. Although group meetings seem to be a shared core activity across the SHGs, the topics discussed and follow-up activities pursued can vary. The extent to which the focus of the groups is on helping the member community only, versus the wider community in a location and region, varies across groups. Some of the groups were organised in such a way that members primarily helped each other, others sought to offer support to people in community who were not direct members of the group, and some were trying to make changes in the community in accordance with the specific needs identified in a location. Flexibility in the groups was in part reflected in how activities were identified and prioritised – by older people themselves. The groups represent a model of activism and social inclusion of older people.

Funding of the CBSI

SHGs across Serbia are funded through a variety of sources. The SHGs which are the focus of this case study have over time been funded through EU funding, NGO funds and local government support:

- The SHG in Bor was historically funded through EU funds, but these have now been used up, and it continues to run through the minimal funding Amity can afford to devote to group meetings.
- The SHG in Paraćin is supported through Serbian Red Cross funds and local government support.

Changes in the amount of funding available for SHGs have had a negative impact on the number of SHG members who can participate and benefit from the peer support offered, as shown in Bor. While the group continues with some actively engaged members, there are challenges to scaling up in the absence of downstream funding.

According to one interviewee, the SHGs in Paraćin have benefited from local government support. The local authorities in Paraćin have financed four SHGs with 50–60 older persons under the 'Care of Older People' programme. In 2015, according to one interviewee, they allocated RSD 18,000 (approx. EUR 150) for the year, which was complemented by approx. EUR 180 plus EUR 33 from other donors in 2016.

In 2017, local government allocated EUR 160 and other donors allocated EUR 40 to ensure the functioning of two groups in urban and the forming of two groups in wider rural areas in that year.

Governance and management

The SHGs covered in this case study have been implemented by the following stakeholders:

- Red Cross of Serbia with Amity (and other members of the HumanaS network).
- HelpAge International as umbrella organisation.

The SHGs were initiated with the help of a coordinating CSO (Amity or Red Cross in our case studies) employee familiar with the local community. The CSO representative organised the group in identifying a meeting space, arranging refreshments and proposing discussion topics in the early stages. However, as the SHG members became more familiar with each other, they began taking a more active role in setting the agenda for the meetings and deciding future activities, in collaboration with CSO coordinators.

Other initiatives in the region

Serbia has a good tradition of pensioners' clubs that allow interaction between seniors. The Serbian state also offers a standardised home care service for older people, comprising subgroups of services developed in accordance with local needs. However, challenges exist in performing a personalised needs assessment.

Interviews brought up other initiatives such as a phone circle of 15 participants, a Red Cross programme. The first call is made by a Red Cross employee to an older person, who then calls a peer and so on; if the last person (no.15) does not call the Red Cross within 15 minutes this is considered a signal that something is wrong, and the Red Cross commences a checking procedure. Another initiative is the SOS phone, a Red Cross phone service which registers the problems of older people and refers them for support (e.g. accessing soup kitchens and receiving hygiene parcels).

Amity undertook other initiatives aimed at helping older people, such as introducing a village helper in the municipality of Mali Idjos, who was available to older people for help with preparing food, obtaining medicines from the pharmacy, performing daily chores and offering help around the household. Other Amity-supported activities include organising writing competitions for elderly people who submitted travel memoirs and stories from their youth. The selected winners received prizes ranging from a weekend away with a loved one to smaller prizes like a meal at a restaurant.

Other institutions, such as the Gerontology Society of Serbia, are also involved in organising annual social events for the elderly.

One interviewee highlighted the idea of creating new foster-family-style arrangements, which is beginning to be discussed at policy levels, as a way to mitigate some of the challenges associated with traditional models (which did not seem to incentivise foster families to ensure well-being and guarantee protection of the elderly, and have been criticised in the way they handled linkages to property rights).

Activities of the CBSI (Process)

Target population and eligibility criteria

The SHG programme is formally open to all older people (older than 60) in communities where an SHG is organised, but recruitment tends to be either through word of mouth or existing community networks. Interviews revealed that participants generally tend to be female, with comparatively very few men attending the SHGs. Anecdotally, one explanation offered by a beneficiary was that women tend to be more willing to discuss personal problems and engage in social initiatives leading to collective action, while men prefer to participate in the pensioners' clubs and play chess, dominoes or cards with their peers.

Both the Amity SHG and the Red Cross SHG seemed to engage more older people from low-income population groups and those without families living close by.

Activities associated with the CBSI

The SHGs offer two main types of activities:

(i) Meetings between peers.

(ii) Support in daily activities such as preparing meals and buying food supplies, cleaning, maintaining hygiene, organising house repairs, attending regular physician check-ups, medicine purchasing, attending to small injuries and assisting in social activities.

The SHGs rely on the availability of a meeting space. Often, refreshments are offered during the meetings. The frequency of the group meetings, the topics discussed and the activities that are undertaken are decided by the groups themselves with the help of a facilitator (CSO representative – either Amity or Red Cross in our case study). Examples of activities undertaken are advocacy efforts, for example leading to the building of a covered bus stop to provide shelter from rain, or, more rarely, crafts or weaving. Other activities included organising excursions to other towns (however, these were dependent on available funding and have been scaled down in Bor as funding support has decreased).

Results of the CBSI (Outputs)

Enrolment of older people

Although not specific to the cases of the SHGs in Bor and Paraćin (for which such data does not exist), data reported by individuals consulted during fieldwork in Serbia and documents CBSI staff have provided (HelpAge International and Red Cross of Serbia, 2015) indicate that from December 2013 to December 2015, 54 groups were functional in Serbia (supported by various

Home visit by a group member

CSOs) involving 572 older persons (financed by the EU Delegation to Serbia). Members, apart from self-help, provided support to other, more vulnerable persons in their communities who could not exercise rights on their own, whether due to lack of information, physical inaccessibility of institutions, economic inaccessibility or functional dependency. According to the final report of the Red Cross of Serbia,[5] in particular these groups provided the following support:

- 997 older persons were helped to exercise their health protection rights: escorting the more fragile to the doctor's; certifying healthcare cards; preparing documents to apply for healthcare cards; acquiring medicines and orthopaedic aids; mediation at the Patient Ombudsman, etc.
- 221 older persons were helped to exercise their social welfare rights: care and support allowance; one-off cash grants; accommodation in institutions, etc.
- 87 older persons were helped to exercise their pension-disability insurance rights: preparing documents and informing about pension rights in Serbia and the region.
- 1,992 older persons – including non-members – were educated on various topics in 96 courses at community level.

5 Personal communication. This data was provided by CBSI staff, which indicated that it is presented in the final report of the Red Cross of Serbia. RAND Europe did not have access to the full report but only to the document provided by CBSI staff. These numbers were retrieved by compiling data submitted by all municipal organisations of Red Cross, Amity, Victoria and Hleb Zivota, reflecting all the activities of the SHGs under the responsibility of those organisations.

- Several advocacy actions were carried out at community level: petitioning for reopening a library; erecting a railroad fence for sound isolation; pavement repairs; erecting a public fountain; laying street paving and street bumps, etc.

Most of these activities (though less so when discussing support in exercising social welfare rights and pension-disability insurance rights) were related in the interviews as discussed in the following sections.

Self-reported health gains from beneficiaries

The potential of SHGs to alleviate loneliness and provide a platform for peer support was a theme that came through strongly from the interviews. Several participants found that the socialising aspect has significant benefits for their well-being, elevating their mood and serving as a source of comfort. SHGs were seen as facilitating engagement activities and initiating connections between peers.

In addition, offering help to other persons was seen as a source of satisfaction and pride. Often participants reported that the desire to help was always a trait of their character and the SHGs provided a means to deliver this help. Interviewees were also appreciative of the help they themselves received.

The opportunity to attend lectures or training on topics such as measuring hypertension and glycaemia was also seen as attractive. However, it is not clear how scalable such an offering is, given that it would require funding to attract professionals. There was strong interest in scaling up this offer, but a recognition that this would require additional resources.

Linkages to health and social care system

There do not seem to be many formal linkages between the SHGs and either the health or the social care system, except for the financial support that some local governments provide to SHGs (largely dependent on relationships between CSOs and local authority leaderships, and the ability to align CSO-facilitated SHG offers to local and national political priorities). SHGs are eligible to bid for some central government support, but interviewees on occasion raised concerns about the *perceived* transparency of selection processes in such tenders. A more substantial challenge was developing skills and sufficient human resource capacity to put together competitive bids (especially for administratively demanding EU funds, but also for national government resources), given competing demands on short-staffed CSO time.

Local and central government was said to offer some support for other types of elderly-care initiatives (such as help in the home, social insurance and various benefits, such as public transport benefits/discounts, or benefits/discounts for utility services for the poor), but less frequently for the SHGs in our case study. An exception (at present) would be the Red Cross-convened SHGs in Paraćin, which do also receive local authority support (attributed to close relations and partnership working between local Red Cross leadership and the municipality).

According to some interviewees, the SHGs could help fulfil a connecting/navigator role in relation to the health and social care system, as a significant proportion of their activities imply gaining access to state services or raising awareness of the rights of older populations within current state services, and minimising demands on some state services by providing alternative means of support and care and self-activation of the elderly.

Impact of the CBSI (Outcomes)

Wider impacts of the programme

The most important existing impact is at micro level, on the well-being of participants. Due to the socioeconomic situation in Serbia many older people either do not live in proximity of their children (e.g. in rural areas), these having moved to cities or abroad (economic migration), or are main financial supporters of their

Cultural activities of the SHG

children and grandchildren due to existing high unemployment. In both situations, older people can be subjected to high stress (emotional or/and financial), as revealed by the interviews. The opportunity to share emotional burdens and experiences with practical challenges with peers provides a respite for SHG members, who can benefit from emotional comfort through these interactions.

Furthermore, SHGs enable peers to help older persons that are frail or incapacitated in obtaining their day-to-day necessities as well as enable older people to help vulnerable populations such as refugees. For example, one interviewee illustrated how in Bor, SHGs were also able to provide socialising support to refugees, or assistance with small gifts such as clothing items or small utensils for the home (e.g. pots). SHG participants felt proud of being able to offer such assistance. Some interviewees highlighted that support provided through SHGs extends beyond peer support to include intergenerational support to local communities. This was seen as important for preventing ageism as well as for offering concrete physical support, as in some cases the services that older people need involve persons of a younger age (e.g. certain types of housework).

A third area of impact is advocacy. The SHGs have in some instances fostered dialogue that leads to small but meaningful changes in the everyday life of older adults. For example, by organising themselves, older adults were able to obtain a shelter at the bus stop in front of the hospital in Bor. However, these initiatives were not always successful, as was the case in asking for a dedicated day for pensioners to receive blood testing at the local hospital, an initiative which did not receive any answer from the relevant authorities and whose goal therefore did not materialise. Unsuccessful attempts such as this were seen to be demotivating and to pose a risk of disengagement. They point also to a potential need for closer dialogue between SHG CBSIs and local government in determining priorities for action and openly discussing which solutions may be feasible, and if they are not, why not.

Sustainability of the programme

The SHGs are dependent on their initiators, which often come from the CSO sectors. The support of the Red Cross or Amity in the initiation stage is therefore very important. A key aspect of running the SHGs was the existence of the physical space for meetings and the provision of refreshments such as coffee and juice. Several participants highlighted that a physical meeting space outside the home is preferable, as this means people do not worry about their living conditions or about having something to offer

visitors – this was seen as important as in our case study sample the SHGs largely targeted a low-income population. Having initiators and coordinators was also seen in a positive light from the CSO side, as it creates a comfortable power dynamic at group level, with participants not feeling that certain peers have more power than others. Still, several beneficiaries see themselves as leaders and organisers of the groups, which reveals a certain degree of empowerment that SHGs were able to foster.

Reflections on the CBSI

Several themes that are relevant to the analysis of CBSIs have emerged and are presented below.

SHGs present an interesting small-scale, low-cost model for improving certain aspects of psychosocial health and well-being.

The SHGs are leading to improvements in the psychosocial health and well-being of participants, resulting from increased socialisation and peer support. The functioning of SHGs relies on low-cost inputs such as local CSO support, existence of physical meeting spaces and provision of refreshments.

SHGs are dependent on their initiators, which often come from the CSO sectors. The support of the Red Cross or Amity in the initiation stage was seen across the interviewees (including beneficiaries) as very important. Such support comprised the organisation of a physical space to meet and the provision of refreshments such as coffee and juice. All these would suggest SHGs as being a low-cost model for improving certain aspects of psychosocial health and well-being.

Sustainability/scale-up is challenging given the lack of funding available.

Throughout the interviews with all categories of participants the lack of financing of SHGs was presented as the greatest challenge to sustainability and scale-up of the programmes. In particular, the beneficiaries wanted more help from their local municipalities, particularly in financing the SHGs. However, the interviews with the representatives from academia and CBSI staff revealed that sometimes the beneficiaries have unrealistic expectations about benefits (e.g. a financial assistance role might be expected, whereby SHGs would offer direct financial help) and end up leaving when some benefits do not materialise.

From the point of view of the interviewees from academia and the CBSI staff, the lack of predictability and availability/continuity of funding streams raises the most difficulties. This is further complicated by the bureaucratic requirements of securing funding. One participant raised the point that it is easier to get pilot projects funded (from EU sources in particular) than existing projects, which makes sustainability of initiatives such as SHGs difficult.

Several participants mentioned the introduction of earmarked funds, sources of funding for local governments provided to support under- or less-developed regions in the development of services within their competence. The local governments can choose to outsource these services and finance them through the earmarked funds. According to participants, while some local governments are making use of this opportunity, others have a less clear strategy for the use of these funds or are unclear as to how best to access them. This is seen by participants as a missed opportunity to fund CSOs or initiatives such as SHGs. However, it was noted that local governments also tend to contract private suppliers (and not civil society) for various types of services.

Varying levels of social capital can enable but also delay the maximisation of the potential of CBSIs.

The interviews revealed various nuanced opinions on the existing levels of trust between various social networks and the institutional setting in which these operate.

One interviewee from academia highlighted the importance of the social network that is being

built through the SHGs, in particular in terms of disseminating information and making peers aware of opportunities. This is possible as a result of existence of a particular type of trust and dynamics that exists or can be built among people with similar needs and/or interests, and through repeated interactions. However, some views also pointed to diminishing levels of social capital as a potential risk to the sustainability of the SHGs, and to the problem of maintaining involvement of beneficiaries in the absence of clear individual (and not only collective) gains.

When it comes to trust in institutions, some concerns were raised pertaining to the fairness of public processes (e.g. adherence to transparent selection criteria in tendering and contracts). In addition, some interviewees commented that the ultimate beneficiaries, end users, may also distrust NGOs (a relic from the war, when some foreign NGOs were perceived to be engaged in questionable practices and alleged financial mismanagement[6]). Whether grounded in reality or not, these types of challenges illustrate some of the issues at play in efforts to foster constructive engagement between civil society and state structures, and between beneficiaries and civil society. This presents itself as an area where further dialogue is needed to maximise the potential of collaboration on common challenges facing both CSOs and the public sector. Joint activities and planning could be a way to foster such collaborations.

SHGs can be further strengthened by integrating more training and expert support opportunities.

Several SHG beneficiaries expressed the desire to help and the satisfaction that comes with helping. However, they also stressed a desire to benefit from expert support, in particular when it comes to health assistance, and saw access to such expertise as an incentive for engagement with the SHGs. Some SHGs had historically brought in medical experts (on occasion) and this was very well received by participants in the groups, especially given the challenges to accessing healthcare in some regions.[7] Providing access to advice and expertise on maintaining good health through the SHGs was seen as a helpful measure towards empowering the elderly on health-seeking behaviours.

SHGs are low-cost initiatives and further research and action are needed to establish evaluation frameworks to help assess what constitutes good value for money when it comes to such CBSIs.

Drawing from the evidence from our interviews, sustaining SHGs is relatively low-cost and interviewees widely perceived the initiatives to be of value, but no formal assessment of value for money exists. SHGs are difficult to evaluate, due to a lack of a universal theory of change and intervention logic and an equal lack of data collection. The former issue is easier to address through theory-driven realist approaches which can accommodate sensitivity to adaptiveness and to local contexts. The latter would require resources to sustain data collection and working with local actors to enhance the existing evidence base.

In an environment where, as expressed by one participant, there is a ‘fight between the economic and social area’ for resources, the social sector is challenged to show economic savviness while not compromising outcomes that pertain to the well-being and quality of life of beneficiaries. The level of funding SHGs need is not necessarily high (though scaling costs remain unclear). However, there would likely be a need to demonstrate both social and health benefits and economic benefits for the wider system to facilitate local investments at scale.

6 Personal communication with interviewees; no specific NGOs were mentioned.

7 While in some areas the connection with health professionals is very good in others it is difficult to access high-quality care – not only because of difficulties arising from lack of resources, such as stripes for glycaemia measurements or needles, but also due to unpleasant experiences as a result of lack of consideration from health professionals towards older adults. Issues of access are further exacerbated by the lack of health centres in rural areas.

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World Health Organization

Centre for Health Development

HelpAge Sri Lanka's programme to improve older people's health

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Preface

The World Health Organization Centre for Health Development Kobe has contracted RAND Europe to serve as a research hub for conducting a systematic review and gathering evidence of middle- and high-income countries' community-based social innovations (CBSIs) for healthy ageing. RAND Europe is therefore undertaking two main strains of research consisting of: (1) a systematic review of CBSIs for healthy ageing in middle- and high-income countries, and (2) a series of ten case studies of CBSIs for healthy ageing in middle-income countries.

The present report presents progress on the systematic review of CBSIs for healthy ageing in middle- and high-income countries, and addresses two main aims:

1. To conduct a systematic review on CBSIs for healthy ageing in upper middle- and high-income countries and in doing so provide an overview of included studies, assessment of quality of research, an account of outcomes reported and synthesis of evidence around the effectiveness and cost-effectiveness of CBSIs.

2. To develop criteria by which to describe and differentiate types of CBSIs for healthy ageing and offer a typology to inform future research and policy discussions.

This report presents the findings from one of our ten case studies, HelpAge Sri Lanka's programme to improve older people's health.

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Summary of the community-based social innovation (CBSI)

Background

Sri Lanka

Locations
Across Sri Lanka

Type of intervention
Adaptive

Year established
1986

The intervention

Establishing the CBSI

- HelpAge Sri Lanka (HASL) is a not-for-profit, charitable non-governmental organisation working for and on behalf of disadvantaged senior citizens in Sri Lanka to improve their quality of life. It is a founding member of the HelpAge International network and is one of the several affiliates of the network in the South Asia region.
- HASL's mission is 'by working together, we ensure that people in Sri Lanka understand how much older people contribute to society and that they must enjoy their right to healthcare, social service and economic and physical security'.
- The programme has attracted a diverse pool of funding sources, including international donors, corporate and private-sector donations and local-level fundraising through income-generating activities.

Activities of the CBSI

- HASL's activities can be grouped into three core areas:
  - **Welfare and services** – training programmes for care volunteers, eye hospital, mobile medical services, day care services, intergenerational programmes.
  - **Development activities** – livelihood assistance, microfinance programmes, establishment of Senior Citizens Committees (SCCs) and their capacity building, environmental initiatives led by older people such as drought mitigation.
  - **Advocacy and rights** – workshops and training to advocate for elderly rights and access to services.
- The programme is strongly linked to government in areas of ageing-related policy in Sri Lanka and has contributed to several policy changes through its advocacy work.
- HASL has a strong M&E culture that allows the organisation to revisit its approach, learn and adapt where necessary.

Results and impact of the CBSI to date

- HASL has estimated that it has reached over two million older people since it was established, and has reached out to more than 600,000 older people over the last five years in Sri Lanka.
- Beneficiaries noted the range of health gains from the different activities, including both physical and mental health gains.
- The interventions have influenced policies related to ageing and several initiatives have been replicated at the national level.
- Despite relatively stable staff turnover within the CBSI, interviewees noted that there is a human resource gap.
- In addition, geographical challenges related to access and the reduction of international funding were seen as challenges to HASL's future activities.

Ageing in Sri Lanka

- In 2015, the percentage of the population aged 60 and over was 13.9 per cent and it is expected to reach 16.4 per cent by 2020.
- Its healthcare system is reported to be one of the most cost-effective in South Asia, although peripheral areas remain underserved, especially in terms of healthcare facilities and human resources.
- Older people are covered by a universal pension system and the 2000 Elderly Protection Act.
- However, a significant proportion still live in poverty, with very little economic security.

Reflections on the CBSI

- HASL has managed to leverage funding for its activities and day-to-day operations from a variety of sources, both locally and internationally, although securing future international funding remains a challenge.
- HASL has a strong reputation in Sri Lanka and can be seen as a trusted partner of the government due to the longevity of its operations. This has enabled HASL to have very strong linkages with the health and social care system.
- The programme has successfully managed to reach a large number of older people in Sri Lanka, building on pre-existing linkages and networks.
- The external context in Sri Lanka can be considered as a limiting factor in HASL's operations, particularly in regard to the supply of skilled workers and geographical features of the country.
- HASL has embedded a culture of M&E in its activities that allows it to revisit its approach, learn and adapt. However, improving strategies for disseminating that evidence could improve the organisation's visibility and may lead to increased funding opportunities.
- HASL can be considered as a mature intervention, which applies a holistic approach to healthy ageing, covering various activities that address the social determinants of health as well as the provision of direct health services and referrals.

Aims of the research

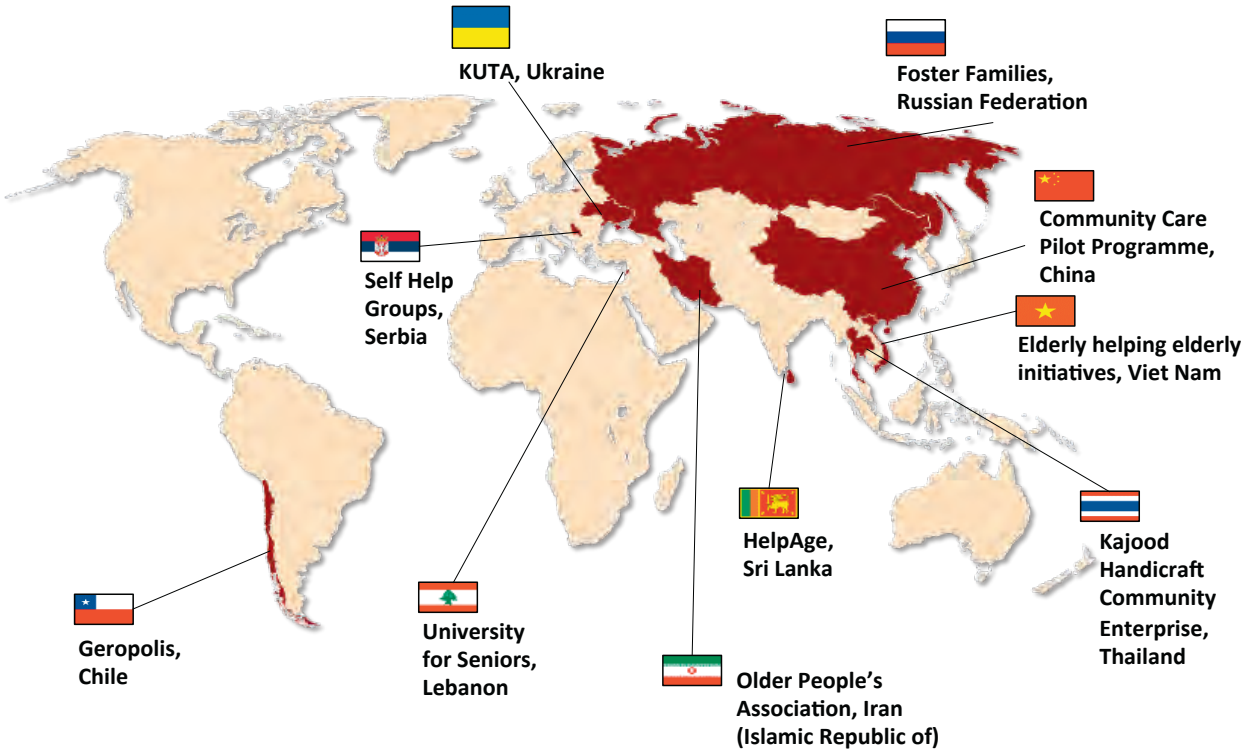
This report presents the findings from one of our ten case studies, HelpAge Sri Lanka's programme to improve older people's health. The overall aim of the research is to describe within a pool of rapidly ageing countries, and from those with high proportions of older people, a) the core roles, services and functioning (including feasibility of scale-up) of community-based social innovations (CBSIs) for healthy ageing that seek to support older people becoming a resource for their own health and well-being; b) their linkages with and sustainable partnerships to deliver health services, strengthen social systems; and c) the nature of enabling policies, programmes, financing and interactions with the health/social care delivery system.

A recent WHO study (Ong et al. 2016) conceptualised CBSIs as initiatives that seek to empower older people to improve their self-efficacy in caring for themselves and their peers, maintain their well-being and promote social cohesion and inclusiveness. They can also help older people to access, understand and navigate health and social care systems (Ong et al. 2016).

While CBSIs may hold the potential to transform health and social care provision for older people, more evidence is needed to improve our understanding of what types of initiatives and service delivery models are pursued in practice that engage communities and span a spectrum of health and social services.

Aiming to develop a typology of CBSIs, this research consisted of three main parts: (i) a systematic review of CBSIs for healthy ageing in upper middle- and high-income countries; (ii) a series of ten case studies to examine the effectiveness of ongoing CBSI interventions in middle-income countries; and (iii) an expert consultation at the World Health Organization's Centre for Health Development (WHO-WKC) in Kobe, Japan, to validate and refine the typology. Given the relative lack of evidence on CBSIs in middle-income countries in academic literature, the ten case studies were identified through an open call for Expressions of Interest (EOIs). Figure 1 below shows the location of the ten case study countries.

Figure 1 Ten case study countries



The data gathered in this case study will serve to better conceptualise what a CBSI is and to present typologies and functions of CBSIs for older populations. Each individual case study will seek to explore:

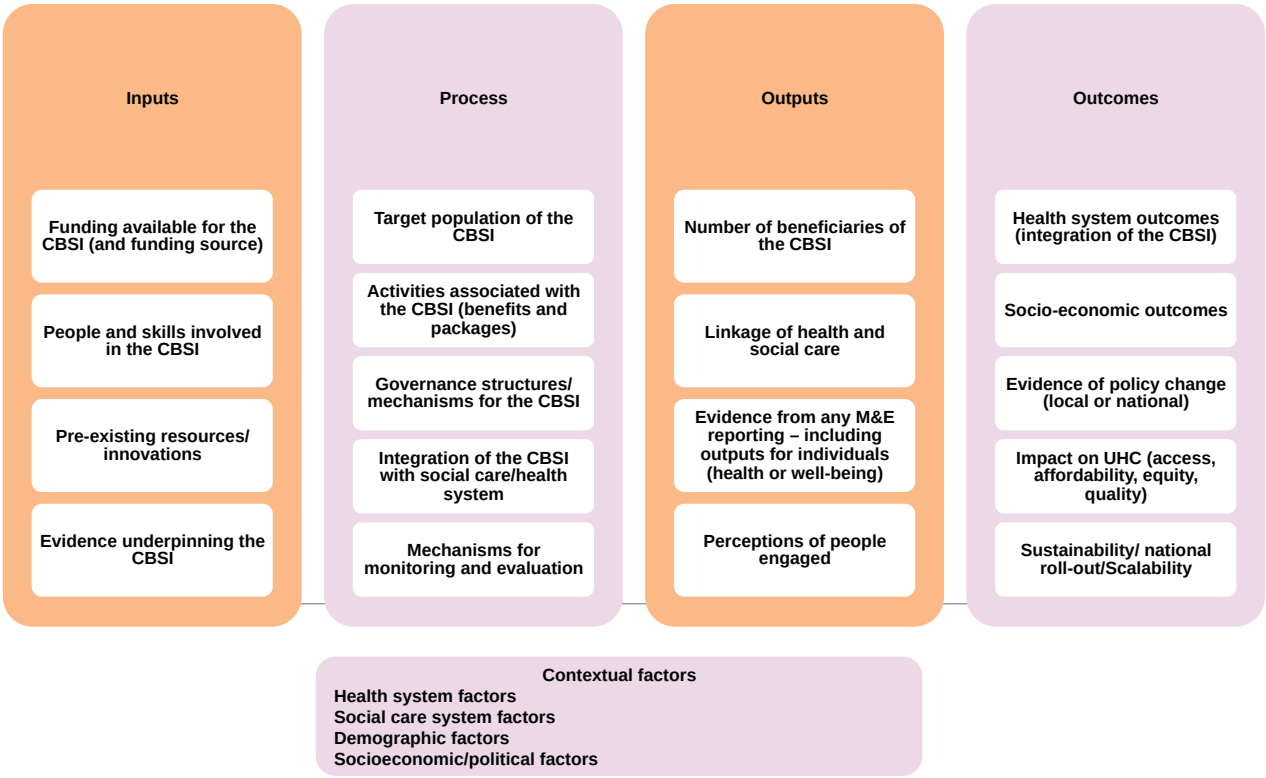
- The role and function of older people as resources for themselves and for others (peers, family, community).
- Health and social services delivered by those initiatives and referral processes when they exist.
- Links made within these communities of support between health interventions and social health protection interventions (e.g. help with transportation, livelihoods, pensions, cash or in-kind transfers).
- Coordination mechanisms with formal health and social sectors, including any formal connections with the health and social care system.
- Coordination and engagement with a variety of health/social-service workers and community-based services.
- Types of metrics (indicators, monitoring tools) implemented to assess impact on health[1] and the concept of health that is being measured.
- Measures to understand and respond to health inequities in the population served.

We have used a logic model approach to examine the effectiveness of selected CBSIs. This helps us assess the intervention logic for CBSIs and track the progress, impacts and evolutionary dynamics of CBSIs at core levels of analysis. As illustrated in Figure 2 below:

- **Inputs** will help us understand the resource environment of each CBSI and provide a foundation for exploring the linkages between resources, outputs and impacts. This resource input environment is likely to capture aspects such as resources for implementation (funding, infrastructure and skills/capabilities). We will also aim to capture the reasoning and evidence base leading to the establishment of the CBSI.
- The **process** dimension will help us examine both the diversity of CBSIs, in terms of activities/services offered, population groups targeted and geographies projects covered, and mechanisms for designing, managing and evaluating the CBSI if present. We will also examine the integration of the CBSI within the wider health and social care services offered to older people.
- The **output** dimension will help us assess the relative progress of CBSIs since they have been established and capture the diversity of outputs and associated achievements. This will involve capturing outputs such as the number of beneficiaries involved in the CBSI and any initial health and well-being outputs for beneficiaries reported.
- The **outcomes** dimension will help us capture a wider range of benefits, including those relating to impact on resources for achieving universal health coverage (UHC), policy-level impacts and other (including unintended) consequences which may affect the health and well-being of older people in a particular country. In particular we will not only consider impacts at an individual level (e.g. beneficiaries engaged in the CBSI) but also look to examine the impact on the wider community and the overall health/social care system.

1 We used the term 'health' very broadly at this stage in anticipation that it could incorporate physical and mental health and broader wellbeing. As the case studies were exploratory, we did not seek to further define or restrict at this stage as we were interested in understanding of the CBSIs themselves conceptualised and measured these types of outcomes, if at all.

Figure 2 Framework for gathering data on CBSIs and the contexts they operate in



- The **contextual factors** will guide us to consider the influence of both health and social care system factors and demographic, socioeconomic and political factors which may help or hinder progress of the CBSI. A greater understanding of the contextual factors underpinning the CBSI will also help to inform reflections on its transferability/ scalability by offering a richer understanding of the setting.

Structure of the case study

The next section of the report begins with a brief overview of the methodology used for the case study. The report then highlights some of the key contextual factors affecting the CBSI, related to the country's ageing population and its health and social care system.

The main section of the report focuses on how the four areas of the logic model (outlined in Figure 2) related to the CBSI, in the following four areas: (i) establishing the CBSI (inputs); (ii) activities of the CBSI (processes); (iii) results of the CBSI (outputs); and (iv) impact of the CBSI (outcomes). Within each sub-section the perspectives of interviewees are presented alongside findings from the desk review. Finally, the report concludes with some overall reflections on the CBSI and draws out key themes and experiences to better conceptualise CBSIs and their role and functions for older populations.

Methodology

Case studies have been used to collect descriptive data on CBSIs through a mix of methods including semi-structured interviews and a review of administrative data and documentation. Each case study follows the same design in order to provide in-depth understanding of each CBSI and allow comparisons to be made between different

actors within a single case, between cases and between groups across cases, taking into account relevant contextual factors. Key-informant interviews were conducted with key stakeholder groups involved in the CBSI, as well as with wider health and social care system actors.

Desk-based document review

Building on any documentation identified in consultation with the CBSI, the literature review draws on academic and grey literature to provide an overview of the health and social services delivered by the CBSI in Sri Lanka and the wider context in which these interventions are taking place. In addition, any available evaluative documentation was reviewed to collect evidence on the metrics, indicators and monitoring tools used to assess the effectiveness of the CBSIs identified. Key documents included journal articles and policy documents, such as commissioned discussion documents and government strategies. Academic literature was identified through PubMed, focusing on the years 2000 to the present. The literature search was conducted between August and October 2017.

Stakeholder interviews

In addition to the document review described above, key-informant interviews were also used as a key means of gaining an insight into the ongoing activities of the CBSI and the wider contextual factors affecting its functioning in Sri Lanka. The interviews followed a common topic guide, with the main topics discussed including: resources that support the CBSI, engagement with older people and functioning of the CBSI, outputs and linkages with the health and social care systems and impact of the CBSI. Emphasis, however, placed on allowing participants to talk from their own perspective.

In order to explore different perceptions of impact associated with the CBSI, and to identify any linkages and interaction between stakeholders, the project team in coordination with the CBSI staff identified suitable interviewees from three major stakeholder groups (as outlined in Table 1 below). A total of 16 interviews were conducted in Sri Lanka between 9 and 11 November 2017.

Prior to being interviewed, written consent to participate was sought from all participants and they were each asked to sign an informed consent form. Interviews were conducted face-to-face across the Colombo and Galle areas of Sri Lanka. The interviews typically lasted between 30 and 60 minutes and were semi-structured in style, to enable participants to raise concerns that may not have been anticipated by the research team or were specific to the practice; this provided a flexible approach which allowed respondents to offer their own

Table 1 Overview of the interviewees

Stakeholder group	Profile of the interviewees
Beneficiaries of the programme (10)	Beneficiaries of HASL activities in the Galle area – including users of mobile medical services, older people having received eye care, women receiving microfinance support and SCC members. The interviewees comprised six females and four males, whose ages ranged from 58 to 75.
CBSI staff (4)	HASL staff members – two senior managers focusing on the women's programme and on advocacy, an eye hospital manager and a finance manager. Two were male and two female.
Policymakers, academia and civil society (2)	One senior government manager from the Ministry of Disaster Management, involved in close examination of older people's needs. One senior manager from a national-level, community-based NGO, working on poverty reduction and with a policy background in ageing.

perspective and raise issues most salient to them, while covering the same topic areas in each interview.

The interview data was then analysed and coded by the project team, and then grouped into the categories and sub-categories outlined in the logic model. In analysing the categories, the team also identify emerging themes, which are presented at the end of this report.

Overview of the context in Sri Lanka

In Sri Lanka, as in other developing countries of South Asia, the rapidity of population ageing continues to outpace social and economic development. Declining fertility and mortality rates and pronounced gains in longevity since the 1950s have led to an increase in the percentage of the population aged 60 and over. Older people in Sri Lanka have traditionally depended on the family as the main caregivers and support base. However, this is somewhat changing in urban areas. According to the Department of Social Services' records, over the last two decades, the number of institutionalised older people has increased considerably in Sri Lanka in urban areas, and the number of care homes nationwide increased from 68 in 1987 to 162 in 2003 (Siddhisena 2005).

Demographic factors

In 2016 Sri Lanka's total population was approximately 20.8 million (UN 2017). Due to a fall in the fertility rate and an increasing life expectancy, the country is experiencing a rate of population growth of 1.1per cent (World Bank 2016). The percentage of the population aged 60 and over was 13.9 per cent in 2015 and it is projected to reach 16.4 per cent by 2020 (UN 2017). Today the average life expectancy is 75, with an average healthy life expectancy at birth of 67 (WHO 2015).

Overview of the Sri Lankan health system

Sri Lanka has a comprehensive countrywide network of health centres, hospitals and other medical institutions. Its healthcare system is reported to be one of the most cost-effective in the South Asian region (PwC 2014). However, peripheral areas tend to be underserved, especially in terms of human resources, whereby medical professionals prefer to work in urban areas where the main facilities concentrate (WHO 2012). Moreover, due to the long waiting times for specialist medical services, healthcare expenditure directed towards the private sector accounted for almost 55 per cent of total healthcare expenditure in 2012 (PwC 2014). In Sri Lanka it is difficult to separate health expenditure for older people from general health expenditure budgets since the government provides free medical treatment for all who need it, irrespective of age (Siddhisena 2005). The majority of health expenditure in Sri Lanka has shifted in recent years from communicable to non-communicable diseases (NCDs), including injuries. With an increased ageing population, the spending on NCDs is still projected to increase substantially.

Overview of the Sri Lankan social care system

Sri Lanka has a long history of social programmes and social protection measures, providing medical care on a universal basis and different forms of income support to its population – whether in the formal or informal economy. While informal social protection afforded by family and community members is commonplace, the rapidly ageing population means that Sri Lanka's social protection system faces major challenges (ILO 2008).

The Protection of the Rights of Elders Act (Number 9 of 2000) was considered a breakthrough in the history of services for older people in Sri Lanka (National Secretariat for

Elders 2016). The Act makes provisions for the establishment of a National Council for Elders, a National Secretariat for Elders, a National Fund for Elders and a Maintenance Board for Elders. The National Secretariat, in collaboration with the WHO, formulated the National Plan of Ageing in 2010. The plan was developed in line with the priority areas and strategies of the National Policy. Senior Citizen Committees (SCCs) have been established all over the island at different administrative levels, including provincial, district, division and *Grama Niladari* levels (equivalent of village level in the Sri Lankan administrative system). In addition, day care centres, home care services and legal aid provisions for older people have been put in place by the government.

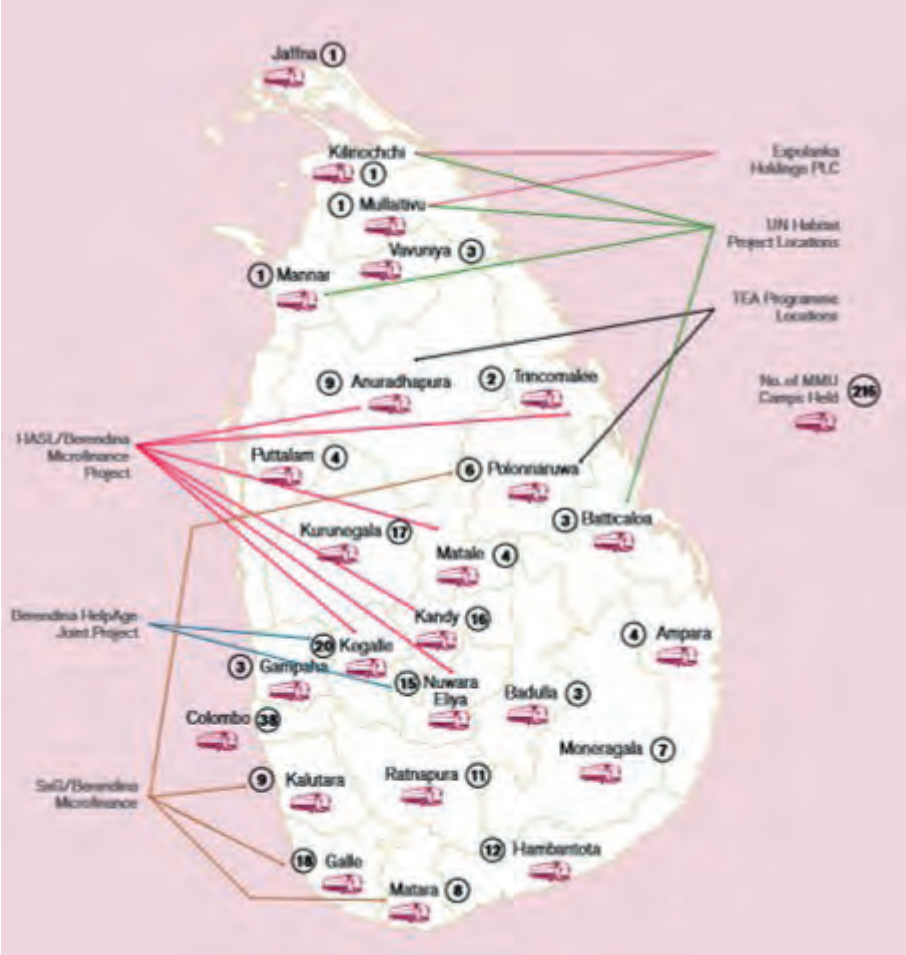
Overview of the CBSI

Establishing the CBSI (Inputs)

Establishing the CBSI

HelpAge Sri Lanka (HASL) is a not-for-profit, charitable non-governmental organisation working for and on behalf of disadvantaged senior citizens in Sri Lanka to improve their quality of life. It is a founding member of the HelpAge International network and is one of the several affiliates of the network in the South Asia region. The organisation was founded in 1986 and since then has led several initiatives focused on older people's health, well-being and development with the aim of giving older people more of a voice in the country. It focuses on service delivery and advocacy.

Figure 3 Location and number of mobile medical and eye care camps run by HASL (HASL 2016)



The organisation started its work in 1986 with a small team of six people focused on needs-based services and training activities for carers of older people (HASL 2017). Over the years the organisation has evolved, expanding its training programme, introducing medical service delivery, establishing day care centres for older people, developing advocacy campaigns and addressing other developmental aspects including microfinance and environment. According to interviewees at HASL, the organisation grew as a result of the increasing demand for services that addressed the needs of older people in Sri Lanka, and the initial interventions launched by HASL were well received.

Aims and objectives of the initiative

Through its work for older people, HASL addresses several needs of older people including healthcare, livelihood support, social protection and rights advocacy. HASL's mission is 'by working together, we ensure that people in Sri Lanka understand how much older people contribute to society and that they must enjoy their right to healthcare, social service and economic and physical security'. This is underpinned by the global HelpAge International vision of 'a world in which all older people fulfil their potential to lead dignified, active, healthy and secure lives' (HASL 2017). Healthcare for older people is an important part of HASL's work in Sri Lanka. It runs a comprehensive and multilayered community-based model of services focused on providing healthcare support to older people.

Funding for the CBSI

Given the range and scale of activities offered by HASL, it requires significant resources to carry out its day-to-day operations. Interviews with the CBSI staff noted that HASL raises financial resources for its work in three ways:

1. **International grants** – mainly facilitated through HelpAge International, its global partner, and other donors such as the European Commission and United Nations agencies. These funds cover the costs of direct interventions and partly cover the costs associated with managing and running the CBSI (e.g. administrative costs).
2. **Corporate donations and government support** from Sri Lankan businesses and government support. CBSI staff interviewed noted that HASL organises a range of events to raise corporate donations, including musical events and conferences. HASL also maintains frequent communication with a list of regular corporate donors.
3. **Self-generated funds** through fundraising events, handicrafts and greeting cards sale and community contributions. In addition, HASL has over 1,200 till boxes in supermarkets, food outlets and bookshops throughout Sri Lanka (HASL 2016a).

Other initiatives in the region

HASL is one of the several HelpAge affiliates in the South Asia region. However, in Sri Lanka, it is the only HelpAge affiliate and is one of the very few organisations in the country focusing on ageing and health in a long-term and holistic way. HASL actively interacts with other HelpAge affiliates in the region for sharing and learning, which has been an important contributor to its growth.

HASL carries out most of its groundwork through the involvement of Senior Citizen Committees (SCCs), which are groups of older people representing their community. Three SCC members who were interviewed in Sri Lanka

Figure 4 Training session for older people on leadership and management

stated that they feel pride and satisfaction in representing their community. The SCCs are a core part of HASL's work with older people in rural and remote areas. The SCCs coordinate with various government-provided services focused on healthcare and social protection. Interviewees noted that they bring older people's issues and needs before service providers and play a facilitating role in converting those government services into age-friendly services.

Beneficiaries noted in the interviews that for activities such as training for older people and carers, mobile medical services and eye care, there are no other options, and they rely on HASL as the only provider. The primary health services of government were perceived to work quite well and interviewees noted that the quality of some services has improved in areas where HASL operates, but these are limited to basic services.

Activities of the CBSI (Process)

Target population and eligibility criteria

HASL focuses on older people aged 55 years or above in different parts of the country, with a particular emphasis on remote and rural areas. Over the years, the organisation has expanded its work to encompass all parts of the island, making it a nationwide organisation. For certain activities, HASL coordinates closely with the SCCs and local health services to recruit potential beneficiaries to its training programmes and identify older people in need of medical services.

According to one interviewee from HASL, older women have been very willing to join the interventions because they trust HASL and its ground-level workers. A 72-year-old female beneficiary suggested that she is very pleased to be involved with the programme and constantly encourages younger members of her community to be involved. She added that a motivation to get involved in HASL's work was that she felt it

Figure 5 Mobile medical unit

was very holistic in terms of identifying social needs and providing care.

Activities associated with the CBSI

The first component of the CBSI is run by the **training** department of HASL and focuses on training of Home Care Volunteers (HCVs). These HCVs (between 55 to 65 years old) are selected from the SCCs in rural areas, subject to certain criteria, and undergo an intensive in-house training programme for five days. The training programme consists of modules on topics such as the ageing process, needs and habits of elders, basic nursing, age-related diseases, first aid, basic counselling and active ageing. After the training these volunteers start visiting the houses of the most vulnerable elders in their locality to provide care. Records of their visits are maintained by these volunteers and necessary feedback is given to their respective SCCs during monthly meetings.

The second component of the CBSI is related to **service delivery**, which is split into two modes. Firstly, HASL organises outreach medical services through a mobile medical unit and day care services through day care centres. Secondly, HASL provides clinical services through an eye care hospital based in Colombo and through its special Ayurvedic centres.[2]

2 Ayurvedic medicine is a traditional type of complementary or alternative medicine originating in India.

The third component of the CBSI is related to **development, research and advocacy**. In the developmental aspect, HASL has been organising activities focused on microfinance, empowerment of older women and disaster risk mitigation. HASL has also been documenting older people's health problems and perceptions and reaching out to the national government to advocate for better health services for older people, particularly those living in remote and rural settings.

Governance and management of the CBSI

The governance structure and management of HASL has evolved over time as the CBSI has expanded. Its headquarters in Colombo now employs around 86 members of staff and is separated into different divisions, including programmes, fundraising, human resources and administration, monitoring and evaluation and finance, as well as an advisory council. Older people are engaged in all aspects of the programme management and delivery of its activities.

Interviewees noted that HASL's Colombo headquarters has a well-equipped training centre, where the team goes through in-house training at regular intervals. It was explained that the organisation's advisory council meets every month and reviews the progress.

Interviewees noted that HASL has strong in-house monitoring and evaluation (M&E) processes. As a result of these processes, the organisation has been constantly addressing course correction and adapting to new needs. For example, one interviewee from HASL noted that the organisation's expansion from providing only training and advocacy-related activities to include service delivery (mobile medical services, eye care, Ayurveda) was based on needs assessments conducted through its monitoring and evaluation division.

Results of the CBSI (Outputs)

Enrolment of older people

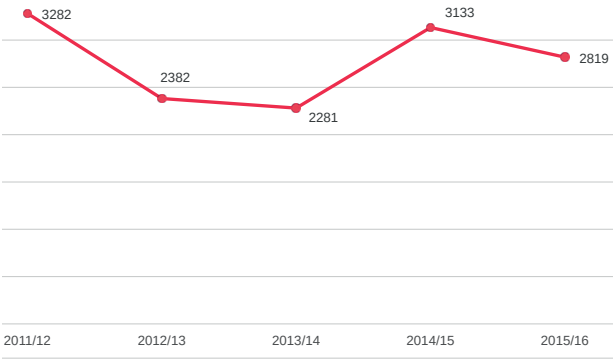
HASL has reached out to more than 600,000 older people over the last five years in Sri Lanka; it estimates that in its 31-year history it has been able to reach approximately two million older people. According to HASL's recent Annual Report (HASL 2016a) over 30,000 older people have received eye care and over 23,000 have been benefitted by mobile medical services. Figure 6 shows that since the establishment of the Eye Hospital in Colombo, HASL has averaged around 3,000 cataract operations annually.

The report states that between 2016 and 2017, over 9,200 older people attended medical camps, over 1,000 families were provided flood relief support, over 1,000 older people were helped facing droughts, 119 microfinance loans were given and 2,849 cataract operations were conducted (HASL 2017). About 50 per cent of the beneficiaries of interventions are older women and the activities cover about 19 districts in nine provinces across the country.

Self-reported health gains from beneficiaries

The interviews with the beneficiaries indicate that the older people involved in HASL activities have been very satisfied with the range of health services provided to them and have experienced a range of health gains as a result of their enrolment in the programme.

Figure 6 Number of cataract operations completed (by year)



Mobile medical services were well received by beneficiaries as the services are free of charge for older people and deliver quality health services at their doorstep. Beneficiary interviewees who had received mobile services stated that the units are extremely helpful in treating common ailments and in getting quicker referrals to hospitals and other health facilities when needed. Older people have full trust in the mobile medical units of HASL. The Ayurvedic centres run by HASL were also reported as being well received in their communities, with the potential to impact on older people's ability to manage chronic diseases such as arthritis, gastro-intestinal diseases and mental health disorders.

HASL eye care services were reported as being very successful in being able to reach a large percentage of the older population. According to the HASL Annual Report (HASL, 2016a), the Eye Hospital in Colombo has been able to perform approximately 3,000 cataract operations every year, free of charge for older people in need, since it was established in 2009. One of the HASL interviewees shared that this work is in great demand because of its high quality, and doctors work at full capacity operating on about 25 cataracts in a day, with a long waiting list. Older people interviewed find the eye care services of HASL of great value. For example, a beneficiary of eye surgery in the Galle area said that the support had transformed her life, with the full recovery of her vision allowing her to be productive and socially interactive.

In addition to impacts on the physical health of older people, interviewees also noted the mental health and well-being benefits of some of HASL's activities. For example, the day care centres were seen by beneficiaries as a place where they could relax; they felt that attending the centres had positive impacts on their mental health. A HASL staff interviewee also reported that attending day care centres brings many mental health gains to older people:

> *They have a good time together, cook and eat in a group, collectively work on income-generating activities such as making greeting cards and envelopes, and take part in spiritual activities. Overall, the time spent at day care centre is very enriching and productive for older people.*

This is reflected in HASL's M&E data on its day care centres, summarised in its recent publication *Growing Old Gracefully*, which states that 'the establishment of day care centres has greatly improved the mental and social health status of this population. [As a result], the Ministry of Social Services has taken the initiative to establish such centres in every village' (HASL 2014).

Linkages to health and social care system

The activities of HASL appear to be closely integrated into the current health and social care system and coordinated with other key stakeholders in ageing-related issues, such as the SCCs. For example, interviewees at HASL and the SCCs noted that HASL provides training and capacity-building support to the SCC members and attempts to link them with various government services and departments. The HCVs trained by HASL also work in close collaboration with the SCCs and with primary healthcare centres run by the government. They provide home-based services to older people and also act as a bridge between older people and government-provided primary healthcare and other forms of private medical care. They also act as health educators and emphasise the value of self-care. Recently, HASL has developed a new training curriculum to train Elder Care Assistants, in collaboration with the national government.

On a broader level, HASL engages directly with the national government on the health issues faced by older people in remote areas, on human resources needs, on development of training materials in the context and on suggesting ways to improve the delivery of healthcare to older people. In important events and meetings with the government, and on important days such as the International Day for Older People (IDOP), HASL has organised advocacy events to draw

attention to the needs of older people. As an important member of the HelpAge International network, HASL contributes actively in the research and advocacy activities organised by HelpAge International regionally and globally. Interviewees noted that as a result of older people and HASL working together with various levels of government, there have been numerous positive policy changes, such as the scale-up of the SCC model at the national level and the introduction of the NVQ training programme for care assistants.

HASL also works closely with the Ministry of Social Services, the National Secretariat of Elders and the Ministry of National Planning to develop policies and programmes on ageing to ensure the welfare and rights of older people in Sri Lanka.

Impact of the CBSI (Outcomes)

Wider impacts of the programme

Advocacy campaigns by HASL and close interaction with the government have contributed to several policy-level changes for older people. For example, these include the setting up of the National Pension Programme for Older People and the National Secretariat for Older People, formulation of the Elderly Rights and Protection Act 2000 and full recognition of the SCC model and HCV programmes.

Interviewees from HASL explained that the organisation has been advocating for old-age pensions since its inception, and when the national government took the initiative, it invited HASL to be part of the committee drafting framing guidelines for the old-age pension programme. Older people have started receiving the pensions, although not all older people are receiving the benefits regularly because of geographical challenges related to access.

Several beneficiaries noted that as a result of HASL's work, the attention given to older people in government-run primary health centres has increased. Beneficiaries believed that they are given more time and care at health centres and that the service providers have become more respectful in addition to the quality of services having improved.

Other developmental initiatives implemented by HASL, focused on microfinance, female empowerment, environmental protection and intergenerational bonding were reported as having wider impacts on older people. HASL's microfinance model for example is considered as particularly successful, with a loan recovery rate close to 100 per cent in most cases. The loans provide older women and men with the resources needed to run income-generating units, which interviewees felt had a significant positive impact on the mental health and overall well-being of older people. HASL training activities are also reported to impact on older people's knowledge on disaster risk mitigation, environment protection and climate change mitigation. This knowledge was considered as also having an indirect positive impact on older people's health.

The intergenerational approach adopted by HASL in some of its activities was also noted as a positive impact of the programme. Several beneficiaries agreed that they like working with younger generations on community development programmes. An interviewee from HASL also noted that the mind-sets of younger generations involved in the programme's activities have also been improving with regard to their views on older people.

Sustainability of the programme

On the programmatic side of HASL's operations, interviewees considered HASL to be sustainable given the strength and experience of the management, leadership and wider team, and the low staff turnover. Interviews with staff indicate the joy and pride that they draw from the organisation. SCCs at the community level were also considered as sustainable and, with the exception of a few SCCs, have remained functional over a long period of time, thus enabling HASL's activities to continue.

Figure 7 Beneficiary of the HASL livelihood programme with his grandson

Despite having relatively stable staff turnover within the CBSI, interviewees noted that there is a human resource gap, particularly on the medical service delivery side and in research and documental activities. In particular, interviewees mentioned challenges in recruiting qualified ophthalmologists and optometrists at the Colombo Eye Hospital, as well as mobile physicians and researchers in more rural parts of the country.

On the financial side, interviewees felt that HASL was able to raise most of the resources needed to sustain its activities nationally through either corporate contributions or local fundraising. However, interviewees noted that international funding for HASL has decreased significantly in recent years, as a result of Sri Lanka being upgraded to middle-income country status in 2010. They felt that additional resources were needed to further scale up HASL's activities across the island.

On the policy side, most initiatives of HASL have received very positive support from the government stakeholders, and they have been actively involved in leading policy changes and developing new acts and provisions in the favour of older people. Through its advocacy work, it was felt that HASL had helped to create a conducive policy environment for future work on older people's rights and well-being in Sri Lanka.

Reflections on the CBSI

The experience of HASL raises some important themes relevant to the analysis of CBSIs.

HASL has managed to leverage funding for its activities and day-to-day operations from a variety of sources, both locally and internationally, although securing future international funding remains a challenge.

HASL is a good example of a CBSI that has been relatively successful in attracting funding from a variety of sources. While the programme receives core funding from HelpAge International and has secured funding from international multilateral agencies such as the European Union and the United Nations, HASL has also developed a wide range of funding sources locally, which is perceived by staff as very effective for sustaining the ongoing work. This includes funding from local communities and philanthropy as well as contributions from the private sector and local fundraising activities. Interviewees noted, however, that international funding has been reduced as a result of Sri Lanka being made a middle-income country in 2010, and therefore highlighted the need to identify more international funding partnerships if the programme is to continue to expand.

HASL has a strong reputation in Sri Lanka and can be seen as a trusted partner of the government due to the longevity of its operations. This has enabled HASL to have very strong linkages with the health and social care system.

The reputation of HASL at a national level (and within the HelpAge Global Network) was reported by interviewees to be very high. The organisation has been active for over 30 years, which has allowed it to foster strong bonds with the local government and communities and enabled it to become a key player in designing, advocating and implementing ageing policies in Sri Lanka. One interviewee at HASL noted that the reputation and longevity of the organisation reflect its commitment, understanding of issues and skills/abilities to provide high-quality services. The role of HASL's Governing Board was also noted by interviewees as an important factor in its reputation in Sri Lanka. Many perceived the members of the board, its Chief Executive and management team to be experienced, capable and strong, which was seen as crucial in establishing fruitful relations and helping to build the brand of HASL in Sri Lanka.

The programme has successfully managed to reach a large number of older people in Sri Lanka, building on pre-existing linkages and networks.

The programme has managed to reach a significant number of older people in Sri Lanka since it was established, with an estimated two million older people being involved in its training, service provision and advocacy activities. Beneficiaries report that the programme has made a valued contribution to improving their health, reducing social isolation and providing them with the opportunity to help each other and socialise on a regular basis.

The external context in Sri Lanka can be considered as a limiting factor in HASL's operations, particularly in regard to the supply of skilled workers and geographical features of the country.

Despite having relatively stable staff turnover within the CBSI, interviewees noted that there is a human resource gap, particularly on the medical service delivery side and in research and documental activities. In particular, interviewees mentioned challenges in recruiting qualified ophthalmologists and optometrists at the Colombo Eye Hospital, as well as mobile physicians and researchers in more rural parts of the country. While some of these challenges are out of its control, HASL is helping to address some of them through supporting the training of the future cadre of workers and volunteers working on ageing-related issues in Sri Lanka. Nevertheless, the current situation is a limiting factor on HASL's opportunities to expand. Interviewees also their physical and mental health, well-being and social interactions. noted that challenges are posed by the geographical features of Sri Lanka. Due to severe weather conditions, poor infrastructure and challenges related to internal conflicts in the country, access to remote communities has been very challenging for HASL at times.

HASL has embedded a culture of M&E in its activities that allows it to revisit its approach, learn and adapt. However, improving strategies for disseminating that evidence could improve the organisation's visibility and may lead to increased funding opportunities.

HASL has a strong, in-house monitoring and evaluation team, which is very proactive. As a result of their efforts, the organisation has been constantly addressing course correction and adapting to new needs. However, interviewees felt that more could be done to disseminate the evidence gathered from M&E activities and suggested that more skills and resources being allocated to dissemination would be helpful for the scalability of HASL. The dissemination of success stories and best practice was thought not only to give the organisation visibility, but and potentially also to help leverage further resources and provide learning for other ageing-related organisations working with a similar approach.

HASL can be considered as a mature intervention, which applies a holistic approach to healthy ageing, covering various activities that address the social determinants of health as well as the provision of direct health services and referrals.

Given the size of HASL and its long-term presence in Sri Lanka, it is able to take a holistic approach to improving older people's health and living conditions through the provision of many different types of activities. Through close coordination with the local healthcare services and SCCs it is able to reach a wide range of older people in both urban and rural settings, providing services which appear to have a direct impact on

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World Health Organization

Centre for Health Development

Thailand: Kajood Handicraft Community Enterprise in Surat Thani

RAND Europe researcher: Emma Pitchforth

In-country collaborating partners: Jongjit Rittirong, Kamolchanok Khamsuwan, Rossarin Gray (IPSR, Mahidol University)

Preface

The World Health Organization Centre for Health Development Kobe has contracted RAND Europe to serve as a research hub for conducting a systematic review and gathering evidence of middle- and high-income countries' community-based social innovations (CBSIs) for healthy ageing. RAND Europe has undertaken two main strands of research consisting of: (1) a systematic review of CBSIs for healthy ageing in middle- and high-income countries, and (2) a series of ten case studies of CBSIs for healthy ageing in middle-income countries.

This report presents the findings from one of our ten case studies, the Kajood Handicraft Community Enterprise (HCE) in Surat Thani, Thailand.

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Summary of the community-based social innovation (CBSI)

Background

Thailand

Locations
Surat Thani Province, Thailand

Type of intervention
User-driven

Year established
2006

The intervention

Establishing the CBSI

- The Kajood handicraft community enterprise (HCE) is a community-based organisation producing handicrafts made from Kajood, a plant material which grows in swamps in southern Thailand.
- The CBSI was derived from a women's group established in 1992 that aimed to promote the production of Kajood-based products in the local community.
- The programme aims to contribute to older people's active ageing in the region through addressing the three core components of health, social participation and economic security.
- In 2006 the programme became a community enterprise, receiving funding and support from local government organisations. As a result of the income generated from selling the handicrafts, the programme is now considered as financially self-sufficient.

Activities of the CBSI

- Participation in the programme provides members the opportunity to gain training, earn dividends and access additional health and social care benefits.
- The programme makes use of different skill-sets across generations, with older people teaching the younger generation to make products and the younger generation helping to market and sell the products.
- The programme has good links with the health and social care institutions in the region, particularly the Village Health Volunteers (VHVs) and the local Elderly Clubs, and participates in local committees on health promotion.

Results and impact of the CBSI to date

- Since its establishment as a community enterprise, the programme has enrolled around 50 members in the local community, of which at least one-third are older people.
- Members of the programme noted a number of health benefits as a result of their participation, including improved physical health, reduced social isolation and a sense of empowerment, through the self-reliance and economic security brought about by additional income generation.
- Longer-term impacts of the programme are difficult to assess as there are currently no monitoring and evaluation activities related to the health benefits of the programme.

Ageing in Thailand

- In 2017, the population aged 60 and over was 17 per cent and it is projected to reach 20 per cent by 2021.
- Since 2001, the Thai population has been covered by the Universal Health Coverage Scheme, which provides access to free healthcare.
- The social care system is managed at the sub-district level, at which elderly clubs and village health volunteers are supported.
- In 1993, the Old Age Allowance programme was launched and later extended to a universal social pension to older people who lacked pension coverage.

Reflections on the CBSI

- Through establishing the programme as a community enterprise, the Kajood HCE has successfully been able to scale up and is now financially sustainable.
- The programme has successfully managed to reduce the social isolation of older people in the region, although there appears to be a gender split in membership.
- Older persons' social engagement in the programme has indirectly encouraged them to be involved in other community activities.
- Intergenerational relationships in the programme are seen as an important feature, both in terms of knowledge transfer and sustainability of the programme.
- The programme has good coordination with local government administration, which indirectly helps members to access healthcare facilities. In addition, the programme provides direct welfare support to its members through a benefit package and access to credit.
- The programme does not primarily aim to improve the health of older people, and as such does not monitor health outcomes of members. However, it has had indirect benefits in regard to social health and physical fitness.

Aims of the research

This report presents the findings from one of our ten case studies, the Kajood Handicraft Community Enterprise (HCE) in Surat Thani, Thailand. The overall aim of the research is to describe within a pool of rapidly ageing countries, and from those with high proportions of older people, a) the core roles, services and functioning (including feasibility of scale-up) of community-based social innovations (CBSIs) for healthy ageing that seek to support older people becoming a resource for their own health and well-being; b) their linkages with and sustainable partnerships to deliver health services, strengthen social systems; and c) the nature of enabling policies, programmes, financing and interactions with the health/social care delivery system.

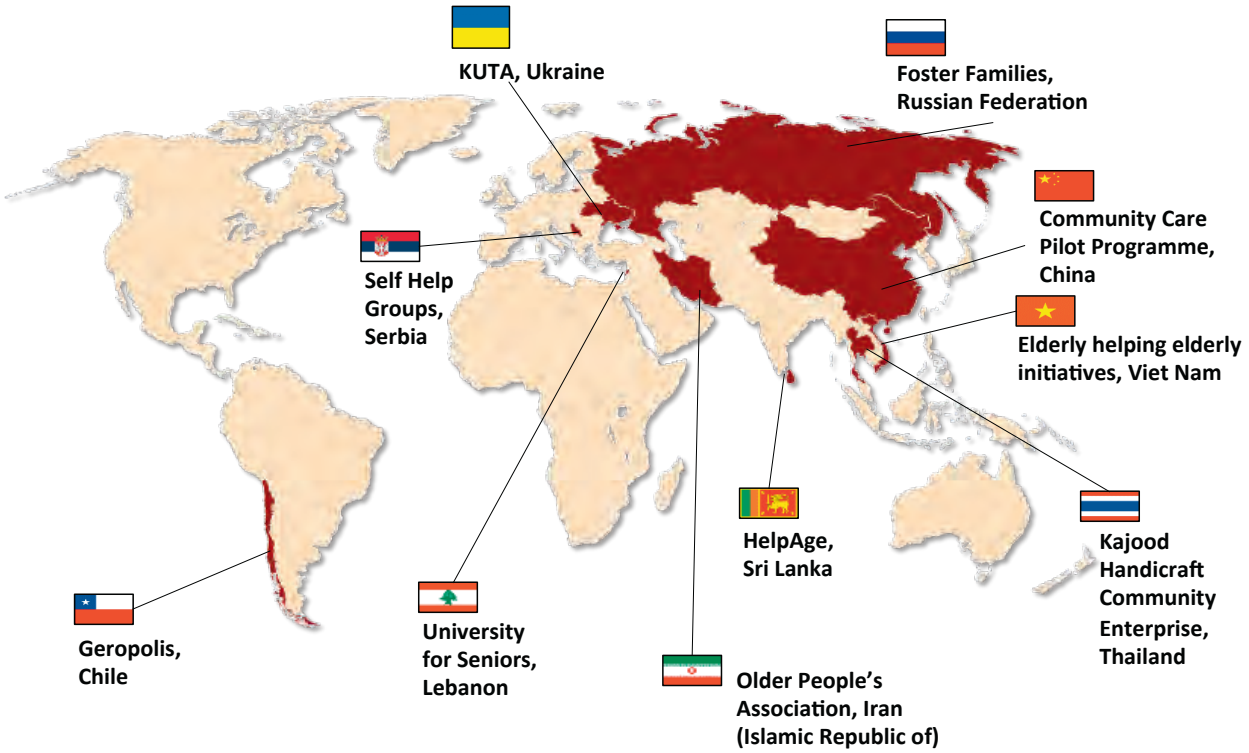
A recent WHO study conceptualised CBSIs as initiatives that seek to empower older people to improve their self-efficacy in caring for themselves and their peers, maintain their well-being and promote social cohesion and inclusiveness. They can also help older people to access, understand and navigate health and social care systems (Ong et al. 2016).

While CBSIs may hold the potential to transform health and social care provision for older people, more evidence is needed to improve our understanding of what types of initiatives and service delivery models are pursued in practice that engage communities and span a spectrum of health and social services.

In order to develop a typology of CBSIs, this research consisted of three main parts: (i) a systematic review of CBSIs for healthy ageing in upper middle- and high-income countries; (ii) a series of ten case studies to examine the effectiveness of ongoing CBSI interventions in middle-income countries; and (iii) an expert consultation at the World Health Organization's Centre for Health Development (WHO-WKC) in Kobe, Japan, to validate and refine the typology.

Given the relative lack of evidence on CBSIs in middle-income countries in academic literature, the ten case studies were identified through an open call for Expressions of Interest (EOIs). Figure 1 below shows the location of the ten case study countries.

Figure 1 Ten case study countries



The data gathered in this case study will serve to better conceptualise what a CBSI is and to present typologies and functions of CBSIs for older populations. Each individual case study will seek to explore:

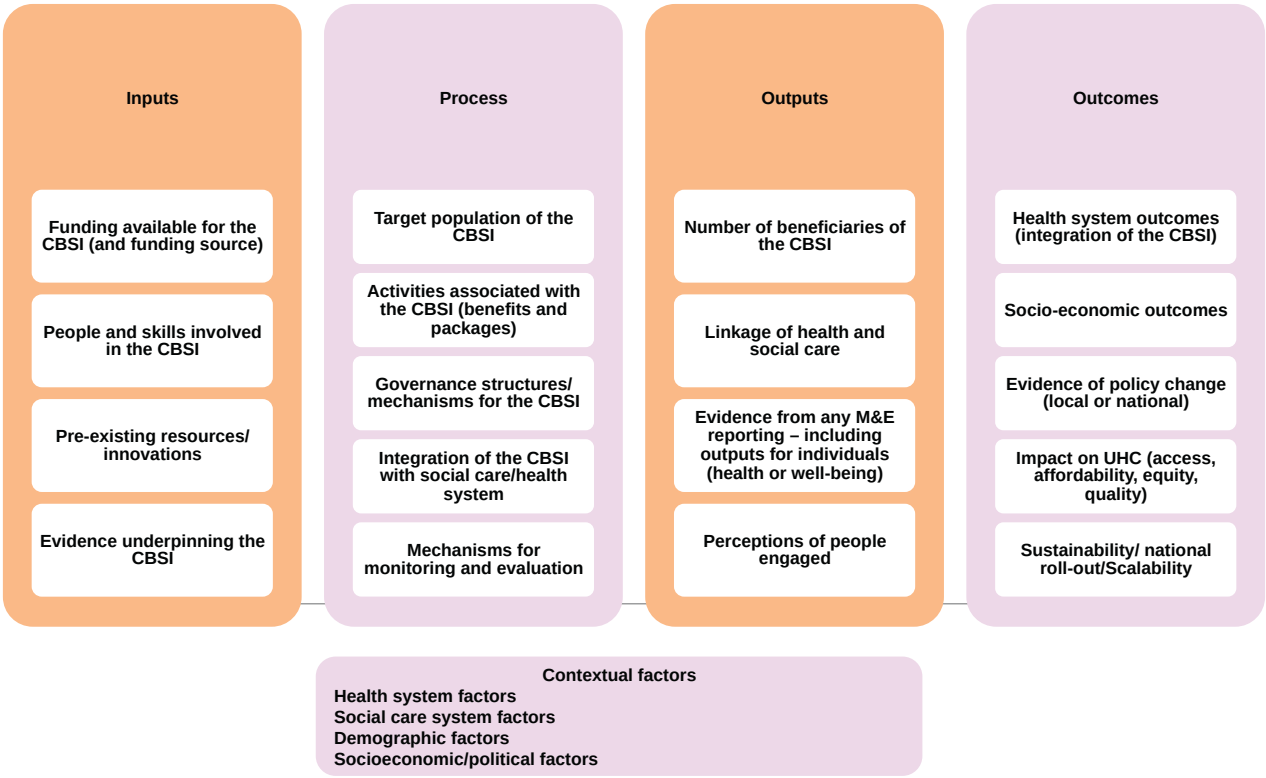
- The role and function of older people as resources for themselves and for others (peers, family, community).
- Health and social services delivered by those initiatives and referral processes when they exist.
- Links made within these communities of support between health interventions and social health protection interventions (e.g. help with transportation, livelihoods, pensions, cash or in-kind transfers).
- Coordination mechanisms with formal health and social sectors, including any formal connections with the health and social care system.
- Coordination and engagement with a variety of health/social-service workers and community-based services.
- Types of metrics (indicators, monitoring tools) implemented to assess impact on health[1] and the concept of health that is being measured.
- Measures to understand and respond to health inequities in the population served.

We have used a logic model approach to examine the effectiveness of selected CBSIs. This helps us assess the intervention logic for CBSIs and track the progress, impacts and evolutionary dynamics of CBSIs at core levels of analysis. As illustrated in Figure 2 below:

- **Inputs** will help us understand the resource environment of each CBSI and provide a foundation for exploring the linkages between resources, outputs and impacts. This resource input environment is likely to capture aspects such as resources for implementation (funding, infrastructure and skills/capabilities). We will also aim to capture the reasoning and evidence base leading to the establishment of the CBSI.
- The **process** dimension will help us examine both the diversity of CBSIs, in terms of activities/services offered, population groups targeted and geographies projects covered and mechanisms for designing, managing and evaluating the CBSI if present. We will also examine the integration of the CBSI within the wider health and social care services offered to older people.
- The **output** dimension will help us assess the relative progress of CBSIs since they have been established and capture the diversity of outputs and associated achievements. This will involve capturing outputs such as the number of beneficiaries involved in the CBSI and any initial health and well-being outputs for beneficiaries reported.
- The **outcomes** dimension will help us capture a wider range of benefits, including those relating to impact on resources for achieving universal health coverage (UHC), policy-level impacts and other (including unintended) consequences which may affect the health and well-being of older people in a particular country. In particular we will not only consider impacts at an individual level (e.g. beneficiaries engaged in the CBSI) but also look to examine the impact on the wider community and the overall health/social care system.

1 We used the term ‘health’ very broadly at this stage in anticipation that it could incorporate physical and mental health and broader wellbeing. As the case studies were exploratory, we did not seek to further define or restrict at this stage as we were interested in understanding of the CBSIs themselves conceptualised and measured these types of outcomes, if at all.

Figure 2 Framework for gathering data on CBSIs and the contexts they operate in



- The **contextual factors** will guide us to consider the influence of both health and social care system factors and demographic, socioeconomic and political factors which may help or hinder progress of the CBSI. A greater understanding of the contextual factors underpinning the CBSI will also help to inform reflections on its transferability/ scalability by offering a rich understanding of the setting.

Structure of the case study

The next section of the report begins with a brief overview of the methodology used for the case study. The report then highlights some of the key contextual factors affecting the CBSI, related to the country's ageing population and its health and social care system.

The main section of the report focuses on how the four areas of the logic model (outlined in Figure 2) related to the CBSI, in the following four areas: (i) establishing the CBSI (inputs); (ii) activities of the CBSI (processes); (iii) results of the CBSI (outputs); and (iv) impact of the CBSI (outcomes). Within each sub-section the perspectives of interviewees are presented alongside findings from the desk review. Finally, the report concludes with some overall reflections on the CBSI and draws out key themes and experiences to better conceptualise CBSIs and their role and functions for older populations.

Methodology

Case studies have been used to collect descriptive data on CBSIs through a mix of methods including semi-structured interviews and a review of administrative data and documentation. Each case study follows the same design in order to provide in-depth understanding of each CBSI and allow comparisons to be made between different

actors within a single case, between cases and between groups across cases, taking into account relevant contextual factors. Key-informant interviewees were conducted with key stakeholder groups involved in the CBSI, as well as with wider health and social care system actors.

Desk-based document review

Building on any documentation identified in consultation with the CBSI, the literature review draws on academic and grey literature to provide an overview of the health and social services delivered by the CBSI in Thailand and the wider context in which these interventions are taking place. In addition, any available evaluative documentation was reviewed to collect evidence on the metrics, indicators and monitoring tools used to assess the effectiveness of the CBSIs identified. Key documents included journal articles and policy documents, such as commissioned discussion documents and government strategies. Academic literature was identified through PubMed, focusing on the years 2000 to the present. The literature search was conducted between August and September 2017.

Stakeholder interviews

In addition to the document review described above, key-informant interviews were also used as a key means of gaining an insight into the ongoing activities of the CBSI and the wider contextual factors affecting its functioning in Thailand. The interviews followed a common topic guide, with the main topics discussed including: resources that support the CBSI, engagement with older people and functioning of the CBSI, outputs and linkages with the health and social care systems and impact of the CBSI. Emphasis, however, was placed on allowing participants to talk from their own perspective.

In order to explore different perceptions of impact associated with the CBSI and identify any linkages and interaction between stakeholders, the project team in coordination with the CBSI staff identified suitable interviewees from three

Table 1 Overview of the interviewees

Stakeholder group	Profile of the interviewees
Beneficiaries of the programme	• Seven interviews with beneficiaries of the programme (two male and five female).
CBSI staff	• One interview with the manager of the programme. • One interview with one of the marketing staff associated with the programme.
Policymakers, academia and civil society	• Three interviews with healthcare personnel from a local healthcare centre: a Director, a nurse and a traditional medicine practitioner. • Two interviews with representatives from the Sub-district Administrative Organisation (social welfare staff member and planning and policy analyst). • One interview with a representative from the Provincial Department of Industry. • One interview with a representative from the Provincial Department of Community Development. • Two interviews with representatives from the Provincial Department of Energy. • Two interviews with representatives from the Provincial Department of Social Development and Human Security. • Two interviews with Village Health Volunteers (VHVs) (one male and one female).

major stakeholder groups (as outlined in Table 1 below). A total of 22 interviews were conducted in Thailand between 17 and 20 July 2017.

Prior to being interviewed, written consent to participate was sought from all participants and they were each asked to sign an informed consent form. Interviews were conducted face-to-face in the Surat Thani sub-district in southern Thailand, across the CBSI's main locations. The interviews typically lasted between 30 and 60 minutes and were semi-structured in style, to enable participants to raise concerns that may not have been anticipated by the research team or were specific to the practice. This provided a flexible approach which allowed respondents to offer their own perspective and raise issues most salient to them, while covering the same topic areas in each interview.

The interview data was analysed and coded by the project team, and then grouped into the categories and sub-categories outlined in the logic model. In analysing the categories, the team also identified emerging themes, which are presented at the end of this report.

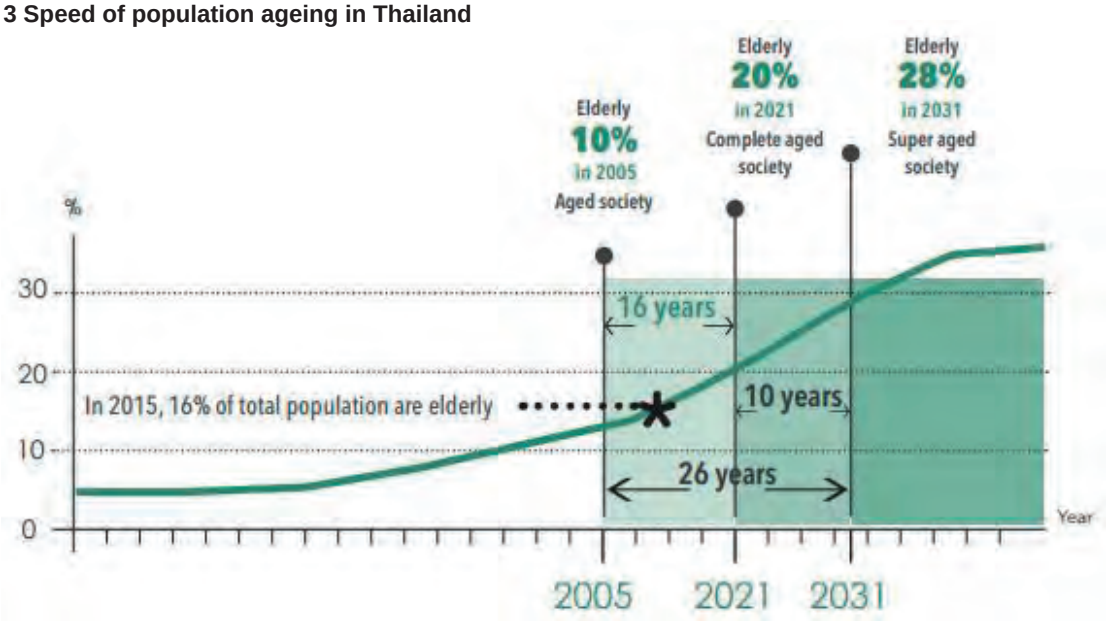
Overview of the context in Thailand

Thailand is an upper middle-income country, with 11 per cent of its 66 million people living below the poverty line (World Bank 2016). While this represents a decrease in the poverty rate of more than half over the last 30 years, development has been uneven: over 80 per cent of Thailand's poor now live in rural areas, particularly in the north-east, north and deep south. In 2001, the Thai government introduced the Universal Coverage Scheme (UCS) to provide tax-funded health insurance for the 75 per cent of the population who were not already covered by the country's two existing health insurance schemes (Limwattananon et al. 2011).

Demographic factors

In 2017, the population in Thailand was approximately 66 million. Thailand reached the status of an aged society in 2005, with 10 per cent of the population aged 60 and over. By 2017, those aged 60 and over accounted for 17 per cent of the population and this is projected to reach 20 per cent by 2021 and 28 per cent by 2031 (Figure 2). The elderly population

Figure 3 Speed of population ageing in Thailand



Source: Foundation of Thai Gerontology Research and Development Institute (2016).

has increased by around 4 per cent per year since 2005, while the growth rate of the Thai population is approaching zero (0.5 per cent per year) (Foundation of Thai Gerontology Research and Development Institute 2016).

In Surat Thani, a rural province in southern Thailand where the CBSI is located, the percentage of the population aged 60 and over is steadily increasing as younger people move to the cities to pursue employment and/or higher education.

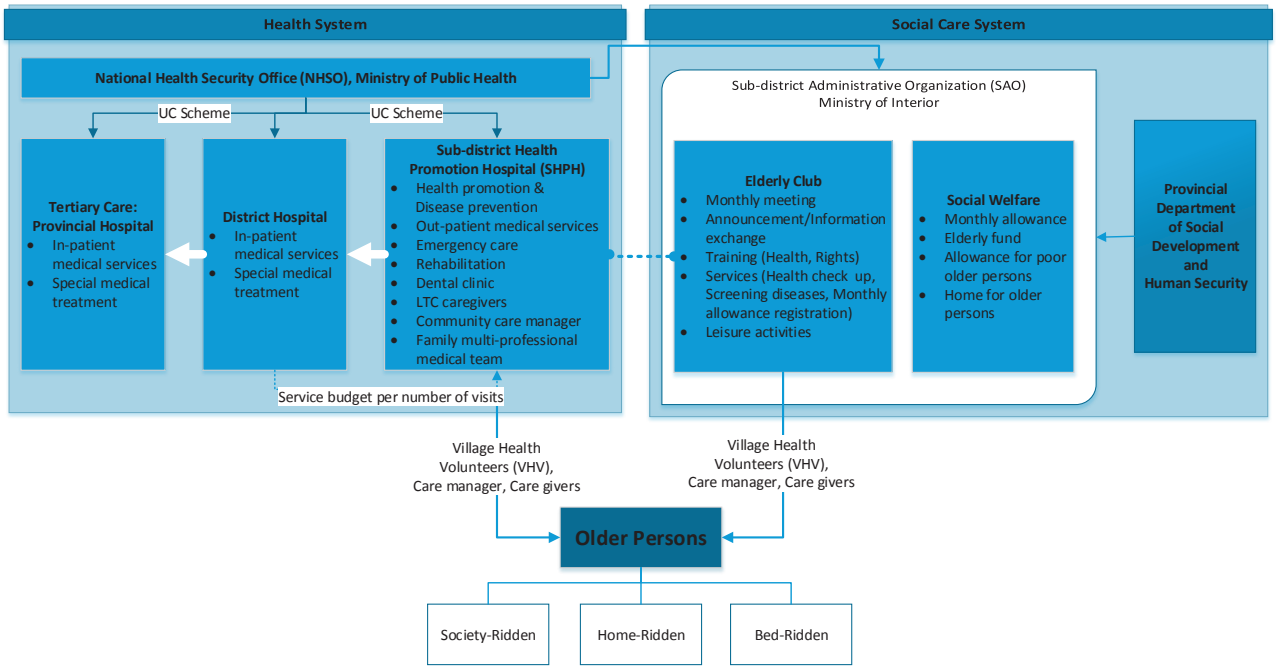
Overview of the Thai health system

The Thai health system is under the responsibility of the Ministry of Public Health (MoPH), which introduced a comprehensive universal healthcare scheme in 2001 to provide free healthcare at the point of delivery for the Thai population, covering the cost of most medical services and medicine (Tangcharoensathien et al. 2002). Older people in Thailand need to access health services through Sub-district Health Promotion Hospitals (SHPHs), which provide health promotion, disease prevention and outpatient medical services and emergency care (Chunharas 2002). The SHPHs receive funding from the National Health Security Office (NHSO) for medical services, dependent upon the number of patients. When an older person requires special medical treatment, they are referred to a district hospital or provincial hospital. In addition, healthcare personnel and village health volunteers (VHVs) provide home care to older people. Long-term care (LTC) is conducted in the community through a recently initiated programme of LTC caregivers and care managers. Unlike VHVs, they receive a salary and training to take care of older persons, especially for LTC.

Overview of the Thai social care system

The social care system in Thailand is managed at the regional level by the Sub-district Administrative Organisation (SAO). The SAO is under the responsibility of the Ministry of Interior (MOI); however, some funding for health promotion within the social care system is provided by the MoPH. In addition, the Ministry of Social Development and Human Security (MSDHS) provides funding for social welfare to older people, which is distributed by the SAO through a monthly allowance and elderly fund.

Figure 4 Health and social care system in Thailand



One of the activities for older people coordinated by the SAO is Elderly Clubs, which recruit older people on a voluntary basis. The Elderly Clubs meet once a month and provide older people with the opportunity to exchange information related to their health and their rights. Moreover, training and services related for example to changing health behaviour, registration for monthly allowances, health check-ups and screening for health problems are provided during the monthly meetings. VHVs are key, transferring knowledge and information from the SHPHs and SAO to older people. Each VHV is responsible for the care of around 10–15 households.

Figure 3 below presents an overview of the interaction between the health and social care system in Thailand.

Overview of the CBSI

Establishing the CBSI (Inputs)

Establishing the CBSI

The origin of the CBSI was in 1984, when a female resident of Surat Thani Province, Mrs Manee, won a prize of royal patronage for designing a betel box made from Kajood, a plant of the sedge family that grows naturally in the swamps around the region. When the Mrs Manee's daughter won another prize eight years later, a women's group was established to promote Kajood handicrafts and encourage people in the community to learn how to produce a variety of products out of Kajood. The group received both financial and marketing support from local government organisations and at the time consisted of around 20 members. Since the majority of workers producing Kajood handicrafts were older persons, new technologies and marketing plans were quite limited.

In 2006, the women's group became a community enterprise, which is run by villagers as a cooperative, retaining older people in the community in economic activities. The

Figure 5 Location of the CBSI in Thailand

community enterprise now brings together older people with the younger generation, who help with applying new technologies and designs to make the products longer-lasting, and enable older people to market and distribute their Kajood products through shops in Surat Thani and at well-known markets in Bangkok, as well as online (Kajood n.d.).

Aims and objectives of the initiative

The Kajood Handicraft Community Enterprise (Kajood HCE) is a community-based programme which aims to empower local people by providing them with the opportunity to generate additional income through making Kajood-based products. The programme has a specific emphasis on older people in the region, who are considered

the key persons in the business as they produce the handicrafts and transfer their wisdom to younger generations through the programme. The Kajood HCE aims not only to provide economic activity for older people, but also to provide activities that help to maintain their physical and mental health. It aims to integrate three core components of active ageing, namely health, social participation and economic security, to promote the health and well-being of older people in the community.

Funding for the CBSI

The programme was initially funded through seed funding from the government, including the Miyazawa project and a One Tambon One Product (OTOP) grant from the SAO to establish the programme as a community enterprise in 2006.

In addition to the grant funding, the SAO has also supported the programme's public relations on its website and provided additional funding to reforest Kajood plants in the area. Many other provincial government departments have provided resources to the programme, including: training in management, accounting, marketing and technical support, as well as technology and equipment such as glasshouses, rolling machines and dyeing stoves. The local university has also helped to improve the quality and design of the Kajood products.

Figure 6 Kajood weaving

One interviewee noted that an initial challenge for the programme was that the diversity of sources meant that funding was not initially effective and organised, as each government department had separate targets and strategies. In order to integrate efforts, an OTOP committee was established to ensure coordination and pool resources with other community enterprises.

All members are required to contribute at least THB 50 on joining the programme, and then on a monthly basis, for which they receive one share. A member can pay for more shares when earning more from producing and selling Kajood handicraft products. The more units of shares the member pays for, the greater the dividend the member gains. According to some interviewees, the programme is now a very strong business and is able to rely financially on the products it sells.

Other initiatives in the region

Interviewees noted that, in addition to the Kajood HCE, there are a number of other community enterprises in other parts of Thailand focused on traditional handicrafts. According to one interviewee, other programmes have struggled to sustain a business as they have not been able to involve the younger generations in the way that the Kajood HCE programme has.

Outside of community enterprises, the main initiative mentioned by interviewees was the Elderly Clubs, which are financed by the SAO and provide older people in the community with health services (such as check-ups, screening and information on health promotion) and access to the VHVs. Villagers aged 45 and over are eligible

to be members of the club and many of the members of the Kajood HCE are also members.

One of the government representatives interviewed also noted several smaller-scale initiatives aimed at older people, including a network of older people in the Muang district who volunteer at a local hospital, helping patients with forms and providing refreshments. The interviewee also noted that the Department of Education has a policy of hiring retired teachers to teach some classes that require specific skills or expertise.

Activities of the CBSI (Process)

Target population and eligibility criteria

Given the programme's emphasis on intergenerational learning and knowledge transfer, people of all ages and generations are able to register and join. Interviewees noted that villagers learnt about the Kajood HCE primarily through word of mouth when meeting at temples or shops in the community.

In addition to the health and social care services covered by the Thai universal coverage scheme, all members of the Kajood handicraft community enterprise can obtain additional financial benefits, including:

1. Up to THB 500 to members who give birth (per child)
2. Up to THB 500 to members for medical services (no more than twice a year)
3. Up to THB 2,000 for members' funeral costs
4. Additional prizes for members who receive the highest dividend.

However, some interviewees noted that membership of the programme was not straightforward and many older people did not know about the welfare benefits associated with becoming a member. They noted that there is no formal registration system to recruit members; rather, membership tends to occur through informal invitations from other members (e.g. a mother may invite her child to join the programme).

Interviewees noted that most members of the programme already had an occupation (typically within rubber farming or fruit production), but were interested in being involved in the programme to gain additional income.

Activities associated with the CBSI

Involvement in the programme provides members with the opportunity to be involved in several parts in the process of producing Kajood handicrafts. This can include: pulling Kajood from the swamp, drying Kajood, dyeing, weaving and assembling parts of handicraft objects.

In addition to the production of products, the programme also provides the opportunity for members to attend training on new skills and techniques, as well as marketing, and to receive support for bringing their products to a wider audience. The programme also provides training on health-related and environmental issues in the production of Kajood, such as using protective clothing and methods to minimise health risks.

The programme has also begun to provide its members with a microfinance scheme, whereby older people can borrow up to THB 10,000 at an interest rate of 1 per cent, provided they have three guarantors.

Governance and management of the CBSI

Originally, Mrs Manee's family members ran the programme's activities on an informal basis. After being recognised as a community enterprise in 2006, an organisational structure was required for efficient management and legal registration. The current structure comprises a head of community enterprise, a deputy head, a secretary, public relations staff, a treasurer, a committee and consultants. As of 2016, older people play an important role occupying management positions in the programme.

Figure 7 Kajood handicrafts

Figure 8 Making of kajood products

Results of the CBSI (Outputs)

Enrolment of older people

In addition to the organisational structure outlined above, the programme has around 60 enrolled members, of whom around one-third are older people. The age range of older members is between 62 and 78 years old. Among older members, 90 per cent are female and about 80 per cent completed primary education. It was felt that there was a range of socioeconomic status among the older members. Approximately 30 per cent have relatively high economic status, while 50 per cent and 20 per cent have middle and low economic status, respectively.

There appears to be a clear gender division in the activities, with male members tending to be involved mainly (although not exclusively) in pulling Kajood from the swamp and female members in weaving the Kajood products.

According to the members interviewed, a primary motivation for their involvement was the opportunity to generate additional income and improve their economic well-being. Two members noted that they initially began weaving Kajood to generate income, but becoming members of the programme appealed as it allowed them to earn dividends and supported them by providing training and places to sell their products.

Interviewees also noted that not only does membership of the community enterprise help older people to be economically active and earn more income to take care of their family, the connection between members also helps them to access information, including on health and social benefits such as elderly allowances.

Self-reported health gains from beneficiaries

According to the interviewees, there are a number of health benefits from being involved in the programme. Several interviewees noted that being involved helped older people maintain their physical fitness, as working on Kajood was seen as physically demanding and good exercise.

In addition to the physical health benefits, interviewees noted that involvement in the programme was also good for their mental well-being and for reducing social isolation. Some members noted that their children had moved away from the area, so the programme helped increased their social participation by creating opportunities for them to meet, discuss and exchange ideas, both among peers and across

generations. Moreover, socialising among Kajood HCE members was considered as providing emotional support. According to one interviewee working in the health system, older people enrolled in the Kajood HCE were more likely to be relaxed and stress-free than other older people in the region, as they had more opportunity for social interaction.

The economic security provided by the programme was also seen as beneficial to the older people's mental well-being, as it enables them to rely on themselves sustainably by providing regular wages and the opportunity to save for emergencies as they get older. Interviewees noted that older people gain pride and dignity through this economic activity and feel like they are a resource for the community. The Kajood HCE offered a particularly flexible form of employment for women and older people, as they worked to fulfil orders rather than having to keep set hours. This meant that older people could be active Kajood HCE members while meeting other, for example family commitments, or in some cases engaging in other forms of income generation such as working on the rubber tree plantations.

Despite the health gains reported by interviewees, some also noted that working with Kajood could create health challenges for older people and that some people did not want their elderly relatives to be involved in the programme, as they perceived the work to be too physically demanding. One interviewee noted that some health problems were commonly reported by members, such as back and knee-joint pain from sitting on the floor while weaving Kajood.

Linkages to health and social care system

The programme has benefited from strong links with the health and social care facilities for older people in the region. Firstly, the programme has benefited from local government investment and support in-kind through the provision of resources, buildings, expertise and equipment. In addition, health personnel from the SHPS provided help and training to members.

In particular, CBSI staff noted that the programme's linkages to the SAO and the Elderly Clubs have meant that it is able to get members involved in health promotion activities, with regular check-ups provided through the Elderly Clubs. However, one interviewee noted that there was no difference in access to services between older people enrolled in the Kajood HCE and those who were not, as most health services came through either the Elderly Clubs or VHVs (the interviewee did note that being a member of the Kajood HCE may help to encourage older people to join their local Elderly Club). Another interviewee noted that the social activities of the Kajood HCE are indirectly organised through the Elderly Clubs.

Impact of the CBSI (Outcomes)

Wider impacts of the programme

Despite the self-reported health gains described by interviewees, there is no monitoring and evaluation data associated with the programme that can demonstrate its long-term impact, especially with regard to the health of the older people involved.

Interviewees felt that the long-term impact of the programme was primarily in providing economic security to older people, as they felt that the welfare system for older people in Thailand has not been fully developed. Typically, an older person involved in the programme can earn around THB 3,000–5,000 per month from weaving, which can provide economic security for them and their families. This is slightly below the average monthly salary among agricultural workers in Thailand (ODI 2014). Few older people involved reported that they 'needed' the income, but that the income from the Kajood HCE provided security, for example in being able to withstand financial shocks or enabling one's children to pursue particular educational or employment opportunities. Social engagement in the programme was also seen as indirectly encouraging older people to get involved with other community activities, for example the Elderly Clubs run by the SAO.

Interviewees also noted that the job creation provided by the programme has had a wider impact on the prosperity of the region. In particular, one interviewee noted that some younger generations who had migrated from the region had returned home due to the job opportunities created by the Kajood products. Moreover, new visitors were coming to the region to see the Kajood HCE, which in turn has created opportunities for villagers to sell other products.

Finally, interviewees felt that the active economic role played by older people in the programme helped to demonstrate the value of older people in society and therefore could reduce the stigma faced by older people. The age dependency ratio, or ratio of older dependants (people aged over 64) to working-age population (15–64), is increasing in Thailand, as it is globally, and there are limited opportunities for employment for older people in rural areas.

Sustainability of the programme

While seed funding was initially provided by local government agencies, CBSI staff noted that the income generated from selling products was now the main source of finance for the programme and that it was self-sufficient. Interviewees felt that a potential challenge for the future of the programme was the lack of interest from younger generations in being involved in Kajood handicraft production. In this respect, intergenerational relationships were considered as key to sustaining the Kajood HCE. Engaging the younger generation in activities was seen as a way to help older people to utilise technology to improve the quality of the products and help them to access new channels for marketing products, such as online marketing.

One interviewee noted that environmental factors may also be a challenge for the programme, as in 2015 flooding caused damage to the swamp forests in the region.

Reflections on the CBSI

The experience of the Kajood HCE programme raises some important themes relevant to the analysis of CBSIs.

Through establishing the programme as a community enterprise, the Kajood HCE has successfully been able to scale up and is now financially sustainable.

Although seed funding was initially provided by local government agencies, the programme is now able to sustain its activities through selling products, both locally and internationally. The profit generated from these activities benefits the members of the programme in the form of dividends and welfare payments, which further strengthens their economic well-being.

The programme may have successfully contributed to reducing social isolation among older people in the region, although there appears to be a gender split in the membership of the programme.

Many interviewees noted that prior to being involved in the programme, older people in the region were often socially isolated, either through the death of a partner or due to their children migrating from the area. The programme provides a good opportunity for older people to remain socially active and several beneficiaries noted the emotional support provided by other members of the programme. Despite the open and inclusive eligibility criteria for the programme, the majority of the members and those leading the activities tend to be women, with men primarily being involved in only the extraction of Kajood from the swamps. However, more research is needed to understand the gender dynamics in the CBSI.

Older persons' social engagement in the Kajood HCE programme may have indirectly encouraged them to become involved in other community activities.

Beneficiaries noted that participating in the programme had encouraged them to be involved

in other community-based activities. For example, most of the older people working in the Kajood HCE have also become members of the local Elderly Club, where they can access health services and contribute to advocacy efforts to promote older people's rights in the region. In this respect, the programme can be seen to contribute to older people's civic engagement.

A significant role is played by intergenerational relationships in the programme.

A key feature noted by interviewees in the CBSI was the significant role played by intergenerational relationships, which was seen as essential to the programme's sustainability. The younger generation are involved in helping older people working with Kajood to utilise new technology to improve the quality of their products, and to access new, for example online channels for marketing. In return, older members transfer their knowledge on extracting and weaving Kajood to the younger generation, to enable them to also gain additional income from the production of Kajood handicrafts.

The programme has good coordination with local government administration, which indirectly helps members to access healthcare facilities. In addition, the programme provides direct welfare support to its members, through a benefit package and access to credit.

Compared to other countries in the region, Thailand's provision of care for older people is relatively strong. In this respect, rather than providing direct health services for older people, the programme has good links with VHVs, Elderly Clubs and local hospitals, which all provide members with check-ups, training and health promotion activities. In addition, the programme complements the welfare provided by the state through a benefits package for members that supports their access to care, and a microfinance programme which gives members access to credit.

The programme presents an interesting case of a CBSI that does not primarily aim to improve the health of older people, but has indirect benefits in regard to social health and physical fitness.

Despite the lack of monitoring and evaluation data on the programme, especially in respect to the health benefits, findings from the interviews suggest that the programme may be having an impact on the beneficiaries' mental health, both directly through the socialisation of older people and indirectly through improving older people's economic security, which in turn can improve their well-being. This is an interesting finding given the primary objective of the programme, which is to sell Kajood handicrafts. However, more research is needed to assess the extent to which the programme's impact on physical health is positive or negative in the long run.

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World Health Organization

Centre for Health Development

Ukraine: Kolping University of the Third Age (KUTA)

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In-country collaborating partners: Grzegorz Gawron

Preface

The World Health Organization Centre for Health Development Kobe has contracted RAND Europe to serve as a research hub for conducting a systematic review and gathering evidence of middle- and high-income countries' community-based social innovations (CBSIs) for healthy ageing. RAND Europe has undertaken two main strands of research consisting of: (1) a systematic review of CBSIs for healthy ageing in middle- and high-income countries, and (2) a series of ten case studies of CBSIs for healthy ageing in middle-income countries.

This report presents the findings from one of our ten case studies, the Kolping University of the Third Age (KUTA) in Ukraine.

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Summary of the community-based social innovation (CBSI)

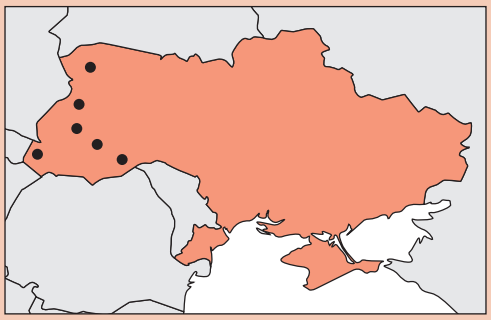
Background

Ukraine

Locations
Lviv, Stryi, Uzhgorod, Ivano-Frankivsk, Lutsk, Chernivtsi

Type of intervention
User-driven

Year established
2011



The intervention

Establishing the CBSI

- The Kolping University of the Third Age (KUTA) was set up in 2010 by the non-governmental organisation Kolping International, across six Ukrainian cities, as a reaction to the demographic changes occurring in Ukraine.
- The overall goal of the KUTA programme is to support older people in adapting to modern social life, through providing educational and voluntary activities to promote their physical and mental health.
- KUTA builds on an international network (Kolping) and learning from other regions (e.g. Poland).
- According to beneficiaries and CBSI staff, there are no similar activities currently taking place that support older people in these cities.
- The programme coordinates with local services (e.g. libraries) to share facilities such as IT equipment and meeting room space.

Activities of the CBSI

- Target population is people aged 50 and above, very inclusive, advertised through local TV and radio, newspapers and word of mouth through friends and family.
- The main activities of KUTA are divided into three areas:
  - Social activity
  - Pro-health activity
  - Civic activity.
- The programme is managed and run exclusively by volunteers. Older people are involved in the whole process, with participants electing representatives to a student council and jointly making decisions about KUTA's activities.

Results and impact of the CBSI to date

- The programme has enrolled over 400 older people across the six cities since 2010.
- Perceptions of the programme among beneficiaries interviewed were overwhelmingly positive. Health benefits of the programme tended to be social/psychosocial (e.g. self-esteem, knowledge, belonging, friendship).
- Given the lack of formal monitoring and evaluation processes at each KUTA, the long-term impact of the programme is difficult to assess. However, some felt that the KUTAs were contributing to improving social attitudes towards healthy ageing and improving older people's civic engagement.

Ageing in Ukraine

- Despite its large population of 44 million, Ukraine has negative population growth of -0.3 per cent, and with around 22.5 per cent of the population over 60 is one of the most rapidly ageing countries in the world.
- The Ukrainian constitution stipulates that healthcare services should be available to all citizens free of charge at the point of use; however, in practice the majority of health services require out-of-pocket spending due to a severe lack of public investment.
- The majority of long-term care in Ukraine is provided through the informal sector, although there are no public finances to support this form of care and data on informal care in Ukraine is limited.

Reflections on the CBSI

- The programme is currently dependent on volunteers to manage the CBSI and coordinate activities, which impacts its ability to scale up/remain sustainable.
- KUTA participants are predominantly educated women, despite the programme being open to all older people. The programme has successfully contributed to reducing social isolation among these women.
- The role of individuals in championing the CBSIs has been crucial in the KUTA case.
- An educational programme such as KUTA presents an interesting case of a CBSI that can have positive impacts on older people's health, without having health as a primary objective of the programme.
- There is no formal linkage with health or social care services, although given the challenges facing the current Ukrainian health system related to out-of-pocket spending, integration with this frail system may pose as many challenges as benefits for older people engaged in KUTA.
- There is no formal monitoring and evaluation system for KUTA, outside of basic funder reporting on financial spend.

Aims of the research

This report presents the findings from one of our ten case studies, the Kolping University of the Third Age (KUTA) in Ukraine. The overall aim of the research is to describe within a pool of rapidly ageing countries, and from those with high proportions of older people, a) the core roles, services and functioning (including feasibility of scale up) of community-based social innovations (CBSIs) for healthy ageing that seek to support older people becoming a resource for their own health and well-being; b) their linkages with and sustainable partnerships to deliver health services, strengthen social systems; and c) the nature of enabling policies, programmes, financing and interactions with the health/social care delivery system.

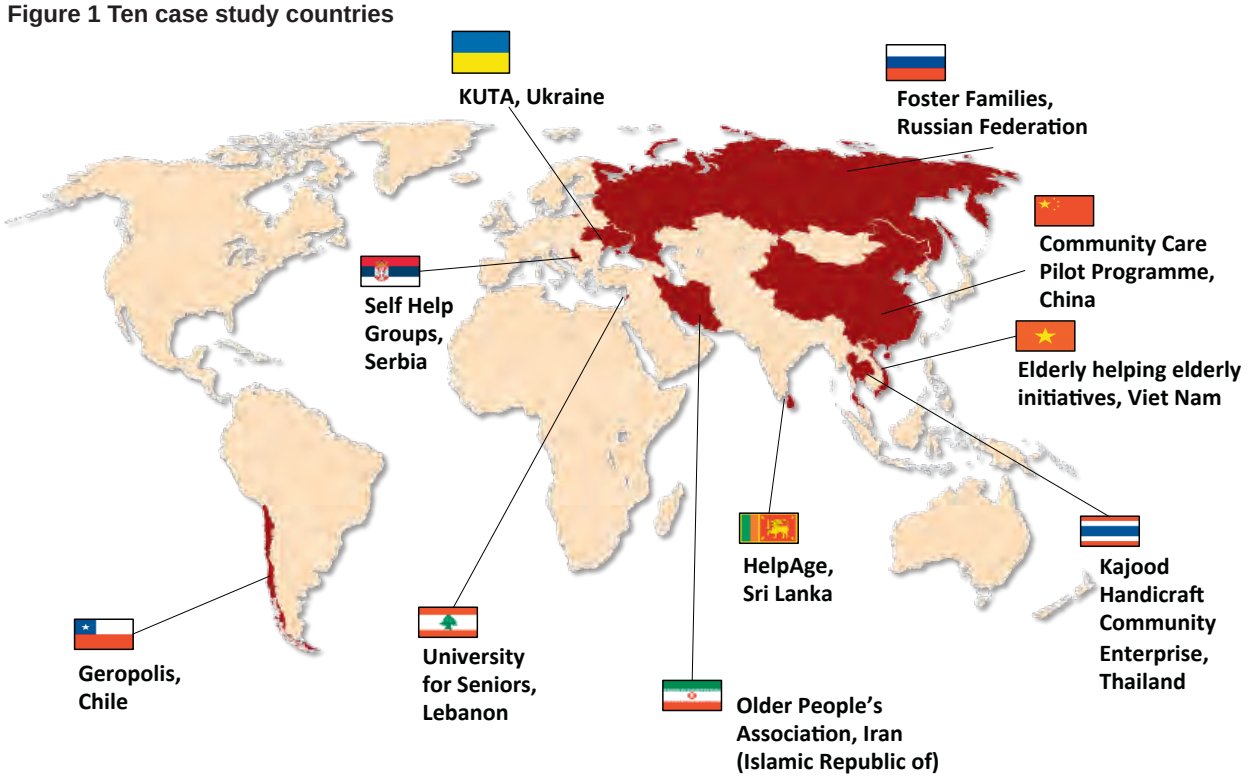
A recent WHO study conceptualised CBSIs as initiatives that seek to empower older people to improve their self-efficacy in caring for themselves and their peers, maintain their well-being and promote social cohesion and inclusiveness. They can also help older people to access, understand and navigate health and social care systems (Ong et al. 2016).

While CBSIs may hold the potential to transform health and social care provision for older people, more evidence is needed to improve our understanding of what types of initiatives and service delivery models are pursued in practice that engage communities and span a spectrum of health and social services.

Aiming to develop a typology of CBSIs, this research consisted of three main parts: (i) a systematic review of CBSIs for healthy ageing in upper middle- and high-income countries; (ii) a series of ten case studies to examine the effectiveness of ongoing CBSI interventions in middle-income countries; and (iii) an expert consultation at the World Health Organization's Centre for Health Development (WHO-WKC) in Kobe, Japan, to validate and refine the typology.

Given the relative lack of evidence on CBSIs in middle-income countries in academic literature, the ten case studies were identified through an open call for Expressions of Interest (EOIs). Figure 1 below shows the location of the ten case study countries.

Figure 1 Ten case study countries



The data gathered in this case study will serve to better conceptualise what a CBSI is and to present typologies and functions of CBSIs for older populations.

Each individual case study will seek to explore:

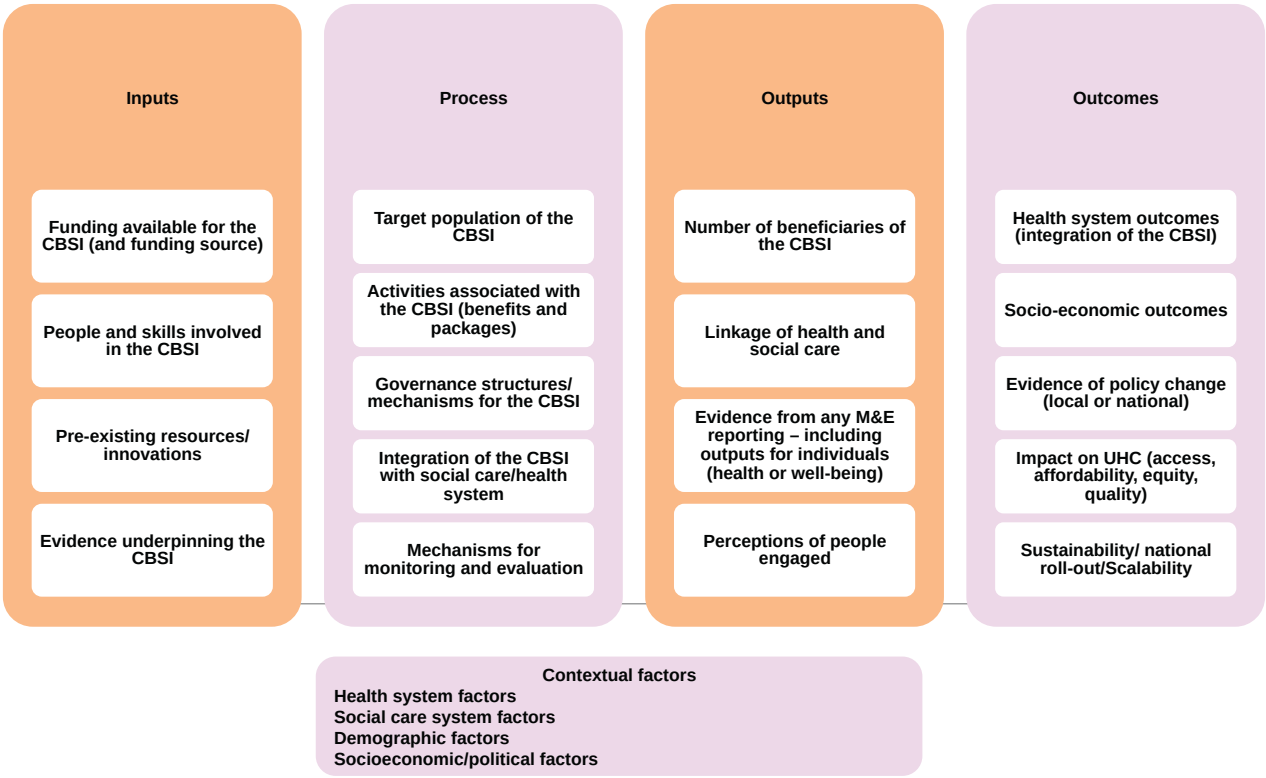
- The role and function of older people as resources for themselves and for others (peers, family, community).
- Health and social services delivered by those initiatives and referral processes when they exist.
- Links made within these communities of support between health interventions and social health protection interventions (e.g. help with transportation, livelihoods, pensions, cash or in-kind transfers).
- Coordination mechanisms with formal health and social sectors, including any formal connections with the health and social care system.
- Coordination and engagement with a variety of health/social service workers and community-based services.
- Types of metrics (indicators, monitoring tools) implemented to assess impact on health[1] and the concept of health that is being measured.
- Measures to understand and respond to health inequities in the population served.

In order to explore each of these factors, we have used a logic model approach to examine the effectiveness of selected CBSIs. This helps us assess the intervention logic for CBSIs and track the progress, impacts and evolutionary dynamics of CBSIs at core levels of analysis. As illustrated in Figure 2 below:

- **Inputs** will help us understand the resource environment of each CBSI and provide a foundation for exploring the linkages between resources, outputs and impacts. This resource input environment is likely to capture aspects such as resources for implementation (funding, infrastructure and skills/capabilities). We will also aim to capture the reasoning and evidence base leading to the establishment of the CBSI.
- The **process** dimension will help us examine both the diversity of CBSIs, in terms of activities/services offered, population groups targeted and geographies projects covered and mechanisms for designing, managing and evaluating the CBSI if present. We will also examine the integration of the CBSI within the wider health and social care services offered to older people.
- The **output** dimension will help us assess the relative progress of CBSIs since they have been established and capture the diversity of outputs and associated achievements. This will involve capturing outputs such as the number of beneficiaries involved in the CBSI and any initial health and well-being outputs for beneficiaries reported.
- The **outcomes** dimension will help us capture a wider range of benefits, including those relating to impact on resources for achieving universal health coverage (UHC), policy-level impacts and other (including unintended) consequences which may affect the health and well-being of older people in a particular country. In particular we will not only consider impacts at an individual level (e.g. beneficiaries engaged in the CBSI) but also look to examine the impact on the wider community and the overall health/social care system.

1 We used the term ‘health’ very broadly at this stage in anticipation that it could incorporate physical and mental health and broader wellbeing. As the case studies were exploratory, we did not seek to further define or restrict at this stage as we were interested in understanding of the CBSIs themselves conceptualised and measured these types of outcomes, if at all.

Figure 2 Framework for gathering data on CBSIs and the contexts they operate in



- The **contextual factors** will guide us to consider the influence of both health and social care system factors and demographic, socioeconomic and political factors which may help or hinder progress of the CBSI. A greater understanding of the contextual factors underpinning the CBSI will also help to inform reflections on its transferability/ scalability by offering a rich understanding of the setting.

Structure of the case study

The next section of the report begins with a brief overview of the methodology used for the case study. The report then highlights some of the key contextual factors affecting the CBSI, related to the country's ageing population and its health and social care system.

The main section of the report focuses on how the four areas of the logic model (outlined in Figure 2) related to the CBSI, in the following four areas: (i) establishing the CBSI (inputs); (ii) activities of the CBSI (processes); (iii) results of the CBSI (outputs); and (iv) impact of the CBSI (outcomes). Within each sub-section the perspectives of interviewees are presented alongside findings from the desk review. Finally, the report concludes with some overall reflections on the CBSI and draws out key themes and experiences to better conceptualise CBSIs and their role and functions for older populations.

Methodology

Case studies have been used to collect descriptive data on CBSIs through a mix of methods including semi-structured interviews and a review of administrative data and documentation. Each case study follows the same design in order to provide in-depth understanding of each CBSI and allow comparisons to be made between different actors

within a single case, between cases and between groups across cases, taking into account relevant contextual factors. Key-informant interviewees were conducted with key stakeholder groups involved in the CBSI, as well as with wider health and social care system actors.

Desk-based document review

Building on any documentation identified in consultation with the CBSI, the literature review draws on academic and grey literature to provide an overview of the health and social services delivered by the CBSI in Ukraine and the wider context in which these interventions are taking place. In addition, any available evaluative documentation was reviewed to collect evidence on the metrics, indicators and monitoring tools used to assess the effectiveness of the CBSIs identified. Key documents included journal articles and policy documents, such as commissioned discussion documents and government strategies. Academic literature was identified through PubMed, focusing on the years 2000 to the present. The literature search was conducted between August and September 2017.

Stakeholder interviews

In addition to the document review described above, key-informant interviews were also used as a key means of gaining an insight into the ongoing activities of the CBSI and the wider contextual factors affecting its functioning in Ukraine. The interviews followed a common topic guide, with the main topics discussed including: resources that support the CBSI, engagement with older people and functioning of the CBSI, outputs and linkages with the health and social care systems and impact of the CBSI. Emphasis, however, was placed on allowing participants to talk from their own perspective.

In order to explore different perceptions of impact associated with the CBSI and identify any linkages and interaction between stakeholders, the project team identified suitable interviewees, in coordination with the CBSI staff, from three major stakeholder groups (as outlined in Table 1 below). A total of 15 interviews were conducted in Ukraine between 1 and 4 August 2017.

Prior to being interviewed, written consent to participate was sought from all participants and they were each asked to sign an informed consent form. Interviews were conducted face-to-face in Lviv, Stryi, Uzhhorod, Ivano-Frankivsk and Lutsk. The interviews typically lasted between 30 and 60 minutes and were semi-structured in style, to enable participants to raise concerns that may not have been anticipated by the research team or were specific to the

Table 1 Overview of the interviewees

Stakeholder group	Profile of the interviewees
Beneficiaries of the programme	Five interviews with participants involved in the programme in Stryi. All of the participants interviewed had been involved in the programme for at least three years, were aged between 60 and 78 years old and were female. Four of the five beneficiaries were retired, with the other beneficiary still working as a teacher in a local school.
CBSI staff	Five interviews with the managers of the CBSI in each of the following cities: Lviv, Stryi, Uzhhorod, Ivano-Frankivsk and Lutsk. All managers were previously involved with Kolping Family as volunteers prior to the establishment of KUTA in their city.
Policymakers, academia and civil society	Three interviews with local government authority officials in Stryi involved in the Department of Education. One interview was with a representative from the local library services in Stryi, which cooperate with and provide resources for KUTA. One interview with a representative from a local non-governmental organisation in Stryi that coordinates activities with KUTA.

practice. This ensured a flexible approach which allowed respondents to offer their own perspective and raise issues most salient to them, while covering the same topic areas in each interview.

The interview data was analysed and coded by the project team, and then grouped into the categories and sub-categories outlined in the logic model. In analysing the categories, the team also identified emerging themes, which are presented at the end of this report.

Overview of the context in Ukraine

Ukraine, like many of its eastern European neighbours, has an ageing population. This issue has been compounded by decades of economic insecurity since the country's independence in 1991, which has resulted in a poorly resourced and inefficient healthcare system, further exacerbated by the global financial crisis and ongoing conflict in the eastern part of the country.

Lekhan et al. (2015) note that the poor health outcomes experienced in Ukraine are also related to low health awareness among the general population and high prevalence of tobacco and alcohol dependency, as well as rampant corruption in the health system.

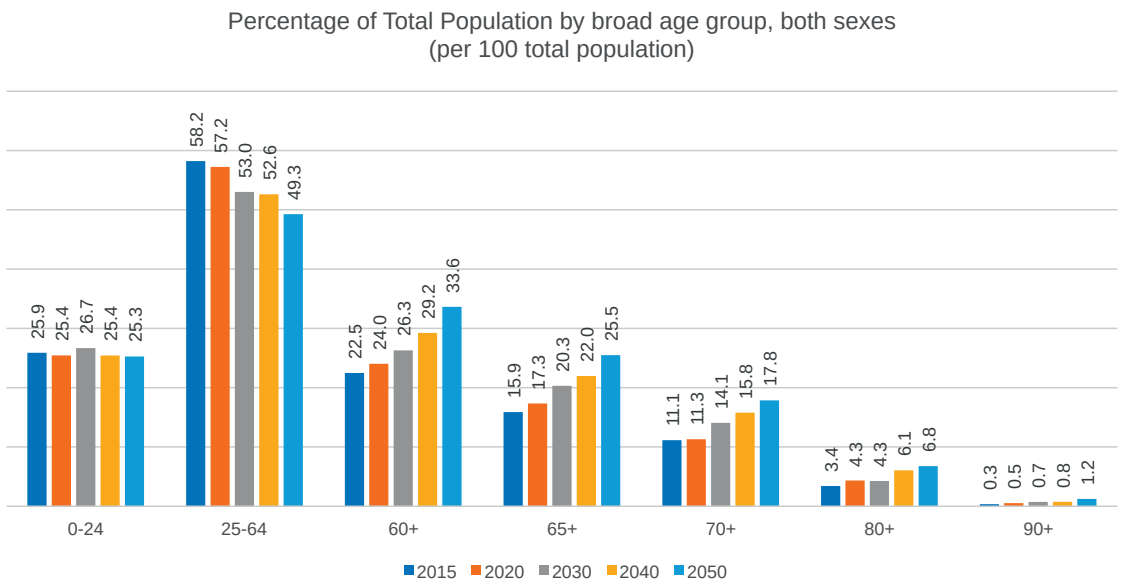
Demographic factors

Despite being the second-largest country in Europe, Ukraine's population of around 44 million people is 14 per cent smaller than it was in 1991 after the collapse of the Soviet Union (UN 2017), and in 2016 it had a negative population growth ratio of -0.3 per cent (World Bank 2017).

Today, the average life expectancy is 71 (for men 66; for women 76), with an average healthy life expectancy at birth of 64.1 (WHO 2015). This is particularly low compared with other European countries, with average European life expectancy standing at around 77 years.

In 2015, the percentage of the population aged 60 and above was 22.5 per cent and it is expected to reach 33.6 per cent by 2050 (UN 2017). In general, the biggest decline in the number of inhabitants is expected in the group between 25 and 64 years old – from 58.2 per cent in 2015 to 49.3 per cent in 2050. On the other hand, the biggest growth is expected in the oldest part of society – the group from 60+ to 90+.

Figure 3 Distribution of population



Source: Own preparation based on United Nations, Department of Economic and Social Affairs, Population Division (2017).

Overview of the Ukrainian health system

The Ukrainian constitution stipulates that healthcare services should be available to all citizens free of charge at the point of use (Article 49). However, in practice the majority of health services require out-of-pocket spending due to a severe lack of public investment (Lekhan et al. 2015). While health expenditure in Ukraine was 7.6 per cent of GDP in 2012, which is higher than many other Commonwealth of Independent States (CIS) countries, only 54.9 per cent of total health expenditure was from public sources, suggesting a significant level of inequity in access to healthcare services (Lekhan et al. 2015).

Following independence, Ukraine tried to reform its extremely expensive Soviet healthcare system but failed to effect significant changes. Although regional and local authorities are now managerially and financially responsible for the provision of healthcare, the system remains inefficient and expensive. The private sector is small and consists mostly of pharmacies, diagnostic facilities and privately practising physicians (Lekhan et al. 2015).

As discussed by Lekhan et al. (2015), the Ukrainian health system is inefficient and poorly financed, resulting in high out-of-pocket spending. Transport costs for accessing care and pharmaceutical costs are often covered by patients and their families; out-of-pocket payments often include also informal payments and gratuities for staff. According to official figures, in 2012, 40.2 per cent of Ukrainian health expenditure was covered by patients (Lekhan et al. 2015).

Overview of the Ukrainian social care system

Given the economic situation, the Ukrainian government has recently reformed the social security system, adopting severe austerity measures. These measures include modifying the organisation and financing of social insurance funds; freezing, delaying and reducing the indexation of social security benefits; and changing benefit entitlements, benefit amounts and taxation rules (ILO 2016).

Prior to the implementation of these reforms, the average retirement age was around 58 years for men and 56 years for women (it is now 62 and 60, respectively) (ILO 2016). Due to this policy Ukraine has over 12 million pensioners, which accounts for almost 30 per cent of the population. This has resulted in a ‘contributors: retirees’ ratio of almost 1:1, one of the lowest in the world (Van Rooden 2017).

Overview of the CBSI

Establishing the CBSI (Inputs)

Establishing the CBSI

Kolping International is a faith-based non-governmental organisation which aims to ‘promote the possibilities of the individual person, support the organisation of disadvantaged people, and strengthen the development of civil societies’ (Kolping International 2017). It is currently operating in more than 53 countries worldwide and has over 450,000 members.

The beginnings of the Kolping University of the Third Age (KUTA) originated in a government programme back in 2010 aimed at organising activities for senior people in Ukraine through local government. One of the partners which joined this initiative was the Ukrainian branch of Kolping International, ‘Kolping Family’, which hoped to help strengthen public and social participation of older people in Ukraine.

Due to a lack of funding, the Ukrainian government was unable to fund the programme. However, off the back of the initiative, and building on its experience in supporting older people in other eastern European countries (Kolping International 2016), Kolping Family decided to help organise the first KUTA in Lviv,

Figure 4 Location of the KUTAs in Ukraine

which was operational by 2012. In 2013, Kolping arranged an informational meeting in Lviv to showcase the achievements of the programme to date to other cities in Ukraine, with the objective of scaling up the CBSI across other Ukrainian cities, with the help of its network of volunteers. The meeting was also attended by a representative from the University of the Third Age (UTA) at the University of Wrocław in Poland, who explained the premise behind the UTA concept and trained participants at the meeting, who would go on to be future managers of KUTAs, on how to organise such institutions in Ukraine.

This resulted in four additional KUTAs being established in the following cities:

- Uzhhorod
- Lutsk
- Ivano-Frankivsk
- Chernivtsi.[2]

During this meeting representatives from Kolping in Stryi also expressed interest in setting up a KUTA in their town. According to one of the CBSI staff, initially Kolping was reluctant to support the programme in Stryi, as it is a small town rather than a city, without a university to draw on for volunteers. The programme in Stryi was therefore organised informally through the Church for the first two years, without funding. After witnessing the demand for the activities in Stryi and the engagement of older people, Kolping began providing financial support in 2016.

Aims and objectives of the initiative

The overall goal of the KUTA programme is to support older people in adapting to modern social life, through providing educational and voluntary activities to help their physical and mental health. It is believed that the organisation of such activities can help improve the quality of life of older people and create the conditions for communication, mobility and active participation in society. KUTA was established with the following main objectives:

- To meet the needs of older people and encourage them to share life experiences.
- To stimulate social activity and mutual support between older people.
- To encourage participation in activities which benefit the cities involved and their residents.
- To provide continuous intellectual development for older people, supporting mental and spiritual needs.
- To promote health lifestyles and allow older people to look after their physical condition.
- To assist in improving social and living conditions for older people.

The CBSI staff interviewed stated that the programme aims to support older people in increasing their knowledge and sharing skills to broaden their circle of friends and interests, with the hope of alleviating social isolation and loneliness through mutual self-fulfilment.

Funding for the CBSI

Each KUTA is run on a voluntary basis and therefore only requires limited funding for costs such as rent, materials for classes, paper, and coffee/tea and other refreshments. As the initial

2 Representatives from the KUTA in Chernivtsi were unavailable for the stakeholder interviews and are therefore not included in this case study.

Figure 5 Social event in Ivano-Frankivsk KUTA

organiser of the programme, Kolping Family has provided the KUTAs with financial support for renting rooms and purchasing equipment such as computers, although this has varied across the cities. The KUTA in Lviv no longer receives funding from Kolping for rent, as it is now able to use rooms at the local university for free.

The remaining costs associated with the everyday operation of the KUTAs are covered by participants, formally or informally. For example, in Lviv each participant pays an annual fee of UAH 200 (around USD 8) to participate, which can be paid in instalments if the participant is unable to pay all at once. Other KUTAs collect monthly contributions or contributions on an ad-hoc basis when they need to buy specific materials or equipment. Some KUTAs outside Lviv (such as Uzhhorod and Stryi) are planning to introduce official fees for participation, but this is yet to be confirmed. The KUTA in Stryi has also managed to leverage funding from alternative sources through networks linked to its CBSI manager (e.g. the Polish Foundation for Freedom and Democracy and the Polish Consul in Lviv). Given the current financial austerity and lack of resources, local government officials noted that they were unable to support the programme financially, but remain committed to supporting KUTA through helping to organise activities and events.

Other initiatives in the region

Almost all interviewees noted that no similar activities were currently taking place in their cities to support older people. One beneficiary noted that it was this lack of similar initiatives that got her involved in the programme, as she was very keen on activating and integrating local seniors for whom there was no prior activity in Stryi.

A local government official in Stryi noted that there are a small handful of recreational activities that older people can get involved in (e.g. literary clubs/art clubs) but that these activities are more general, do not have a health focus and are not exclusively for older people.

In general, it was felt that Ukraine lacks initiatives and support for older people, especially in smaller towns and villages.

Activities of the CBSI (Process)

Target population and eligibility criteria

The target population for the programme is any older person aged over 50. The KUTA managers noted that the programme's eligibility criteria are deliberately very broad, in order to be as inclusive as possible. In order to participate in the programme, each older person must complete a short questionnaire providing basic information such as name, address and phone number, as well as their interests. There is no formal referral process to get involved in the programme.

The beneficiaries highlighted the various ways in which they got involved in the programme – primarily through word-of-mouth via friends,

Figure 6 KUTA lesson in Lutsk

family and the wider community through the Church. Some beneficiaries also mentioned that they had heard about the programme through advertisements in the local newspaper or on local TV and radio. KUTA has also produced leaflets about the programme, which are available through various local institutions such as the social welfare office, the municipal office and pension fund institutions.

Beneficiaries also discussed their motivations for getting involved in the programme. The primary motivation seemed to be that they wanted to have the opportunity to interact and cooperate with other older people and stay active, as many of them now had a lot of free time due to retirement. One beneficiary also noted that the programme offered a great opportunity for social interaction as many women's husbands had passed away and their adult children had moved away from the area. Another beneficiary noted that the most important factor for her was the opportunity for continuous educational development, and she was keen to maintain an active life.

Activities associated with the CBSI

Various activities are offered through KUTA and these have expanded and changed over time. The activities offered are tailored to the needs and expectations of the older people involved in the programme. The main activities of KUTA can be divided into three areas:

- **Social and educational activities**: participation in meetings with peers and other members of local communities; participation in lectures, workshops, meetings, etc. – lifelong learning; organising and participating in various activities for the benefit of local communities; participation in the social life of the cities; combating social exclusion; improving quality of life and elderly self-esteem – through numerous classes, affecting the growth of knowledge, developing abilities, exploring new technologies to help seniors find themselves in the surrounding world.[3]
- **Health promotion activities**: improving elderly physical health – participation in group gymnastics; gaining knowledge about healthy lifestyles; participation in trips in the open air; combating feelings of loneliness and depression.
- **Civic activities**: the creation of councils of seniors; cooperation with local authorities; active participation in the creation of the senior local policy; gaining a sense of the subjectivity of citizenship.

Usually, seniors' meetings are held three or four times a week, with each taking about three or four hours. They are filled with seminars, workshops, lectures and other activities on different topics of interest to the participants (e.g. psychology, travel, history, culture, healthy lifestyles, new technologies).

Every year new activities are introduced (e.g. new topics of study, meetings with new people such as specialists in various fields) through discussions between the KUTA manager and the participants in each city.

Governance and management of the CBSI

KUTA is managed and run exclusively by volunteers, with older people involved in the whole process, including electing representatives to a student council of participants and jointly making decisions about the KUTA's activities.

Over time the governance of each KUTA has changed. Initially most of the KUTAs were being run by one or two managers, who were responsible for organising all of the activities. However, all have now established a student council, selected by participants, which helps in organising classes and recruiting participants and volunteers.

3 KUTA conducts training in the following areas: computer skills; foreign languages (English, German, Hungarian); sociology, psychology; economy; religious; healthy lifestyles; choral singing; entertainment (tours, trips to the theatre, concerts).

Given the lack of funding, all activities are run on a voluntary basis. Classes are taught both by specialists from different fields (students, teachers, doctors, government representatives and representatives from non-governmental organisations) and by the older people themselves. In addition, some KUTAs have made use of expertise from local universities (e.g. Ivan Franko National University, Lviv Polytechnic National University and the University of Lutsk).

Beneficiaries noted that a particular strength of this collaborative, user-driven approach to the management of the CBSI was that it offers the opportunity to share learning and exchange skills and experiences. The different abilities and experiences of participants are used as the basis for organising different courses (e.g. if one participant can sing, they can arrange a singing class for everyone; if one participant has artistic skills, they can arrange an art class for everyone). All beneficiaries interviewed appreciated the opportunity to constantly develop their activities, establish new contacts (e.g. with other KUTAs) and try to exchange experiences.

Results of the CBSI (Outputs)

Enrolment of older people

To date, KUTA has enrolled over 350 older people, aged between 50 and 80, since 2010. Table 2 below shows the breakdown of participation by KUTA location.

Table 2 Total number of participants in each KUTA

City	Number of participants when established	Current number of participants
Lviv	20	130
Stryi	25	80
Lutsk	30	80
Ivano-Frankivsk	25	54
Uzhhorod	12	40

An interesting pattern observed across all cities was that the participants were predominantly women (only 4 per cent of participants are men), despite the programme being open to all older people, regardless of gender. While this may be due to demographic factors in Ukraine, with women on average living longer than men, or the fact that many men would still be working in their fifties and early sixties, the CBSI staff also felt that men were not interested in joining the programme. One female beneficiary also noted that her husband did not want to join as he felt the programme was better suited to women.

In addition to the gender differences of participants, some interviewees also remarked on the fact that participants tend to have a higher level of education than the average for people their age. While this data is not comprehensive, the CBSI manager in Lviv noted that around 80 per cent of beneficiaries enrolled in the city had higher-educational backgrounds.

Self-reported health gains from beneficiaries

Perceptions of the programme among the beneficiaries interviewed were overwhelmingly positive, although this may reflect the small sample of beneficiaries interviewed. The CBSI staff, as well as the beneficiaries interviewed, noted that the health benefits of the programme tended to be social or psychosocial, such as improvements in participants' self-esteem and confidence, improved knowledge and a sense of belonging and friendship. It was also hoped that the programme could have an indirect impact on participants' physical health through some of the health promotion activities and exercises, although beneficiaries did not mention the impact on their physical health.

Interviewees also felt that mental well-being was improved, not only through the social interaction experienced through the classes and activities, but through the skills and knowledge acquired. For example, one beneficiary noted that thanks to the programme, she had learned how to use a computer, which allowed her to contact friends and family who live far away from her home town.

Figure 7 Drama class at the KUTA in Stryi

The theme of loneliness and social isolation also came up in all of the interviews with beneficiaries. One beneficiary noted that, unfortunately, after retirement many older people often become passive and are socially excluded in Ukraine. However, thanks to KUTA, older people in Stryi have gained a sense that they are still needed and valued, and are provided the opportunity to meet with other people, which is considered important given that many are living alone.

There is currently no formal monitoring or evaluation of the KUTAs, beyond basic financial reporting to Kolping. Therefore, there is currently no mechanism to monitor the health gains of beneficiaries more systematically. However, CBSI volunteers who work in KUTA regularly collect feedback from participants, although this does not explicitly relate to health gains.

Linkages to health and social care system

The CBSI staff noted that although the KUTAs each promote healthy lifestyles within their groups of participants, they are not affiliated with the health or social care systems in Ukraine and any interactions or linkages with local health authorities are limited to non-existent. All activities are independent of the health policy in Ukraine and are organised based on the needs and expectations of the older people enrolled in the programme.

The KUTAs in Lviv and Uzhhorod both noted that they had tried to cooperate with the local authorities, although no formal linkages or programmes have been established. In 2015 a KUTA Coordinating Council was established in order to support cooperation between the KUTAs and local government. The undertaken actions included:

- Organisation of meetings with representatives of various municipal institutions
- Establishment of Councils of Elders in local governments
- The creation of municipal information centres for older people
- Organisation of ‘round tables’ with older people and local government officials.

In 2016 participants from the KUTA in Lviv were working with the Department of Social Protection at Lviv City Council to try to establish a home care programme for older people and people with disabilities, with the hope of creating a regional interest group. However, after two meetings the programme ceased to develop. In Uzhhorod there was a hope that the participation of some of the KUTA beneficiaries in the Social Council at City Hall would create opportunities for facilitating linkages with health and social care systems, but this has not happened.

Despite the lack of coordination or linkage with the local health and social care systems, the KUTAs have been relatively successful in coordinating with other sectors of local administration, in particular educational services such as libraries, schools and universities. The KUTAs have coordinated with local services to share facilities such as IT and meeting room space, recruit volunteers and advertise activities and events. Particularly in Stryi, the coordination between the local library and the KUTA was perceived as beneficial for participants, as it allowed older people access to IT facilities and training that they would not be able to afford on their own. According to one interviewee, the cooperation between the KUTA and the library was also recognised by the city authorities, and

the decision was made to fund the renovation of the library building in part due to the KUTA's achievements. In Lviv, Ivano-Frankivsk and Lutsk, the KUTAs are also very well connected to local universities and are able to share resources and draw on their expertise.

Impact of the CBSI (Outcomes)

Wider impacts of the programme

Given the lack of formal monitoring and evaluation processes at each KUTA, outside of basic funder reporting on financial spend, the long-term impact of the programme is difficult to assess.

According to two interviewees, the KUTAs were contributing to improving social attitudes towards healthy ageing and were breaking negative stereotypes about older people, showing them to be active, engaged and independent. Interviewees in Stryi also noted the prominence of KUTA activity among the local population, though coverage on local TV and in newspapers, which has helped to recruit participants.

Several interviewees also noted the KUTA was having a positive impact on the wider community in their respective cities through activities such as fundraising for local charities and faith-based organisations (e.g. Caritas, Order of the Knights of Malta), organising cultural events, providing care for vulnerable populations and interacting with younger people through a range of intergenerational activities.

Sustainability of the programme

Currently the KUTAs are wholly dependent on volunteers to manage, coordinate and conduct activities, which may impact the programme's ability to be sustainable. One interviewee noted that there was a challenge in finding new volunteers who were willing to give up their time for free. Another interviewee also highlighted the challenges of communicating and sharing resources across the KUTA network without core funding, and there was a desire to be able to meet with KUTAs in other cities more regularly in the future. It was felt that while the programme could carry on without this networking, an opportunity could be missed to improve and enhance the programme through sharing experiences and resources across the cities.

Reflections on the CBSI

The experience of the KUTA programme raises some important themes relevant to the analysis of CBSIs.

CBSIs are able to impact on health, even when health improvement is not a primary objective.

The experience of an educational programme such as KUTA presents an interesting case of a CBSI that can have positive impacts on older people's health, without having health as a primary objective of the programme. In this respect, benefits related to well-being and social and psychological health are reported by beneficiaries as the primary outcomes of the intervention, in addition to increases in health literacy. These findings have also been highlighted in other studies on UTAs (e.g. Patterson et al. 2015) and are often given as a rationale for starting such a programme (University of Plymouth n.d.). Nevertheless, without core funding, interventions such as KUTA will struggle to evaluate their impacts and capture the breadth of outcomes experienced by beneficiaries. Developing low-cost mechanisms for monitoring and evaluating CBSIs may help interventions such as KUTA to demonstrate the health gains from being involved with the programme, which in turn can be used to demonstrate success to policymakers and leverage funding from donors.

The role of individuals in championing the CBSIs has been crucially important in the case of KUTA.

One of the key success factors associated with KUTA appears to be the role of individual leadership from CBSI staff. According to interviewees, the strong leadership at KUTA was

respected across volunteers, participants and partners, and has enabled local institutional buy-in and leveraging of additional funding. Strong leadership also appeared to be an important enabler of linkages between the CBSI and local administration.

Participants are predominantly educated women.

The gender imbalance in the programme observed across all cities, whereby participants were predominantly women, raises questions about the equity of this type of CBSI. This finding also seems to fit with the experiences of UTA interventions in high-income countries. For example, Williamson (2000) notes that ‘gender differences in U3A membership reflect a variety of issues centering on retirement interests, marital status, social group membership, and the feminisation of U3A’. In addition to the gender divide in participation, it was also noted that participants tend to be educated. One government official noted that the people involved in KUTA in Stryi have usually been active all their lives and that it is therefore important to interest others in the programme.

Focus on local community and fight against stereotypes about old age.

KUTA beneficiaries try to participate in local life. They really care about being active and participating in local events. They want to be visible in their cities and prove that older people have a lot of potentially useful knowledge and skills. They try to help in the organisation of charitable activities (such as raising money for specific people in need) and to participate in cultural and civil society development.

Lack of linkages to the health and social care system but good coordination with other local services.

KUTA as a CBSI does not have formal linkages to the health and social care system and has acted independently of national health policy, despite trying to coordinate with local services. While integration with health and social care services may be important for linking participants with access to treatment, and management of declining health and serious disabilities in older populations (Ong et al. 2016), the lack of linkages does not appear to have been a hindrance to KUTA’s operations. Given the challenges facing the current Ukrainian health system related to out-of-pocket spending, integration with this frail system may pose as many challenges as benefits for older people engaged in KUTA.

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World Health Organization

Centre for Health Development

Viet Nam: Elderly helping elderly initiatives

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Preface

The World Health Organization Centre for Health Development Kobe has contracted RAND Europe to serve as a research hub for conducting a systematic review and gathering evidence of middle- and high-income countries' community-based social innovations (CBSIs) for healthy ageing. RAND Europe has undertaken two main strands of research consisting of: (1) a systematic review of CBSIs for healthy ageing in middle- and high-income countries, and (2) a series of ten case studies of CBSIs for healthy ageing in middle-income countries.

This report presents the findings from one of our ten case studies, the elderly helping elderly initiatives in Viet Nam.

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Summary of the community-based social innovation (CBSI)

Background

Viet Nam

Locations
Various provinces, Viet Nam

Type of intervention
State-supported, Networked

Year established
2009

The intervention

Establishing the CBSI

- The Viet Nam Public Health Association (VPHA) established a network of 110 Elderly Public Health Volunteers (EPHVs) in two communes of Tien Hai District in 2010. The EPHVs are trained in the community to develop knowledge and skills to promote the prevention of common conditions among older people.
- The Retired Health Workers Volunteers (RHWVs) programme was established in 2009 as an initiative of the Viet Nam National Committee on Ageing (VNCA). A pilot of 92 RHWVs working in ten communes of five provinces of Viet Nam was launched.
- Elderly Home Care Volunteers (EHCVs) form part of Intergenerational Self-Help Clubs (ISHCs), which are self-managed, multifunctional organisations involving different generations within communities that aim to promote equitable and inclusive development. EHCVs provide home care help and assist with daily living for older people, who typically live alone in the community. In 2016 the government of Viet Nam committed to the expansion of ISHCs to cover half of all communes in the country.

Activities of the CBSI

- EPHVs are trained in health promotion and communication. Each EPHV visits neighbouring households (approx. 25–30) to check on the health of older people (having been trained in using screening checklists) and provide advice about health behaviours such as tobacco use, alcohol abuse and physical activity. They also work with commune health station staff to organise elderly meetings where attendees can have their blood pressure checked.
- RHWVs work to provide primary healthcare services to older people in their local area. In doing so they link with village workers and other volunteers at a grassroots level.
- EHCVs may provide help in the form of physical, mental and social care services and help with daily activities such as moving around, bathing, dressing or eating, or provide social support, for example taking elderly people to social or religious activities.

Results and impact of the CBSI to date

- EPHVs reported that volunteering improved their own health, well-being and knowledge. They also reported benefits for their family members and other older people they were providing services for.
- An evaluation of the ISHCs, of which EHCVs are part, reported that perceived health status and knowledge of prevention of non-communicable diseases were higher among ISHC members than non-members.
- Volunteers also received benefits such as regular health check-ups, reduced treatment costs and health insurance.
- Wider impacts were reported to include a more positive view of older people within communities. In the case of ISHCs older people were an active part of problem solving for socioeconomic development within their community.

Ageing in Viet Nam

- Around 10 per cent of the population of Viet Nam are aged 65 or above. This is projected to increase to around 17 per cent by 2029.
- Around three quarters (72 per cent) of older people live with their children or grandchildren but family structures are changing and more are living alone or with a spouse.
- 30 per cent of older people in Viet Nam are without health insurance.
- A Law on the Elderly has been enforced since 2010 and a National Action Plan on Ageing is in place for 2012–20.
- Primary healthcare services are poorly distributed and under-resourced (human resources, medicines and equipment).

Reflections on the CBSI

- The inclusion of three models provides an interesting insight into scale-up and sustainability. The experience of the ISHCs suggests that there are benefits in developing a strategy for replication and scale-up at an early stage within a programme, and that it is important to invest in capacity building to ensure clubs are self-sustaining.
- By its nature, the RHWV role was restricted to retired professionals. EPHVs also tended to be retired professionals. There were perceived advantages reported in this model, but it may be that elderly helping elderly volunteer schemes reinforce social hierarchies.
- Political, social and cultural norms in Viet Nam mean that significant social capital is available at commune level. These programmes leverage that and contribute to it. The degree to which this is achieved horizontally or vertically may differ from one programme to another.
- The ISHCs explicitly sought intergenerational interactions. Even though the EPHVs and RHWVs did not, it was still reported that volunteers felt the status of older people had improved.
- All three programmes were linked closely with health services at the level of the commune.
- Some external evaluations of impact had been conducted. The ISHCs seemed to more proactively seek data and act on learning for the development of the model.

Aims of the research

This report presents the findings from one of our ten case studies, the elderly helping elderly initiatives in Viet Nam. The overall aim of the research is to describe within a pool of rapidly ageing countries, and from those with high proportions of older people, a) the core roles, services and functioning (including feasibility of scale-up) of community-based social innovations (CBSIs) for healthy ageing that seek to support older people becoming a resource for their own health and well-being; b) their linkages with and sustainable partnerships to deliver health services, strengthen social systems; and c) the nature of enabling policies, programmes, financing and interactions with the health/social care delivery system.

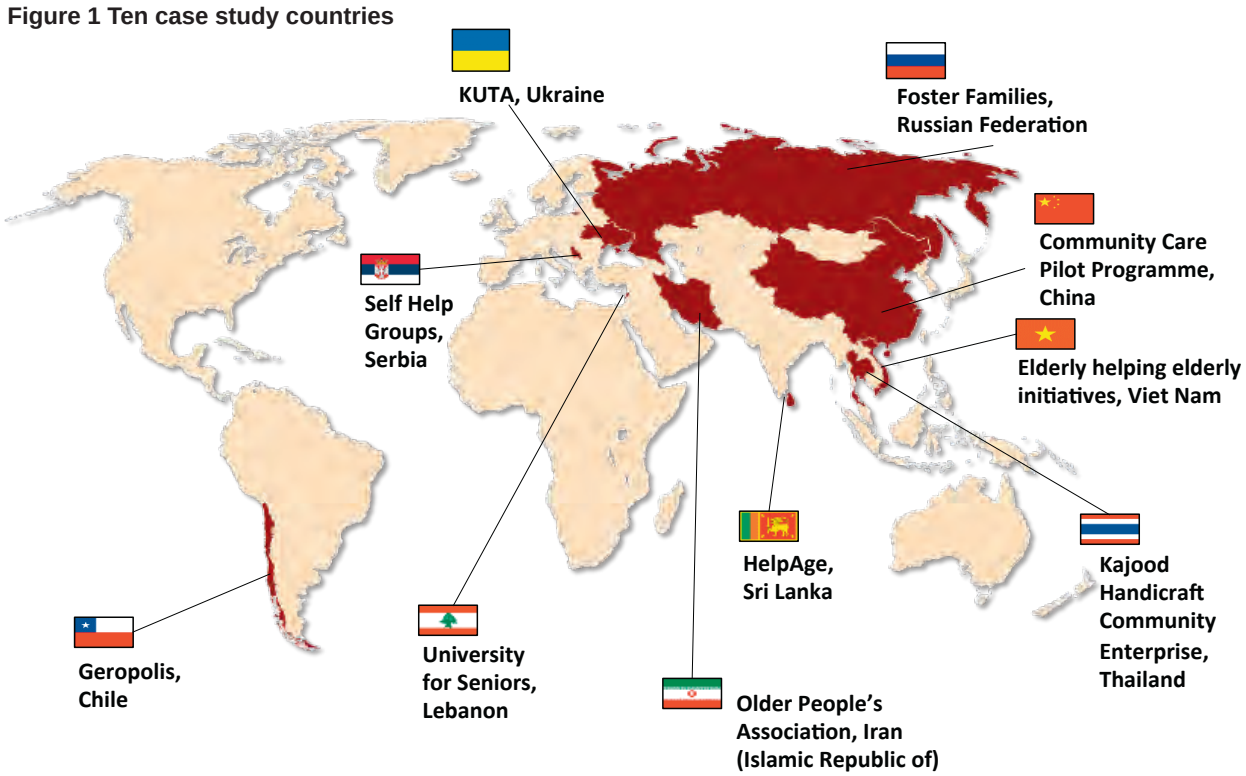
A recent WHO study conceptualised CBSIs as initiatives that seek to empower older people to improve their self-efficacy in caring for themselves and their peers, maintain their well-being and promote social cohesion and inclusiveness. They can also help older people to access, understand and navigate health and social care systems (Ong et al. 2016).

While CBSIs may hold the potential to transform health and social care provision for older people, more evidence is needed to improve our understanding of what types of initiatives and service delivery models are pursued in practice that engage communities and span a spectrum of health and social services.

Aiming to develop a typology of CBSIs, this research consisted of three main parts: (i) a systematic review of CBSIs for healthy ageing in upper middle- and high-income countries; (ii) a series of ten case studies to examine the effectiveness of ongoing CBSI interventions in middle-income countries; and (iii) an expert consultation at the World Health Organization's Centre for Health Development (WHO-WKC) in Kobe, Japan, to validate and refine the typology.

Given the relative lack of evidence on CBSIs in middle-income countries in academic literature, the ten case studies were identified through an open call for Expressions of Interest (EOIs). Figure 1 below shows the location of the ten case study countries.

Figure 1 Ten case study countries



The data gathered in this case study will serve to better conceptualise what a CBSI is and to present typologies and functions of CBSIs for older populations.

Each individual case study will seek to explore:

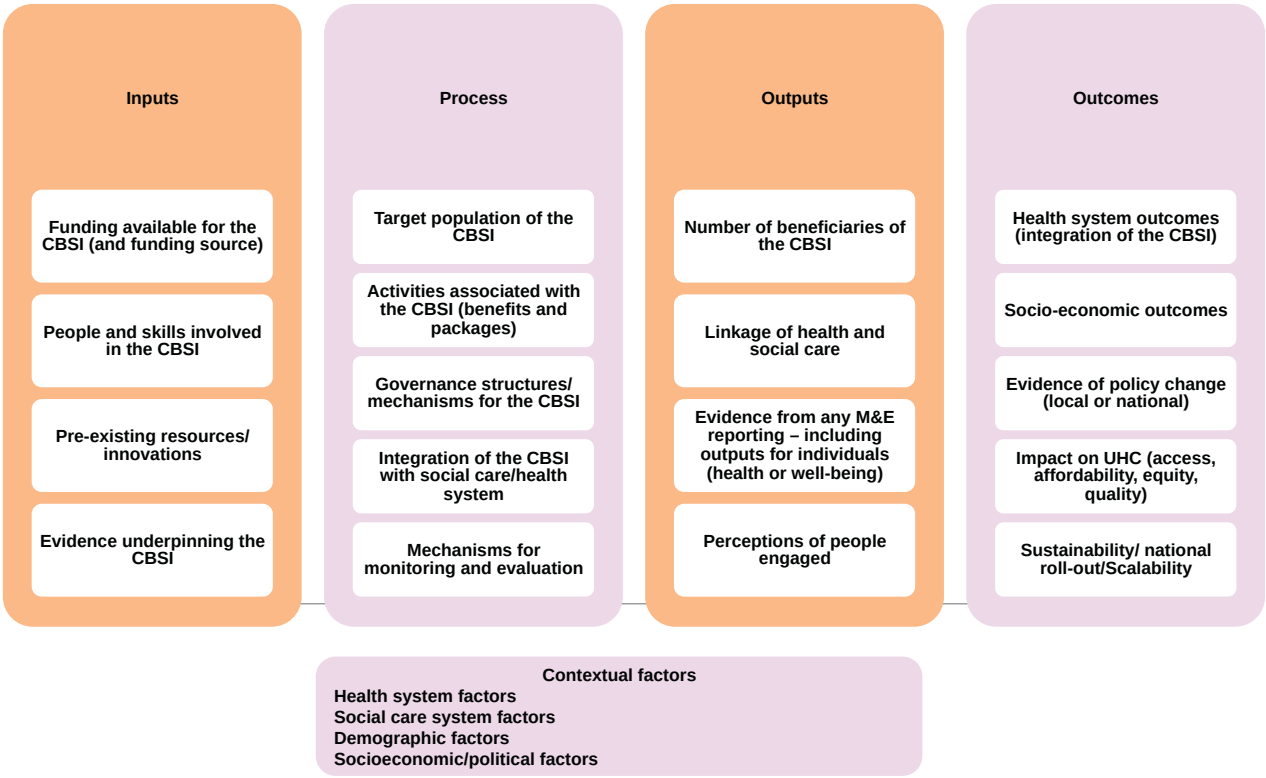
- The role and function of older people as resources for themselves and for others (peers, family, community).
- Health and social services delivered by those initiatives and referral processes when they exist.
- Links made within these communities of support between health interventions and social health protection interventions (e.g. help with transportation, livelihoods, pensions, cash or in-kind transfers).
- Coordination mechanisms with formal health and social sectors, including any formal connections with the health and social care system.
- Coordination and engagement with a variety of health/social-service workers and community-based services.
- Types of metrics (indicators, monitoring tools) implemented to assess impact on health[1] and the concept of health that is being measured.
- Measures to understand and respond to health inequities in the population served.

We have used a logic model approach to examine the effectiveness of selected CBSIs. This helps us assess the intervention logic for CBSIs and track the progress, impacts and evolutionary dynamics of CBSIs at core levels of analysis. As illustrated in Figure 2 below:

- **Inputs** will help us understand the resource environment of each CBSI and provide a foundation for exploring the linkages between resources, outputs and impacts. This resource input environment is likely to capture aspects such as resources for implementation (funding, infrastructure and skills/capabilities). We will also aim to capture the reasoning and evidence base leading to the establishment of the CBSI.
- The **process** dimension will help us examine both the diversity of CBSIs, in terms of activities/services offered, population groups targeted and geographies projects covered and mechanisms for designing, managing and evaluating the CBSI if present. We will also examine the integration of the CBSI within the wider health and social care services offered to older people.
- The **output** dimension will help us assess the relative progress of CBSIs since they have been established and capture the diversity of outputs and associated achievements. This will involve capturing outputs such as the number of beneficiaries involved in the CBSI and any initial health and well-being outputs for beneficiaries reported.
- The **outcomes** dimension will help us capture a wider range of benefits, including those relating to impact on resources for achieving universal health coverage (UHC), policy-level impacts and other (including unintended) consequences which may affect the health and well-being of older people in a particular country. In particular we will not only consider impacts at an individual level (e.g. beneficiaries engaged in the CBSI) but also look to examine the impact on the wider community and the overall health/social care system.

1 We used the term ‘health’ very broadly at this stage in anticipation that it could incorporate physical and mental health and broader wellbeing. As the case studies were exploratory, we did not seek to further define or restrict at this stage as we were interested in understanding of the CBSIs themselves conceptualised and measured these types of outcomes, if at all.

Figure 2 Framework for gathering data on CBSIs and the contexts they operate in



- The **contextual factors** dimension will guide us to consider the influence of both health and social care system factors and demographic, socioeconomic and political factors which may help or hinder progress of the CBSI. A greater understanding of the contextual factors underpinning the CBSI will also help to inform reflections on its transferability/scalability by offering a rich understanding of the setting.

Structure of the case study

The next section of the report begins with a brief overview of the methodology used for the case study. The report then highlights some of the key contextual factors affecting the CBSI, related to the country's ageing population and its health and social care system.

The main section of the report focuses on how the four areas of the logic model (outlined in Figure 2) related to the CBSI(s), in the following four areas: (i) establishing the CBSI(s) (inputs); (ii) activities of the CBSI(s) (processes); (iii) results of the CBSI(s) (outputs); and (iv) impact of the CBSI(s) (outcomes). Within each sub-section the perspectives of interviewees are presented alongside findings from the desk review. Finally, the report concludes with some overall reflections on the CBSI and draws out key themes and experiences to better conceptualise CBSIs and their role and functions for older populations.

In a slightly different approach to the other nine case studies included in the project, this report on Viet Nam looks at three different examples of elderly helping elderly initiatives. Programmes involving elderly volunteers have been attempted in Viet Nam over recent years with differing models, extent of scale-up and duration. Looking at three examples rather than one provides the opportunity to examine differences to draw potential lessons. The three programmes we consider are:

- Elderly Public Health Volunteers (EPHVs)
- Retired Health Worker Volunteers (RHWVs)
- Intergenerational Self-Help Clubs (ISHCs).

Methodology

Case studies have been used to collect descriptive data on CBSIs through a mix of methods including semi-structured interviews and a review of administrative data and documentation. Each case study follows the same design in order to provide in-depth understanding of each CBSI and allow comparisons to be made between different actors within a single case, between cases and between groups across cases, taking into account relevant contextual factors. Key-informant interviews were conducted with key stakeholder groups involved in the CBSI, as well as with wider health and social care system actors.

Desk-based document review

Building on any documentation identified in consultation with the CBSI, the literature review draws on academic and grey literature to provide an overview of the health and social services delivered by the CBSI in Viet Nam and the wider context in which these interventions are taking place. In addition, any available evaluative documentation was reviewed to collect evidence on the metrics, indicators and monitoring tools used to assess the effectiveness of the CBSIs identified. Key documents included journal articles and policy documents, such as commissioned discussion documents and government strategies. Academic literature was identified through PubMed, focusing on the years 2000 to the present. The literature search was conducted between July and September 2017. Specific requests were made for documentation from the following organisations in Viet Nam: United Nations Populations Fund (UNFPA), HelpAge International in Viet Nam, the World Health Organization (WHO), the Viet Nam Association of the Elderly (VAE), the Centre for Ageing Support and Community Development (CASCD) and the Viet Nam National Committee on Ageing (VNCA). Additional Internet searches were undertaken using the terms ‘elderly public health volunteers’, ‘retired health worker volunteers’ and ‘intergenerational self-help clubs’.

Stakeholder interviews

In addition to the document review described above, key-informant interviews were also used as a key means of gaining an insight into the ongoing activities of the CBSIs and the wider contextual factors affecting their functioning in Viet Nam. The interviews followed a common topic guide, with the main topics discussed including: resources that support the CBSIs, engagement with older people and functioning of the CBSIs, outputs and linkages with the health and social care systems and impact of the CBSIs. Emphasis, however, was placed on allowing participants to talk from their own perspective.

In order to explore different perceptions of impact associated with the CBSIs, and to identify any linkages and interaction between stakeholders, the project team in coordination with the CBSI staff identified suitable interviewees from three major stakeholder groups (as outlined in Table 1 below). A total of 15 interviews were conducted in Viet Nam between 14 July and 8 August 2017. The interviews focused on the EPHVs and ISHCs, as the RHWVs initiative had ceased operation, although policymakers and stakeholders were able to talk about learning from this initiative in addition to the two current programmes.

Written consent to participate in the study was obtained from all participants after sharing information about the project. Interviews were conducted face-to-face. The interviews typically lasted between 30 and 60 minutes and were semi-structured in style, to enable participants to raise concerns that may not have been anticipated by the research team or were specific

Table 1 Overview of the interviewees

Stakeholder group	Profile of the interviewees
Beneficiaries of the programme (n = 6)	Three interviews with EPHVs: 1. 81-year-old male, retired soldier • Joined EPHVs when established by the Viet Nam Public Health Association (VPHA) in 2010. • Former president of commune association of the elderly. • Team leader of EPHV network and coordinator of EPHVs in five villages (49 active EPHVs). 2. 71-year-old female, retired worker • Had been EPHV since 2013. Joined after meeting with the EPHV coordinator. • Head of EPHV group (nine EPHVs in the village) and to held on the elderly health communication meeting in her village. • Undertakes home visits for health communication and supervision for 29 households around the village. 3. 3.75-year-old male, retired district cabinet • Had been EPHV since establishment in 2010. • An active EPHV in terms of sharing experiences of elderly health education. • Has good communication skills and the first EPHV to participate in pilot of elderly health communication in his village mentored by a lecturer working at the Hanoi School of Public Health. Three interviewees from ISHCs: 1. 72-year female, farmer, not retired • Member of ISHC from 2012 and commune Association of the Elderly before this. • Was team leader of volunteers and home care for the elderly. 2. 70-year-old male, retired secondary-school teacher • Previously Vice-President of the commune Association of the Elderly. • Had been key member of ISHC since launch in 2012. 3. 66-year-old female, retired farmer, • Had been member since 2012. • Was team leader for indoor exercise and art performance.
CBSI staff (n = 4)	One interview with manager of EPHVs in Hai Duoung (Tien Hai District). Had managed and monitored pilots in two communes and was working with the district hospital to expand into five more communes. One interview with manager/representative of the Board of the Elderly in Hai Duong Province. Had been instrumental in the establishment of the ISHC. Provided training for management and staff, offered supervision and led annual review. One interview with manager from the Viet Nam Women's Union. Coordinator for the VIE022 project concerned with promoting rights of poor and disadvantaged older people in Viet Nam. Had been core person in the design of the ISHCs. One interview with manager of the Centre for Ageing Support and Community Development (CASCD) with responsibility for EHCVs and ISHCs.
Policymakers, academia and civil society (n = 5)	One academic with experience of evaluating ISHCs and expertise in models of community care for older people. One government representative from the Viet Nam National Committee on Ageing (VNCA). One senior representative from the Viet Nam Association of the Elderly (VAE). Wide involvement in ageing initiatives in Viet Nam and region. One Programme Analyst (ageing) at UNFPA. Director, HelpAge International Viet Nam.

to the practice. This ensured a flexible approach which allowed respondents to offer their own perspective and raise issues most salient to them, while covering the same topic areas in each interview. Interviews were audio-recorded with permission.

The interview data was analysed and coded by the project team, and then grouped into the categories and sub-categories outlined in the logic model. In analysing the categories, the team also identified emerging themes, which are presented at the end of this report.

Overview of the context in Viet Nam

Demographic factors

The estimated population of Viet Nam is around 96 million people (Central Intelligence Agency 2017). Estimates of the proportion of older people vary. World Bank estimates show that 7.1 per cent of the population was aged 65 or over in 2017 and project this to increase to 12.9 per cent by 2030 (World Bank 2017a). Life expectancy at birth is 76 years and, at age 60, is 22 years (WHO 2017).

The Viet Nam National Aging Survey in 2011 showed that over 40 per cent of adults aged over 60 were still working and that 60 per cent reported that they did not have enough income to cover the costs of daily living. Living arrangements were also reported to be changing rapidly, with a growing proportion of older people living alone or with their spouse only, rather than with their children as would have traditionally occurred (Thanh 2012). Seventeen percent of older people (over 60 years of age) live under the poverty line in Viet Nam (Thanh 2012). In the same survey just over half of older people reported being comfortable in life both physically and spiritually. For those who were not, loneliness and depression were commonly reported problems (Thanh 2012). Non-communicable diseases cause the greatest burden of ill-health in Viet Nam and the leading causes of death are stroke, ischaemic heart disease and chronic obstructive pulmonary disease (WHO 2015).

There has been increasing concern about older people in Viet Nam at a policy level over the last two decades, leading to the enforcement of a Law on the Elderly in 2010. There were four periods of policy development leading to this point (Hoang Dang Huay 2010, Huy 2010; Luan Trinh Duy 2013):

- 1945–1995: Concern of the Vietnamese government about the elderly population grows and is increasingly expressed in legal documents.
- 1995–1999: The establishment of the Viet Nam Association of the Elderly (VAE) in 1995 as the most important event for the ageing system in Viet Nam.
- 2000–2009: Ordinance on the Elderly is issued in 2000 and the first national plan of action is developed, 2005–2010. In 2005 the Viet Nam National Committee on Ageing (VNCA)and 10,000 elderly committees within communities are established.
- From 2010: Law on the Elderly is established by the middle of 2010; the government develops a system supported by legal documents (Decrees and Circulars) to implement and enforce the new law and the national action plan on ageing in Viet Nam for the period 2012–2020.

The Law on the Elderly (defined as adults over 60 years old) defines the rights of older people, state policies and responsibilities of agencies, organisations, families and individuals.

Overview of the Vietnamese health system

Viet Nam's health system is the responsibility of the Ministry of Health. Health expenditure has increased over the last two decades to a current level of around 7 per cent of GDP (WHO 2015).

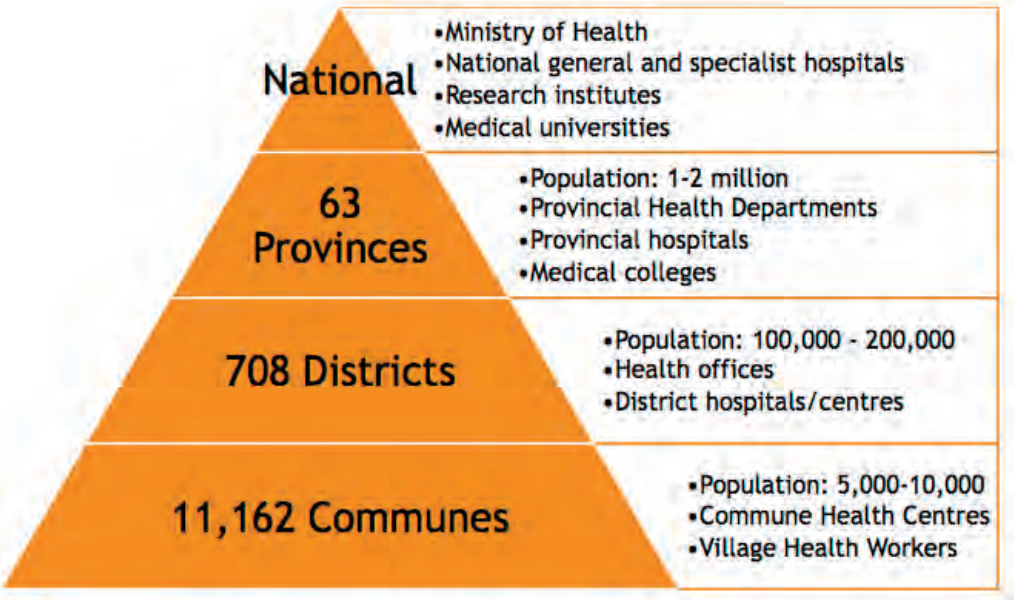
Out-of-pocket expenditure has decreased as a proportion of overall spending on health from 63 per cent in 1995 to 37 per cent in 2014, but still accounts for 80 per cent of private spending on health (World Bank 2017b).

Health services are organised at a national, provincial, district and commune level (Figure 3). The elderly volunteering initiatives considered in this case study are situated and have most opportunity for linkage at the commune level. Historically, the focus within health services has been on secondary and tertiary care. Increasing focus has been given to primary care and grassroots levels but the system is still recognised to be unbalanced in favour of acute care (Le Tuan 2015). Significant challenges exist in terms of shortage and low quality of health workforce in providing primary health care services, particularly in rural and mountainous areas where it is difficult to recruit and retain staff. Shortages of medicine and equipment also mean that primary healthcare is under-resourced and inequitably provided. The health system is therefore not currently established to meet the chronic care needs of older people. The Viet Nam Law on Health Insurance of 2008 sought to establish mandatory participation in health insurance by 2014. Currently, 30 per cent of older people are without health insurance, preventing access to services or risking impoverishment through out-of-pocket expenses.

Overview of the Vietnamese social care system

Older people have traditionally relied on family members for assistance with daily living (Hoi et al. 2011) but changing family structures mean that older people may be increasingly vulnerable. Pension benefits vary considerably between public-sector retirees, who receive higher benefits, and private-sector retirees. Those in the informal sector and farming do not receive a pension and a high proportion of older people continue to work beyond retirement age. In 2013 just over one-fifth of the elderly population received a pension. Some elderly are also eligible to receive a monthly social allowance, for which the amount varies according to poverty level. In general the level of support provided through social allowances does not meet the costs of daily living. In total 37 per cent of elderly receive either a pension or social allowance. The remaining 63 per cent are reliant on family and self-support. There is some support available through social protection centres which aim to target lonely, helpless or disabled elderly. One hundred and eighty-two centres at a provincial level provide support for just over 40,000 older

Figure 3 Health system hierarchy in Viet Nam (Le Tuan 2015)



people without dependants. This support is provided for free but facilities are poor and often overcrowded because of high demand. In urban areas private care facilities are available but are associated with high fees. Care can also be provided by domestic workers on a private basis.

Overview of the CBSI

Establishing the CBSI (Inputs)

Establishing the CBSIs

There has been a growth of programmes in Viet Nam that seek to actively engage older people in health, social care and wider development activities. In this case study we consider three CBSIs, summarised in Table 2, which involve elderly volunteer programmes.

Aims and objectives of the initiatives

The three volunteer programmes have in common that they seek to benefit those volunteering, through keeping them active, as well as other, often vulnerable older people, and enhance health and social care provision at a community level. The main objectives of each of the programmes are:

EPHVs – To adopt an active ageing model that seeks to improve the health of older people while at the same time drawing on their energy and skills to contribute to the information, education and communication commitments of the grassroots healthcare system.

RHWVs – To draw on the skills of retired health workers (doctors and nurses) to help deliver primary healthcare services, including home healthcare services, for vulnerable older people and to work as part of commune health networks.

EHCVs – To provide home care to vulnerable older people, typically those living alone or who are poor or otherwise disadvantaged, as part of a wider community-based effort to provide

Table 2 Summary of selected elderly volunteer programmes

Elderly Public Health Volunteers (EPHVs)	Organised through the Viet Nam Public Health Association (VPHA) from 2010 onwards. The VPHA is the professional organisation for nationwide volunteers working in public health in Viet Nam. It is a member of the Central Committee of the Viet Nam Fatherland Front (an umbrella organisation of mass movement groups aligned with the Communist Party of Viet Nam, which forms part of the Vietnamese government). The VPHA set up a network of 110 EPHVs in two communes in Tien Hai District. EPHVs are trained in the community to develop knowledge and skills, and to improve health promotion and prevention of common diseases among older people.
Retired Health Worker Volunteers (RHWVs)	The RHWV programme, established in 2009, is an initiative of the Viet Nam National Committee on Ageing (VNCA). Retired health workers are provided with three days' training involving lectures from lecturers working at medical universities or the geriatric hospital. The volunteers then provide elderly primary healthcare services at the village and commune level. They are part of a community health network and link with village health workers through this. The initiative was piloted with 92 retired health workers in ten communes of five provinces in Viet Nam, but was not continued after 2010.
Elderly Home Care Volunteers (EHCVs)	EHCVs are part of Intergenerational Self-Help Clubs (ISHCs) in Viet Nam. There are about three to four EHCVs per club. ISHCs have been widely expanded with government and HelpAge support in Viet Nam. They are self-managed, multifunctional organisations, involving different generations within communities, that aim to improve equitable and inclusive development. The clubs have eight key activities including home care. EHCVs provide home care help (e.g. bathing, dressing) to older people, typically those living alone or in difficult circumstances. In 2016 the Prime Minister of Viet Nam agreed to expand ISHCs to 5,000 communes.

comprehensive support to older people through ISHCs.

Funding for the CBSI

The funding for the initial stages of the programmes has largely been provided through international donors and the Vietnamese government. Important issues around the sustainability of different funding models are discussed later in the case study.

EPHVs	Funded through Atlantic Philanthropies (AP) (philanthropic organisation working in Viet Nam and seven other countries globally). AP funded larger projects on public health networks and enhancing effectiveness of the VPHA; grant giving finished in 2016. The EPHV network was a pilot intervention as part of this wider agenda of work.
RHWVs	Implemented through the VNCA, pilot funded by the Deutsche Gesellschaft für Internationale Zusammenarbeit (German Society for International Development – GIZ).
EHCVs	ISHCs, in which the volunteers work, are funded and supported by AP and HelpAge International to the scale of VND 80–100 million/club (approx. USD 3,500–4,400), with additional initial investment from UNFPA to help ensure sustainability. The government has committed to the expansion of the ISHC model from four provinces to 12 provinces using the national budget. Fundraising is also carried out at a local level from private enterprises and local authorities, and through membership fees. Interest can be generated on club funds. In the initial four provinces, AP and HelpAge International worked through the Viet Nam Women's Union (which in turn collaborated with the VAE and a local NGO, the Centre for Ageing Support and Community Development – CASCD), the ISHCs of which the elderly volunteers were one aspect.

Provision of training

All of the initiatives involved training for volunteers at the input stage. It is not clear that any support or training is provided to volunteers beyond this. RHWVs are provided with training on basic elderly healthcare over three days, provided by lecturers working at medical universities or the National Geriatric Hospital. Training for the EPHVs was provided through the VPHA and Hanoi School of Public Health. The EHCVs worked on a 'training of trainers' (TOT) model where UNFPA and HelpAge International provided training for the project management board at the provincial level. This training pertained to management skills and project activities. These trained staff then provided hands-on training to intergenerational club members, including home care volunteers. One volunteer explained that she also attended training provided directly through HelpAge International. The intergenerational clubs also aimed to support peer learning among members.

Other initiatives in the region

These three initiatives were selected as different examples of elderly volunteer programmes in Viet Nam aiming to provide a productive and active role for older people and to take on some tasks of social care and primary healthcare for older people in order to enhance health and well-being. Other initiatives have greater involvement from the private (for-profit) sector and include the Saigon Medical Doctor Volunteer Club, established in 2011 through the Ho Chi Minh City Business Association. The purpose of the Club is to bring together retired health workers in Ho Chi Minh City and other places who are doctors, pharmacists, nurses and health workers in collaboration with organisations, individuals, enterprises and entrepreneurs who are dedicated to social charity work. Activities include the provision of medical education, medical examination, medicine distribution, and distribution of free gifts for people in poor and remote areas. To date the club has provided medical examinations and treatment and given gifts to tens of thousands of people, including elderly people, in different localities of Viet Nam and Cambodia.

Activities of the CBSI (Process)

Target population and eligibility criteria

The eligibility criteria for older volunteers is largely similar across the initiatives. RHWVs programme specifies the professional background of volunteers, and although the EPHVs programme does not it was noted that volunteers tend to be retired professionals, as they have greater income stability and more time than older people working in farming or informal sectors.

Activities associated with the CBSI

The activities associated with each model of volunteering vary slightly from one model to another depending on the focus of the programme:

EPHVs are trained in health promotion and communication. Each volunteer visits households (approx. 25–30) in their surrounding area to check on the well-being of older people and to help communicate advice about issues such as tobacco use and cessation, alcohol abuse and physical activity. Volunteers are also provided with a checklist for elderly screening risk check. Every two months the volunteers collaborate with the commune health staff and the commune health centre, taking part in a meeting of the older people in the village to talk about a health topic. Older people attending these meetings can also have their blood pressure checked by commune health staff.

RHWVs were established by the VNCA in 2009 to work to provide primary healthcare services for older people in their local areas, including home healthcare services for older people living at home. Retired health workers are given three days' training in basic elderly healthcare from lecturers working at the National Medical University or National Geriatric Hospital. The volunteers form a network of RHWVs and link up with village health workers and other older volunteers in the community. They perform primary health services for older people in the context of elderly clubs or commune associations for the elderly, providing annual elderly health check-ups, measuring blood pressure or weight, and providing health information in elderly village meetings. They also guide elderly care for village health workers and may become key persons in local elderly volunteer networks.

EHCVs may provide help to other older people in the form of physical, mental and social care and activities of daily living, such as walking and moving around, getting up from a chair, bathing, dressing, going to the toilet or eating, or social support, for example taking them to

Table 3 Overview of target population for each volunteering initiative

Volunteering initiative	Target population and eligibility criteria
EPHVs	• Initially targeting retired older people under 80 years old. In replication of model revised to those aged 60–70 years. • In good health with desire and time to commit.
RHWVs	• Retired medical doctors (primary and secondary care) and nurses who have served in the army or public services. • Local to commune. • In good health with time to commit to volunteering.
EHCVs	• ISHCs are multigenerational, although most members are aged 55 and over. • EHCVs will comprise around five club members, selected on the basis of living locally within the commune, being in good health and having time to commit.

social or religious activities. Home care is one of a number of key categories of activities that are covered by ISHCs. Others include healthy and active living, governance and participation, social and cultural activities, income security, disaster risk reduction, right and entitlement, healthcare and insurance, and gender and ageing. As members of the ISHCs EHCVs contribute to and benefit from these activities.

Benefits or remuneration for volunteers

EPHVs receive benefits in the form of regular health checks at the district hospital every six months, paid for by health insurance. They also received a health insurance card from the district public health association, if they do not already have one. EPHVs are given privileges by district health centres and commune health stations to be examined and treated when they are ill, and regular practice of TAKE 10 (an exercise programme) for the elderly. On a quarterly basis, the network of EPHVs votes for active and efficient members and receives small gifts from the commune public health association. EHCVs receive benefits as members of the ISHCs, including two health check-ups per year, health insurance and regular practice of physical activity.

Intergenerational activities associated with the CBSI

Intergenerational activities were not a focus of the EPHVs or RHWVs. The EHCVs are part of the wider ISHCs, which are multigenerational, with around 30 per cent of members aged under 55. The intergenerational composition of the clubs is key to their remit in wider development efforts in communities. It is not clear however how elderly care volunteers within these are specifically involved in intergenerational activities.

Governance and management of the CBSI

All of the elderly volunteer schemes involve management at the commune level with further support at either the district or national level. The EPHVs network is managed by the district

EPHVs 2meeting

and commune public health association with approval through the local district and commune People Committee. The District Communist Party issued directive number 3 in September 2010, which sought to promote the role of the elderly in community healthcare and socioeconomic development. The Party in Tien Hai Town and Phuong Cong Commune then developed and issued a resolution on elderly health promotion to support the role of the elderly in January 2011. Local governance is provided through the People Committee, which supports the EPHV network through the Public Health Association and health system. Ten leaders of EPHVs are members of the People's Health Board at the commune level and have involvement in planning development and supervision. EPHVs are being expanded to all communes in Tien Hai District. This expansion is being supported by the district Public Health Association.

The RHWVs were implemented initially by the VNCA working with the Ministry of Labour, Invalids and Social Affairs and the Department of Labour and Invalids within the district People's Committee. At a commune level the People Committee staff with responsibility for labour-invalides and social affairs and ageing worked with commune health stations and provided supervision for the RHWVs. Initial funding for the project finished in 2010 and a lack of budget and policy support meant that the VNCA and the layers of governance below it could no longer provide support.

The EHCVs as part of the ISHCs have achieved strong support from national, provincial, district and commune levels of government. The National Action Plan on Ageing in Viet Nam (2012–2020) stipulates a specific target for at least 50 per cent of communes, wards and small towns to have an ISHC or other model of care to promote the role of the elderly, and for over 7 per cent of older people in these areas to benefit from these models of care. From this national directive, each province has developed a plan for establishing and replicating the ISHC model. As mentioned above, ISHCs when implemented involve capacity building for management at a local level. The ethos of an ISHC is inclusive and members are part of the management board. It is not clear to what extent EHCVs form part of management boards.

Monitoring and evaluation

EPHVs network

The EPHVs network has established a system for monitoring and supervising the work of members that was reported to be carried out regularly. Supervision and observation is provided by the district and communal public health officials and field officials of the Association of Public Health. The VPHA also conducted an evaluation comparing quality of life of EPHVs (case group) with non-EPHVs (control group) for the period January 2011 to February 2012 (reported below) (Le Vu Anh 2012) and the impact of the tobacco control and alcohol-related harm programmes. According to interviewees, the sustainability of the programme has been assessed more informally on the basis of the experience of elderly volunteers and families involved.

RHWVs

Monitoring and supervision of the RHWVs was reported to have been carried out by responsible the VNCA during the period of implementation up to 2010. No final evaluation of the programme was undertaken but the decision not to continue it was made on the basis of available funding.

Book for fund of Golden Heart

EHCVs as part of ISHCs

In comparison to the other two programmes a more formal monitoring and evaluation plan was instigated from the beginning for EHCVs. Monthly observation was undertaken by a representative of the district Elderly Association and quarterly observation would be conducted by the provincial Elderly Association. The monitoring activities included participating in club meetings, reviewing documents and reports and monitoring the activities of the volunteers (EHCVs and others). Direct feedback was provided to the club from each episode of monitoring. An external evaluation was also conducted by experts of the Development and Policies Research Centre with UNFPA and the Institute of Social and Medical Studies. On an ongoing basis, monitoring of the ISHCs has been taken up by the commune Elderly Associations. The ISHCs provide a monthly report of activities which is fed to higher levels within the elderly association system and the Labour, Invalids and Social Affairs system.

Results of the CBSI (Outputs)

Enrolment of older people as volunteers

The scale of enrolment of older people as volunteers is varied across programmes. From 2010 to 2013 there were 110 EPHVs in two communes. The RHWVs comprised 92 retired health workers across ten communes from 2009 to 2010. The programme of EHCVs working in ISHCs has been larger in scale, involving 2,337

EHCVs from 2009 to 2016 in 12 provinces (working in 779 ISHCs, where each ISHC has three EHCVs). These volunteers have provided care for 3,505 older people living in poverty or alone and requiring help with activities of daily living. Participants in the case study reflected that EPHVs and RHWVs were more likely to be retired professionals of relatively high socioeconomic status within their communities. Older people working in farming or the informal sector were less likely to have retired or have stability of income during retirement. Participants felt there were some advantages to this, as these people were more likely to have had positions of responsibility and experience in communication. The characteristics of EHCVs are less clear, although ISHCs are more targeted to poorer older people and this is reflected in membership, with 70 per cent being classified as 'poor, near poor or disadvantaged'.

Self-reported health gains from beneficiaries

The older people we spoke to who were EPHVs or EHCVs as part of ISHCs explained that they felt volunteering had benefited their health. In the case of EPHVs this was mainly through improved knowledge of health risks and the prevention and management of non-communicable diseases in particular. These benefits then reportedly spread to family members and other older people locally through their communication activities. An evaluation showed that quality of life (mental and physical health scores) among EPHVs was higher and showed greater improvement than older people who were not EPHVs (Le Vu Anh 2012). The evaluation also suggested that the tobacco control programme communicated by the EPHVs may have encouraged some older males in the community to reduce the number of cigarettes they smoke or to quit completely, although there was no comparison group in this analysis (Le Vu Anh 2012).

An evaluation of the ISHCs for the Viet Nam Women's Union reported that perceived health status and knowledge on the prevention of non-communicable diseases was similarly higher in members compared to non-members (Long Giang Thanh 2014). Members also had increased access to health services and received more regular health examinations.

Linkages to health and social care system

All three volunteering initiatives are linked to some extent with the health and social care system.

EPHVs work directly with staff from the commune health station in arranging meetings and communication activities. EPHVs are formally written into five-year plans for healthcare activities at the grassroots level. **RHWVs** are in place to directly deliver primary healthcare services for older people and hence form part of the health system, linking to village health workers and other volunteers in their locality. **EHCVs** take a role in providing social care for older people. The ISHCs are linked to the health system, providing health insurance facilitated through an agreement at a national level with the Directorate of the Ministry of Health. The decision by the government to roll out the expansion of ISHCs and EHCVs is indicative of their value to the health and social care system. ISHCs are being integrated into a new rural programme aimed at reducing poverty in rural areas.

Impact of the CBSI (Outcomes)

Wider impacts of the programme

Wider impacts of the programmes include a more positive view of older people within communities. EPHVs reported that their activities increased their status within the community and also increased the knowledge and awareness of older people and others. Older people were becoming more actively engaged in communities' problems and in community development. The professional background of RHWVs meant that they are perceived to be in a strong position to advocate for the rights of older people, beyond their role in delivering health services.

The ISHCs and EHCVs are perhaps more explicitly targeted at improving the rights of older people in Viet Nam, based on a combination

EPHVs Phuongcong commune.Tien Hai

of approaches including self-help, multiple generations, participation, capacity building and influencing. The model has been seen as successful in promoting the rights of older people and the role of older people in doing this. Older people are seen to be an active part of socioeconomic development within communities.

Sustainability of the programme

EPHVs

From the piloting in two communes, the EPHV programme has been judged to be sustainable and worthy of expansion to other communes. Retention of volunteers has not been problematic. The EPHVs are being extended to five communes in Tien Hai District. The VPHA has also actively communicated and deployed the programme in other regions in 12 provinces/cities (four provinces in the northern region, four provinces/cities in the central region and three provinces/cities in the southern region).

RHWVs

The RHWV programme faced a number of challenges in terms of sustainability, and did not continue. Participants in the case study explained that the VNCA did not have policies that would support the RHWVs in the longer term and lacked financial means to continue to support or expand it. Some particular challenges were thought to have come from the vertical systems of the Labour, Invalids and Social Affairs and that there was no input to support the sustainability or capacity of the programme at the level of commune health stations, where the RHWVs could be most usefully linked.

EHCVs

The ISHCs and EHCVs have received support nationally to expand, with a target of having a club in 50 per cent of communes, which is around 5,000 ISHCs. Participants in the case study noted important contributing factors that would enable such expansion and sustainability. At the outset ISHCs had drawn on the technical expertise of international NGOs such as HelpAge and UNFPA, in addition to funding from these bodies. This support included capacity building at different levels to ensure that clubs could manage and sustain activities themselves. Training and capacity-building activities were carried out at all levels, from the ISHC management board to club members. There were also mechanisms in place to support learning between ISHCs and to inform replication of the model. It is thought that this early attention to sustainability has been key in the current expansion of the model.

Reflections on the CBSIs

The commonalities and differences across the three elderly volunteer initiatives highlight a number of themes.

Elderly helping elderly models in Viet Nam appear to result in benefits to volunteers, their families and the wider community.

These benefits were reported in terms of improved health status, access to health services and the improved status and role of older people within communities.

Training and support for elderly volunteers may be an important consideration, particularly as some programmes expand.

Some concern was raised throughout the case study research that ongoing support and training for volunteers may be lacking and that this might be important to consider, particularly if elderly volunteers are going to be relied upon to deliver vital functions of health promotion and education and some care services. Beyond the initial training it was not clear that EPHVs received further training, although they expressed a desire for this. Relatively little attention within ISHCs was reported to be given to capacity building of EHCVs.

Elderly helping elderly models may reinforce social hierarchies, unless there is an explicit effort to address this.

Volunteers within the EPHV and RHWV initiatives are more likely to be retired professionals. This is partly because they have more capacity to engage, as they have been able to retire more fully from paid employment. This pattern is generally reflective of volunteering universally. In terms of benefits reported in improved health status and knowledge among volunteers, it is likely that these are benefiting those who were already relatively better off in these regards. There is evidence of benefits extending to family members and other households, but some benefits in terms of improved status within communities are perhaps being afforded to those in least need. The ISHC model targets poorer older people more explicitly, and shows that it is possible to engage with them. Future models should think about selection and criteria to ensure a greater cross-section of the population has the opportunity to be involved.

Successful expansion and sustainability of models benefit from early-stage strategic planning.

The ISHCs show that expansion and replication of models require active planning, skills and capacity. Our interviews also suggest that there is advantage in building these aspects into programmes from an early stage if possible, and in capturing learning from different sites in order to inform the replication of a model.

Older people are active in the delivery of health promotion or services but there is not much evidence of them shaping the content.

The EPHV programme in particular showed that elderly volunteers could be an asset to the local health system, with the programme bringing benefits to the volunteers directly and to the wider community. Volunteers we spoke to were passionate about communicating around behaviour change for things like tobacco use, drinking and exercise. They also reflected that they would like to increase their knowledge and be able to communicate around more issues, but appeared to have little role in determining this. Perhaps reflective of the broader context within Viet Nam, some of the elderly helping elderly programmes can appear quite top-down in this regard.

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