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MODELLING THE COMMUNITY SUPPORT FOR SENIORS. THE CASE STUDIES IN LOW- AND MIDDLE-INCOME COUNTRIES

MODELOWANIE LOKALNEGO WSPARCIA DLA OSÓB STARSZYCH. STUDIA PRZYPADKU W KRAJACH O NISKICH I ŚREDNICH DOCHODACH

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Summary: In 2014 WHO issued a call for preparing case studies on community-based initiatives that support older people in low- and middle-income countries. Finally, seven case studies were completed with one cancellation. The main objective for this article is to match the selected initiatives to available in the literature five main theoretical models of social support. They will be used as a theoretical basis for the analysis. It seems very interesting if studied initiatives that operate in different conditions of social and cultural development will implement similar or different mechanisms of social support for seniors and whether it will be possible to assign these initiatives to one of the previously described models.

Keywords: aging, social support, models of social support, low- and middle-income countries.

Streszczenie: W 2014 r. WHO ogłosiło konkurs na przygotowanie studiów przypadków dotyczących lokalnych inicjatyw społecznych na rzecz wsparcia osób starszych, w krajach o niskich i średnich dochodach. W wyniku procesu rekrutacji wyselekcjonowano siedem zgłoszeń. Głównym celem niniejszego artykułu jest próba dopasowania tych inicjatyw do funkcjonujących w literaturze pięciu głównych teoretycznych modeli wsparcia społecznego. Będą one wykorzystywane jako teoretyczne podstawy do analizy. Dla celów pozawczych jest bowiem istitne czy studia, które działają w różnych warunkach rozwoju społecznego i kulturalnego, będą realizować podobne lub różne mechanizmy wsparcia społecznego dla seniorów i czy będzie można przypisać te inicjatywy do jednego z wcześniej opisanych modeli.

Słowa kluczowe: starzenie, wsparcie społeczne, modele wsparcia społecznego, kraje o niskich i średnich dochodach.

1. Introduction

In December 2014, The World Health Organization's Centre for Health Development (also known as the WHO Kobe Centre, or WKC) issued a call for preparing case studies on community-based initiatives that support older people in low- and middle-income countries (LMICs). Key criteria of selection were that case studies described initiatives implemented in a community, with older people at the centre of the initiative, aiming to assist other older persons to increase autonomy and to maintain or enhance their health and quality-of-life for as long as possible [WKC 2016a, p. 1].

The author of the presented article was one of the researchers involved in this project responsible for the preparation of selected cases of Polish initiative. In this article, the main objective is an attempt to match the analysed initiatives to available in the literature theoretical models of social support. Researchers interested in the issues of social support usually refer in their analyses to the five main models. Also, in this article, the models will be used as a theoretical basis for the analysis. It seems very interesting if studied initiatives, that operate in different conditions of social and cultural development, will implement similar or different mechanisms of social support for seniors and whether it will be possible to assign these initiatives to one of the previously described models.

2. Demographic changes of present days

It is justifiable to consider that the world is in the middle of one of the most profound social revolutions of all time – the Age Revolution. This is not a phenomenon that can surprise us with the sudden appearance, but a part of a gradual transformation that has unfolded over the past 150 or more years. A combination of reductions in infant mortality, low birth rates and increasing longevity has restructured the population in a significant way across the developed world [Coleman 2008, p. 9].

Today the older population (aged 65 and over) represents 7% or more of the total population in many parts of the world and the number of older people is projected to increase to 1 billion in just next 15 years. But this will be not the end of this process. According to further predictions of demographers, the share of older population will continue to grow in the following 20 years and by 2050, there will be 1.6 billion older people worldwide [He, Goodkind, Kowal 2016, p. 3]. It must be emphasized that global trends mask wide differences at the country level both in their current demographic profiles and in the direction and pace of future change. Many of today's high-income countries have had decades of low fertility rates and high life expectancies. In contrast, many developing countries have seen declines in their fertility rates only more recently, with some of the poorest countries still experiencing persistently high fertility [World Bank 2016, p. 137]. Specific situation can also be observed in many low- and middle-income countries (LMICs). That is why in response to drastic demographic and

social changes as well as to the rapidly growing need for care and support among aging populations, WKC attempted to explore existing community-based initiatives implemented to address health and social support for older people at a community level. Understanding their key organizational, financial, programmatic, and policy factors will help inform how best communities and countries can plan for sustainable and scaled up approaches, thereby contributing to programs development and continuous services for older populations [WKC 2016a, p. 17].

3. Social support needed

In the most general terms, social support is the provision of a variety of resources (emotional, informative, factual, etc.) to the individual who is experiencing some difficulties and is unable to face them on his own. Insufficient availability results in an unsatisfied or insufficient level of human needs. Although social support is needed for people of all ages, it is particularly important for seniors. The scope and forms of providing social support to this specific group depend on many factors – cultural, family structure, spatial accessibility of people who can be a source of support, access to the institution and the scope of entitlements to social services [Szweda-Lewandowska, Szatur-Jaworska 2016, p. 13]. Therefore, in the modern literature the main view of social support is based on environmental gerontology and different community theories and place identity theories which indicate the relevance of the known environment in lives of the older people, through known social networks and identity building. This is why the environmental gerontology context is important for the researching a well-being, identity and autonomy of older people, which depends on the processes of belonging, such as cognitive and emotional evaluation, the representation of physical environment and attachment to place [Wahl, Oswald 2010; Hlebec, Mali, Filipovič Hrast 2014].

The social support can be used in narrow and wider meaning [Loughran 2003]. The first one, typical for modern research, refers to various forms of support from community, daily cohabitation and symbiosis of different groups of people. The wider, and more traditional meaning assumes that social support is carried out by different societal bodies (e.g. care centres, intergenerational centres, voluntary organizations and associations) [Hlebec, Mali, Filipovič Hrast 2014, p. 6].

It refers directly to structural and functional definition of social support. The structural support should be interpreted as objectively existing and available social network. Meanwhile, the functional approach suggests that social support is a type of social integration undertaken by one or both of the participants, who are in a problematic situation [Sęk, Cieślak 2005, p. 5]. In general meaning structural support focuses on the existence of interconnections between social ties, whereas functional support focuses on the specific functions that these relationships serve [Uchino 2004].

The term 'social support' is also often used changeably to refer to three distinct aspects of social relationships: their existence or quantity, their formal structure, and

their functional content or the degree to which they involve flows of affect or emotional concern, instrumental or tangible aid or information [House 1981].

However, in practice and applied theory the boundaries between the concepts ‘support’, ‘care’, ‘help’ and ‘service’ are often unclear, the terms are used partly interchangeably to describe the support for older people in need of help. The concept ‘support’ thus refers to a broad range of different needs and brings together different dimensions of support-giving and support-receiving. Even if supporting is universal, the concept has multiple meanings, and can be imprecise and vary depending on time and culture, social values and norms [Sigurðardóttir 2013, p. 21]. This situation is due to the complexity of this issue, which is also reflected in the variety of possible types of support. Researchers typically distinguish the five types (general categories) of social support (after: [Cohen, Underwood, Gottlieb 2000]):

1. Instrumental support – refers to tangible items, such as financial assistance, goods, or services.
2. Emotional support – includes provision of love, caring, sympathy, and other positive feelings.
3. Appraisal support – includes feedback given to individuals to assist them in self-evaluation or in appraising a situation.
4. Informational support – refers to helpful advice, information, and suggestions.
5. Companionship support – refers to the presence of others with whom to participate in meaningful or enjoyable activities.

Differentiating among the intangible types of support can be difficult, as can be quantifying the level of support provided. That is why it is sometimes used interchangeably with terms such as ‘social integration’, ‘social networks’, or ‘social relationships’. But a narrower definition of social support is also common. In that usage, social support refers to social interaction in which the actions of one party are intended to benefit another party. Thus, though social support may be seen as one aspect of other, broader terms, it is differentiated in part by its focus on the provider’s intentions and the potential benefits to the recipient [Cohen, Underwood, Gottlieb 2000]. Even though in each case social support can be distinguished as the different element, every time it is obtained from one’s social network [Taherian 2010]. So here should be mentioned the theories of Social Networks, which can be traced back over 100 years ago to one of the most influential intellectuals of sociology, E. Durkheim. As it is known, E. Durkheim contributed to the understanding of social influence and integration. Social integration consists of attachment and regulation. Attachment is the degree to which a person is capable of sustaining ties with network members of society and regulation entails the extent to which an individual is held in the structure of society by its values, beliefs and norms. Social network theories focus on the characteristic patterns of ties between individuals in the social system rather than on characteristics of the individuals themselves. It is based on the understanding that individuals are embedded in a web of social relations and interactions which are the basis of social structures [Berkman, Kawaschi 2000]. It is important to recognize,

however, that because the social networks of adults are likely to include a remarkably diverse set of potential sources of support – ranging from the most intimate of ties to those of a far less intimate nature – we must learn more about the source-specific impact of anticipated social support [Shaw 2005].

Apart from a microsocial focus on the pathways by which social support influences well-being, there is a need for macrosocial analysis of the determinants of levels and types of social support. People's support networks are shaped in part by the locations they occupy in a larger social structure [Dykstra 2015, p. 7]. It is the basis for the differentiation of social support due to the level of formality. In this perspective, the system is dichotomous because the support can be informal or formal. The most frequently informal support is identified with the assistance persons in need receive from their spouse, children, other relatives, friends or neighbours. It is mostly unpaid support and refers to different tasks of unregulated activities [Sigurðardóttir 2013, p. 24].

Sometimes the concept of informal support is integrated in the term of 'family support' and can be used both in theory and research to further analyse the care expanding from an individual caregiver to the family as a whole. However, informal support is a wider term [Jegermalm 2005]. Because while close family members usually provide the majority of the care also members of the extended family, friends or neighbours often provide support when needed. Given the absence of culturally-prescribed obligations to provide such help to older network members, commitment and support expectations tend to be individualized within the relationships and are subject to continuous negotiation. Relationships with peers are more susceptible to dissolution if exchanges are unbalanced than are parent-child relationships. The availability of friends, relatives and neighbours for intense support-giving depends on the buildup of reciprocity over the course of their interactions with older network members [Komter 2005].

Though informal networks respond to increasing incapacity by expanding the scope of their assistance, there is a point beyond which the needs of the older adult exceed the resources of the network. At that point supplementary support is sought in public services [Brandt, Haberkern, Szydlik 2009]. So here we have the formal support which is identified with the care services provided by professionals employed by formal organizations, public authorities such as the state and municipalities and private for-profit or non-profit organizations. Formal support is provided by institutions, usually carried out in accordance with laws and regulations and is generally paid for by the care receiver or by the state and municipalities. Consequently, formal support can be defined as the care and help performed by persons employed by the state or municipalities, and the assistance they provide is usually paid for by officials or the care receiver [Sigurðardóttir 2013, p. 25].

Demand for support is dynamic – both in the unitary dimension (varies depending on the change in the personal situation of the elderly person) and in the dimension of the population [Szweda-Lewandowska, Szatur-Jaworska 2016, p. 13]. Therefore, the

new social task is to adapt and create new formal and informal solutions for social support in the aging process [Racław 2011]. There is no doubt that local governments and local communities will play a major role here. In the near future, they will be confronted with the need to take a position on such a transformation of the structure of expenditures and investments in order to meet the expectations of a growing group of increasingly elderly inhabitants to a greater extent than at present. A possible change in local politics requires social discussion, analysis and time, and – what is important – development of appropriate plans for the future. An important element of such discussion should be the cooperation of local government bodies and institutions with residents in shaping their living conditions and the implementation of individual, age-specific needs, and not replacing seniors and their families and other members of local communities in activities to meet needs. To achieve this, it is necessary to have mechanisms to facilitate social participation and active participation of seniors in the life of the city, so that older people are subjects, and not just passive recipients of activities carried out under local social policy [IPiSS 2012, p. 148].

The initiatives to explain links between formal and informal support originates already from 1970s. Main concerns were, and still are, to understand the cultural and societal origins of support preferences (informal vs. formal), consequences of introduction of formal care services on informal care (compensation, supplementation or substitution) and to evaluate determinants of interplay between informal and formal support arrangements (e.g. enabling, predisposing and needs factors) [Hlebec 2015, p. 78]. They are also used to describe the relationship between the older person in need of care and those who are providing support [Kröger 2005]. Although between these models significant differences can be found, their authors had common goal to increase the understanding of processes behind receiving and giving support and care within the family and social interaction between individuals.

4. Modelling the social support – a review of existing theoretical findings

As mentioned, there are several explanations for the distributions of informal and formal support arrangements. These have been developed by various authors, and the gerontological literature distinguishes between five distinctive theoretical models: *the hierarchical compensatory model*, *the substitution model*, *the task-specific model*, *the supplementary model*, and *the complementary model* (Figure 1).

The first one, *hierarchical compensatory model*, was proposed in 1975 by M.H. Cantor. She states that the function of support giving is generally ordered according to primacy of the relationship of the support giver to the elderly recipient rather than to the nature of the task. Who actually provides support to an older person needing assistance depends upon the availability, proximity, and emotional closeness of individuals in the person's network. But the premise behind this model is that blood is thicker than water [Cantor 1979, p. 453] and the role of formal support is to compensate for informal

hierarchical compensatory model	**IFS**	>	**FS**
substitutional model	**IFS**	<	**FS**
task – specificity model	**IFS**	=	**FS**
supplementation model	**IFS**	≥	**FS**
complementarity model	**IFS**	≈	**FS**

IFS – informal support; **FS** – formal support.

Figure 1. Selected models of support for the elderly

Source: own preparation.

support only in absence of complete informal network [Hlebec, Nagode, Filipovič Hrast 2014, p. 888]. Nevertheless, this model has been criticized for not keeping up with demographic reality and favouritism of conventional view on family [Dykstra 2015; Connidis, McMullin 1994].

Another proposal for model has been prepared by V.L. Greene. *The substitution model* hypothesizes that formal services replace part of the support provided by informal networks. It thus implies a negative correlation between the evolution of formal and informal support. The introduction of formal services may prompt relatives and friends to curtail their informal caregiving efforts and curb their feeling of responsibility for care [Armi, Guilley, Lalive D'epinay 2008, p. 6]. Unlike the previous model, here the potential availability and proximity of informal groups is not important. Informal carers will withdraw their support to older family members because of adoption of formal services and that formal care will substitute for informal care [Hlebec 2015, p. 79]. However, critics of this model argue that empirical evidence does not support the withdrawal of informal support [Denton 1997].

The task-specificity model introduced by E. Litwak in 1985 asserts that tasks of caregiving can be classified according to the required proximity, length of commitment, group size, degree of common life style and commitment of support providers [Litwak l985, p. 32]. Thus the support is divided between the informal and formal caregivers on the basis of what kind of help and care the older person needs and who is best suited to performing the tasks needed. It allows the family to provide other forms of support not available from the formal care system [Sigurðardóttir 2013, p. 32]. Usually informal caregivers are better suited to performing nontechnical and diffuse tasks. Formal organizations are more likely to provide services for tasks that require a higher level of technical knowledge, or when a task requires an expenditure of time and effort that exceeds the resources available in the typical primary group in modern society [Hlebec, Nagode, Filipovič Hrast 2014, s. 890]. However, some critics suggest that

formal support is often performed in some of the same task areas in which informal support is performer so it is lack of real supplementation [Denton 1997].

The supplementary model of support (initiated by P. Edelman and S. Hughes) postulates that informal support is a preference and major source of care for frail older people living in the community. So, the name of this model is related to the unequal distribution of responsibility for supporting seniors [Edelman, Hughes 1990]. The role of formal support is to add to care provided by informal carers, especially when the needs of older person exceed the resources of the informal network. The authors found that the size of informal networks did not change. However, the scope and complexity of support tasks changed as a response to the increased needs of support recipients. Increased needs can exceed the capacity of informal networks, and the authors suggested that formal services are an essential supplement to the support provided by informal networks. Formal services should be designed to supplement and enhance the effectiveness of the support provided by informal networks [Hlebec, Nagode, Filipovič Hrast 2014, p. 889].

Finally, the fifth model – *complementary* (proposed by N. Chappell and A. Blandford) –is based on a combination of the hierarchical compensatory model (preference for informal care in a specific order: spouse and child first) and the supplementary model. The authors of that model claim that formal support is activated at two instances, related to absence of key elements of informal support network and to great need. Formal support will increase the likelihood of independent living in community for people with limited informal network and to people with responsive and caring informal network with high support need [Hlebec 2015, p. 81]. The formal support is activated in two instances, namely when the crucial elements of informal networks are lacking (for example, the older person is not married and/ or has no children) or when key informal carers are present in informal networks (spouse and/or child), but the need for support (severe illness or disability) exceeds the capabilities of the informal networks [Hlebec, Nagode, Filipovič Hrast 2014, s. 891].

The need for different services increases with age. Because of different historical paths of development, population structure, welfare regimes and culture, the development and patterns of community care services for older people are necessarily diverse across different countries. Such programmes, initiatives and models will be increasingly required in all countries. Presently, about two thirds of the world's older persons already live in LMICs and will be increasingly concentrated there. Therefore, WKC began its work in these countries, reflecting impacts on existing under-performing and under-resourced health and social systems [WKC 2016a, p. 1]. It is worth to look at the initiatives selected by the WKC from the perspective of the models referred to and try to choose the most matching.

5. Community-based initiatives that support older adults in LMICs – selected cases

As it was mentioned in the Introduction, in 2014, an integral part of the Geneva-based Secretariat of the World Health Organization (WHO), the WHO Centre for Health Development in Kobe (WKC) issued a call for preparing case studies on community-based initiatives that support older people in low- and middle-income countries (LMICs).

The case studies should concern initiatives implemented in a community, with older people at the centre of the initiative, aiming to assist older persons to increase autonomy and to maintain or enhance their health and quality-of-life for as long as possible. After six month of verification of the thirty eight received proposals, just seven case studies were completed with one cancellation.

1. Case Study in India: *Promoting and advocating for age-friendly healthcare in the Thar Desert, India*.
2. Case Study in Poland: *Tychy local network of support centres for the elderly*.
3. Case Study in South Africa: *AgeWell, a peer support service in community settings to improve well-being and health among older persons*.
4. Case Study in Thailand: *Community-based initiatives of rural districts in Thailand – Nang Rong District, Buriram Province*.
5. Case Study in Vietnam: *Community mechanism to promoting health and active ageing and community care*.
6. Case Study in Uganda: *Empowering older people and mobilising communities in Uganda: The social gerontology manual*.
7. Case study in China: *Taking comprehensive measures to prevent disability among the Chinese elderly*.

In general the main objectives of all the initiatives implemented were to reduce poverty of disadvantaged older people through support of vulnerable communities, to meet their needs, improve the quality of their lives, and reinforce the development capacities of older people within those communities. But it was undertaken and organized in a different ways.

In India the Project ADOPT was developed by Help Age International (HAI, global network of not-for-profit organizations) and its local partner GRAVIS (Gramin Vikas Vigyan Samiti) through a process of consultations with older people and village leaders. The project was funded by the EU and was implemented by GRAVIS with technical support from HAI, in 18 remote and needy villages of Thar Desert. The project started in May 2003 and ended in June 2008. The goal was poverty reduction through support for disadvantaged and vulnerable communities in the Thar Desert of Rajasthan, to meet their basic needs, improve the quality of their lives, and reinforce the development capacities of older people within those communities.

Poland was represented by project implemented in Tychy – one of the Silesian cities. It was the Local Network of Support Centres for the Elderly including three

Catholics parishes running NGO. The main objective of this initiative was to provide daily support for 85 people aged "60+" who are feeling lonely, suffering from various health problems, wishing to stay in a group, make new social contacts, spend their free time in a friendly environment and take care of their physical and mental condition. This initiative began in 2002 and is still ongoing.

The next initiative, AgeWell, was realised in two pilot communities in Cape Town, South Africa, in 2014. It was community-based program with the goal of demonstrating operational capacity and improving well-being and social support for home dwelling elders over the age of 60. The main activity consisted of employing 28 peer supporters to provide services to a enrolled clients. Results of the pilot study demonstrate significant shifts in both subjective well-being and social support in clients. Successful program implementation was linked to effective partnerships with existing community-based organizations working in the elder person sector, a strong organizational culture focused on effecting social change, and a receptive community of elders willing to accept services.

The Case Study in Thailand was related to the initiative where sub-district administrative organization, village health volunteers, and sub-district hospital work together for elderly care and help older persons to maintain their well-being. Nang Rong District in Buriram Province was the case for this study of community-based initiatives. This policy has been implemented in 2011 in every community across the country to engage people in the community by encouraging them to solve problems within their own community. The Village Health Volunteers (VHV) were the key persons to improve healthcare access.

Intergenerational Self Help Club (ISHC) which has been initiated in 2012 in Vietnam was a model of using a holistic and inclusive approach, which targeted not just older people but also those with disadvantages, vulnerabilities and difficulties, to promote mutual support for synergy impact to healthy and active aging. Managing agency of ISHC is the Association of the Elderly who helps ISHC to maintain its autonomy and flexibility as community-based organization as well as to access to essential support from local government and collaboration from public agencies.

In Uganda the development and implementation of the initiative started in 2014 with a request of the Commissioner of the Department of Elderly and Disability of the Ministry of Gender, Labour and Social Development (MGLSD) to the Uganda Medical Research Council (MRC). The objective was to develop a social gerontology manual to support the implementation of the national policy. The Social Gerontology Manual was built with two existing approaches, the Community-Life Competence Process (CLCP) and EASY Care which were adapted and combined to enhance individual, family, community, civil society and government action in support of the health and well-being of older adults. The manual offers both a training of awareness of older persons' needs and providing skills to mobilize resources within the community and from the district.

Finally, the Chinese initiative was implemented in 2011 in one of the provinces of Beijing. It has several components conducted by the institution and those by

community health centre. First, outdoor activity area where the old people can have physical exercise and doing some leisure and recreation activities. Second, elderly volunteer team to help those with disability or living alone in the community. Third, the community health centre provides medical service to the residents including the elderly in the community, conducts health education, health examination and management of chronic diseases.

For preparing the reports with case studies WKC has provided special guidelines. It gave the opportunity to compare the initiatives to each other (Table 1) and will be halpfull in matching them to the theoretical models of support.

Table 1. The comparison of case studies

Case studies in	Points of analysis		
	the role and function of older people as a resources for themselves and for others (peers, family, community)	main health and social services delivered by those initiatives, and referral processes when they exist	coordination mechanisms with formal health and social sector, including the articulation with the health system
1	2	3	4
India	old people are beneficiaries of support and also actors in intervention	• health promotion and prevention activities • health care services • social and livelihood services	• implementation of intervention is aligned with national and regional policies • coordinate health and social services with the public sector
Poland	older people are mainly receiving support and have little involvement in the process of the intervention	• health promotion and prevention activities • social and livelihood services	• implementation of intervention is aligned with national and regional policies • coordinate social services with the public sector
South Africa	old people are beneficiaries of support and also actors in intervention	• health promotion and prevention activities • social and livelihood services	• implementation of intervention is aligned with national and regional policies • coordination with private health and social sector
Thailand	old people are beneficiaries of support and also actors in intervention	• health promotion and prevention activities; • health care services; • social and livelihood services	• implementation of intervention is aligned with national and regional policies • coordinate health and social services with the public sector

1	2	3	4
Vietnam	old people are beneficiaries of support and also actors in intervention	• health promotion and prevention activities • health care services • social and livelihood services	• implementation of intervention is aligned with national and regional policies • coordinate health and social services with the public sector
Uganda	old people are beneficiaries of support and also actors in intervention	• health promotion and prevention activities • health care services • social and livelihood services	• implementation of intervention is aligned with national and regional policies • coordinate health and social services with the public sector
China	older people are mainly receiving health and social care and have little involvement in the process of the intervention	• health promotion and prevention activities • health care services • social and livelihood services	• implementation of intervention is aligned with national and regional policies • coordinate health and social services with the public sector

Source: own preparation, based on: [WKC 2016a].

In all case studies, active participation of the older adults has helped in achieving the objectives and in strengthening the relationship with the communities. The high degree of participation of the older adults within the community in developing and implementing the initiatives increased the likelihood of achieving sustainable behavioural change. In several initiatives older adults were even key players to improve healthcare access because as the local people they are often more respected than outsiders. The involved seniors were often the key persons to give great support another older adults. On the other hand, in some initiatives involved seniors mostly only received health and social support and had little involvement in the process of the intervention. But in addition to the impact on people receiving services, older peer supporters have also been shown to benefit from their helping roles in terms of self-development and overall sense of purpose [WKC 2016a, p. 18].

When we look at the next point of analysis, the three main types of services delivered by the initiatives are most apparent: health promotion and prevention activities, health care services (either delivered by volunteers or older people), and social and livelihood services [WKC 2016a, p. 19].

One of the main services provided by the community-based interventions is related to health promotion and prevention activities. Indeed all the community interventions provide educational, informational and health promoting events throughout many villages. Many of these events promote healthy lifestyle and self-care training to

enhance members' healthy living. Prevention services are run through home visits and advocacy events with screening tests to detect NCDs (Thailand, Vietnam, China) as part of a prevention and health promotion approach. Several health camps are organized where physical and recreational activities are implemented (India, Poland, China, Thailand, Vietnam) [WKC 2016a, p. 20].

For example in India, Village Health Workers act as health educators, counselors and referral linkages between communities and health services. They organized health camps, trainings and educational campaigns for village people, what enhanced older people's health awareness. Similarly, the Tychy Local Network of support centre in Poland provides activities to promote healthy lifestyle, and organize events with volunteer therapists and physiotherapist, providing maintenance and rehabilitation exercises. The Centres only promote healthy lifestyle and educate the older adults about it and have as main objectives stimulation of social activity and willingness for the provision of mutual support.

Health care services are delivered by volunteers (China, Thailand) or by older people because in several initiatives they are part of the health care team or even become the main caregivers for their peers in the village (India, Uganda, Vietnam). But it has to be said that the health care services delivered by the programs remain very basic. Two out of seven initiatives do not deliver health care services at all (Poland, South Africa) [WKC 2016a, p. 22].

The community health centre in China provides medical service for the older persons with basic health check-ups (such as blood pressure measurement, blood glucose tests and other simple medical treatment services). Also in Thailand, the program provides primary health care and recruiting multi-disciplinary health personnel for regular visits to older adults in their homes. But in Uganda, older adult leaders are trained in care for older persons and are also taught basic clinical care practices such as first aid care for older adults. They also monitor keeping to the rules of treatment or explain the correct usage of the drugs.

The basic objective of all initiatives seem to be the social and livelihood aspects. Every intervention is organized and implemented to empower and engage older adults, aspecialy through cultural and social activities. The different programs provide mostly empowerment and social support activities to prevent isolation and exclusion of older adults at the community level [WKC 2016a, p. 24]. In Poland, older adults can interact with others and meet their needs for social activities. The Centres operate the Daily Support Centres for Children program giving the possibility of integration between generations. In China, the intervention implemented an indoor Senior Activity Centre where meals are provided every day. Cultural and physical activities are organized every year. The program also developed an older adult volunteer's team to help those with disabilities or living alone in the community. The range of help goes from daily living activities to befriending in order to prevent isolation.

The last but not least, the important aspect are the coordination mechanisms with formal health and social sector. All the case studies revealed a collaboration of the

interventions with formal health and social sector. There can be distinguished two categories: coordination with the public health and social sector and coordination with private sectors [WKC 2016a, p. 26].

For example, in Vietnam there is a network of village health care collaborators organized by the government in all villages. They have training on primary health care, work part-time and are paid by the government to help Community Health Station officials through community-outreach activities. On the other hand, the program in South Africa does not provide health care or social service support, however, they serve as a central link between social supports of family and community and healthcare offered by private licensed medical and social providers. Older adults assessed as having health and social service needs are sent to their health care provider or to social services.

6. Community-based initiatives that support older adults in LMICs – attempt to match a model of support

Although the discussed initiatives were carried out in different conditions (social, cultural, territorial, etc.), they have many common elements. Multiplicity of common features does not change the fact that fitting them into one of the theoretical models is a very difficult task. Partly it is because the source reports which describe each of the initiatives do not contain precise information about the informal support the seniors can benefit from. However, other studies show that, in most LMICs, support for older people is often provided by the immediate family. Yet, even prior to anticipated large increases in the percentage of older persons in these countries, the traditional family care system is gradually eroding due to decreasing childbirth rates, migration of younger people, engagement of ever more family members in the workforce, and rapid urbanization [WKC 2016a, p. 28].

Constantly, taking into account the available knowledge, it can be said that, relatively, the presented initiatives fit the most in *the supplementary* or *complementary model*.

As it was described above, these two models assume that informal care is a preference and a major source of support for frail older people living in the community. Their authors also postulate that formal care is activated in the specific instances, related to the absence of key elements of informal care network and to great need. Formal care supplements the care provided by informal carers, especially when the needs of the older person exceed the resources of the informal network. It seems pretty clear that presented initiatives should not be treated as an alternative (either deferring from state responsibility or simply an inexpensive option) to what should be universally available – health, social and care services.

To be more precise, it has to be emphasized that presented programs should be treated as a kind of supplement for the formal support and the application of which affects the achievement of a fuller complementarity of social support for the

elderly. The implementation of the community-based programs is often aligned with national policies and aims at filling the gap between seniors' needs and public support. Volunteer caregivers are the key link between the older population and either public or private formal health and social sectors. Coordination with formal health and social services is made by most of the community-based programs [WKC 2016a, p. 17].

7. Conclusions

The analysis of selected case studies has showed that although their organization took place under different conditions (geographical, social and cultural) they share some common features. One of the most important is the fact that they are successful attempts to answer the existing demand for support for seniors as members of local communities. Each case was based on determining the real needs of older people and their satisfaction through the activation of local resources. Each time they were based on mixing formal and informal sources of support, the use of which created an inclusive atmosphere. Of course, those case studies should be treated as evolutionary rather then static solutions (models). Mostly it is because, as we know, with each social and community innovation cycle, when one gap is filled, then other gaps might open up, and thus those initiatives should be continuously developed.

This applies especially to older members of society. Mainly because the oldest population segment became more and more heterogeneous. We can observe that some old people seem to be very activ and open to new experiences, realizing that old is still a part (stage) of life rather than a preparation for death. But at the same time, we can find how others remain rigid as to the changes characteristic of old age and the way of seeing and identifying old age. Thus, the way of thinking and the meanings attributed to old age and aging by each old person are founded on dynamic and continuous relations with the values the society attributes to aging [Freitas, Queiroz, Sousa 2010, p. 404].

It is certain that such programs and initiatives will be increasingly required in other countries. However, given the nascent nature of analysis of these cases, solid conceptual work is still required, along with rigorous assessment and evaluation research, leading to improvements and development. Therefore, WHO has gone one step ahead, and launched the next stage of research. In 2017 it conducted identification of case-studies on community-based social innovations (CBSIs) that support older people in middle-income countries (LMICs). This time they have selected cases from ten countries (Chile, China, Iran, Lebanon, Russia, Serbia, Sri Lanka, Thailand, Ukraine[1], and last but not least Vietnam). The CBSIs identified will form the basis of a series of case studies which, together with an ongoing systematic literature review,

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[1] The author of this article was responsible for preparing the Ukrainian case study. This time it was *Kolping University of the Third Age (KUTA)* which operates in six Ukrainian cities (Lviv, Stryj, Uzhgorod, Ivano-Frankivsk, Lutsk, Chernivtsi).

aims to create a typology of CBSIs and examine their effectiveness and integration with the wider health and care system in MICs. Selected case studies will become the focus of primary data collection and in-depth analysis which will make possible understanding the CBSI, including how it operates, how it links to other health and social care services and what benefits it brings for participants [WKC 2016b, p. 2]. There is clearly a need to continually explore better ways of helping older individuals to remain in the community. The pressure to seek and find alternative or complementary means of care will expand [Angel, Angel 1998, p. 185]. This broad and deep analysis of local initiatives can also be a great resource for the development and complement of the existing theoretical models of social support.

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