2013

Akshara Livelihoods

SaGP 2010-13 Evaluation

Acknowledgements

We are thankful to HelpAge India and HelpAge International and their SaGP Partners and their management for providing this opportunity to evaluate 'SaGP – Sponsor a Grandparent Programme 2010-13' across the regions/states where the SaGP has been/is being implemented.

The team has interacted with the HI and its partners, visited sampled 'partners' during July-August 2011. This could not have been possible without support from the elders and their families, the staff of the partners and HI in various places and other stakeholders and opening up before us to throw visible and not-so-visible insights. We are thankful to all of them. Specifically, our thanks are due to –

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Acronyms

ANM	Auxiliary Nurse Midwifery
CBHC	Community Based Health Centre
DI	Direct Implementation
DRR	Disaster Risk Reduction
ESHG	Elder Self-help Group
HAI	HelpAge International
HI	HelpAge India
IEC	Information, Education, Communication
IGA	Income Generating Activity
IOL	Intraocular Lens
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MMU	Mobile Medical Unit
NCD	Non-Communicable Disease
NRHM	National Rural Health Mission
NRLM	National Rural Livelihoods Mission
NULM	National Urban Livelihoods Mission
NTFP	Non-Timber Forest Produce
OAH	Old Age Home
SHG	Self-help Group
SAGP	Sponsor a Granny Programme
TOR	Terms of Reference
UN	United Nations

Executive Summary

India is home to about 100 million elderly. HelpAge India [HI], since 1978, has been working for the cause of elderly and Sponsor a Gran Program (SaGP) is one of its flagship programs. SaGP has transitioned from a purely welfare program to a rights-based welfare and development program. SaGP 2010-13 is based on 4 critical Objectives – Health, Elderly Self-help Groups (ESHGs), Destitute Care and Advocacy for Active, Assisted and Destitute Elders. HI carried out the above activities directly and through its 95 partners across 20 states in the country and reached out to 19000 poor elders (active, assisted and destitute)**.**

Results planned versus Achievements -

Objective	Intervention	Parameter	Planned	Achieved
Health	Medical Consultation and Medical Camps	Fortnight/monthly camps	4040	4866
	Physiotherapy consultations	At centre level and field level	3032	5179
	IOL	Surgeries performed	3235	4353
ESHGs	No of SHGs	Organizing Elders in ESHGs	862	1375
	Community Animators	No of Animators	94	104
	Federating ESHGs	Cluster/block level federations	95	10
	Capacity Building of ESHGs	Function of ESHG/ Management	366	425
	Grading ESHGs	Function of ESHG	730	824
	Seed Capital/Revolving Fund	Livelihood	667	646
Destitute Care	Commodity Support	Number of Grain Banks	181	154
	Old Age Homes (Institutes)	Institutes	1669	1889
Advocacy	Age Demand Actions	Activities conducted	305	372
Recreation/ Pilgrimage	Number of Elders benefited		194	227

SaGP 2010-13 Evaluation by Akshara Livelihoods during July – October 2013 was based on Secondary Data provided by HI and its Partners, 4 Regional Workshops, Field Visits across 4 regions (North, South, East and West) covering about 20 Partner/Direct Intervention Projects and Interim Sharing workshops with HI. The final sample included 156 individual elder interactions, 30 ESHGs, 5 Grain Banks, 4 Federations, 5 Collective Actions, apart from 100+ elder patients [camps: 64; consultations: 33, physiotherapy: 24 and IOL: 47].

Key Outcomes and Challenges Observed

As envisaged originally, SAGP 2010-13 has started to move from provision of ration to provision of services to sustainable provision of services, viz., Health; Socio-economic; Destitute care; and Advocacy. The evidences on ground are broadly in line with the objectives and activities. The results achieved generally exceeded the planned results, except federations. Overall, it indicated a decent value for money in terms of investment versus the changes it had brought in the lives of elders.

However, some components of health services are not cost-effective. Destitute care could improve its qualitative and quantitative performance. Advocacy effort is not significant despite enormous need and scope. Interventions like old age homes and day care centres are significant but cost intensive. Separate attention to psychological counselling needs of men and women is missing in the interventions. SaGP 2010-13 did not give attention to the gender aspects in general.

Healthcare interventions include Medical Consultations, Medical Camps, Mobile Medical Units (MMUs), Physiotherapy and Palliative Care services and IOL treatments. Specifically -

- Medical Consultations and Medicines through CBHC/SMUs are more cost-effective than the other mode of delivery – MMU. Initial medical camps followed up with SMU/MMU and referral support have been very useful while general medical camps without patient follow-

up are not serving any useful purpose. Community-based SMU with local barefoot geriatric assistants, with referral linkages may be the most sustainable and cost-effective option.

- Physiotherapy equipment to Partners ended as "Physiotherapy" equipment distribution. In HI direct intervention centres, physiotherapy was found quite useful and need-based. However, the camp based approach to "physiotherapy" was found not useful and effective.
- The eye camps have significantly served the purpose of enhancing quality of vision of the elderly through helping with cataract removal surgeries. However, as the number of elders with cataract is too large, there is a need for large-scale convergence with government.

Elderly Self-help Groups (ESHGs) restored their dignity, hope and they are able to access cheap credit; credit is used to enhance family and/or individual livelihoods, meet their domestic and consumption needs, meet education expenses of their children/grandchildren, health expenditure in the family and also fulfil their tiny desires. Being in ESHGs increased a sense of solidarity, interdependence and sharing among elders. Specifically -

- The average savings is Rs.30 per month/member; most groups received a seed capital of Rs.13500; only a small percentage of groups are actively engaged in inter-lending process. Loans are taken to service different activities like agriculture and allied services, business, house repair, consumption, education, health and marriage needs etc.
- 'A' grade groups successfully invested seed capital in generating enhanced incomes on their livelihoods; Women have taken up alternative livelihoods in more numbers.
- Very limited collective business activities have been taken up though the scope is significant.
- There is a need to do livelihoods scoping and evolve participatory livelihoods plans.
- Federations are in a nascent stage and need strengthening. With systematic nurturing ESHGs and Federations, they could shape up into sustainable platforms for integrated eldercare.

Support systems for the destitute elderly have been through Old Age Homes and Commodity support through ESHGs. Specifically -

- Old age homes are no substitute to family; the limited number of elders they service make them unviable on cost-front; some have unmet infrastructural needs; and alternative approaches like village level community-managed care centres can be explored.
- Commodity Support (commodity fund of Rs.10000 to establish grain banks to support the destitute) through ESHGs has been utilised in different ways in ESHGs – Grain Banks, Margin Free Shops, Purchase of assets for ROI, commodity fund going into the regular revolving fund of the ESHG (and did not get utilized for any organized destitute care) etc. On an average, 2 destitute elders are being benefitted from the groups that received commodity fund.
- The need for destitute care is strongly felt by all ESHG members but mechanisms to deliver the same are sporadic. This calls for some handholding support, mentoring and monitoring.

Advocacy is a significant way forward where the elders in particular and community at large will voice the cause of the elderly. These include universal pensions, ration cards, MGNREGA works etc. Specifically -

- Nearly 50% of the elderly are now getting old age pension, 45% are getting widow pension and 50%+ got ration cards; the celebration of International Day of Older Persons (October 1) marked the provision of services to the elderly, redressal of grievances, by the officials.
- Still, planning on Advocacy as an agenda is missing. Partners need orientation on advocacy; many do not appreciate the concept of elders fighting for their own cause. On the other hand, elders are ready to leverage ESHGs to come together and demand their rights and entitlements. ESHGs should be nurtured as advocacy platforms to disseminate information pertaining to elders and positively influence the National Policy for Elders.

Day Care Centre for Dementia affected elderly cannot be sustainable as it costs Rs.8 lakh per year to service 18 patients; but this intervention may serve as a model for government/CSR to scale-up.

Elders have been happy with Recreation activities - Daily recreation; Pilgrimage or Heritage tours.

HI's cutting-edge staff members are not able to give quality time with the community of elders. The programme staff members have to increase their time being with elders and partners. Where the state coordination, staff and partners have worked hand in hand, the results are more comprehensive. There is a need to review and conclude partnerships with small number of beneficiaries for reasons of cost-effectiveness and significant demonstration of integrated model(s).

Budget spent as per the stipulated provisions; healthcare and ESHGs effectively implemented; however, livelihoods scoping and planning could have utilised seed capital more effectively; commodity support could not fully fulfil its objective of destitute care. Some budget remained unspent under advocacy and destitute care. This is largely due to perceived lack of flexibility and insufficiently geared up skills of HI's staff and partners. The program delivery is still in its early stages of building ownership of the community of elders, and graduating towards established sustainability.

Recommendations/Way Forward

Health

- Build (elderly) community-managed healthcare including palliative care, physiotherapy etc.
- Build cadre of barefoot caregivers and geriatric assistants in rural and urban areas
- Scale-up cost-effective SMU/CBHC model of healthcare primarily
- Evolve differential (for destitute and others) user fee models
- Ensure updation of patient card with treatment details and take the same data into MIS
- Promote convergence with NRHM and other agencies

ESHGs

- Target and mobilize destitute and vulnerable elders in the village on a saturation basis
- Facilitate livelihoods scoping and livelihoods plans
- Ensure space in ESHGs for psychological and gender counseling processes
- Ensure several rounds of training on mutual help/support and the functioning of group etc.
- Pursue linkages with government rights and entitlements as a priority

Destitute Care

- Promote family-based or at least community-based care of the elderly as a first priority
- Encourage Institutions of Elderly and Local Community Institutions to care for the destitute
- Leverage Pension, Antyodaya, Annapurna and other rights and entitlements for the destitute

Advocacy

- Nurture ESHGs (and other community institutions) as platforms of advocacy for elders' rights
- Campaign for Universal Coverage of Pension
- Demand Bank Linkage and insurance for ESHGs
- Build and strengthen the movement Elders for Elders
- Make policy efforts so that the government engages elders in NRLM/NULM

Partnerships, Programme Management and Programme Delivery

- Saturate coverage of elders in an area; limit partnerships based on minimum outreach etc.
- Increase working with Elder Community as Partners
- Establish demonstrable, replicable models of integrated elderly care in different regions
- Build knowledge, skills, attitudes and capacities of staff and partners in integrated eldercare, gender, sustainability and community advocacy; involve partners in program development
- Encourage collaboration among 'Elders', community, civil society, government, corporate
- Strengthen MIS that can track the target group and their institutions on an up-to-date basis
- Facilitate and involve elders and their institutions in Management at various levels
- Ensure that all this leads to and supports the movement – Elders for Elders

The next phase of SaGP that takes the way forward as part of its design and implemented with diligence would improve on the good results that SaGP 2010-13 and shows ways forward for the country and its various flagship programmes with focus on elderly.

Introduction

Ageing is an important emerging demographic phenomenon in India. India has around 100 million elderly at present and according to UN report the number is expected to increase to 323 million by 2050. While graceful aging is the most desired way forward, in reality most elderly have to deal with social and psychological fallouts of dependency and old age, suffering neglect, loneliness, lack of activity, failing physical and mental health etc. These vulnerabilities of old age multiply with poverty and illiteracy. In the case of women, gender-based discrimination adds another vulnerability factor.

In this context, to facilitate graceful aging of the elderly in general and poor elderly in particular, HelpAge India (HI) came into existence in 1978 as a Society. Its Mission is ***"to work for the cause and care of disadvantaged older persons to improve their quality of life".*** One of its early programs is the Sponsor a Gran Program (SaGP) through which the poor and destitute elderly were given monthly rations and a small pocket money. Implementation of SaGP has been done - directly by HI or through its Partner NGOs. In this effort, HI is supported by HelpAge International which in turn gets financial support from Age UK and individual donations in the UK.

Gradually, in line with HI's transitioning from Welfare to Development and Rights-Based approach, new elements have been added in SaGP over time. In 2010, SaGP has been redesigned with new elements like – the institutions of the poor elderly - Elderly Self-help Groups (ESHGs), Health, Destitute Care and Advocacy for Active, Assisted and Destitute Elders. The goal has been to build and nurture ESHGs and their Federations that would eventually emerge as platforms for self-supporting integrated elderly care; their members would come together and fight for their rights and entitlements, and advocate the cause of elderly at various levels, in multiple platforms and forums.

Specific objectives of SaGP 2010-13 included -

- **Health** – to provide appropriate treatment, medication and overall health care services to elders. This helps elders to remain active, keeps their self-respect and dignity intact, reduces their dependency and increases their productive life.
- **Elderly Self-help Groups** – to organize elders into ESHGs and federate ESHGs. ESHGs help elders to gain confidence and feel themselves as a productive part of the community. ESHGs take up member-savings, credit, group income generation activities, support destitute Elders and organized advocacy to claim their rights and entitlements.
- **Destitute Care** – to provide care (commodity and emotional support) to destitute elders including those living in the old age homes directly or through ESHGs.
- **Advocacy** – to create platforms of the elderly and advocate about the cause and care of the elderly in the society and with the state for demanding their due Rights and Entitlements.

Table 1: Activities to achieve SaGP objectives

Health	ESHGs	Destitute Care	Advocacy
▪ Medical Consultation ▪ Medical Camps ▪ Mobile Medical Units (MMU) ▪ Physiotherapy and Palliative Care ▪ Cataract (IOL) surgeries	▪ Organizing Elders into ESHGs ▪ Training Elders and Community Animators ▪ Federating ESHGs ▪ Grading ESHGs ▪ Provision of Seed Capital/Revolving Fund	▪ Commodity Support ▪ Old Age Homes ▪ Community counselling	▪ Celebrating International Day of Older Persons and World Elders Abuse Awareness Day ▪ Rallies, campaigns, workshops, IEC ▪ Demanding Elders Rights and Entitlements ▪ Positively influencing the National Policy on Older Persons

In addition to the above, activities like establishing and running Day Care Centres and Recreation and Pilgrimage for the Elders were taken up.

With these activities, SaGP 2010-13 has reached to 19000 elders (active, assisted and destitute) in 95 locations - directly and through its partners - across 20 states in the country. The activities chosen in each State are relatively consistent, but in some areas – particularly in the realm of health, there was diversity based on the local context and partner skills and experience.

Table 2: Objective-wise Planned Vs Achieved[1]

Objective	Intervention	Parameter	Planned	Achieved
Health	Medical Consultation and Medical Camps	Fortnight/monthly camps	4040	4866
	MMU	Village visits	NA	NA
	Physiotherapy consultations	At centre level and field level	3032	5179
	IOL	Surgeries performed	3235	4353
ESHGs	No of SHGs	Organizing Elders in ESHGs	862	1375
	Community Animators	No of Animators	94	104
	Federating ESHGs	Cluster/block level federations	95	89
	Capacity Building of ESHGs	Function of ESHG/ Management	366	425
	Grading ESHGs	Function of ESHG	730	824
	Seed Capital/Revolving Fund	Livelihood	667	646
Destitute Care	Commodity Support	Number of Grain Banks	181	154
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Advocacy	Age Demand Actions	Activities conducted	305	372
Recreation and Pilgrimage	Number of Elders benefited		194	227

To take the SaGP forward, HI has decided to reflect on the past 3 years by assessing the processes and the opportunities, limitations and challenges faced in its Direct Implementation and as well as by the Partner organizations. Among other things, the Evaluation (Assessment) would -

- Confirm that the results declared by HI and its partners are valid and can be evidenced
- Review the targeting of the programme
- Determine the effectiveness and impact of the activities run delivering better health (primary health), income and social inclusion for those older people supported
- Determine – where appropriate – the cost-effectiveness (value for money) of differing methodologies used to provide a guide to future programming, with an emphasis on health service delivery
- Determine which activities or models used are, or have the potential to be, self-sustaining
- Appreciate the role played by HI in the programme
- Identify key learning relating to the methodologies used that could advise future programme design and suggest recommendations accordingly

With this background, at the instance of HI, a team from Akshara Livelihoods (ALPL), a livelihoods support organization, has carried out the SaGP 2010-13 Evaluation (Assessment) during May – September 2013.

[1]Overall SaGP for 2010-2013

SaGP 2010-13 Evaluation (Assessment) Methodology

The SAGP 2010-13 Evaluation (Assessment) has begun with the team becoming familiar with the SAGP through initial discussions with HI program management team and the perusal of secondary data. The understandings from Secondary Data provided by HI and its Partners and from the Evaluation (Assessment) Parameters[2] evolved by HI set the milieu for designing the Assessment Methodology.

The Secondary Data comprising 6 months reports, Spokesperson report, Annual Report and Consolidated Budget for three years from 95 Partners and Direct Interventions of HI gave a preliminary understanding of the types of interventions taken up directly by HI and by its Partners[3] and also an understanding of the scale of interventions.

SaGP Evaluation (Assessment) Methodology and Processes

Based on the above understanding and the Terms of Reference of the Evaluation (assessment), the methodology adopted for assessment included -

Selection of locations for visit

The 95 locations have been categorized under 4 regions - Hyderabad, Chennai, Delhi and Kolkata. Of these regions, the following criteria have been used for selection of locations -

1. Locations with highest number of beneficiaries in each region.
2. Locations around the median number of beneficiaries.
3. Additionally from the listed Old Age Homes, Locations with highest number of beneficiaries and locations around the median number of beneficiaries.
4. To cover the range of interventions under SaGP, the highest direct intervention location and an integrated location (with direct intervention, Mobile Medical unit and IOL), two locations with Mobile Medical Units and One Day Care centre have also been selected for visit.

Table 3: Details of 20 Partners selected for Assessment

#	Region	Location	Partner	Beneficiaries
1	South - Hyderabad	AP – Anantapur	St. Vincent de Paul Society - SVDPS	47
2	South - Hyderabad	AP – Kothagudem	OCD Service Centre for the Aged	213
3	South - Hyderabad	AP – Gollapudi	St. Anthony's Health Centre - SAHC	293
4	South - Hyderabad	Maharashtra – Aurangabad	Institute for Integrated Rural Development (IIRD)	513
5	North - Delhi	UP – Kanpur	Shramik Bharti	118
6	North - Delhi	Punjab - Nurpur Bedi	Direct Implementation - Ropar	451
7	North - Delhi	Punjab – Patiala	Direct Implementation - Patiala	320
8	North - Delhi	HP - Kunihar	Society for Development & Environment Protection	650
9	North - Delhi	Rajasthan – Bikaner	Direct Implementation - Bikaner	125
10	South - Chennai	TN – Madurai	CSI - Mercy Home (Diocese of Madurai & Ramnad)	51
11	South - Chennai	TN - Kanyakumari	Association of Sisters of the Destitute Anpakam	120
12	South - Chennai	TN – Madurai	St. Charles Convent (Sneha Illam)	175
13	South - Chennai	TN – Coimbatore	Direct Implementation - Chennai	320
14	South - Chennai	TN – Chennai	Guild of Service (Meals on Wheels)	573
15	South - Chennai	Karnataka – Udayarpalayam	Dalai Lama's Central Tibetan Relief Committee	193
16	East - Kolkata	Odisha – Bhubaneswar	People's Cultural Centre (PECUC)	123
17	East - Kolkata	Odisha – Kandhamal	Banbasi Seva Samiti	138
18	East - Kolkata	West Bengal – Midnapore	Child & Social Welfare Society	341
19	East - Kolkata	Bihar – Patna	Direct Implementation – Patna Dementia centre	18
20	East - Kolkata	Bihar – Sasaram	Direct Implementation - Sasaram	150

20 partners in 4 regions covering 11 states; Total beneficiaries are 4932

[2] Refer to Introduction Chapter for Assessment Parameters
[3] Refer to Annexure 1 for list of partners and their outreach

The sample spread across India include 3 from Andhra Pradesh, 1 each from Himachal Pradesh, Karnataka, Maharashtra, Rajasthan, Uttar Pradesh and West Bengal, 2 each from Bihar, Punjab and Odisha and 5 from Tamil Nadu. The sample chosen is to assess the overall program design, results and impact, rather than to assess any one or more individual location(s). The sample provided a fair understanding of the wider quantitative and qualitative outreach of all the partners and direct interventions of HI.

In addition to the Secondary Data Analysis and Sample Selection, the summary of the Evaluation (assessment) processes that from part of the methodology could be seen in Table 4 below.

Table 4: Evaluation (Assessment) Processes

Steps	Actions	Processes
1	Collection of Secondary Information - reports submitted by partners to HI with respect to planned and achieved	Review and Analysis – Reports and Case studies
2	Selection of Partners for Assessment	Sampling logic
3	Development of Protocols for Assessment	- Check list for Regional workshops - Development of Economic (5) and Health (4) Schedules - Community consultation questionnaire
4	Drawing Perspectives and Perceptions of partners on • Programme implementation – planned achieved • Opportunities, Limitations and Challenges • Sustainability • Cost-effectiveness of programme • Partnership and its processes • Role of HI	Regional Workshops at Hyderabad, Chennai, Delhi and Kolkata
5	Discussions with the Individual elders, Group and Federation of Elders SHGs a. Economic b. Social c. Health d. Advocacy	- Questionnaire - Interview - Focussed Group Discussion, - Recall and Reflection - Observation
6	Documentation of field visit notes and analysis of questionnaires	- Collation of information from various field visits - Data entry-questionnaire information - Analysis of information
7	Budget Review and reflection	Budget Analysis – sectoral analysis on the cost-effectiveness of the programme
8	Interactions with HI, Interim Sharing with HI and Sharing Workshop with HI and Partners	Analysis of secondary and primary source of information

Protocols for Regional Workshops and Partner Visit[4]

To facilitate workshops and visits, following protocols have been developed and used -

1. Partner visit protocol

Lead questions for each of the objective for community consultation

2. Templates for E1-E5

1. Profile of the individual (E1)

[4] Refer to Annexure 2 for Templates

2. SHG profile (E2)
3. Grain Bank (E3)
4. SHG Federation (E4)
5. Collective Action (E5)

3. Templates for H1-H4

1. Medical Camps (H1)
2. Medical Consultations (H2)
3. Physiotherapy, Palliative care and Day (H3)
4. IOL camps (H4)

Regional workshops with Partners

Drawing perspectives and perceptions of Partners including HI - through the Regional Workshops

The objective of the regional workshops is to draw the perspectives and perception of the partner organizations including HI on -

1. The opportunities, limitations and challenges in implementing the SaGP and the achievement made against the planned activities and lessons learnt
2. The process of mobilization and targeting and understanding and impact of livelihoods and vis-a-vis the formation of ESHGs and its Federations
3. Impact of Health programme in the lives of elders
4. The social inclusion and well-being processes established
5. The nature of evolving sustainability forms and practices
6. Cost-effectiveness and value for money
7. Openness, Transparency, Participation and Accountability
8. Community Management/ownership
9. The role of HI, Partner Support /services by HI and in turn by itself to the community

Table 5: Schedule of Evaluation (Assessment)

Particulars	**Period**
Collection of Secondary Information and Preparation	7-16 July 2013
Conducted Regional Partner Workshops	17 July 2013 - Hyderabad 20 July 2013 - Chennai 21 July 2013 - Delhi 22 July 2013 - Kolkata
Review and Analysis of Programme Implementation: Report and Case Studies	18 July - 7 August 2013
Selecting sample partner for visit	11-15 July 2013
Piloting the process of Filed visit	18 July 2013
Field visits	20-31 July 2013
Data entry and analysis	11-15 August 2013
Presentation to HI	21 August 2013
Report writing	1 August – 15 September 2013
Sharing Workshop	24 August 2013
Final Draft report	September 2013
Final Report	October 2013

Partner visits

Discussions with the individual elders, ESHGs and their federations and partners

For community level consultations, Qualitative and Quantitative Assessment tools; and Participatory Process tools have been used.

The Quantitative/Qualitative information, including perspectives and perceptions of:

i. Elders
ii. Partner organization's and HI – Direct Implementation teams
iii. For the Quantitative assessment, schedules, interview methods were used for collecting the information
iv. Individual and Group information is sought through interviews and questionnaire

Participatory tools

i. Focussed Group Discussions (in leisure) to enable the elders to put forth their perspectives and perceptions on the quality of life
ii. The Recall and Reflection processes to enable the elders to recall the situation, position and condition that they lived and are living with
iii. Observation methods to comprehensively understand the individual and community situation, response to the issues that they confront or that were resolved or actions initiated individually, collectively or by the partner organization, which includes HI
iv. The following filled-in schedules have been collected
    a. **Economic –**
        - **E1 - Individual Profiles** – 8-9 individual profiles/partner
        - **E2 – SHG Profiles** - 2-3 SHGs/partner
        - **E3 - Grain Bank and E4 - SHG Federation**: Profile of one Grain Bank and one SHG Federation, if present, from each non-institutional partner organization.
        - **E5 - Collective Action** processes – 1-2 per partner assessment organization, if present
    b. Health – H1 to H4 - In the case of Health for the respective four formats H1, H2, H3 and H4 information is collected and along with it subsidiary information at the community level 7-8 beneficiaries is collected for H1, H2, H3 and H4

Data from partners

- No. of locations (partners and DI locations) visited: 20
- No. of individual beneficiaries interacted: 156
- No. of ESHGs interacted: 30
- No. of Grain Banks: 5; No. of Federations: 4; No. of Collective Action Processes: 5
- No. of Patients interacted with -
  Camps (H1): 64; Consultations (H2): 33; Physiotherapy (H3): 24 and IOL (H4): 47

Analysis

Qualitative and quantitative data collected from regional workshops and partner visits was analysed. The information in the specified formats helped in analysing the situation, position and condition of the elders based on the evidence. The quantified elder's response and the qualitative information are used for mutual corroboration of the data. The evidences on ground are broadly in line with the objectives and activities carried out by the partners.

Budget Analysis

3-year budgets of the partner organizations and HI have been analysed to appreciate component/ activity-wise utilisation and the per capita investment at the partner level. SaGP indicated a decent value for money in terms of investment versus the changes it had brought in the lives of elders.

Analysed data has been shared with the partners and HI in the sharing workshop. Based on the comments received in the workshop and on the way forward, the report has been revised.

Observations and Evaluation

SAGP 2010-13 has started to move from provision of ration to provision of services to sustainable provision of services, viz., Health; Socio-economic; Destitute care; and Advocacy.

The observations are drawn from Secondary Data, Partner reflections from the 4 Regional Workshops, Community reflections during the field visits and the reflections of the Evaluation (Assessment) team.

Health

Healthcare of the Elderly is one of the most critical interventions of HI and its Partners. The interventions include Medical Consultations and Medicines, Medical Camps, Mobile Medical Units (MMUs), Physiotherapy and Palliative Care services and IOL treatments.

Medical Consultations and Medicines

Medical Consultation and disbursement of Medicines is done through Community-based Health Centres (CBHCs) or Stationary Medical Units (SMUs). These centres provide primary healthcare services including physiotherapy, lab tests at concessional rates and free drugs. There are a total of 74 CBHCs of which 70 are run by partners and 4 are direct intervention of HI; of these a sample of 7 CBHCs has been visited for the purpose of this study.

- On average 50-60 patients avail medical consultation and free drugs in a day and 30-40 avail physiotherapy services. In a year about 14000 medical consultations happen. On an average each patient has two consultations in month. More than 60% are women.
- On an average each patient received free drugs worth Rs.25-30. Medicines are disbursed for 3 to 5 days duration but in case of non-curable diseases it is done for 2 weeks; there are cases where elders availed treatment for more than 6 months.

HI Agecare Facility in Patiala, Punjab has conducted medical consultations and medicines for free of cost in its own centre with a full time doctor (9am-5 pm). More than 1400 patients got treatment in the last one year of which most of them were visiting multiple times to avail treatment for chronic diseases. Patient registration cards were well maintained with the patient details name and dosage of medicines provided.

- Centralized drug approval and supply system is practiced which ensures uninterrupted supply of quality drugs.
- Basic lab tests are done at the centre and some pathology tests are outsourced to private labs on concessional rates.
- MIS is maintained. Generally, all elders are aware of the schedule.
- The intervention is highly beneficial to the poor Elders where government health facilities are not functional and private care is expensive. Elders expressed great satisfaction with the easy access to treatment and free drugs, the quality of medical doctor and the staff.
- Budgetary constraints have negatively impacted the availability of drugs; Doctors feel they are underpaid by 200% compared to HI's CSR funded projects and local government's pay;
- Apart from the consultation fee of Rs. 750 per day of consultation supported by HI, it costs Rs.25-30 per patient to provide medicines. Overall cost per patient on an average is about Rs.60. Sustaining the delivery of free services is a challenge. But, this is more cost-effective than the other mode of delivery – MMU.

Medical Camps

Medical camps are both general camps and theme-based like eye camps. They are usually done once or twice in a quarter and cover people of all age groups. The camp provides free medical consultation, basic pathological tests and medicines. The camps serve as good forums to establish rapport with community-based volunteers and spokespersons, senior citizen associations, local representatives etc.

- On an average 70-80 people availed medical consultation per camp; in the last 3 years the medical camp intervention would have reached out to not less than 20000 people during the last 5 camps; camps were beneficial to identify elders with cataract, arthritis, TB, skin diseases etc.
- Camps were organized with well qualified doctors and efforts were made to mobilise medicines from networking with government facilities, local hospitals and medical shops.
- Partners have maintained good MIS regarding patient registration and issuance of medicines. Some of the documentation practices like doctor's consultation note-sheet, patient slip etc., can be replicated as standard practices in all its camp based interventions.
- Many elders are suffering with arthritis ailments - means low in calcium. Calcium supplements (a preventive measure) need to be made available to young elderly so they are not aging into such bad arthritis – an area for advocacy for state action!
- The camp approach is good only when at least one medical camp is organized for a cluster of hamlets or small villages. At least one follow-up check-up is necessary for elders with chronic health problems. In the absence of this the relevance of camps were found doubtful; referral cases, except that of Cataract was not followed up.
- The average cost of running a medical camp exceeds the amount supported by HI.

Mobile Medical Unit

All 2 MMUs visited are direct interventions of HI. Generally MMU is staffed with a qualified doctor, a social protection officer, a pharmacist and a driver cum MIS assistant. In some MMUs, a nurse is also present.

- Operating with pre-defined weekly schedule, MMU services were found very effective and efficient in systematically reaching out to the needy elders in Villages.
- The average number of patients that avail MMU services per day is 44 (from available data).
- Web-based MIS system exists for reporting service delivery and management of drug procurement and supply.
- On an average, an elderly patient receives medicines worth Rs.30/- per consultation. The total per patient treatment value would be Rs.90/- plus.
- MMU emerged as very useful but less cost-effective intervention. If sponsorships are available, it should be scaled up for quality coverage of medical needs of the elderly where government health care system is dismal. Partnerships need to be established to work towards some cost recovery for the intervention to be sustainable.
- Thus, community-based SMU with local barefoot geriatric assistants, with referral linkages may be the most sustainable and cost-effective option. MMU is the next best option if long duration sponsorships are forthcoming.

Physiotherapy and Palliative Care

HI has established Physiotherapy centres in CBHCs as well as with select MMUs and Partner centres. Qualified physiotherapists are appointed to provide the required care and work in coordination with the doctors. Physiotherapy includes palliative care.

- Total physiotherapy treatments provided are 12084; 10% women and 16% men who visited the physiotherapy centres are above 70 years of age; 32% women and only 19% men are from the age group of 55-65 years which means that very old women are not availing physiotherapy services.
- Those patients interviewed expressed satisfaction with the physiotherapy treatments given. There was general perception that physiotherapy is greatly beneficial and it helps them to gain better health and mobility.
- Patient waiting time more than an hour in Patiala due to heavy patient load- more than 35 patients in a day for a single Physiotherapist to handle
- Lack of Space for exercise therapy in camps; Issues related to hygiene, linen and couch needs attention in camps; Poor patient record keeping. Set of electric therapies, exercise therapies, muscle strengthening exercises, stretching incomplete in camp mode.
- No systematic follow-up of beneficiaries needing other medical attention. Communication with physician, orthopedic surgeons is missing in Camps as well as in CBHC. Regular periodic consultation with physician and orthopedic surgeons has to be made an integral element.
- Partners who received physiotherapy equipment mostly were found depending on HI for further resource support for taking up physiotherapy care in an organized manner; a proper assessment of Partner capacity to leverage physiotherapy was not done. It merely ended as "Physiotherapy" equipment distribution. There is a need for tapering financial support so that user fee-based physiotherapy is offered on a sustainable basis. Select partners (to whom some equipment support was given) may be encouraged to offer cost-effective therapy centres with user fee charges on pilot basis.
- Overall, the CBHC approach to Physiotherapy was found quite useful and need-based. It has tremendously helped in responding to the non-medical therapeutic needs of the elderly; the camp based approach to "physiotherapy" was found not useful and effective as physiotherapy treatments are for a course of seven days, 15 days and so on. Camp approach does not ensure continuity of treatment and thus not useful.

IOL

- Intraocular Lens Surgery (IOL) needs are identified through medical camps and OP consultation in CBHC. Networks are established with local eye hospitals and on a fixed appointment date the taken to hospital for treatment. Key services offered include – cataract screening by qualified ophthalmic personnel, cataract surgery at base hospital, free pick-up and drop, basic medical and pathological tests, cataract surgery, immediate check-up on next day, follow-up check-up on 30th day and post-surgical follow-up as required.
- 8319 elders were screened in the eye camps of which 2702 were found eligible for surgery and 630 elders benefitted with cataract removal surgeries free of cost; most of those above 55 years have gone for screening in the eye camps.
- The eye camps have significantly served the purpose of enhancing quality of vision of the elderly through helping with cataract removal surgeries; the cataract surgeries were carried out with a nearly 100% success in restoring vision. Some of the elders had to be operated

twice for proper vision restoration. These were also done through follow-up post-surgical check-ups.

- Some elders have reported that they had to pay for own conveyance for reaching the health facility; some of the elders had to pay extra cost for fixing IOL of their choice.
- Documents related to post-surgical outcomes were maintained. In some places good documentation system was found to be in place. However as a program there is lack of MIS
- For cataract surgical outcome measurement, it is important to have in place pre-and post surgical outcomes for assessing impact. The partner and self-reporting on this is very minimal.
- More volume needs to be considered. Twenty IOL per partner per year is too small as the number of elders with cataract is too large. Screening camps with the support eye hospital may need to be encouraged.

Elder Self-help Groups

One of the critical focuses of SaGP is to build sustainable Elders for Elders platforms where in Elders gain social and economic security, self-confidence and dignity; fight for their rights and entitlements; and have their voice heard at various levels. Towards this end, SaGP supported formation and strengthening of Elderly Self-help Groups (ESHGs). While most of these groups are mixed consisting of both men and women, there are random instances of exclusive women groups and exclusive men groups. The ESHGs include all categories of elders – Active, Assisted and Destitute.

Formation and Strengthening

- Most elders expressed that being in ESHGs restored their dignity, hope and they are able to access cheap credit; credit is used to enhance family and/or individual livelihoods, meet their domestic and consumption needs, meet education expenses of their children/grandchildren, health expenditure in the family and also fulfil their tiny desires. Being in ESHGs increased a sense of solidarity, interdependence and sharing among elders.
- Average group membership is 14 and the ratio of women: men is varied across
- Group norms with respect to repayment, loans, attendance, timings etc., are evolved in some groups but not strictly enforced.
- Where there are literate elders in the group, books (Cash register, Loan register, Meeting minutes etc) are maintained by the elders themselves and in other cases the services of external animator is used. The quality of former seems to be better than the latter in this case.

Trainings

- Majority of the groups received capacity building trainings on group management, book keeping and disaster management.
- More refresher trainings would be beneficial as books are poorly maintained in some sites. Further, many ESHG members seem to lack clarity on the purpose of the group, group norms, leadership, livelihoods etc.

Grading

- Majority of the groups are graded into A, B and C categories.
- While grading in many cases is done by HI, some are done by Partner NGOs and few by external agencies.

Savings, Inter-Lending, Loans and Repayment

- The average savings is Rs.30 per month; most groups received a seed capital of Rs.13500 but some groups could not get due to FCRA issues that surfaced in 2011-2012; only a small percentage of groups are actively engaged in inter-lending process but the overall amount of money lying in bank accounts show the lack of confidence and age-associated conservative nature of the groups with respect to taking loans and also reflects on the possibility of unexplored opportunities to invest in.
- Savings and Credit almost in the ratio of 1: 1 showing that there is not much return on investment accumulated.
- Inter-lending range anywhere from Rs.1000 to Rs.10000; an outlier of Rs.28000 is seen in one case where this amount is taken by one person.
- Most groups charge an interest rate of 2% but there are instances of 3% as well.
- Loans are taken to service different activities like agriculture and allied services, business, house repair, consumption, education, health and marriage needs etc. In some cases elders are also taking loans from outside sources like banks, cooperatives, by pledging jewellery, from money lender.
- Repayment norms have been evolved in some groups but not strictly practiced. In many cases, only interest is being repaid promptly.

G.Chandravathi 62 years - " I have taken a loan of Rs 3400/-from *RANI ESHG* for setting up business which gives me regular income of Rs.5000/-; my group is united and brings all our peer group together, I am planning to extend to clothes business with support from ESHG"

Livelihoods

- It is clearly evident that among the poor most elders work for living till serious physical and/or mental sickness reign upon them; the livelihoods they are engaged in range from agriculture, daily wage labour, dairy, goat rearing, poultry, artisanal occupations, running small businesses like tea shops, road-side hotels, selling fruits and vegetables, collection and processing of NTFP, domestic workers etc. Even when living with their children they are engaged in both household work and income generation activities. Only few elders particularly women spend their time at home taking care of grand children and doing household chores.
- Women are engaged in all varieties of livelihoods like men and in fact more diverse because they are also engaged in very small scale activities like going door-to-door and selling vegetables and brooms, domestic workers and works that can be done from home like mat weaving, leaf plate making etc.
- 'A' grade groups successfully invested seed capital in generating enhanced incomes on their livelihoods; Women have taken up alternative livelihoods in more numbers.
- Very limited collective business activities have been taken up though the scope is significant.
- There is a need to do livelihoods scoping and evolve participatory livelihoods plans.

Federations

10 federations of ESHGs are formed and only 3 are registered so far. These federations are in a very nascent stage and need lot of strengthening. With adequate and systematic handholding and nurturing ESHGs and their Federations can shape up into sustainable platforms for building integrated elderly care systems.

Profile of Federation: Swasakthi Vrudha Sahayaka Sangham
Partner: OCDS, Vemsur, Khammam district, Andhra Pradesh state

Swasakthi Vrudha Sahayaka Sangham is a ESHG federation formed by 7 groups (Vennela, Kranthi, Jyothi, Marymatha, St. Joseph, Gandhi and Santhi groups) from 3 villages. One member from each group constitutes the governing body of the federation.

Currently, the federation constitutes 3% of elders in these 3 villages. All the members are educated. The President of the federation is K. Devanand and the Secretary is S.K.Gousuddin.

The federation was formed with an objective to address the elder's problems. They conduct meetings once every month to discuss the problems of members and bring these problems to the notice of concerned officials for solution. No other group activity is taken up by the federation.

The expenses incurred for starting the federation were Rs.2000 and was shared by the president and secretary. No member ship fee is collected from the members. No savings are made in the federation. It does not have a bank account as well. Meetings are managed at the own cost of leaders.

Going forward the federation members desire to start savings in the federation so that they can open an account in bank and thus get the support from financial institution. In the member's opinion, the federation is a good platform to discuss the problems of elders and bring them to the officer's notice.

In general it is observed that though the federation is formed, the concept per se is yet to be completely appreciated by the members. Federation level trainings are needed both for the members and the leaders to on institution building and management, collective actions, collective livelihood activities.

Destitute Care

One of the critical directions of SaGP is to establish support system for the destitute elderly. In this context, two interventions – Old Age Homes and Commodity support through ESHGs have evolved.

Old Age Homes

Old Age Homes are functioning for more than two decades with support from philanthropists, local and institutional donors. This outreach of this intervention is 250 elders.

- Old age homes are no substitute to family living but within their purview are offering support services; recreation activities are limited; social interaction is confined to the boundaries of the institution. However, sometimes, outside community celebrates events with the old age home members.
- Old age homes are yet to reach out to the real vulnerable; the limited number of elders they service make them unviable on cost-front; some have unmet infrastructural needs.
- Alternative approaches like village level community-managed care centres can be explored.

Yesupadam, 95 years - " About 10 years ago, I joined in old age home, I have two sons who are employed in factory, but sad part is they never turned up to see me, the sisters and other group in old age home replaces this bondage and becomes a family for me"

Commodity Support

Commodity Support (commodity fund of Rs.10000 to establish grain banks to support the destitute) was provided through ESHGs. However, commodity fund has been utilised in different ways in ESHGs – Grain Banks, Margin Free Shops, Purchase of assets for ROI, commodity fund going into the regular revolving fund of the ESHG (and did not get utilized for any organized destitute care) etc. On an average, 2 destitute elders are being benefitted from the groups that received commodity fund.

The need for destitute care is strongly felt by all members of ESHGs but mechanisms to deliver the same are sporadic. This calls for some handholding support, mentoring and monitoring.

Grain Banks

Mahapatha ESHG, Bataguda, Odisha:

We have received 400kg rice and 100 kg dal under HI's commodity support for destitute elders. We distributed this among all of our 17 group members which need not to be repaid. In our regular monthly meetings of ESHG, each member saves 2 kg rice along with the thrift. We then distribute this rice among us in lean seasons or in festival seasons. It has provided us food security during lean periods. We are also helping one destitute woman from the rice collected.

Margin Free Shop

Karunambika and Mother Theresa ESHGs, Kothagudem, Khammam

A margin free shop was started on 19 October 2011 under commodity support. The shop carried all the essential items used by the members after taking monthly indent from them. The objective was to make essential items available to the members on credit at 2% interest and use the earnings from interest to support destitute elders. Initially the shop was run by the community animator also a Sister in the organization. However the interest collected was not used for destitute care. A decision was made by the animator along with the consent of the ESHG members to sell the items to non-members as well. However the non-members defaulted on payments and the shop was closed a year later. However the members are keen on reopening the shop and take over the management of the shop.

Assets

Rahabali group in Irpiguda, Kandhamal, Odisha purchased a mike set for income generation by custom hiring under HI's commodity support to the destitute. Income received from this commodity is supposed to be used for the care of destitute. The mike set is yet to be used.

Jankalyan group in Shivchak village, West Midnapore, WB purchased catering utensils set for income generation with an objective of providing support to destitute elders. They are hiring out the utensils at Rs.200 per day. For now the income earned is going into the ESHG account and destitute care has not been initiated yet.

Advocacy

Advocacy is a significant way forward where the elders in particular and community at large will voice the cause of the elderly.

- Issues like old age and widow pensions, ration cards, antyodaya cards, works under MGNREGA, aadhar cards, senior citizen cards have been demanded and nearly 50% of the elderly that demanded old age pension are now getting it, 45% are getting widow pension and more than 50% got ration cards; Elders checked up in NRHM's "Muskan" Camp for elders. Under this camp elders got free dental check-up and treatment to an extent.
- The celebration of International Day of Older Persons (October 1) marked the provision of services to the elderly persons, redress the grievances of the elderly persons particularly the Old Age Pensions, by the Guests of Honour (the officials).
- Still, planning on Advocacy as an agenda is missing. Partners need orientation on advocacy; many do not appreciate the concept of elders fighting for their own cause.
- On the other hand, elders are ready to leverage ESHGs to come together and demand their rights and entitlements. ESHGs should be nurtured as advocacy platforms to disseminate information pertaining to elders and positively influence the National Policy for Elders.

Day Care Centre

Observations from One Day Care Centre for Dementia affected elderly (HI's direct intervention):

- Day care centre creates a secured care system for the poor elderly and a peace of mind for their family members who inevitably have to go out for work.
- The centre creates an enabling environment for the elderly to recover or at least stabilize; two mild dementia patients have recovered completely and are working at the centre.
- The staff (ANM, Assistant, and Driver) provides family and community counselling services; and senior citizen associations, legal experts, medical practitioners support the cause.
- The intervention cannot be sustainable – it costs Rs.8 lakh per year to service 18 patients; but this intervention may serve as a model for government/CSR to take up such initiative.

Recreation and Pilgrimage

Recreation helps elders to rejuvenate themselves and overcome boredom. HI and partners have implemented this activity in different intervals in the three years. The Recreation activities are of two types - Daily recreation; and Pilgrimage or Heritage tours.

Daily recreation

The Daily recreation for the elders at Old Age homes was religious prayers, television and peer group interaction. Activities like bible reading and singing songs by students helped them connect with younger generation. At the community level, the elder's recreation is gossip, household chores, television and spending time with the grandchildren as well as spending time alone in leisure.

Pilgrimage or Heritage tours

Each of the implementing organizations on an average had taken two to three members from each group to 3-4 locations either within their district or outside the district for enabling the elders to enjoy, learn and build solidarity. This activity has brought visible impact in the lives of the elders, as happiness was visible in the discussions even now. These opportunities was a refreshing change for the elders and also the joy of visiting much desired religious places was seen.

Program Delivery

Broadly, the program components and program delivery of SaGP are designed as a part of HI's larger integration process with development and rights-based work.

Program Delivery and Management – Partners and Direct Implementation

Human Resources

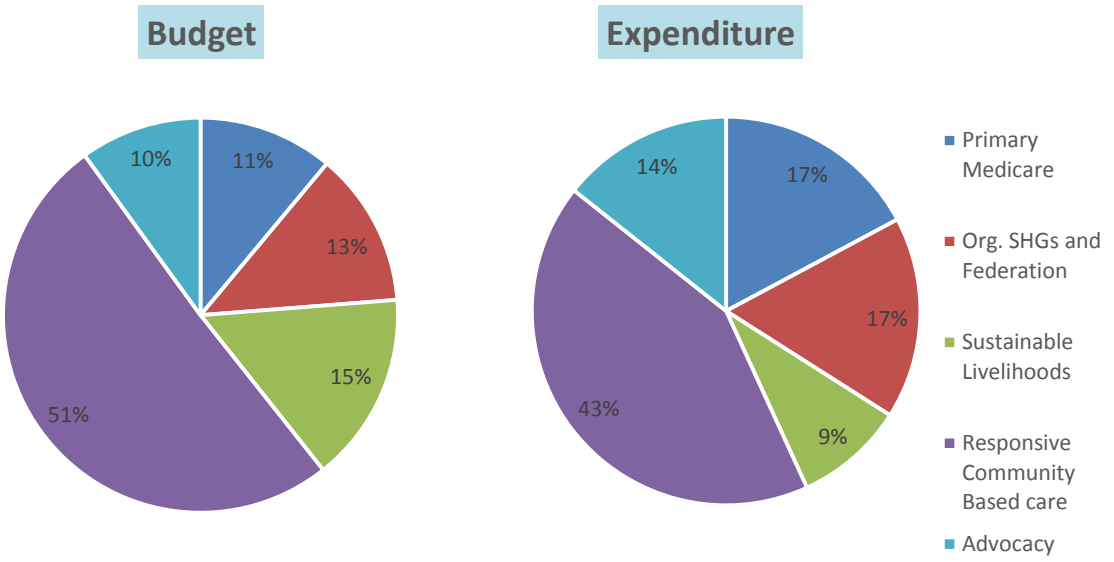
- HI's human resources worked on a mission mode with the agenda of health, ESHGs and care giving processes; this left little room for innovation due to time and space constraints; the capacities of staff are limited particularly in advocacy and livelihoods domains.
- HI's organization of cutting-edge staff – young professionals, development professionals and direct SaGP programme staff – spread out across the states with responsibility of a few partners – are not able to give quality time with the community of elders. They are drawn to service the SaGP through multiple layers of accountability. This could be improved with their direct link with HI's Head Office.
- Further, the programme staff have to increase their time being with, staying (including night stays) with and working with elders and with partners. At least 30-40% of their time has to be with elders and the remaining time with partners, except for programme meetings.

- Where the state coordination, programme management staff, cutting edge staff and partners have worked hand in hand, the results are more comprehensive. This working hand in hand needs to be improved.

Partnership Development and Engagement Processes

- HI staff and Partners were able to operationalise the program at the grassroots level by making few changes to suit the local context. Partner orientation switch from service delivery to development approach has not happened completely; partners' orientation on community participation and community ownership needs to be strengthened.
- The partners' strengths and abilities to access opportunities were limited in the given scale of operation. Within these limitations, program delivery broadly met the needs of HI.
- Limited knowledge of Partners and HI staff on advocacy did not take the program adequately forward in terms of rights-based approach.
- Delay in budget transfers hurt the delivery system; and partners were apprehensive on the utilization of revolving fund and inter-lending processes.

Effective Utilisation of Resources and Financial Resource Management



- Budget spent as per the stipulated provisions; healthcare and ESHGs effectively implemented; however, livelihoods scoping and planning could have utilised seed capital more effectively; commodity support could not fully fulfil its objective of destitute care.
- Some budget remained unspent under components like advocacy and destitute care. This is largely due to perceived lack of flexibility and insufficiently geared up skills of HI's direct implementation staff and Partners to take the agenda under these components forward.

MIS and Documentation

Management Information System (MIS) by HI is good. However, at various levels in general and at the partner level in particular inconsistencies are observed. There was no capitalization of lessons learnt on a periodic/yearly basis except at the end of the programme, after 3 years. Periodical capturing of outputs/outcomes would have helped HI to push for more programmatic changes amongst the partners who are at the end of the spectrum of realization of activities.

Cost-effectiveness of the Program

While some components of the SaGP are cost-effective, others are critical but not so cost-effective.

Health

- The average cost of medical care through stationary healthcare services including free drugs would come to Rs.60 per elderly if the total cost of stationary medical care is calculated. This model is cost-effective. This is a highly value-added service for elders especially when more or less all of them suffer from one or more types of non-communicable diseases.
- MMU is serving a useful need. Interviews with patients confirmed receipt of quality services/ care, improved physical fitness, and reduced incidence of diseases resulting in active ageing. On the cost-front, however, SMUs (CBHCs) are more effective than MMUs.
- Medical camps are cost-effective only when at least one medical camp is organised for a cluster of hamlets or small villages in a month. At least one follow-up check-up is necessary for elders with non-communicable diseases and other chronic health issues.
- CBHC-based physiotherapy is found to be more beneficial and serving the need. It has greatly helped in responding to the non-medical therapeutic needs of the elderly. On the other hand, camp-based approach, however, does not ensure continuity of treatment.
- The eye camps have significantly served the purpose of enhancing quality of vision of the elderly through helping with cataract removal surgeries.

ESHGs

With respect to formation and strengthening of groups, the achievements are commendable given the short project period of 3 years. 1375 ESHGs are formed, most of them trained and graded. However, there is a case of underperformance in utilizing seed capital to promote livelihoods of the elderly, due to inadequate understanding and absence of requisite skills in HI's direct intervention teams and partners.

Destitute Care

Elderly destitute care needs to improve its performance. ESHGs and Partners need intense orientation so that the commodity support is fully directed for the cause of destitute elderly. Community-managed local destitute care centre may be more cost-effective than old age homes as elderly do not feel removed from their familiar surroundings. Familiarity gives comfort in old age.

Advocacy

The planning on advocacy as an agenda was missing, in spite of the active elders in the respective groups. It is therefore important to evolve the needs and aspirations and to prioritize them. Strengthening ESHGs to voice the cause of elderly and networking with other institutions is critical and pursued as long-term agenda.

Program Delivery leading to Ownership and Sustainability

The program delivery is still in its early stages of building ownership of the community of elders, and graduating towards established sustainability. The level of trust for elders to come together and take ownership has taken more than 18 months time. In the year of the programme, the members have begun to come together in cohesive ESHGs and their federations. This foundation needs to be built on.

Conclusions and Way forward

HI's Sponsor A Gran Programme has moved from provisioning rations to service delivery to elders for elders and rights-based approach, as planned albeit in a small way. The investments planned and activities formulated were in health, destitute care and strengthening of the institution building process, of the Elders Self-help Groups, apart from some advocacy.

Under SaGP 2010-13, health care services in general are reaching out to the needy elderly. Their continuation is critical but some components of health services are not cost-effective. ESHGs have established themselves as platforms of solidarity and support and budding forums for collective economic activities and advocacy. Destitute care could improve its performance both in terms of quantity and quality, calling for some organized effort and capacity building of the delivery agents. Advocacy effort is not significant despite enormous need and scope. Interventions like old age homes and day care centres are significant but cost intensive. Separate attention to psychological counselling needs of men and women is missing in the interventions.

SaGP 2010-13 did not give attention to the gender aspects in general. SaGP organised elders, both men and women, separately or in mixed groups, without any specific gender attention. Women's longer life spans, men's tendency to marry women younger than themselves and widowed men remarrying more often than widowed women etc., make older women often more socially and economically vulnerable than older men. As disability rates rise with age, there are more old women than old men living with disabilities. Thus, a large percentage of old women are at risk of dependency, isolation, and/or dire poverty and neglect. Further, older women are working harder in families especially in their children's families for accommodation and food. Sometimes they are even paying the pension they receive to them. The older women are also taking care of their older men with more health problems. The women continue to play their gender roles till their death.

Program management and program delivery is commendable given the 3-year tenure of the project. However, there is a need to review and conclude partnerships with small number of beneficiaries for reasons of cost-effectiveness and significant demonstration of integrated model(s). HI and its limited partners need to arrive at shared vision, common perspective and team performance at the state/cluster level. There is scope to work on the orientation and skills of the staff and partners.

In this context of program performance, SaGP way forward during the next phase is discussed.

Way Forward

In its next phase, SaGP should continue its portfolio of Health, ESHGs, Community-based Destitute Care and Community-based Advocacy.

Health

- Build (elderly) community-managed healthcare including palliative care, physiotherapy etc.; initiate and run campaign on Generation Next Elders to care for present elders
- Build cadre of barefoot caregivers and geriatric assistants in rural and urban areas; train active elder para-interventionists (therapy initially) [could also be seen as an income generation activity]; improve animators' understanding of geriatric issues and care and ensure they getting continuous in-service training; dispense with camp-based physiotherapy and promote trained community physiotherapy interventionist at the village/local level.
- Popularize model quality primary healthcare services for elders, a la Patiala.

- Scale-up cost-effective SMU/CBHC model of healthcare primarily; operate MMUs only if sponsored and in areas unreachable otherwise but with significant elder population; evolve differential (for destitute and others) user fee models for both SMU and MMU.
- Ensure updation of patient card with treatment details at SMU/CBHC/MMU - e-Chikitsa is one option to take the same data into MIS with ease.
- Promote quality of life through grain banks (particularly in tribal areas), nutrition and calcium supplements to elderly in convergence with NRHM and other agencies.
- Scale-up linkage with government for IOL.
- Ensure medicine supply and immediate follow-up in the medical camps and in a consistent manner.

ESHGs

- Target and mobilize destitute and vulnerable elders in the village on a saturation basis but with flexibility in the group norms.
- Facilitate livelihoods scoping and livelihoods plans with freedom for elders to choose appropriate livelihoods activities; train partners to take up this agenda seriously.
- Bridge gaps in institution building, leadership, book keeping etc., with additional trainings.
- Ensure space in ESHGs for psychological and gender counseling processes - mixed groups are a blessing but beware that the old women are not burdened with more responsibilities.
- Facilitate ESHGs to help in building better relationships with families.
- Promote community polytechnic/college concept so that all kinds of back up services for maintenance & repair works could be available within reasonable distance and at reasonable price for promoting collective activities of ESHGs in a group of villages.
- Ensure several rounds of constant training and discussions on mutual help/support and the functioning of group etc.
- Pursue linkages with government rights and entitlements as a priority.

Destitute Care

- Promote family-based or at least community-based care of the elderly as a first priority.
- Encourage Institutions of Elderly and Local Community Institutions to care for the destitute elderly including meeting their food, health, hygiene and emotional needs.
- Leverage Pension, Antyodaya, Annapurna and other rights and entitlements for the destitute so that community care is institutionalized at the village level.
- Include care of the destitute elderly along with organizing and working with the working and assisted elderly, as part of the comprehensive eldercare in a village. Corpus and Commodity support in adequate quantities could ensure this.
- Where such care is not possible, take destitute elderly to 'A' grade state/private Old Age Homes; facilitate them to go back to their families/villages when they express such an urge.
- Advocate with states to start and maintain 'A' grade Old Age Homes in each district, with on par or better standards at Elders' Village at Cuddalore.

Advocacy

- Nurture ESHGs (and other community institutions) as platforms of advocacy for the rights and entitlements of the elders – towards all elderly getting old-age/widow/disability pension as appropriate; having ration cards and provisions under Antyodaya; getting works under MGNREGS where needed; and being part of group insurance. These are every elder's rights.

- Demand for increase in old age pension and any 60+ elders should get (both wife and husband) pension. Campaign for Universal Coverage.
- Campaign on IOL and link all elders to government IOL.
- Demand Bank Linkage for ESHGs.
- Demand Insurance including Funeral Insurance.
- Build and strengthen the movement Elders for Elders through saturation in existing geographical coverage first and build constituency of elders.
- Make policy efforts so that the government engages elders in NRLM/NULM.

Partnerships, Programme Management and Programme Delivery

- Saturate coverage of elders in the area of operation, with limited number of partners with support for a reasonably long period, say 5-6 years; limit partnerships based on criteria like outreach - minimum of 1000 elders through ESHGs. In any case, discontinue all partners with less than 100 elders and increase working with Elder Community as Partners.
- Establish demonstrable, replicable models of integrated elderly care in different regions; ensure each geographical region to have sizeable numbers for demonstration and visible impact; choose partners that can facilitate integrated community-based elderly care models.
- Facilitate user-fee-based village/locality-based elder care including medical care, palliative care, physiotherapy etc.; the user-fee itself could come from elders, their families, community or the state.
- Focus on empowerment and saturated inclusion rather than welfare. Welfare is to be part of accessing rights and entitlements from the family and the state.
- Build the knowledge, skills, attitudes and capacities of staff and that of the partners in integrated elderly care systems, including psychosocial facilitation, institution building, participation, governance, sustainability and community advocacy.
- Sensitize staff and partners on gender issues, mainstream gender in the program design.
- Evolve a clear strategy with partners for destitute care and advocacy with measurable activities; Build advocacy agenda for mainstreaming.
- Introduce community participatory identification of needy vulnerable elders and seeking rights and entitlements for them.
- Resolve FCRA issues and ensure seed capital to the institutions of elderly
- Involve partners in program development and beyond – entrepreneurship development, disaster management etc.
- Bring in specific expertise from outside – like legal aid, as per the community need.
- Encourage collaboration between 'Elders' community, community at large, civil society, government(s) and corporate; document the processes and share widely; build a consortium and/or coalition of implementation, knowledge and support partners for the cause of elders.
- Strengthen Management Information System that can track the target group and their institutions on an up-to-date basis.
- Facilitate and involve elders and their institutions in Management at various levels.
- Ensure that all this leads to and supports the movement – Elders for Elders.

The next phase of SaGP that takes the way forward as part of its design and implemented with diligence would improve on the good results that SaGP 2010-13 and shows ways forward for the country and its various flagship programmes with focus on elderly.

Annexure 1: SaGP Partners/Locations

#	Place	Partner/HI Direct Location	Beneficiaries
1	Tirupathi	Rashtriya Seva Samithi	300
2	Vizag	Organisation for Rural Reconstruction (ORRC)	130
3	Kovvur, Rajmundhry	Niranjana Old Age Home	173
4	Bapatla	Bethany Colony Leprocy Association	151
5	Gollapudi	St. Anthony's Health Centre - SAHC	293
6	Anantapur	St. Vincent de Paul Society - SVDPS	47
7	Kothagudem	OCD Service Centre for the Aged	213
8	Chirala	Mahila Mandali	110
9	Chintoor	Girijana Seema Welfare Association	295
10	Hyderabad	Women's Organisation for Managing Economic & Educational Needs (WOMEN)	330
11	Hyderabad	Human Action for Rural Development (HARD)	340
12	Ramayampet	Navajyothi Youth Club	413
13	Kaikaluru	Integrated Rural Development Society (IRDS)	460
14	Guwahati	Direct Implementation - Guwahati	267
15	Bihar Shariff	BHARTIYA JAN UTTHAN PARISHAD	115
16	Patna	BAPU SMARAK MAHILA CHARKHA SANGH (BSMCS)	105
17	Patna	DAUDNAGAR ORGANISATION FOR RURAL DEVELOPMENT	110
18	BEGUSARAI	BIHAR GRAMIN VIKAS PARISAD (BGVP)	108
19	New Delhi	CHETANALAYA	245
20	Siolim	St. Joseph’s Home for the Aged	24
21	Ahmedabad	Blind People Association	151
22	Baroda	Direct Implementation – Ahmedabad	100
23	ROHTAK	NAV YUVAK KALA SANGAM	110
24	Sonipat	Adarsh Saraswati Shiksha Samiti	103
25		Adarsh Gram Udyog Samiti	151
26	Kunihar	Society For Development & Environment Protection (DEEP)	650
27	Sirmour	Parvatiyan Jan Shiksha Avam Vikas Sangathan	98
28	Chopal	Manav Kalyan Seva Samiti (MKSS)	276
29	Sirmour	Society For Advancement of Village Economy (SAVE)	376
30	LOHARDAGA	LOHARDAGA GRAM SWARAJYA SANSTHAN (LGSS)	103
31	GHATSILA	BHARAT SEVASHRAM SANGHA (BSS)	108
32	Dharwad	Belgaum Diocesan Social Service Society	105
33	Mangalore	St. Joseph's Prashanth Nivas	138
34	Udayarpalayam	Dalai Lama's Central Tibetan Relief Committee, Dharamshala	193
35	Mysore	Rabgayling Tibetan Family Welfare Association	103
36	Mangalore	Abhaya Ashraya	75
37	Kottayam	Kottayam Social Service Society	365
38	Thiruvananthapuram	Cheru Resmi Centre	110
39	Ernakulam	House of Providence	112
40	Thrissur	St. Joseph's Home	92
41	Aluva	Association for Social Development - Suhruth Sadan	328
42	Ernakulam	Ernakulam Social Service Society	563
43	Indore	ADIVASI SEWASHRAM TRUST	208
44	Betul	Dayanand Sewa Ashram Sangh	210
45	Bhopal	Direct Implementation - Bhopal	100
46	Mumbai	Bandra East Community Centre	108
47	THANE	ADIWASI GRAM SEVA SANGH	178
48	AHMEDNAGAR	PRIYADARSHANI GRAMIN & ADIVASI SEVABHAVI SANSTHA	113
49	AURANGABAD	INSTITUTE FOR INTEGRATED RURAL DEVLOPMENT (IIRD)	513
50	AMBAJOGAI	MANAVLOK	333
51	NAGPUR	HOME FOR AGED AND HANDICAPPED	43

52	NANDED	SHRIMATI NARSABAI MAHILA MANDAL	108
53	Pune	The Poona Blind Men's Association	124
54	NANDED	SANDHI NIKETAN SHIKSHAN SANSTHA	368
55	MUMBAI	SOCIETY FOR HUMAN AND ENVIRONMENTAL DEVELOPMENT (SHED)	100
56	AURANGABAD	SOCIETY FOR EDUCATION IN VALUES & ACTION (SEVA)	120
57	RAYAGADA	UNIVERSAL SERVICE ORGANISATION (2011-12)	155
58	BHUBANESWAR	PEOPLE'S CULTURAL CENTRE (PECUC)	123
59	CUTTACK	VOLUNTARY ASSOCIATION FOR RURAL RECONSTRUCTION & APPROPRIATE TECHNOLOGY (VARRAT)	110
60	KANDHAMAL	BANBASI SEVA SAMITI	138
61	Rayagada (Bhubaneswar)	Direct Implementation - Odisha	268
62	Nurpur Bedi (Ropar)	Direct Implementation - Punjab	320
63	Ajmer	Rajasthan Mahila Kalyan Mandal (RMKM)	143
64	Bikaner	Direct Implementation - Rajasthan	125
65	Chennai	Share and Care Children's Welfare Society	338
66	Chennai	Mercy Homes Halls	33
67	Chennai	YWCA	138
68	Vellore	Karunya Community Development Centre	110
69	Suviseshapuram	Suviseshapuram And Neighbourhood Development Society (SANDS)	45
70	Palayamkottai	CSI - Tirunelveli Diocese Project for the Diasabled & Aged	44
71	Erode	St. Joseph Dispensary of the Society of the Sisters of the Destitute (day care)	95
72	Ooty	Lawrence Family Helper Project	228
73	Chennai	Don Bosco Beatitudes	43
74	Chennai	Guild of Service (Meals on Wheels)	573
75	Madurai	St. Charles Convent (Sneha Illam)	175
76	KK District	Association of Sisters of the Destitute Anpakam	120
77	Coimbatore	Direct Implementation – Chennai	320
78	Trichy	Grama Suyaraj	113
79	Kumbakonam	Holy Angels Convent	66
80	Trichy	St. Antony's Home for the Aged	75
81	Coimbatore	St. Joseph Home for the Aged and Destitute	69
82	Kanyakumari	Society of the Daughters of Mary St. Joseph's Province	533
83	Madurai	CSI - Mercy Home Madurai (Diocese of Madurai & Ramanad)	51
84	Gorakhpur	MANAV SEVA SANSTHAN "SEVA"	115
85	Hardoi	Gyanyog Charitable Trust	113
86	Lucknow	Tirupati Mahila Gram Udyog Kendra	110
87	Varanasi	Manav Sewa Kendra	103
88	Kanpur	Shramik Bharti	118
89	Azamgarh	All India Children Care & Educational Development Society	115
90	Meerut	Grameen Vikas Sanstha	118
91	Dehradun	YOUNG WOMEN'S CHRISTIAN ASSOCIATION OF INDIA, Delhi	63
92	Dehradun	Direct Implementation – Dehradun	100
93	HOOGHLY	MANDRA UNNAYAN SAMSAD	330
94	PURULIA	MANDRA LIONS CLUB	200
95	MECHEDA	NABARUN SEVA NIKETAN	330
96	KOLKATA	EAST INDIA CHARITABLE TRUST (Tollugung homes)	17
97	New Cooch Behar	New Bharti Club	150
98	Kolkata	Calcutta Metropolitan Institute of Gerontology	118
99	South 24 Pargnanas	Bani Mandir	320
100	Midnapore	Child & Social Welfare Society	341
101		Sir Syed Group of Schools (SSGS)	120