

Participatory planning of community-based approaches to healthy ageing



A guide for community-based organisations



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Contents

Acknowledgements	4
Common Terms and Acronyms	6
Section 1. Introduction	9
Section 2. What is healthy ageing?	15
Section 3. What are community-based approaches to healthy ageing?	21
Section 4. What is community mobilisation?	24
Section 5. Overview of participatory planning of approaches to healthy ageing	28
<i>Step 1. Prepare to mobilise the community.</i>	30
<i>Step 2 – Organize the community for action</i>	41
<i>Step 3 Explore the Health Issues and Select Priorities</i>	47
<i>Step 4 Preparation and facilitation of the 'plan together' workshop</i>	51
<i>Step 5. Act Together- Implement the Community Action Plan</i>	60
<i>Step 6. Evaluate together.</i>	63
Section 6. Partnership development and networking	72
Section 7. How to plan, conduct, monitor and evaluate advocacy.	84
Section 8. Older people's association's contribution to healthy ageing	94
Section 9 How to motivate and support community volunteers	98
Section 10. Additional community based initiatives to support healthy ageing	102
Appendices	106

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¹ How to mobilise the community for health and social change. (2003) Health Communication Partnership.
<https://resourcecentre.savethechildren.net/document/how-mobilize-communities-health-and-social-change-field-guide/>

Definition of Common Terms

Term/ Acronym	Definition
Accountability	Community representatives or groups can be perceived as structures that hold the government health system accountable for delivering quality health care services and for meeting the needs of communities. At the same time, representatives selected by the community are accountable to the communities whom they represent. They must therefore develop mechanisms to 'give account' to those they represent. In other words, health committees must provide feed- back to communities on how they carry out their mandate and what they achieve. They must also give reasons for why they do not achieve certain goals.
Ageism	Ageism refers to the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age. Ageism is serious form of discrimination that is everywhere and severely impacts older people's health, wellbeing, livelihoods and even their survival. It also increases older people's vulnerability to violence and abuse.
Approach	An approach is the course to be followed, in a broad sense. A method; technique or best practice.
Community development	Community development is a structured (organised) intervention where communities have greater control over the conditions that affect their lives. That is a process aimed at working with the community as they define their goals, prepare plans, mobilise resources and take action to address themes they have collectively identified.
Community mobilisation	Community mobilization is the process of engaging communities to identify community priorities, resources, needs and solutions in such a way as to promote representative participation, good governance, accountability, and peaceful change.
Empowerment	Empowerment is the interpersonal process of providing the proper tools, resources, and environment to build, develop, and increase the ability and effectiveness of others to set and reach their goals.

Good governance	<p>Good governance refers to the effective and responsible management of a group or organization. It involves principles such as transparency, accountability, rule of law, participation, and responsiveness to the needs of the people. In simple terms, it's about making fair and ethical decisions, ensuring that resources are used efficiently, and promoting the well-being of those being governed.</p>
Human Rights Based Approach (HRBA)	<p>A human rights-based approach (HRBA) is a model that places the principles and standards of human rights as central to all aspects of service planning, policy and practice. A HRBA has the following key elements:</p> <ul style="list-style-type: none"> - all key stakeholders are empowered and can participate in achieving the realisation of rights; - the rights promoted are explicitly linked to national and international human rights; - accountability is clear; <p>The most discriminated against, marginalised or excluded people are prioritised.</p>
Meaningful Participation	<p>Meaningful participation means engaging a diverse group of stakeholders who are representative of the communities that policies and programs will impact, not only in consultative roles to provide input, but also to co-plan or lead program development efforts, have access to data and resources to make informed decisions. When every member of a community has the chance, directly or through representation, to participate in the design, implementation and monitoring of community-level initiatives, there is a higher likelihood that the program accurately reflects their real needs and interests. The approach takes into consideration the different experiences, needs and capabilities of various groups in a community – women and men, youth and the elderly, persons with disabilities and the able-bodied, ethnic/religious/language minorities and majorities.</p> <p>Rather than “passive participation,” we aim to inspire “self-mobilization”, where communities organize and take initiative independent of any external actors.</p>
Personal agency	<p>Agency is the power people have to think for themselves and act in ways that shape their experiences and their lives.</p> <p>Personal agency is related to self-efficacy, defined as the belief we have in our abilities, specifically our ability to meet the challenges ahead of us and complete a task successfully.</p>

	Our belief in our own ability to succeed plays a role in how we think, how we act, and how we feel about our place in the world.
Strategy	A strategy sets forth the direction in which you move towards achieving a specific goal.
The Right to Health	<p>The right to health goes beyond access to health services to embrace 'a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment'.ⁱ</p> <p>A central component of the right to health is the right to the goods, facilities, and services necessary to support a person's enjoyment of the highest attainable standard of health. These facilities, goods and services must be available, accessible, acceptable and of good quality. The right to health also explicitly includes the right of populations to participate in all health-related decision-making.</p>
VOICE	Voice is about older people's ability to claim their rights, to make choices and to participate meaningfully in decision-making in all parts of their lives, including the personal, family, social and political.

Section 1. Introduction

Welcome to the participatory planning of community-based approaches to healthy ageing guide. In this section we will discuss:

- The aim of the guide and how to use the guide to support your planning for healthy ageing approaches.
- An overview of the current situation for older people in low- and middle-income countries, and the barriers they face to achieve healthy ageing.
- Why it is essential that groups of older people, community groups, organisations etc. participate in the design, implementation, monitoring and evaluation of community-based approaches to health ageing.

Who is the guide for?

This guide is for community-based groups working on healthy ageing related issues with communities in low- and middle-income countries, e.g., community-based organisations (CBOs) including older people's associations, older people groups, community health committees, national non-government organisations and community development committees.

What is the aim of the guide?

The guide provides guidance and tools to support the facilitation of an inclusive community mobilisation process for the design of community-based approaches to healthy ageing, that involves meaningful participation of community members, especially groups of older people, including those furthest behind. And promotes and supports their ownership of a process that is feasible and relevant to them, to help them achieve their right to experience healthy ageing.

How should we use this guide?

This guide is not intended to be prescriptive. You are the experts in your context. Ideally the design of community-based approaches should come from the community, with technical support from external stakeholders as required. The guide is a resource with information and tools related to healthy ageing. The main body of the guide provides an outline of a community mobilisation process, general principles, and examples of helpful methods and tools. You can pick what is relevant and adapt it to your context. The most important principle of the mobilisation approach is that it is inclusive and includes representatives of diverse groups of community members.

Particularly the people who are furthest behind in achieving their right to health and wellbeing.

Each community is unique, and your approach will be guided by the context, experiences, individual capacities; community strengths and resources available from the community and externally, human resources, in kind contributions, and budget. By working together within your community, and leveraging the strengths of external stakeholders, it is possible to make progress towards healthy ageing.

The first step is to review sections of the guide and select what is useful. Adapt the process and tools to fit with your local context. Many community-based organisations will already be experienced in community mobilisation methods, others may just be beginning to bring community groups together around healthy ageing issues. Start as small or big as feasible, gradually build on your experience and increase your ambition.

What is the situation for older people's health and well-being?

Millions of older people, particularly those living in low- and middle-income countries are missing out on experiencing healthy ageing. Many older people are invisible, and their voices are unheard. They are among the groups who are furthest behind in being able to achieve their right to health and care, to access services they need, to have their voices heard, and to meaningfully contribute to decisions on issues that impact them. One of the main causes of older people being left behind is the persistent forms of discrimination they face including ageism.

A key principle of the Sustainable Development Goals (SDGs) is to "leave no one behind." It is widely acknowledged that the SDG health goals cannot be achieved unless we can reach the groups of people who are furthest behind, in the places where they live, to meaningfully engage them in actions to achieve their right to health, care and wellbeing. And to combat all kinds of discrimination they face and reduce inequality and exclusion.

Our world is rapidly ageing. It is forecast that by 2030 the global population will include 1.4 billion people aged 60 years and over, with approximately 70% of older people living in low- and middle-income countries. People's longer lifespan is to be celebrated. The diverse roles, skills and experience of older people contribute in multiple ways to their families, communities, and societies. Yet the extent of their contributions depends on their health. Our health is influenced by the cumulative advantages or disadvantage we experience across our life cycle. This is visible in the inequity found among older people groups, with wide differences in health status and longevity between different social and economic groups, and individual older people. For many older people a longer life span does not necessarily mean that their extra years of life will be lived in good health.

With the increasing numbers of people living longer, there is also a shift in disease patterns, with an increased prevalence of non-communicable diseases (NCDs), disproportionately affecting older people. In 2023 non-communicable diseases contributed to 74% of all global deaths, and 86% of all years lived with a disability. Of all NCD deaths 77% occur in low- and middle-income countries. The most common NCDs are cardiovascular diseases, chronic respiratory diseases, cancers, diabetes, mental health and dementia. Often people will be affected by multiple NCDs. The good news is that with appropriate actions from governments, society and individuals most NCDs are preventable.

With the increased need for NCD prevention and long-term management of people living with NCDs, health care systems must adapt to be able to meet the

needs of an ageing population. This includes concerted action by global, national and multi sector stakeholders to fulfil their commitments to achieve universal health coverage, including considerably strengthening the quality of primary health care services.

Currently, the global community is mostly unprepared to meet the health and care needs of the older population by providing age-friendly, inclusive health and care services and creating a conducive environment to support older people to achieve healthy ageing. This is particularly vital for the large percentage of older people who live in low- and middle-income countries, where governments already face challenges to provide basic health and care services to their population.

Additionally, older people face multiple barriers to accessing the health and care services they need, including inadequate quality and range of services; a lack of essential medicines, vaccines and equipment; inadequate number of health staff and lack of competencies to manage the needs of older people; limited access to assistive technology; barriers to travel to health facilities due to poverty, lack of health insurance coverage, inadequate roads, insufficient transport services, inaccessible facility infrastructure; limited community outreach services and scant availability of health information.

Another pervasive barrier faced by older people is ageism. Ageism refers to stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards others or oneself based on age. Ageism is a serious form of discrimination that is everywhere and severely impacts older people's health, wellbeing, livelihoods and even their survival. It also increases their vulnerability to violence and abuse. Ageism is defined as having unfair and untrue beliefs about people or discriminating against people based on their age.

Discrimination is the unfair treatment of people and groups based on their characteristics such as age, race, gender, socio-economic group; sexual orientation etc. Many older people are affected by multiple layers of discrimination e.g., an older person can also be, poor, older female, widowed, unemployed, living with a disability and belonging to a minority group. Older people can be affected by two types of ageism, systematic and self-directed ageism. Systemic ageism is the ways in which sections of society, including individuals, institutions, laws and policies work together to sustain ageist attitudes, actions or language. Self-directed ageism is when older people 'take to heart' negative attitudes to ageing they experience from others. They may then start to have self-doubt and develop a negative perception of themselves such as believing they are a burden, or that they are worthless in their community. This can result in poor self-esteem, a lack of confidence to participate in their community, loneliness and mental health issues.

Why is it important for communities to take action for healthy ageing?

To make lasting progress for older people's health and wellbeing older people must be meaningfully involved as equal partners in the design, implementation and evaluation of actions related to healthy ageing. Acknowledging the rights of older people to participate and leveraging their strengths such as their local wisdom, knowledge and lived experiences will increase the relevance, feasibility, ownership and effectiveness of community-based approaches to healthy ageing. Older people do not want to be passive onlookers, they are heavily invested in healthy ageing. They do not exist to be 'done to' or 'looked after'. They want, need and have the right to be active participants in their own health and care decisions, to be able to voice their needs, share their priorities and contribute their experience, to improve their health and wellbeing, and benefit their peers, their community and beyond.

Older people do not live in a vacuum. Their lifestyle choices, roles and interactions within their community and how their community perceive, treat and include them has a huge influence on their health and wellbeing. Communities thus have a powerful influence on their members health and wellbeing. When diverse groups of the community come together, they create real strength and resilience. Communities who work together with older people to improve their health and wellbeing, not only benefits the current generation of older people but also future generations, and positively impact their community development, prosperity and members wellbeing.

A good indicator of a strong and cohesive community is when an older person in the community no matter what their socioeconomic status, age, gender, ethnic group and physical and mental health status can confidently say they enjoy wellbeing.

The key underlying principles of the community mobilization process for healthy ageing will be discussed in more detail in other sections of this guide. Three non-negotiable principles are:

- Ensure that older people who are the 'furthest behind' to achieve healthy ageing are meaningfully engaged in the community mobilization process by intentionally identifying them, reaching out to involve them, and reducing the barriers they face to participate.
- Apply a right-based approach including promoting an inclusive and equitable approach to ensure older people's right to participation, accountability, non-discrimination, equality empowerment and legality.

- Prioritise strengthening the capacity and confidence of older people to claim their rights, to make choices and to meaningfully participate in decision-making in all parts of their lives, including the personal, family, social and political (guided by the HelpAge Voice Framework).

Section 2. What is healthy ageing?

In this section we will:

- Define healthy ageing and discuss why is important for everyone.
- Discuss the social determinants of health and their influence on healthy ageing.
- Review why UHC and Primary Health Care are essential to healthy ageing.

What does healthy ageing mean?

Healthy ageing is about maximizing our ability to enjoy wellbeing in later life and to continue to do the things that matter most to us. Being free of disease or disability is not a requirement for healthy ageing, everybody can experience healthy ageing. Even if we have one or more health conditions, when they are well-managed, they have little influence on our wellbeing. Things that matter most to us usually include:

- ✓ Being able to meet our basic needs.
- ✓ Continuing to learn, developing our knowledge and skills, and making our own decisions.
- ✓ Being able to stay mobile (ability to go where we want to)
- ✓ Continuing building and maintaining our relationships
- ✓ Contributing to our families, community, and society.
- ✓ Being respected, listened to, maintaining our self-esteem and dignity, and being included.

Our ability to enjoy healthy ageing is influenced by our physical and mental abilities and the environment in which we live, and how these interact (functional ability). Our environment is made up of all the elements of our home, our community, and our broader society. It includes the infrastructure, people and relationships, attitudes, and values we and others around us hold, and the systems and services that support us throughout our lives. These are called the social determinants of health. They have a huge influence on our health, and wellbeing throughout our life.

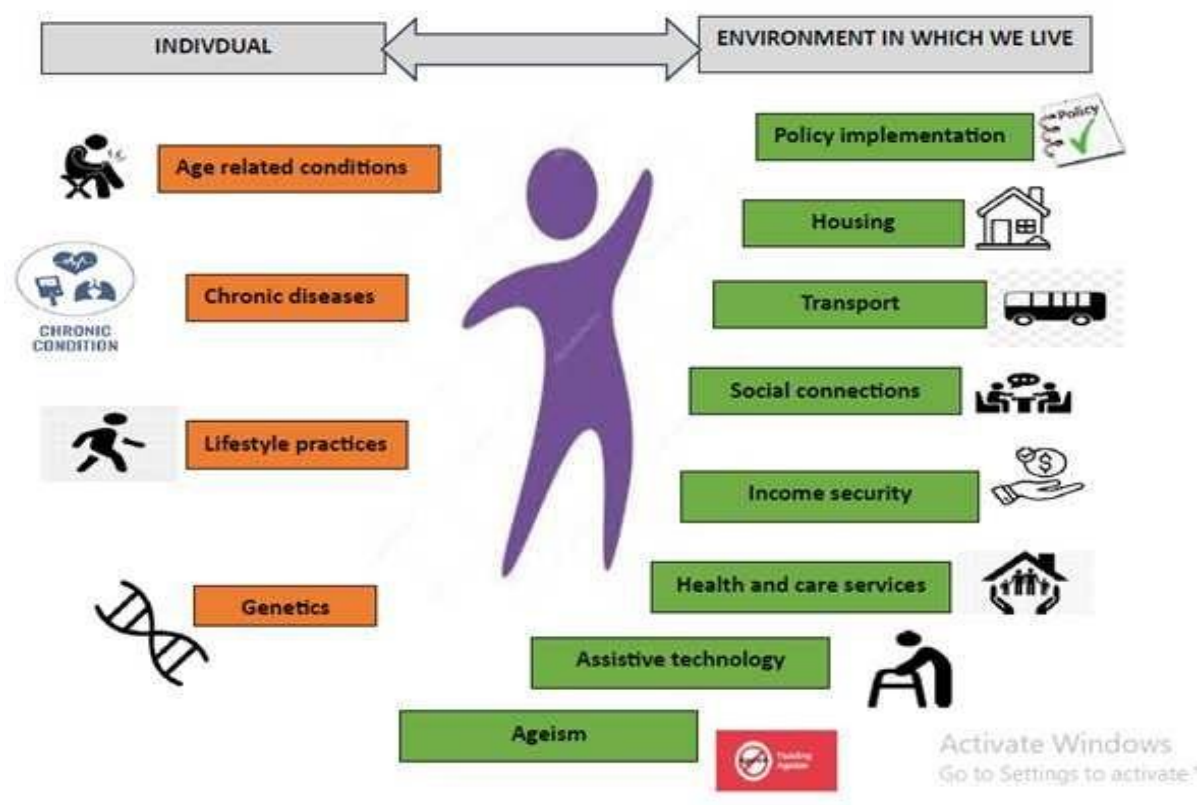


Figure 1 Healthy ageing depends on a person's physical and mental capacity and how these interact with the environment in which the person lives.

Ageing does not suddenly happen overnight or when we reach the age of 60 years; it is a lifelong process throughout all the phases of our lives. Healthy ageing is important to us all, no matter what our age. We can help preserve and strengthen our physical and mental health, independence, mobility, and mental health as we pass through each phase of our life, by maintaining or adopting healthy lifestyle choices; practicing good self-care; maintaining our relationships; staying engaged in our communities; continuing to be lifelong learners and developing ourselves.

Health and wellbeing is greatly influenced by the effects of the cumulative advantages or disadvantage that we experience across our life cycle by things like diseases, injuries, or general age-related changes. As we age, we continue to have changing needs according to our physical and mental capacity and the environment we live in. E.g., the health and care needs of a 60-year-old may be vastly different from those of an 80-year-old. Conversely, it could be that an 80-year-old has better physical and mental abilities than a 60-year-old, or even a much younger person. Older people are as equally diverse as the general population.

For people to achieve their right to health and enjoy healthy ageing, they require access to a continuum of services that meet their specific health and care needs according to their health status, e.g., health promotion, counselling, early detection and management of diseases, chronic care services; specialist services such as eye care, rehabilitation, and assistive devices; long term care and support and end of life care. These services need to be people centred and available, accessible, acceptable and of good quality. Government's commitment to achieve universal health coverage for all is integral to the achievement of healthy ageing.

No matter who we are, regardless of our social or economic status, place of residence, age, gender, ethnicity, or health status we have the equal right to achieve the highest attainable standard of physical and mental health without discrimination, and to have equitable access to the facilities, products, information, and services that we need for our health and wellbeing. We also have the right to meaningfully participate and have our voices heard in decisions about health and care services in our local area and beyond.

What is universal health coverage?

Universal health coverage (UHC) means that all people everywhere have access to the full range of good quality, people centred, health services, that they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services across the life course. In addition, the SDG leading principles include the need to leave no one behind, and to reach the people furthest behind first. Groups of older people in each community are invariably among the people that are 'furthest behind' for a variety of reasons discussed in the introductory chapter. Protecting people from the financial consequences of 'out of pockets spending' to cover the cost of health services, reduces their risk of being pushed into poverty. Research has shown that older people are very vulnerable to out-of-pocket spending on health care.

UN Member States Recommitment to Increase Efforts to Achieve UHC 2023

A 2023 UN review of progress on UHC showed that the world is off track to achieve the SDG health targets by 2030. Millions of people are still unable to access the health services they need. Out-of-pocket spending on health continues to seriously affect over 1 billion people, pushing hundreds of millions of people into extreme poverty.

Failure to achieve UHC is having a disproportional impact on older people. At a high-level United Nations meeting in September 2023 global leaders, representatives of states and governments reaffirmed their commitment to accelerate progress to achieve their UHC commitments.

The 2023 UN high-level meeting's political declaration on UHC was approved by member states with a strong re- commitment to increase efforts to achieve UHC. Point 60 in the declaration explicitly addresses older people and healthy ageing;

" Scale up efforts to develop, implement and evaluate policies and programmes that promote healthy and active ageing, maintain and improve quality of life of older persons and to identify and respond to the growing needs of the rapidly ageing population, especially the need for continuum of care, including promotive, preventive, curative, rehabilitative and palliative care as well as specialized care and the sustainable provision of long-term care, including home and community care services, and access to assistive technologies, taking note of the proclamation of the United Nations Decade of Healthy Ageing (2021-2030), reaffirming the importance of extending universal health coverage to all older persons."

Why is universal health coverage vital to achieving healthy ageing?

Achieving UHC is a key target the global community committed to achieving during the adoption of the 2030 Sustainable Development Goals (SDGs) in 2015. The commitment of governments to achieve UHC as part of the Sustainable Development Goals (SDGs) aligns directly with their duty to respect, protect and fulfil all people's right to enjoy the highest attainable standard of physical and mental health, which is indispensable for the exercise of our other human rights. Making progress towards achieving UHC for everyone, is essential to achieve healthy ageing, and for delivering social and economic development and building resilient and equitable societies.

What role can communities and civil society organisations play to achieve universal health coverage?

To achieve UHC countries need to achieve equitable, strong and well managed health systems that are situated close to the communities they serve.

Strengthening primary health care (PHC) is an effective and affordable way to make progress for UHC. Not everything can be achieved at once. Each country will need to strategise about how to achieve UHC based on the needs of their populations and their resources. Investing more in PHC ensures that the populations needs are identified, prioritized and addressed in a holistic and integrated way; that the PHC health care workforce are well trained, equipped and supported; and that governments, service providers and government multi sector managers at all levels work together with their communities. Addressing the specific barriers faced by the people and groups that are furthest behind to achieve their right to health, including groups of older people need to be prioritised.

Governments need to be accountable and transparent to the population about progress towards UHC. Civil society is well placed to complement the role of the government to access, engage and prioritise the 'furthest behind' groups. Civil society is a critical voice to ensure that people have the necessary access to equitable health services; that people are informed of their rights and are aware of their countries' health policies and plans, and that they can meaningfully engage at the local level and link to sub level and national level efforts to provide inputs into their country's health systems strengthening efforts.

Communities including older people benefit from partnering and working in close collaboration with a network of local and national civil society organisations to jointly monitor progress for UHC and hold the government accountable, and to provide inputs into planning for strengthening the quality and range of services that meet the needs of older people in their area.

The SDG goals have established targets and indicators to measure progress on UHC. The two global indicators used to measure progress are coverage of essential health services (SDG 3.8.1) and catastrophic health spending (and related indicators) (SDG 3.8.2).

Why is primary health care the cornerstone of UHC?

The World Health Organisation recognises primary health care as the cornerstone to achieving UHC and recommends governments refocus and ramp up their efforts to increase their investment to strengthen the primary health

care (PHC) approach. Most (90%) of essential UHC continuum of care services can be delivered through a PHC approach.

Primary health care is the provision of essential preventive, promotive and curative health care services, including community health care services that are universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain. Primary health care forms an integral part of the country's health system and is a core contributor to the overall social and economic development of the community. It is the first level of an individual's contact with the health system. Providing the population with health care as close as possible to where they live and work. The key principles of primary health care are inclusion, equity, community participation, intersectoral participation and appropriate technology. The involvement of individuals, families, and communities in the promotion of their own health and well-being is an essential component of primary health care. Importantly, inclusive PHC coverage cannot be achieved without the engagement of the community, including all groups of older people, in the planning, implementation and evaluation of health services.

(See appendices for links to resources and tools for taking action to achieve UHC)

#	Useful resources
2.1	Help Age Healthy Ageing- and introduction slide set
2.2	A human rights approach to healthy ageing – slide set
2.3	Healthy ageing, UHC and access to services for older people
2.4	HelpAge International UHC Strategy

Section 3. What are community-based approaches to healthy ageing?

In this section we will discuss:

- What are community-based approaches to healthy ageing?
- The underlying principles of community-based approaches
- Examples of activities that could be included in the design of a CBA approach.

Community-based approaches (CBA) to healthy ageing are 'bottom-up interventions' to achieve results for healthy ageing. The actions happen at the community level where people live, involving groups of older people and other key stakeholders, to catalyze action around healthy ageing issues that matter most to them; and facilitate their meaningful participation in addressing them.

The overall goal of community-based approaches (CBAs) to healthy ageing is to improve the health and wellbeing of older people, particularly those who are furthest behind. How the goal will be achieved is decided by the community groups. The underlying aim is to empower communities by building their capacity and leadership to manage sustainable, community-owned approaches to healthy ageing. The CBA approaches selected are unique to each community, depending on their priorities and resources; guided by human rights principles, policies, and practices, and informed by evidence of what works. Technical inputs and resources will be sought as required via the community group's partnerships with a variety of key stakeholders.

Key principles underlying the design of community-based approaches are:

- ✓ To work with community groups particularly groups of older people who are furthest behind, to design an approach that is sustainable, using initial resources from the community and outside resources to put in place sustainable systems and structures.
- ✓ Community-based approaches promote a 'whole of society' collaboration to achieve healthy ageing, leveraging the potential of intersectoral collaboration, private sector and health information and communications technologies (ICT).
- ✓ Recognize the diversity of older people and avoid stereotyping, prejudice and discrimination based on age and any other grounds, and ensure the inclusion of all groups of older people, irrespective of age, sex, gender identity, ethnicity, religion, level of ability, location or any other characteristic; ensuring non-discrimination and equity in participation of

the design of services, to have their voice heard, and to access to services (prioritises reaching those with the greatest needs first).

- ✓ Governments as duty bearers are responsible for delivering health and care services that ensure that their populations achieve their right to health. Community-based approaches do not aim to replace the work of the government but rather collaborate with and complement the government's work. Community groups working on healthy ageing will hold governments accountable to ensure the right to health for all people, including the availability, accessibility, acceptability (physical and financial) and quality of health and care services. And to ensure that older people are treated with dignity and respect and without discrimination.
- ✓ To advocate for health and care systems to adopt a person-centred approach, which recognises older people as participants as well as recipients, placing them at the centre of decision making about their health and care. And to increase the linkages between health and care systems, services and communities, to enable the provision of a more holistic continuum of care.
- ✓ To advocate for data disaggregation and analysis to support an inclusive design, implementation and evaluation of healthy ageing interventions (sex, age, disability, disaggregated data (SADDD- minimum standard), and considers other factors which may influence inclusion and exclusion such as location, socio economic status, ethnicity, education etc.

Example of activities that may be included in community-based approaches:

- Advocacy on areas related to healthy ageing such as UHC and health system strengthening for PHC services. Linking with advocacy efforts and groups at local and national level.
- Health promotion and health education.
- Capacity building for self-care skills, internet technology etc.
- Physical exercise groups.
- Basic community health screening, including for non-communicable diseases.
- Peer support groups.
- Intergenerational activities.
- Intersectoral interventions to address air pollution, gender equity, nutrition, income generation, environmental impacts etc.
- Mental health and psychosocial support groups
- Social and culture events for older people to alleviate loneliness and isolation.

- Home-based care services for people with long term care and support needs,
- Strengthened linkages, coordination and communication between health and care service providers and the community e.g., a formal two -way referral system; and holding government accountable via establishing 'community score card intervention' and / or and community monitoring groups.

#	Useful resources
3.1	Community based approaches to healthy ageing SANA Brief
3.2	SUNI -SEA Policy Brief Digital technology for community-based approaches
3.3	Community based approaches to healthy ageing resource package 1. Self-Care Guide, 2. Facilitators Guide 3. Community Volunteers Training Manual,

Section 4. What is community mobilisation?

In this section we will discuss:

- What is community mobilisation?
- The key elements and benefits of community mobilization
- The role of external organisations for supporting community mobilisation

Community mobilisation is a process of motivating communities to organise in a cohesive group to meaningfully participate in a sustained process towards achieving a goal that is important to them. The essence of community mobilisation is community ownership, capacity building and empowerment. It is a process through which diverse groups of stakeholders including individuals, groups, civil society organisations and government staff work together to plan, implement, monitor and evaluate activities to achieve their goals.

The sustainability of social change is more likely if the individuals and community groups most affected by the issue own the process. Community mobilisation should be empowering, giving a voice to the most unheard members of the community and be biased towards the local inputs and ownership. Communities should be the agents of their own change. Emphasis should shift from persuasion and the transmission of information from outside technical experts to support for dialogue, debate and negotiations on issues that are most important to the community.

Emphasis on the communities planned outcomes should shift away from changing individual behaviour, to changes in social norms, policies, culture and the supporting environment.

Community mobilisation not only helps people improve their health and wellbeing but strengthens and enhances the ability of the community to work together for a goal that is important to them. The result of a successful community mobilisation effort is not only a “problem solved” but the increased capacity of the community to successfully address other community needs and future initiatives as well.

What are the key elements of community mobilisation?

- Community mobilisation is an approach to define and put into action the collective will of the community, rather than a mechanism to achieve community consensus for externally defined objectives.
- The mobilisation process should unfold at a pace according to what the community decides is feasible for them.
- Outside supporters should aim at strengthening the capacity of communities rather than leading in delivering interventions and services. The external organization's role should be to sensitise, mobilize, and build capacity. Outside supporters can help catalyse the process but neither they nor funding agencies should dictate what specific activities communities eventually decide to undertake.
- The timing of outside support is crucial. Bringing in outside resources before a community begins to take action through internally generated resources, is likely to be detrimental to local leadership, ownership and responsibility.
- Community committees or groups that can mobilise their community to carry out the plan will be the strongest and have the most potential to sustain motivation in the long run. A community group that assumes responsibility for addressing issues on behalf of its community is likely to burn itself out.
- External organisations can bring important resources to the community such as technical expertise; outside perspectives that may be lacking in the community; broader experience on the issues being addressed; financial resources or links to groups, institutions or resources.

Benefits of community mobilisation:

- Communities can generate and contribute valuable additional resources that may not be available to the health system or other government departments alone.
- Communities have learned how to be powerful advocates to improve services.
- Empowering communities has strengthened their ability to address many of the underlying causes of poor health and lack of wellbeing.

- Community mobilisation has helped to facilitate changes in social strategies, structures, and norms to increase the participation of people who are often left out of decision-making and increase their access to information and services to reach those who most need it.
- Community mobilisation has increased community members' awareness of their right to decent treatment and has strengthened their ability to claim this right.
- In short, community mobilisation builds confidence. And when communities start believing in themselves, they become inspired to take action.

What is the role of external organisations?

- In some cases, community mobilisation is prompted and carried out exclusively by community members. More often, however, mobilisation is a collaboration between the community and one or more external organisations, which may be local, national, or international, governmental or the private sector. In many cases, an outside organisation is the catalyst for the community to take action.
- One of the most challenging areas of community mobilisation for external organisations is to define and agree on their specific roles and responsibilities and how to work with the community at the beginning of the community mobilisation process. The role of external organisations may include:
 - facilitation and accompaniment
 - capacity building
 - linking communities to resources and experience from other areas
 - helping to ensure equitable, inclusive and genuine participation of community members especially those most affected by healthy ageing issues
 - developing and maintaining trust and an open and ongoing dialogue between community and other partners
 - creating or strengthening community organisations that work on community health issues.
 - assisting in creating an environment in which community individuals can empower themselves to address their own and their community's health needs.
 - working in equal partnership with community members.

External organisations roles should not involve deciding for the community what is best for them.

In the next section we present an outline of a community mobilisation process with links to tools, that can be adapted according to your context, and the priorities of the community you work with.

Section 5. Overview of participatory planning of approaches to healthy ageing

#	Step	Activities	Time
1	Prepare to mobilise the community	<ul style="list-style-type: none"> • Identify priority health issue and the communities. • Form a community support team. • Gather information. • Identify resources and constraints. • Draft a community mobilisation plan. • Prepare the community support team 	2 weeks
2	Organize the community for action	<ul style="list-style-type: none"> • Increase community awareness about healthy ageing. • Invite community participation. • Identify and develop a 'core community group' 	2 weeks
3	Explore the issues and select the priorities	<ul style="list-style-type: none"> • Decide on objectives for this step. • Explore the community's health issues. • Analyse the information. • Select priorities for action. 	2 weeks
4	Preparation and facilitation of the 'plan together' workshop	<ul style="list-style-type: none"> • Decide the objectives of this step. • Select the workshop participants, roles, responsibilities. • Design the planning workshop. • Facilitate the development of the action plan 	1 week
5	Act together	<ul style="list-style-type: none"> • Define the support team's role for community action. • Monitor progress • Conduct ongoing capacity strengthening for core group. • Monitor community progress. • Problem-solve and mediate conflicts 	2- 3 years

6	Evaluate together	<ul style="list-style-type: none"> • Determine the focus of evaluation. • Form an inclusive evaluation team. • Develop an evaluation plan and tools. • Conduct the evaluation. • Analyse the results. • Provide feedback to the community. • Disseminate results, learning and recommendations. • Adapt/ update the community action plan according to the evaluation findings 	4 weeks
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Step 1. Prepare to mobilise the community.

In this section we will discuss how to:

- Identify the health issue and community.
- Form the community support team.
- Gather information.
- Identify resources and constraints.
- Develop a community mobilisation plan.
- Prepare the community support team for community mobilisation.

➤ Identify the overall goal:

- From the beginning it is important to identify a well-defined goal. The goal will steer a clear direction through each step of the community mobilisation process. This guide is focused on community action for healthy ageing, the overall goal is - 'to improve the health and wellbeing of older people particularly those who are furthest behind.'
- How to achieve the goal (objectives, inputs, activities etc.) will be decided by the community during the process. The goal will also be further refined as you move through the steps. The goal should be specific, measurable, achievable, realistic, and timely (SMART goal).

➤ Select the communities to work with:

- Your first impulse might be to select communities that have the biggest needs first. Consider starting small with a 'stronger' community you have experience working with. This will make it easier to trial the approach and make timely adaptations.
- It is vital to achieve meaningful participation of diverse groups and those furthest behind. Research indicates that to have a greater chance of forming alliances and having their voices heard, the most marginalised (furthest behind) people need a representation of at least 35% of the participants. Consider the community environment for participatory approaches when selecting your target communities. Will it be feasible to achieve 35% representation of the furthest behind groups?
- Consider the extent of the health issues and barriers faced by for older people, the political support, existing policies and plans, and the available human and

financial resources within the community. Consider the socio-cultural context e.g., values, beliefs, attitudes, and practices related to ageing issues that may facilitate or prevent participation.

- Consider your group/ organization's capacity, resources, and time available. Will you start small in one community or cover several communities? Who are the key stakeholders and existing networks in this area that you can work with? Is there good all-year-round accessibility to the community?

➤ **Form the community support team:**

- Form a support team. Their job is to accompany the community throughout the mobilisation process.
- This team may consist exclusively of members from your organisation or depending on the gaps in their skills and experience, you require to include members of partner groups or other stakeholders.
- Consider your team, who is available, and has the experience needed? What budget is available?
- Most important is the team member's personal attributes: a commitment to participatory approaches and ownership by the community. Community mobilisation skills can be developed or strengthened via ongoing mentoring or other capacity building approaches.

Mix of skills required for community mobilisation:

- ✓ Experience working with older people / healthy ageing approaches.
- ✓ Public health or social services background
- ✓ Understanding of the local context
- ✓ Basic mobilisation skills i.e., communication and facilitation skills,
- ✓ Program/ project design, and project management skills
- ✓ Experience with adult education methods, and capacity-building skills
- ✓ Experience using a variety of participatory methods.
- ✓ Personal attributes, such as openness, flexibility, patience, good listening skills, belief in people's potential.
- ✓ Fundraising, management of resources.
- ✓ Report writing/ record-keeping/book-keeping.
- ✓ Basic, planning, monitoring, and evaluation skills
- ✓ Conflict resolution skills

➤ **Gather information about the community and situation of groups of older people:**

- You will likely already have a lot of available information. It will be helpful to consolidate the information in an easily accessible summary format such as an excel sheet.
- Review the information to identify information gaps. Information about the community is essential for the next step to draft the community mobilisation plan.
- The mobilisation plan will guide your mobilisation process. It will also be useful for fund raising.
- The below table is an example of information that will be helpful.
- The extent of your information gathering depends on information gaps, time available and your resources. As much as possible use secondary data at this stage. Conduct a few key informant interviews for more in-depth information (e.g., community leaders, community health volunteers; local government health manager; older people associations leadership); and one or two focus group discussions with older people.
- If you are planning conducting community mobilisation in multiple communities and have budget for data collection, consider hiring a local consultant to conduct a survey to collect more in-depth information about older people across several communities (such as the 'Health Outcome Tool').

Category	Details	Source of information
<p>National laws, policies, strategies and plans.</p> <p>What periods do they cover?</p>	<ul style="list-style-type: none"> - Human rights framework related to older people? - National laws, policies, strategies or plans on ageing and older people? - National plan for healthy ageing? - National health strategy? - UHC strategy or plan? - PHC strategy or plan? - National health insurance policy? Are older people covered? What services are they covered for? 	<p>Government health administration offices at provincial or district level.</p> <p>Government social services departments.</p>
Demographics	<ul style="list-style-type: none"> - Total population? - Total number of households? - Population disaggregated by sex, age, disability? - % of poor families? - % of male and female older people over 60 years 	<p>Local administration records</p> <p>Community leader register</p>
Sociocultural context	<ul style="list-style-type: none"> - Administrative structure of the community - What community representation is there in groups at different levels of government structure? - Informal / traditional leaders? - Ethnic groups? - Languages spoken? - Main livelihoods? - Who is wealthy? Who is poor? How is it measured? - Gender relations, men's/boy's, women's/girls' roles? - Community infrastructure: type of roads, electricity supply, water system, internet, toilets, % access to phone - Types and number of development projects in the community? - History of collective action by the community? - What are the beliefs and practices related to ageing? 	<p>Key informant interviews with community leaders</p> <p>Community associations etc.</p> <p>FGDs with groups of older people</p>

Sociocultural context continued	<ul style="list-style-type: none"> - Who decides and/ or influences community development- what will be done and how at the community level? - Is there a history of mobilisation around health issues? - How do older people in the community interact with the rest of the community and with community leaders and decision-makers? 	
Community resources	<ul style="list-style-type: none"> - CBOs focus of their work, funding sources. - OPA membership- main activities, funding sources? - Other associations/ traditional groups and roles? - Community health workers? - Community volunteers and role? Who manages them? What linkages do volunteers have to health facilities? - Government support for community development? - NGO supported projects/ focus of support? 	Key informant interviews with community associations and other groups
Health and care services	<ul style="list-style-type: none"> - What types of health and care services are available in the area? - Government services; private sector, traditional healers? - Distance to the nearest government health service? - Distance to the next level of referral for health system? - Types of transportation to health facility from community - Number and level of staff at nearest PHC facility-? - What are the most common health problems in the community? - What is the approximate coverage and utilization of public, /private/traditional health services? - What is the approximate utilization of government health services by people over 60 years? 	Key informant interviews with health care staff at PHC level

	<ul style="list-style-type: none"> - What type of health and care services are available at the nearest health care facility? - What specific services are available for older people? - What type of health services are provided during community outreach? - How does health care financing work in this setting? - Are older people included in the health care financing? - What are the most significant challenges faced by the local health facility team? - What are the strengths and weaknesses of the health services/system? - How good is the quality of care? From providers perspective? - Is there a community health committee linked to this health facility? - Is there a mechanism for community involvement in decisions about health service provision? - Age friendly health facility ideas? 	
Situation of older people in the community	<ul style="list-style-type: none"> - What are the most common health problems for older people in this community? - Where is the most common place older people go if they have a health problem? - What are common challenges faced for accessing health services? - What do older people in the community think about the available health services? - What could be done to improve the health services for older people? - Can older people living with disabilities such as sight, hearing, mobility etc. access services? - Can they access assistive technology such as glasses, hearing aids, walking sticks, wheelchairs etc? - What services are available in this community for older people who are housebound or bedbound? - Are there older people in the community who feel lonely or depressed? 	FGDs with older people

	<ul style="list-style-type: none"> - Have older people in this community ever faced discrimination because of their age? - Among the older people in the community which groups of older people face the most barriers to achieve their right to health and care services? - What is the status of older people within the family? Within the community? 	
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➤ **Approaching the community for preliminary information gathering:**

- If you are working with a new community the objectives of the first meeting with community leaders will be to start to establish a relationship, and to explore whether the community is interested in participating in addressing healthy ageing issues.
- Be respectful of local practices and protocols. Know local customs and protocols.
- Be respectful of people's time and schedules. Check when making the appointment about how much time the community leaders can provide you for the introductory meeting.
- Ensure that someone on the team speaks the local language.
- Prepare materials before the visit to share with the community leaders (a short description of the project/program, presented in a clear way using key messages, complemented by pictures and simple graphics. Allow plenty of time for listening and answering community questions.
- Be honest - don't promise things that you can't deliver.
- Ask advice from the community leaders about how you can work together. Learn more about the community. At this first meeting clearly present the project goal and why this goal is important to the community. Share national or local level data to illustrate the situation of older people. Provide a brief overview of how propose to work with the community. Explain your organisational capacities and the role your team.
- Ask for advice about other key informants, discuss a schedule for interviews with key informants.

➤ **What does the information collected mean – looking for underlying themes.**

- When you have compiled the secondary data and completed the key informant interviews, review the data and explore the underlying causes of the issues identified.
- One simple method to use is to repeatedly ask "Why?" until you get to some of the real underlying issues. Brainstorm using white or black boards or flip chart paper.
- Consider who are positive deviants in the community? E.g., older people living in the same area and/or under the same conditions who are doing well despite the barriers they face (strengths-based approach).

➤ **Identify available resources.**

- Now that you know more about the situation in the community, compile an inventory of the available resources: human, in-kind and financial resources, including from local government, the private sector, national level government, CBOs, and other nonprofit organisations.
- Human resources and the types of skills and experience they can contribute from collaborating organisations staff/members, groups of older people; community members and network connections, willing to work with the community on health ageing.
- In kind/ material resources: meeting space, supplies, computers, vehicles, other equipment, time.

➤ **Identify constraints and solutions.**

- Usually, most constraints will be related to resources. E.g., project staff do not possess the right skills, have insufficient time to achieve the desired results, or limited financial or material resources.
- Brainstorm on possible solutions/ alternatives.
- Do not hesitate to adapt your plan considering your realistic assessment of resources and constraints. It's better to make changes during the early stages of preparation.

➤ **Draft a community mobilisation plan.**

- When you understand more about the community context and have formed your community support team, it is time to draft a community mobilisation plan.
- The mobilisation plan is a general description of how your team will support the community to mobilise and take action for healthy ageing issues.
- If you are seeking external funding for the community mobilisation process, the draft plan can inform the content of a concept paper or proposal.
- The mobilization plan will define the overall program goals and objectives and describe the process to support the community groups to achieve them. The mobilisation plan will not determine specific community actions or activities, these will be decided by the community during the mobilisation process. As you draft the plan, keep in mind the 2 overriding

goals of the community mobilisation process:

1. To improve the health and wellbeing of the community, particularly older people most affected by barriers to achieve healthy ageing.
2. To strengthen the community's capacity to address its health and other needs

The draft community mobilisation plan should contain the 7 elements below. See the link to the template in the appendices.

- ✓ Background information
- ✓ The overall goal of the mobilisation effort
- ✓ The overall objectives of the mobilisation effort
- ✓ The detail of the community mobilisation process
- ✓ Monitoring and evaluation plan
- ✓ Management plan
- ✓ A draft budget

➤ **Organise the community support team.**

- Work with the support team to define their roles, 2 support team members per community are recommended.
- Partner groups/ organisations can play a variety of different roles depending on the needs of the community.
- The support teams roles may include one or more of the following:
 - **Mobiliser:** Works directly with community leaders and groups to stimulate action. Bring community groups and organisations together in new ways around an issue that matters to them.
 - **Capacity-builder:** Build capacity of the 'community core group' to achieve their mobilisation goals.
 - **Partner organisations:** Complement your group or organization in various ways in a joint effort.
 - **Liaison:** Links communities with resources and partners, builds networks.
 - **Technical Advisor:** Provides technical assistance to community core group for specific advice/ technical expertise.
 - **Advocate advisor:** Supports community advocacy efforts to design advocacy approach link to networks or obtain resources.

➤ **Decide on support teams roles and responsibilities for the mobilisation process?**

- Review the draft community mobilisation plan with the support team. Decide who is going to be responsible for what. Identify any gaps in skills and capacity of the team. You can address this issue in several ways:
 - add people to your team from partner organisations who have the necessary skills.
 - Identify opportunities for skills building from other organisations / people who can provide skills building support.

➤ **Plan a skill building workshop for the support team prior to the next step – ‘organising the community’.**

- Skills may include adult learning principles; community mobilisation principles, strategies, and methods; facilitation skills; participatory techniques; interpersonal communication skills; and other relevant topics such as community-based approaches to healthy ageing’ rights-based approaches etc.

#	Tools for Step 1
Step 1.1	Sample questionnaires for key informant interviews
Step 1.2	Sample health facility assessment form
Step 1.3	Sample community mobilisation plan
Step 1.4	Help Outcomes survey Tool (HOT)
Step 1.5	Checklist for planning a community orientation meeting
Step 1.6	Non formal education manual (1989) Old document but very useful resources for adult learning and community participatory approaches

Step 2 – Organize the community for action.

In this section we will discuss how to:

- Increase community awareness about healthy ageing and older people's issues.
- Invite community participation.
- Identify the 'community core group.'
- Build trust, credibility, and a sense of ownership within the community.
- Commence working with the 'community core group.'

➤ Conduct introductory meeting(s):

- Hold an introductory meeting with community leaders and include representatives from various community groups. Explain the program's goals and objectives, the mobilization approach etc. If the community leaders prefer this activity could be integrated with the introductory meetings with community leaders in 'Step One'.
- Following this meeting, request the community leaders to include an orientation session on the agenda of the next scheduled community meeting. Or community leaders may suggest a special orientation meeting for the community if there are no regular meetings planned. The invitation to the meeting is best delivered through community communication channels used by the community leaders. Consider house-to-house visits to deliver personal invitations to people who usually do not attend, to ensure that a diverse group of older people attend.

➤ Think about your approach for inviting community participation:

- How do you plan to orient the general community to the mobilisation process?
- Who are the individuals, groups, and organisations you most want to reach and to have participate. Why?
- Who will organise the community orientation meeting and agenda?
- Consider using participatory/ consultative methods /media, timing, and other issues.) **See appendices for community mobilisation meeting checklist.**
- Make sure to identify people and groups who are most affected by barriers

to achieving healthy ageing? Also invite older people who are managing well (positive deviants).

- Use the findings from the information gathering phase to identify people you want to participate community registers, key informant interviews, FGDs, community mapping exercises etc.'
- Identify the right person among the community leadership to convene the orientation session. The person who convenes the meeting is usually the attraction to community members and will help their decision if they should attend or not. Sensitively identify someone who is widely respected, and is committed to the health and wellbeing of the community including older people?

A community orientation session may include the following topics:

1. Introductions of participants and facilitators
2. An introduction to your organisation
3. An overview about healthy ageing. Why it is important?
4. Overview of findings from information gathering. Open discussion about the health and wellbeing of older people in the community.
5. Presentation of project goals/ question time
6. An overview of the community mobilisation process
7. Invite nominations for the 'community core group'

Note While working through existing community structures and organisations is the norm, it is essential to ensure that people who do not normally participate and are affected by the issues being discussed have the opportunity to participate. Long-established groups may not represent the diversity of all older people in the community.

Invite nominations for the community core group.

- Present/ discuss about the formation of the 'community core team' and their role. Be clear about the volunteer nature of this role, non-financial benefits of being part of this group and level of effort required per month. It will be challenging to provide an estimate of level of effort (LOE) before the community has developed their action plan. At this time, it may be useful to explore the participants expectations about how much time they can contribute.
- The community core group will lead the community mobilisation effort on behalf of the community. The support team's role is to build skills, assist and advise the community core group as they carry out the mobilisation activities. Developing the capacity of the core group and accompanying them throughout the process are the two most important

roles of the community support team.

- The membership of the core community group can be from self-nominated volunteers or be proposed by other community members. Explain about the importance of a diversity of representatives from the community. e.g., representative from community leaders; older peoples associations; older people groups, local government, local health management; CBOs; health volunteers, people with disabilities, minorities groups, lower socio-economic status, literate, and low literacy people; younger people, women's groups, government extension workers, traditional healers, others who are suggested by the broader community.
- The main criteria are invested in improving the health and wellbeing of older people, represent a group in the community, and have enough time to participate. To ensure the group is manageable it is recommended not to exceed 25 members per community core group. Older people should represent 35% of the group (9 people 60 years old and older). The membership of the core group may be fewer depending on the population size and number of community groups.
- Provide the participants time to consider who should be their representatives on the community core group. Provide self-nomination/ nomination forms to participants. On the form include name, sex, age, position in community, and contact number or address. Leave a space for the person to explain why they would be a good community core group member. Request participants to put their nomination form into the box at the back of the meeting place.
- The support team will review the nominations and conduct follow up visits with the nominated people to confirm the group they represent, their interest, ability, and agreement to volunteer. The support team should check that at least 9 of the nominations are for a diverse group of older people aged 60 years and over. When the final list is compiled meet with the community leaders to request their review of the list and confirm that all community groups are represented. Ensure that the wider community is informed about the final list. If feasible celebrate this step by taking passport photos of the core group members and add brief details about them. Design a community poster or handouts that can be posted on a community notice board.

➤ **Spend time to build trust, credibility, and a sense of ownership with the community.**

- If the support team is new to the community, it is important to take time to establish trust and credibility and develop community ownership of the mobilisation effort. Consider joining with the community core group to organise an enjoyable community event that bring people together, such as a traditional cultural event, a sporting activity, or a community fair. The event does not need to have a specific healthy ageing focus, although it can include healthy ageing activities if the community wants to highlight this issue.
- Learn more about the community. Aim to build on their strengths rather than starting from where you may assume or think they should be.
- It is easier to work only with people who show up in response to a meeting invitation, but for community mobilisation we need to remain focused on truly wanting to reach and include the priority older people groups for healthy ageing who for various reasons do not participate. Identify barriers to participation and work to reduce them.
- Common barriers are limited physical access to meeting sites; time constraints and workload; language issues; low literacy skills; responsibility for childcare, carer of a sick partner or relative etc.; low self-esteem; stigma and discrimination; fear of lack of identification with other participants from different socio economic or ethnic groups; poor health; disabilities.

Start planning together with the community core group.

- Meet with the core group to determine next steps: when and where the next meeting will be? When planning meetings allow the community members to select the meeting times and places based on convenience and availability. Providing a clarity of purpose for meetings is very important.
- It is not necessary for the core group to be skilled and experienced in community mobilisation. The support team will work with them to identify their strengths and areas for capacity building, then support them to develop into an effective team. There will be a continuous process of skills building and learning by doing and reflection on learning.
- Work with the community core group for group norms on ways of working together.
- Below are questions to the core group members that you may want to discuss during the first meeting:

- ✓ Do you want to select official leaders of the community core group?
- ✓ How do you want to assign roles and responsibilities within the group?
- ✓ How will you communicate with each other? How often will you meet?
- ✓ What role do the core group want to play in relation to the support team.
 - Example a core group with experienced leaders may opt to have their leader be responsible for developing the core team's facilitation and leadership skills; other groups may initially prefer for the support team to facilitate their capacity building process.
- ✓ What team norms do participants want to set for the group (e.g., confidentiality, be on time, respect others' opinions even if you do not agree; provide everyone the opportunity to share their ideas, listen carefully to others, ask questions when you don't understand something)? Consider how you can reduce barriers to participation for people with disabilities, low literacy skills etc. so that they can actively participate.?
- ✓ How do members of the core group want to document the process, outcomes and learning from their meetings and activities (short notes, photograph stories, short video report, recording learning using telephone recording app etc.? Who will be responsible for making and keeping notes for the core group?

➤ **Ongoing assessment and monitoring core group capacity**

- Organising and strengthening the community core group is an ongoing, process, throughout the community mobilisation process. Below are some measures of community capacity that you may want to monitor throughout the process. These indicators can be included in the monitoring and evaluation plan.
- If a group is newly established, the support team will need to assess its potential capacity (individual members' skills, abilities, and experience), and decide with the core group members about their priorities for capacity building.

Suggested indicators for assessing a group's capacity for collective action:

- Improved status, self-esteem, and cultural identity
- The ability to reflect critically and solve problems.
- Increased collective bargaining power.
- The ability to make choices.
- Recognition and response of people's demand by duty bearers

- Self-discipline and the ability to work within the team and with others.
- Increased access to resources.

It is important for groups to be able to assess their own progress over time. Encourage the members to first assess their group's capacity individually, then share their observations with the others in the group. It will be helpful for the support team or others outside of the core group to also observe the group's progress and provide feedback to the core group members. Discuss the sample self-assessment tools and adapt with the core team as necessary (**see appendices for link to sample self-assessment tool for community core group**)

#	Tools for Step 2
Step 2.1	Checklist for planning the community awareness raising meeting
Step 2.2	Sample self-assessment tool for community core group

Step 3 Explore the Health Issues and Select Priorities

In this section the community core group and support group will work together to:

1. Decide the objectives for this phase
2. Explore the situation of older people in the community and their health issues
3. Analyse the information
4. Set priorities for action

- This objective of this phase is not only to support the core group to collect relevant information that will help them decide on what the priorities should be to take action for healthy ageing but is also part of the 'learning by doing; capacity building process for the core group.
- This exploratory phase can help foster the core groups and community members ownership of the process and catalyse actions for change, by bringing together and mobilising the key influencers and people most affected by the issues.
- The aim of this phase is to build a common understanding, skills, and relationships between individuals and groups who are affected by and/or care about the health and wellbeing of older people. It also prepares the core group members for the next step in the process- 'Plan Together phase' by increasing their awareness on key topics including:
 - The community's social and demographic characteristics
 - Older people's health and wellbeing situation. Which older people are most affected?
 - The key barriers faced by older people for achieving healthy ageing.
 - Community members values, knowledge, attitudes, beliefs, and practices related to older people and healthy ageing.
 - The number and groups of older people directly and indirectly affected by health and wellbeing issues.
 - Older people's experiences of ageing. What they think and do about it, and how others perceive them?
 - Available community resources including skills and experience, networks, and budget?

- Plan and conduct a workshop with the core group members to explore older people's health and wellbeing issues. What do they know, and how they feel about the health and wellbeing of older people?
- In collaboration with the core group, plan how to further explore the issues for older people within the broader community.
- Agree together to what extent the core group will be involved in developing and participating in this exploration process with the community. Ideally, core group members would act on their own, or in collaboration with the program support team to design the exploratory process and collect the information from the community members. This may be a very new activity and they may feel hesitant to take the lead. They may prefer to follow the approach selected by the support team and participate in facilitating the exploratory exercises. This is OK, it is another way of learning by doing. It is important to give them the choice of how they would like to participate.
- **Together** with the core group decide on the objectives for this phase. What do they want to learn about the health and wellbeing of the broader community and why?
- What do they want to achieve with the broader community during this phase (e.g., raise community awareness about healthy ageing; broaden community participation, involve local leaders, others)?
- **What methods will they use to collect information:** How will they gather and use information from the community? Does it already exist, or do they need to collect it? Who will be responsible for planning, coordinating, collecting, and analysing the information?
- **Resources:** what human, financial, and material resources will they need? What resources do they have now?
- **What are the resources gaps?** How will they bridge the gaps in the resources? Are there technical experts in the area who can support them such as people with skills on ageing issues, monitoring and evaluation, data analysis, social sciences etc, that they could invite to support them?

Bringing the information together and identifying information gaps

- First, review the information about the community that is already available (previous surveys; research studies, national demographic studies, situational analysis etc). Look at this information considering your objectives for the community exploration and identify what additional information you will need to inform you about the priority issues for older people's health and wellbeing.
- The second step of this process is to supplement the information gathered by the support team members during the first step, by collecting information from the community that will fill the information gaps.
- You can select from a variety of participatory tools for information gathering in the community, depending on what information you require. **Example;** community resource mapping; key stakeholder mapping; wealth ranking of older people; social networks mapping.
- When have you selected the topics, you want to explore with the community consider if you have the resources to facilitate data collection using the tools? What training will the core group require to use these tools.
- Choose the tools that are relevant to your information needs and will be interesting and engaging for the participants. It will make the information gathering exercises relevant and enjoyable for the participants and the core team.
- How long will it take? Using some tools requires more time than others. You will need to be sensitive to participants 'time constraints and weigh the quantity, quality, and dept of information gained against the time it takes to gather it. **(See link in appendices to participatory tools for data collection)**
- Practice using the tools with each other and provide peer to peer feedback for improvements.
- Support the core group to plan for the exploration activities, make appointments and prepare supplies and equipment.
- Provide support if requested during the core groups facilitation of the exploration activities.
- Work with the community core group to analyse and discuss the information collected from the community. Identify innovative ways to present the findings in different ways such as pictures, diagrams, quotes from

community members, Display the community produced visuals such as community map, social network mapping, wealth ranking, community resources analysis etc., during the analysis session.

- Select the priorities issues that the core group want to take action on.

Caution When the core group is largely composed of individuals and groups that have little power in the broader community, such as poor people, minority groups, people with disabilities, older men and women, adolescents, or others, the risk of moving forward from this step to the next step 'Plan Together' is that priorities will be set by those who have more power but may not be directly affected by the issue and do not reflect this group's concerns. It is important the support group team have the skills to facilitate inclusive discussions where each person has equal opportunity and respect, and all people's experience and ideas are listened to.

#	Tools for Step 3
Step 3.1	Workplan templates for learning more about the community
Step 3.2	List of participatory tools with advantages and disadvantages
Step 3.3	Examples of participatory tools
Step 3.4	Qualitative participatory research methods: community mapping; social network mapping; stakeholder analysis; wealth ranking etc.

Step 4 Preparation and facilitation of the 'plan together' workshop

In this section the community core group and the support group work together to:

1. Decide the objectives of the planning exercise
2. Determine who will plan the workshop, and their roles and responsibilities
3. Design the planning workshop
4. Conduct/facilitate the planning workshop to create a community

➤ Decide the objectives of this step.

1. **What** would you like to achieve?
2. **How** you will achieve it?
3. **Who** will be responsible for each activity and for results?
4. **What resources** you will need, how you will obtain them?
5. **When** and **where** you will implement your activities?
6. **How you will monitor your progress**, and when will you know you have achieved results.

➤ Example of planning objectives?

- Ensure that key policy and decision-makers, community leaders, and health service providers support and contribute to the community action plan.
- Ensure that those who are most affected by the health issue set the agenda and have a meaningful voice in the planning process.
- Enlist technical assistance from external groups/ organizations as needed.
- Identify and leverage needed resources to carry out the strategies that are developed.
- Ensure that what was learned through the community exploration about the situation of older people is applied to the planning process.
- Strengthen community, individuals' and organizations' analysis, planning, and negotiation skills and build their confidence to take collective action.
- Ensure that opposing points of view can be voiced and discussed in a constructive manner.

➤ **Determine who should be involved in the planning workshop.**

Questions to consider when deciding who should join the workshop:

- ✓ Is the person/group directly affected by the health and wellbeing issues?
- ✓ Is the person a local leader (formal or informal) or key opinion leader?
- ✓ Is the person very interested in the health and wellbeing of older people?
- ✓ Does the person/group make or influence decisions or have access to information or provide services for those directly affected by barriers to healthy ageing?
- ✓ Does the person/group have special skills, knowledge, or abilities that could help the planning group make more informed decisions or implement the action plan when it is completed?
- ✓ Would strategies selected to achieve healthy ageing require this person/group's assistance or approval?

➤ **Decide on the roles and responsibilities for planning the workshop and design the methods for sessions, logistics, and documentation.**

- The core group should review its community findings and priorities selected during the previous step to identify the important information to be included in the planning workshop.
- Review facilitation guidelines and practice facilitation and experiential learning principles as part of your preparation:
 - Interpersonal skills
 - Technical expertise in health, group dynamics, planning
 - Language and communication skills
 - Cultural sensitivity and awareness
 - Gender equity
 - Representation and inclusion

➤ **Consider the expectations of the workshop participants:**

- The workshop should aim to produce a draft action plan that clearly states what the participants want to achieve, and how they intend to intend to do it.
- The job of the community core team and support group during this planning workshop is:
- Review the 16 tasks described below and decide which ones are appropriate for your context. Then develop the agenda and session plans accordingly.

- Decide who will be responsible for facilitating sessions.
- Develop the session plans, methods and materials.
- Decide on logistic arrangements and other tasks that need to be completed before the workshop.

Review and select the tasks for your planning session that are appropriate to your context	
Task	Description
1	<p>Provide an overview of healthy ageing and community-based approaches to healthy ageing. Underlying principles etc.</p> <p>Orientate the participants to the overall goals of the community mobilisation process. Even though many of the participants may already have heard about the community mobilisation plan it is important to review the goals, the timeframe, and who is involved in the process, for the participants who have not previously participated.</p>
2	<p>Clarify the specific objectives of the community planning process and workshop participants expectations.</p> <p>Participants should understand what they are trying to achieve during the workshop. Clarify participant expectations and address their concerns.</p>
3	<p>Consolidate and review the relevant information that was collected in previous steps (situational analysis).</p> <p>This is the time for core group members to present what they have learned during the exploration phase concerning the situation of older people in the community and the barriers faced by older people to achieve healthy ageing.</p> <p>Use creative methods to present the information – older people speakers sharing their personal challenges to healthy ageing; short videos to highlight the community health and wellbeing issues for older people, simple charts, or tables to present key data, pictures, photographs, quotes from key informants etc.</p> <p>Provide participants with the opportunity for questions. And contribute their knowledge and experience of the issues faced by older people.</p>

4	<p>Present the priority issues that were identified by the core group during the previous step. Work with the participants to agree on the priority issues that need to be addressed (facilitate an inclusive discussion ensuring that participants who are most affected by barriers to achieve healthy ageing are able to share their ideas). Decide on the action plan objectives, desired results. Or other indicators of success.</p> <p>The priority issues selected by participants should be re- stated in a positive way so that they can be seen as "desired results", "dreams," or "objectives." For example: "Older people are able to access age friendly people centered health care services at the PHC facility;" "Older people have increased access to information about self-care for healthy ageing.'</p>
5	<p>Identify resources, opportunities, challenges, and constraints.</p> <p>When the participants have agreed upon their desired results, they should then reflect on their current situation and what it will take for them to get to where they want to go. As they do so, they will begin to identify challenges they will need to plan for, opportunities that may open up new possibilities, resources they may need to reach the objective, and barriers or constraints they may have to overcome. Participants should be specific and provide concrete examples rather than talk in general.</p> <p>Some techniques you may want to consider using to make this exercise more real include role playing, socio-dramas or skits, storytelling (real stories or composites of real stories), making an inventory of participant knowledge and skills, and identifying potentially available public and private resources</p>
6	<p>Develop strategies to achieve the objectives and desired results.</p> <p>Request the participants to think of strategies they have used in the past that have been successful. What made these strategies successful? How can they apply what they have learnt to this exercise?</p> <ul style="list-style-type: none"> • Imagine that you could enlist anyone to help you. Who would you enlist? Why? What would that person do to help achieve the desired result? • Think of what your community does better than any other communities What skills, systems and resources contribute to your community doing this so well?

	<ul style="list-style-type: none"> • Organize participants in smaller groups that may be based on gender, age, occupation or another characteristic that may influence their perspectives. • Request all the small groups to develop strategies for the same desired result. When the groups are ready, ask them to present their ideas to the other groups. • Consider asking individual participants to think of their own strategies before they work within a small group. This process may encourage more independent, creative thinking that can then be contributed when everyone works in one larger group.
7	<p>Discuss in the large group to select the strategies with the most potential to result in the improved health and wellbeing of older people (achieve the results we want)</p> <p>Once participants have developed a number of strategies to choose from, they will need to select one or two to develop further. Establishing selection criteria, such as those listed below, will help participants better assess a strategy's potential.</p> <ul style="list-style-type: none"> • Feasibility. Can we, do it? Do we have the necessary resources, skills, time? • Reasonable costs? • Probability of success for improving older people's health and wellbeing? • Political support? • Available resources? • Easy to understand, clear? • Length of time needed?
8	<p>Identify the specify activities, resources needed and how resources can be obtained.</p> <p>If participants have carefully thought through the earlier tasks, it will be relatively easy for them to specify activities. If the participants have very limited experience with group planning, the facilitator may want to take them through the example template in the appendices 'Learning to plan in groups – building on what we already know.'</p>
9	<p>Assign responsibilities.</p> <p>Participants need to determine who will be responsible for each activity and the desired results. Rather than delegating everything to the formal community leaders, which often happens, community members should consider who would be most effective in implementing each activity and how best to share responsibility so</p>

	that activities can be accomplished more efficiently and fairly. Does the person have the time required to accomplish the task? Would it be better for one person or a group to do it? Simply assigning responsibilities is unfair if the assignees do not have the knowledge or skills, they need to complete the tasks. Part of your plan, should include knowledge and skill building activities for the community implementors.
10	<p>Determine timelines.</p> <p>When community groups are excited about beginning to work on an issue, they often propose that everything be initiated immediately or very soon after the planning meeting. The facilitator's role is to help them think through whether their proposed timelines are realistic. Participants should consider whether the dates they propose would conflict or opportunistically coincide with other community activities. What happens if implementers encounter a delay? How will this delay affect the other planned activities? It may be helpful for groups to make a planning timeline template (Gantt chart) to help them visualize when activities will occur and if this is realistic (See appendices for link to timeline template)</p>
11	<p>Establish or reaffirm coordination mechanisms.</p> <p>Planning workshops may result in wonderful plans, but the plans are at risk of not being followed due to a failure to set up coordination mechanisms during the planning phase. Here are some questions to discuss during the planning session about coordination:</p> <ul style="list-style-type: none"> • How are we going to make sure these plans are carried out? • Who will track our progress? • How often will we review our progress? • What happens if we need to change our plans? <p>If participants decide they would like to form a coordination group within their team, they will need to determine the role of the coordination group and criteria for selecting members.</p>
12	<p>Determine how the community will monitor progress.</p> <p>The participants should also consider how it will monitor progress. Two of the most common types of monitoring are process and outcomes:</p> <p>Process monitoring asks:</p> <ul style="list-style-type: none"> - Are we doing what we said we would do? - How well are we doing it? - What difficulties or challenges have we faced? - What have we learned?

	<p>Outcome monitoring asks:</p> <ul style="list-style-type: none"> - Are we achieving our desired results? - Changes in health and wellbeing status of older people? - Changes in key health indicators? <p>Community capacity to address older people's health needs.</p> <ul style="list-style-type: none"> - Changes in health policies including resource allocation for health. - programs? - What other spin-off effects and outcomes do we see from us efforts? <p>For this session you should consider the level of experience of the participants and time considerations during the planning workshop. For less experienced groups it may be enough to introduce the concept of monitoring and then plan another meeting later that focuses on monitoring tools and techniques.</p> <p>If you use planning template for your plan it can easily be converted into a monitoring tool by adding three more columns on the right side of the template.</p> <p>One entitled "status," one entitled "observations/comments," and one. called "next steps"</p>
13	<p>Determine next steps and congratulate the group.</p> <ul style="list-style-type: none"> - Provide the planning participants the opportunity to determine immediate next steps. If they need to present their draft plan to others before they can commit to it, they should determine when they will do this and who will do it. - They should establish a time and place for their next meeting and identify who needs to attend. They may have other next steps that they would like to work out before leaving the group. It helps to write these agreements down. - Planning together is hard work and participants should be congratulated when they have completed a draft or final plan. This is very important.
14	<p>Present draft plans to the broader community if appropriate.</p> <p>As mentioned above, participants may like to seek broader community support for the plan before they commit to it, particularly if they represent others in the community who were not present during the planning sessions. A community meeting is an easy way to accomplish this.</p>

15	<p>Revise plans (if necessary) based on feedback.</p> <p>When participants share the plan with others, they may receive helpful feedback that will need to be discussed with the other members of the planning group. The plan may need to be revised before it is finalised.</p>
16	<p>Finalise plans in a formal document.</p> <p>The final action plan should be a formal agreement. Communities often have traditional practices to recognise, formal agreements, and these practices should be honored. For example, some communities ask all participants to sign and seal or stamp the agreement. They may celebrate the agreement with a meal or dance. Ask participants how they would like to celebrate.</p> <p>NOTE Once a plan is in “final” form, communities can still modify it. Indeed, it should be a ‘living document’. However, recognising that the plan has been agreed to publicly means that implementers are accountable to others in the community when they change directions. These, then, are the key tasks and activities involved in creating a community action plan.</p>

➤ **Facilitate the planning sessions to create a community action plan.**

- Setting up the meetings to prepare the community action plan, prepare for things that could go wrong and how to deal with them examples below:
- **Issue- not enough time to complete the draft plan.** If it is taking longer than planned quickly prioritise what should be achieved with the remaining time. Review the meeting objectives and request the participants to decide the priorities.
- **The approaches and activities selected to address the priority issues are unclear** about how they will contribute to improved health and wellbeing for older people. Ask the participants to describe how the approaches/ activities they are proposing will have impact for the health and wellbeing of older people. Revise, reword as needed after the participants have had time to discuss and agree together.
- **Issue- participants identify activities in the plan which seem overambitious or unrelated to the priority issues that were identified** such as building new roads to the community or constructing new health facilities. Explain to participants that these activities are important long-term ambitions, which will require a long-term advocacy effort. It may be more

strategic to focus on other actions that will provide tangible benefits to older people in the shorter term. For the participants who are keen to work on improved infrastructure advise them to think about linking with other organisations and resources who are working in this area.

- **Issue- participants get stuck on how they can address the priority issues.** The facilitator should not take, but rather guide them to find the way forward. Maybe provide examples of other projects / communities to inspire them to think of new things.
- Discuss with your team and core group ahead of time what you will do if these problems arise during the planning session. Prepare for problem solving and building consensus among the participants.

#	Tools for Step 4
Step 4.1	Timeline template
Step 4.2	Checklist for planning the participatory planning workshop
Step 4.3	Workplan planning matrix
Step 4.4	Sample monitoring tool for action plan monitoring

Step 5. Act Together- Implement the Community Action Plan

In this section the core team will commence implementation of the community action plan, with the support team technical inputs as needed (accompaniment)

1. Define the support team's role in accompanying the community core group action plan roll out.
2. Strengthen the community's capacity to carry out its action plan activities.
3. Monitor community progress
4. Problem-solve, troubleshoot, advise, and mediate conflicts

➤ Define the support team's role for accompanying the community core group during the implementation of the action plan.

- Once the support team have a sense of what skills and knowledge the community may need to implement their action plan, think about the capacity building support you will provide, how much, and what kind?
- In collaboration with the community core group draft a capacity building plan.
- As much as possible capacity building should move away from traditional classroom learning sessions to focus on a mentoring approach (learning by doing), reflecting on the learning and adapting as needed.
 - Are there other capacity building persons/ resources in the community that can support the core group.
 - Are there other external resource people with the required expertise?

➤ Monitor the community mobilisation progress.

- Monitoring during the 'Act Together' phase is carried out by various support team and core team members using a combination of formal and informal systems, methods, and tools.

Teams should refer to the monitoring template in the action plan and review:

- What is our goal?
- What are our “desired results”?
- How do we currently assess progress related to our goal and desired results?
- What formal and informal monitoring processes currently exist to share observations about progress (e.g., monthly community meetings, neighbour’s informal discussions, OPA meetings and activities etc.
- What indicators do we use to assess our progress, successes, or failures?
- What do we want to monitor that we currently do not monitor, and how will we do this?

- What kind of tool and/or process do we need to implement? Build on monitoring systems that already exist and avoid duplicate data collection activities.

- The support team also need to monitor the overall project including progress on the community objectives, community core group capacity, and its own performance to inform program learning.
- It is not sufficient to merely collect the data; the whole team needs to review, analyse, and discuss the monitoring information on a regular basis.
- Depending on the context and availability of the core team you may decide that monthly, bi-monthly or quarterly review meeting are reasonable.
- Updates on progress of the action plan will be provided to community members at the routine community meetings.

- **The support team will also monitor the overall management of project activities** including:
 - budget versus expenses, work plans progress
 - personnel performance and staff development,
 - reporting to donors, relations with partners,
 - management of logistics, and program resources

- **Problem-solve, troubleshoot, advise, and mediate conflicts.**
 - Clearly, it’s best to prevent conflict as much as possible, through open communication, focusing on shared goals and promoting team building, with respect for differences of opinion.
 - However, conflict within a community group or between community groups and others does happen and can be healthy and natural for a

group.

- Many communities will rely on existing systems to lodge their complaints. For example, community members may consult village elders to determine what should be done. Other communities may seek guidance from community councils or committees.
- Review the community history with the core group and identify times when the community faced difficult challenges. What strengths pulled them through? What can they build on now to maintain their motivation and energy?

#	Tools for Step 5
Step 5.1	Assessment checklist for the capacity building needs of core group for implementing the plan
Step 5.2	Capacity building worksheet for community core team
Step 5.3	Mentor skills handbook

Step 6. Evaluate together.

In this section we consider how to plan and conduct a participatory evaluation, analyse the information, and share the results with key stakeholders.

1. Determine who wants to learn from the evaluation
 2. Form a representative evaluation team with community members and other interested parties
 3. Determine what participants want to learn from the evaluation
 4. Develop an evaluation plan and evaluation tools
 5. Conduct the participatory evaluation
 6. Analyze the results with the evaluation team members
 7. Provide feedback to the community
 8. Document and share lessons learned and recommendations
 9. Prepare to reorganize
- The emphasis in the evaluation phase will be to apply a participatory approach to review and reflect upon what has and has not been achieved and what we have learned.
 - It is important to keep in mind that while you will be evaluating the growth in community capacity, this phase is also the opportunity for capacity-building about the evaluation process for the community.

➤ Who are the stakeholders who should participate in the evaluation?

Consider the many stakeholders who have been involved or have a direct interest in the project. The community core group should continue to be the primary participants and should have a strong voice in the evaluation process. The support team will continue to accompany them throughout this process which provides another capacity building opportunity for the core team.

Other interested parties—such as representatives' broader community, the various levels of the health system, people from the municipal/district/regional/national governments, key decision makers, the support team, and donors—should also be invited to participate. It is particularly valuable to involve donors or potential future donors in the evaluation, even if they cannot participate in the whole process, you can suggest some participation in the data collection

process, analysis of findings phase, or dissemination of results and learning with key stakeholders.

➤ **Form a representative evaluation team.**

It is important to have a diverse team and include representatives from the various community groups including the groups of older people, and other stakeholders such as local health staff, village leaders, local government and representatives from other organisations or govt departments that have an interest in the community's action plan for healthy ageing a mix of internal and external evaluation team members will bring different valuable perspectives.

For ease of management and coordination the group should not be too big. After working with various stakeholders during the community mobilisation process the community core team and support team will have a good idea about who would be suitable, available and interested in participating in the evaluation process. Select an overall evaluation team leader and consider appointing small group leaders who will lead a small group evaluation team during the evaluation data collection.

➤ **Determine what participants want to learn from the evaluation.**

- People involved in an evaluation usually want to learn what was achieved compared to what was planned, and what was not achieved, how, why, and at what cost. They may also want to extract lessons to apply in the future.
- Often evaluations set out to assess whether a project did what the project planned to do. Participatory project evaluation does this too, but evaluators may also need to look beyond what was initially planned to do to determine whether project teams altered their plans if they realized that a strategy was not working.

➤ **Review the community action plan monitoring and evaluation plan and consider:**

- ✓ What were the goals and objectives?
- ✓ What health outcomes did the project aim to achieve?
- Next brainstorm with the evaluation team members to develop a few key questions that will enable your evaluation to determine whether you have achieved these goals and objectives; the simpler and clearer the questions, the better. Many of the participatory evaluation techniques and tools are likely to be similar to the quantitative and qualitative tools and techniques that you used during the exploratory phase to explore the health issues (step 3).
- The emphasis for the evaluation will be to review and reflect upon what has and has not been achieved and what we have learned.
- It is important to keep in mind that while you will also probably be

evaluating the growth in community capacity, this phase is in itself a capacity-building exercise for the community core group and evaluation team members.

- Consider seeking technical support for capacity building on participatory evaluation methods if the support team feels they do not have enough expertise in this area. The technical support person may also be able to provide support for planning the evaluation and facilitating the data analysis phase.
- If the project covered many communities, you may have contracted a consultant to conduct a baseline survey such as the 'health outcomes survey tool'. This survey can be repeated as an endline to compare the changes from baseline to endline.

Example of evaluation questions:

Goals:

1. To improve the health, care, and wellbeing of older people in the community particularly the older people furthest behind.
- 2 To strengthen the community's capacity to take action to address its health needs and other community development issues.

(Note important to define clearly what you will measure to assess health and wellbeing)

Example questions for goal 1.

- ✓ Are older people who are the 'furthest behind' able to access the health and care services they need (available, accessible, acceptable, and quality health and care services)?
- ✓ Are older people who are the furthest behind able to participate in decisions about their health and care services?
- ✓ Are older people who are the furthest behind able to access information about self-care practices that is in format easy for them to use?
- ✓ What are the changes in confidence and capacity of older people who are the furthest behind to participate in community actions for healthy ageing?
- ✓ Have older people who are the furthest behind, made any changes to their lifestyle choices during the life of the project?
- ✓ What do older people who are the furthest behind think are the most important results achieved during the community mobilisation process?

Example questions for Goal 2

- ✓ How has the community's capacity grown during the project period?
(See link in appendices to criteria to measure community capacity-

outcomes)

➤ **Measuring outcomes related to underlying health factors.**

- There are many underlying factors that may have influenced the community mobilisation process and the results achieved e.g., gender equity, shared responsibility, power balance or empowerment. The evaluation team may be interested to evaluate progress in some of these areas. It will not be possible to measure all the underlying factors. The team could select a few factors that they think have most influenced the process. Some helpful methods and tools to measure progress on underlying factors include:
- In-depth individual interviews with key informants
- Venn diagrams that explore what it was like before the project and what it is like now, and what changes the respondents' attributes to the project.
- Case studies that document the evolution of an underlying factor over the life of the Project such as the participation of older people furthest behind
- Analysis of audio- and/or video clips to track progress related to the selected underlying factors.
- Analysis of attendance lists at community events, meeting, planning, advocacy etc. (disaggregating participation by sex, age, disability, etc.
- Picture/ photograph histories (series of pictures showing evolution over time related to the underlying factor).
- Social mapping to depict relationships before and now.
- Storytelling to depict how things were before and how they are now.

➤ **Work with the community core group and other evaluation team participants to set the priorities.**

- Review with stakeholders and the evaluation team all the topics you could potentially evaluate to determine priorities, since you will be unable to address all these areas in depth.
- Are there any indicators that you are required to report on by the donor, participants, or other stakeholders?
- What is the primary purpose of the evaluation? Which questions, if answered by the evaluation, most directly relate to the main primary purpose of the evaluation.
- What would participants be able to do or decide if you had the answer to this question?
- Consider the resources and budget available for the evaluation. Is what you are proposing feasible with the resources you have available?

- **Develop an evaluation plan and identify the evaluation instruments/ tools.**

NOTE Keep the evaluation simple and realistic; don't make things more complicated than they are or need *to be*. (see links in appendices to evaluation plan template)

- When the evaluation team and core group have identified the questions, they want to ask, and the indicators they will be looking at, put this information together into an evaluation plan. At a minimum, an evaluation plan should answer 7 key questions:

1. What were the project's objectives and expected outcomes?

- Make a list of the overall goals and objectives of the community mobilization project and a second list of the expected outcomes.

2. What questions do we need to ask?

- This is a list of questions you will need to ask to determine what the outcomes of the project were; whether the project met its goal and objectives; and why or why not. E.g., questions include:
 - ✓ What happened?
 - ✓ What elements of the project worked?
 - ✓ What elements did not work?
 - ✓ What were some key successes?
 - ✓ What were some key failures?
 - ✓ What remains to be done?
 - ✓ What is the community's vision for the future?
 - ✓ How has the community's capacity grown during the project period?
 - ✓ Which results obtained during the project period are likely to be sustained or improved upon?
 - ✓ What information do we need?
 - ✓ How will we collect it?
 - ✓ Who will collect?
 - ✓ What resources will be needed?
 - ✓ When?

3. What information do we need to answer these questions?

- This will be a list of the indicators you will have developed including the ones you have in your action plan (or you need to develop further) with the help of the information you collected during the community exploratory phase.

4. How will we collect this information?

- As much as possible use information you have already collected throughout the life of the project. Monitoring reports, community meetings, community core group self-assessments, review of the project proposal, reports, and documents
- Include in this section of the evaluation plan a list of the instruments/ tools and methods you will be using to collect the information you have decided you need.
- **Some suggested methods include:**
 - Repeating the baseline survey
 - Most significant change stories.
 - Drawings (e.g., of community mobilisation process)
 - Short role plays /skits to present important milestones or events.
 - In-depth interviews with project participants and observers
 - Group discussions
 - Picture card pile sorts (sort interventions that worked/did not work)
 - Rankings (rank initiatives/interventions from what worked best to worked least)

Planning the roles and responsibilities for the evaluation team

Every team member doesn't need to do everything. It is important to maximise members' skills and program resources. If you have many team members, it can be counterproductive for all members to attend all evaluation activities. In most cases where group discussion is involved, for example, one or two facilitators is sufficient. For example, one person can facilitate the discussion while another observes and records information. If team members are interested in building their skills in conducting a variety of evaluation methods and techniques, they can divide up the work keeping this objective in mind.

STEP 5: Conduct the participatory evaluation.

- When the team has developed the plan, methods, and instruments to collect information and has practiced using them and has worked out the logistical details (transportation, meals, accommodations, meeting places, equipment needs, communication with community participants and interviewees to set schedules), it is time for the team to conduct the evaluation.
- The team leader should determine how she or he can best support the other

members, identifying which sub teams may need more help with certain tasks or community groups. Whether all teams have the materials they require and assisting as needed. The team leader should ensure that the information is organised as it comes in, so that notes, surveys, and other evaluation documents, pictures, audio tapes, and video do not get lost.

- If you have access to a computer and someone with good computer skills who can help with you can set up a simple database using Excel to enter the data into the computer as it is collected to facilitate analysis. If you don't have access to a computer, you can record data manually using tally sheets.
- Try to make it a priority for the small teams to meet at the end of each day. These meetings help support the teams and keep them motivated, helps them to identify and solve problems promptly and to share and consolidate learning, and make adjustments in the plan, collection instruments, and methods if necessary.

STEP 6: Analyse the results.

- To begin the analysis, evaluation team members review the information collected in the community. Use the template in appendices for reporting results and documentation to help organise the data coming from various sources related to the same question.
- To help facilitate the evaluation team analysis meetings using the data, make copies of these tables and/or prepare flip charts of the key findings so that all group members can see them and make notes on a common draft document. If there is a lot of information, the team leader may want to divide the team into subgroups to concentrate on specific questions before the whole group meets together to analyse the findings.

Suggested general questions to guide the analysis:

- To what extent has the project achieved its objectives?
- To what extent has the project strengthened community capacity/ability to sustain and further improve its health and well-being.
- To what extent were process outcomes achieved?
- What lessons have been learned? (What worked? What didn't work?)
- What will we do differently in the future?
- What questions remain to be answered?
- What new questions have emerged?
- What do we recommend to others based on our experience?

STEP 7: Provide feedback to the community.

- When the team has finished its analysis, it is important to feed the results back to the participating communities in a way that everyone can understand. The

feedback session is a chance to validate the results and to raise questions that the team and the community have about them. In preparing for the feedback session, consider the primary purposes of the session.

- Prepare for the community feedback meeting. Arrange the time and place with communities well in advance so that people can arrange their schedules and to avoid conflicts with other meetings and community events.
- To make best use of this time with the community, the team will need to be well-prepared. Simplify the results so that the major findings are covered. Think of how you can present the results in an interesting and engaging way. Use visuals, simple graphics, and key messages. Consider participatory methods such as a gallery walk, you can post the results on a wall using pictures or graphics with key messages. Invite participants to walk around the room and view the wall charts. Small groups stop at each chart and describe what they see. A facilitator from the evaluation team can explain the results in more detail and can answer questions. You can also provide a blank chart with stick on notes and pens for people who want to add comments and questions about the results and learning.
- Also present disappointing results and use this opportunity discuss what happened and how we can learn from this for the future. What will we do differently.
- Consider providing a summary 1 -2 page of key findings and recommendations that people who are interested can take home. Allow plenty of time for participants to feedback, ask questions, discuss together.
- At the end of the event take the time to celebrate and congratulate the community for the results. Acknowledge all the key stakeholders etc. Use culturally acceptable ways to acknowledge people e.g., certificate of appreciation, group photographs to commemorate the occasion or having a small community get together with snacks and refreshments.

STEP 8: Document and share lessons learned and recommendations for the future.

- Many communities and organisations engaged in fieldwork undervalue their community work and achievements, thinking that other people will not be interested in their work. This results on information about many effective community-based approaches to health never spreads beyond the local area.

The learning from every community is very valuable and can inform a variety of other stakeholders, government policy makers, non-governmental organisations and civil society networks.

- Review your key stakeholder list that was developed during Step 1, to identify the external stakeholders who may benefit to learn from your evaluation. Then develop a tailored summary according to each stakeholder's particular interest and needs. Example - if you were planning a dissemination of results with the MoH staff at national level what would they be interested in learning from the evaluation and how can you influence them for community needs for healthy ageing approaches. **(See the link in appendices to a sample dissemination plan template)**
- Finally discuss the key recommendations with the community core team to guide their decisions on future actions. Prepare to adapt the next phase of the community action plan according to the findings.

#	Tools for Step 6
Step 6.1	Evaluation plan template
Step 6.2	Criteria to measure community capacity (outcomes)
Step 6.3	'Most significant change' method guidelines
Step 6.4	Participatory rural appraisal data collection tools
Step 6.5	Worksheet for reporting results
Step 6.6	Documentation and dissemination plan template

Section 6. Partnership development and networking

In this section we will:

- Discuss the basic concepts of building partnerships.
- Outline an approach to building partnerships.
- Provide tips for working with various partners.
- Provide an overview of networking.

What is a partnership?²

Building partnerships is about working collaboratively with others to achieve what we cannot achieve on our own. A good partnership provides mutual benefits to all partners. It involves working together to achieve a common purpose.

When we build partnerships, we aim to achieve a special kind of relationship based on respect, trust, equity, and collaboration; in which people, groups or organisations combine their resources to carry out a specific set of activities. Partnerships can be between two partners or multiple partners. Developing a good partnership requires using a strategic approach. Developing partnerships should be part of everything we do. As partnerships take team effort and time it is a good idea to always include building strategic partnerships as a key activity when developing funding proposals or concept papers.

Benefits of partnerships

Community based organisations who spend time to build partnerships can widen and sustain the impact of their work and gain a wider variety of resources to carry out their work well.

² Pathways to Partnership (2002) The International HIV/AIDS Alliance, UK.
<https://www.participatorymethods.org/sites/participatorymethods.org/files/pathwaystopartnerships>

Example of benefits

- Increased influence with government decision makers
- Improved environment by working across different sectors.
- Increased access to technical expertise
- Improved coordination with communities
- Reaching more people in a larger coverage area
- Strengthened support and policies for older people's health and wellbeing.
- Increased access to technical, financial, in-kind resources.
- Improved quality of services and increased access for vulnerable communities.
- More effective, creative work– through wider sharing of lessons and experiences.

In summary building partnerships is all about working collaboratively with others to maximise each partners strengths and opportunities, and leverage networks to achieve progress for healthy ageing. For sustainable work, it's important that the decisions of the partnership are carefully documented.

Process for developing partnerships.

- 1. Develop a partnership plan.** It is easier to build partnerships when you have a clear idea of your overall goal and the communities' priorities related to healthy ageing issues; and they have identified potential opportunities and challenges. By using a planning framework – which outlines the steps that your organisation/ group will take, will help you builds effective and strategic partnerships.

Steps to building strategic partnerships	
1	Revisit your organisation's overall goal, and review the communities' priorities related to healthy ageing issues that need to be addressed
2	Identify the opportunities and challenges that you will work on
3	Set specific practical goals for what you want from your partnerships
4	Select potential partners
5	Reach out to potential partners. Build the partnership (agreeing what you will do together)
6	Monitor and share lessons learnt from your partnership. Adapt your partnership approach as needed.

Step 1: Revisit your overall goal and review the community's priorities related to healthy ageing.

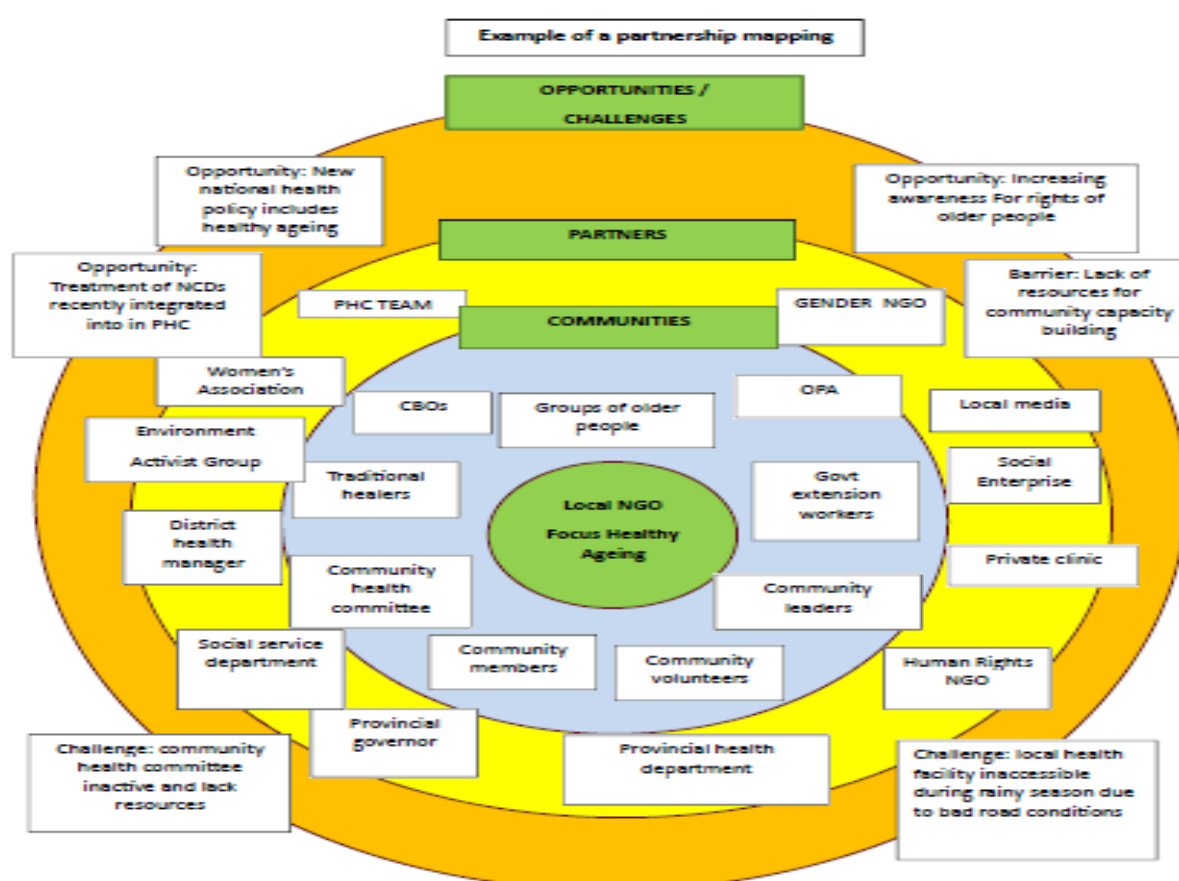
Keep a focus on your overall goal and the priority needs of the community related to healthy ageing, they will guide your selection of partnership, that will help you achieve your goal.

Step 2: Identify opportunities and challenges.

Prioritise the opportunities and challenges that you want to work on. These will inform your criteria for selection of partnership that you need to fill gaps in experience, skills, relationships and resources.

- Start by identifying the various partners (groups, organisations and people) who are active in your area. There are many ways to do this, and you already may have this information. Example you could conduct a stakeholder analysis (see appendices for links to stakeholder analysis tool). Then make a simple visual partnerships map. See example below.
- Ideally you would develop the map together with community representatives (community core group) who are working with you on the healthy ageing activities. The local community groups are included in the 2nd circle of the map diagram below. They are already assumed to be your partners. In the third circle on the map include both your existing and potential partners. For potential partners be imaginative, look beyond the usual partners. Consider the private sector; youth groups, art, music, traditional cultural groups and other entertainment groups, variety of media channels etc, and reflect on how they can help you achieve your goal.

- Enter the key opportunities and challenges into the 4th circle on the map. This information will come from your experience working with the community, and from the information you have gathered. You may identify many opportunities and face a variety of challenges. You will not be able to work on them all. Prioritise which challenges and opportunities you think will have the most impact for the community and are feasible to achieve. Circle the priority ones on the map. Discuss ideas for how you might leverage the opportunities and address the challenges. Next write a sentence for each of them describing what you want to achieve for this opportunity or challenge. E.g., "To address the lack of age friendly health services we will partner with relevant groups including local health managers, groups of older people, community leaders, community health committee and local NGOs working on health system strengthening programs to achieve age friendly and people centred health services for older people."



Step 3: Use the priority opportunities and challenges sentences to set your partnership goals. Example: "Our partnership goal is to work with partner organisations / groups/ departments that can work with us to address ageism; strengthen the quality of local health services for older people; and build capacity of community groups for conducting advocacy for universal health coverage."

Step 4: Select the partners you want to approach to propose a partnership. Develop a table to summarize the strengths of each partner and describe what you would like to work with them on.

#	Priority partner	Description	What we want them to do
1	'AHEAD' Local NGO	Health system strengthening expertise. Funded by international NGO until 2025 10 years' experience with government departments in this area. Works at provincial, district and PHC level	Improve quality of services at PHC level. Age friendly and people centred care for older people
2	PHC health team District and provincial health managers	Provides PHC services and outreach to the community. Short of staff, equipment, and medicines. Low awareness of ageing issues, and lack of training and skills for providing health services for older people.	Improve quality of local health services for older people in collaboration with AHEAD
3	Women's Association	Member of a national network of Women's Associations working on gender equity issues and women's rights. Works with support from the government's Ministry of Women's affairs and UNFPA.	Increase awareness about older people's right to health and care and participation

4	Older Peoples Association	Promotes health and wellbeing of older people. Prioritizes member's needs. Includes intersectoral activities such as rights awareness, income security, health and care, cultural programs, Volunteers conduct home visits to housebound older people and their carers who are housebound	Increase awareness among key stakeholders at community and local level about older people's rights to health and care.
	National level human rights NGO	Large human rights Organisation with representative at local level. Advocates for rights of the most disadvantaged people	Build the capacity of the community groups for planning a campaign to address ageism
	Local media, TV, radio and newspapers	Disseminates local news and information. Entertainment shows, music events etc.	Develop communication products for ageism campaign.

Step 5: Reach out to the potential partners and start to build partnership (process of agreeing what we will do together). The way we approach the partner should be appropriate to the position and interests of the partner, and to the capacity of your team. It is also important from the start of contact to be clear about what you are requesting from the partner. Select the right person/s in your team to reach out to the partners. What mix of skills and experiences are within your team for talking with partners? Who on the team has previous experience with the partner?

Select an approach that is most suitable to your context, and to the partner you are approaching (see tips in this section for approaching various kinds of partners). You may decide to start with sending a brief introductory note to the partner to request a meeting to discuss a potential partnership. Add supporting information to the letter/ email such as your key messages. Then when you meet if there is mutual interest you can plan to follow up with a series of short meetings, firstly to introduce your organisation and team, and to learn about your partners work, and identify areas of common interest.

As part of preparation to meet with potential partners reflect on the pros and cons of partnerships.

- To build a strong and effective partnership, you need to get to know and understand your partners.
- A first step in making a “partner analysis” is to think about how your team and partner view each other. The partners may have negative or positive views about you; they may not know what you do, or how you work. Also, partners from different sectors including private sector may lack awareness about older people’s health and care needs and rights. Or they might have negative opinions about working with older people:
 - Review available public information about your partner (e.g., strategic plans, technical reports etc.).
 - Consider the pros and cons of working with different partners. Reflect on your team’s experience with partnerships. This analysis helps you to think more clearly and deeply about your chosen partners, and approach them with understanding.
 - Using the right language with each type of partner is vital for the success of partnerships. (see resources tips for working with various types of partners)
 - Prepare well for the first meeting with the potential partner. Plan how you will convey the key messages about your organisation, your work, why you would like to partner, mutual benefits of working together.
 - Prepare short key messages that are clear and motivational statements, to help you connect quickly with your partner, in a way that interests them and is easy to remember. You can use the key messages as a reminder when you meet with the partner.
 - Good messages reflect your organisations identity as well as its values and expertise. All the members of your team should use the same key messages when talking to partners. Powerful messages are short, simple, positive, accurate, consistent, action- orientated.

Questions to answer when developing key messages.

1. Why is it important to address healthy ageing?
2. What does our organisation/ group do, and what do we stand for?
3. How other people/partners can complement our work. What are the mutual benefits?

The principles for developing a good partnership are:

- Partners engage in a joint action that focuses on their respective areas of influence and complement each other's work.
- Jointly develop clearly defined and agreed on objectives for the partnership; and define the mutual benefits to be gained (immediate, mid- term and long-term)
- Agree on a collective understanding of the purpose of the partnership and its intended outcome that is agreed by all partners.
- Identify and agree upon clear roles and responsibilities of each partner, according to their ability and resources.
- Explicitly recognise that the skills and contribution of each partner are valuable to the success of the partnership.
- Identify together both the risks and benefits of the partnership and explore ways to mitigate the risks.
- Identify ways to strengthen mutual trust and confidence and good governance.
- Establish and promote the values of the partnership through effective communication and commitment. Plan how you will achieve regular communications.

Develop an MoU or a formal agreement.

A memorandum of understanding (MOU) is valuable for establishing mutual agreements between parties. It clearly outlines how parties will work together and define responsibilities and expectations. MOUs are often the first step before creating a more formal agreement. The kind of agreement you will make depends on the policy/ practice in your organisation and the needs of the organisation or group you are partnering with.

The benefits of a memorandum of understanding (MOU) provides clarity for each of the involved parties on their first steps of working together, allowing stakeholders to gain a mutual understanding of the responsibilities of each partner. However, one of the potential drawbacks of an MOU is that it's not usually an enforceable, legally binding contract. The MOU does, however, create a paperwork trail outlining what has been agreed as part of negotiations, and it also sets out terms for cooperation. Essentially, it's a preliminary agreement that reduces uncertainty and the potential for disputes. It is important not to forget to complete due diligence checks on potential partners as per your group/ organisations policies.

Example simple format for a partnership MoU

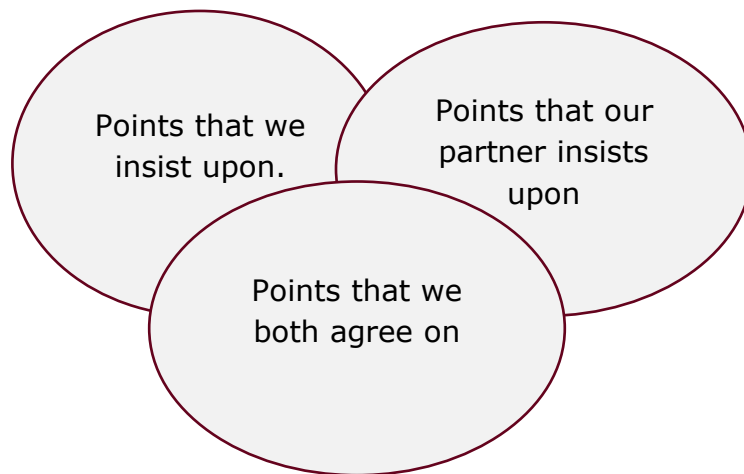
- **Title** - Add the title, such as "Memorandum of understanding between (organisation name) and (organisation name).

- **Date** - Add the date. Include month, day, and year, showing the date agreement was made when it goes into effect and the expected duration.
- **Parties Involved** - Begin by clearly identifying the parties involved in the agreement. Provide the full legal names, addresses, and contact information of each organisation or individual. This section should also state the intent to form a relationship between the parties and outline the purpose of the MOU.
- **Scope and Objectives** - Define the agreement's purpose in more detail. In this section, outline the scope of the agreement by defining its boundaries and limitations. Clearly state the objectives and goals you aim to achieve through the collaboration. Be specific and concise to avoid ambiguity or confusion. Ensure that both parties are aligned in their understanding of the scope and objectives of the MOU.
- **Terms of Agreement** - This defines what each party will bring to the agreement. Explain which roles are to be performed and who will perform them. Specify the responsibilities and contributions of each party involved in the agreement.
- **Important** clearly define the tasks, deliverables, and timelines expected from each party. Ensure there is clarity on how the parties will collaborate and communicate throughout the duration of the agreement.
- Other terms and conditions- You may wish to use other clauses such as a method for termination, intellectual property rights, a non-disclosure agreement, or steps for dispute resolution.
- **Signatures** - You should add a signature to the template and allow all interested parties to sign.

Step 6: Monitor and share lessons learnt from your partnership. Adapt your approach as needed.

From the beginning plan how, you will monitor your partnership, and share lessons learnt. Example – plan joint activities, regular partner meetings to review progress and discuss challenges and identify solutions; share quarterly/ biannual and annual reports; conduct joint visits to the communities where you work; plan joint advocacy events, link to each other's network of partners etc. Agree on the key contact person in each partner organisation. Agree to hold ad hoc meetings if partnership problems arise to ensure timely discussion and solutions.

- Timely management of difference of opinions or discontent within the partnership



➤ **What is networking?**

- Networking is the interaction among people, groups, or organisations to establish professional contacts for the exchange of information and other resources.
- Networking can be informal and ad hoc, or formal and intentional to reach out to stakeholders who you have identified as been relevant to your area of work.
- Networking helps build relationships and trust, share information and ideas, helps identify new opportunities, gain support for your work, and achieve wider impact.
- Networking build connections and helps nurture future partnerships. Networking should always be reciprocal, not just one way extraction of information or resources.
- Networking is different from partnerships, activities are usually less in-depth, involve various targets, and be for the general purposes of information-sharing and solidarity.
- Networking can mean a lot of things, from keeping in touch; exchanging newsletters; participating in joint study visits; organising or participation in joint seminars or joint campaigning about a common issue.
- For networking to be effective and sustainable, it generally requires active participation among all the participants of the network. Networking, thus, is about sharing information, not merely to passively receive it.

➤ **Benefits of networking:**

- Sharing information and resources
- Promoting communication and increasing awareness on issues of mutual interest
- Building relationships of trust and commitment
- Promoting coordination and sharing of mutual benefits at the local, national, regional, and international levels
- Serving as mutual learning and capacity building mechanisms
- Bringing multiple stakeholders together
- Increasing leverage and ability to influence important positions by acting together as part of a coalition.

➤ **How to effectively network**

- Keep up to date about what other members of the network are doing. Follow them on social media, websites etc. Congratulate them on successes, special achievements.
- Create an excel file of network partners contacts details. Keep it up to date.
- Keep your network posted about what your organisation / group are doing. Send short emails, messages, make an effort to catch up with them when you meet at the same venues, events.
- Share ideas, resources, new learning etc. via various social media with your network members.
- Keep in touch by either offline or online catch-up meetings.
- Engage with all network partners equally and be accountable for what you say you will do.

The benefits of networking

- Linkages to facilitate communication and learning among groups and organizations with similar programmes.
- Platforms to coordinate programmes, activities and resources of multiple groups and organizations to achieve shared policy or program goals.
- Increased visibility and legitimacy through networking
- It attracts new programmes, initiatives and innovations locally, regionally, state-wide and internationally.
- It provides a voice that enables individuals, groups or society to contribute their views and advice to a wider, collective voice on issues importance.
- It is timesaving on sector development and issues.

#	Tools for partnership and networking
6.1	Example template for partnership mapping exercise

6.2	Conflict resolution tips (see Principle 4 in MSP guide multi sectoral partnerships)
6.3	Section 4.1 Pathways to partnership `Tips for partnering with various kinds of partners.
6.4	MSP Guide to multi sectoral partnerships

Section 7. How to plan, conduct, monitor and evaluate advocacy.

In this section we will:

- Define advocacy.
- Outline the steps involved in planning an advocacy strategy.
- Provide links to advocacy toolkits and templates to guide the process.

What is advocacy?



Advocacy is taking action to create change. That is working for change in attitudes, policies or practices that affects people's lives and wellbeing. Advocacy and influencing is a long-term process that requires strong commitment and should involve the genuine participation of the people most affected by the issues.

What is community-based advocacy?

It is a process where older people and communities themselves identify their priority issues and develop a plan to influence the relevant decision makers for a change in policy, practice, or provision of a service to fulfil their rights. Once the older people and their communities are successful in influencing a change, they continue to monitor the implementation of that change.

Advocacy includes many different types of activities such as:

- Forming coalitions of like-minded people.
- Compiling the evidence on what needs to change, and proposing how that change can happen.
- Developing a public campaign to increase awareness about an issue.
- Raising attention about issues and giving voice to those most affected.

- Building the capacity of those most affected by the issue to raise their voices, share their stories and participate in selecting the issues that matter the most to them.
- Influencing those in power to provide leadership, take action and invest resources.
- Creating a positive change towards greater social justice and equality

What are key advocacy issues for healthy ageing?

The advocacy issues will vary according to the context. The priorities are best identified in close consultation with older people and their community. Advocacy issues can involve many areas of health and care, including broader issues that affect the health and wellbeing of older people. Advocacy strategies may work to influence decision makers at multiple levels (national, sub national and local level), but may also focus only on the local level decision makers, especially in a decentralized system of governance; while influencing decision makers at national level via partners and coalitions of groups working on the same issues at the national level.

Examples of advocacy issues are:

1. To reduce ageism (stereotype and discrimination against older people)
2. To achieve progress on the achievement of universal health coverage
3. To bring changes in the quality of services and policies related to healthy ageing.
4. To increase engagement of older people and local decision makers in the development of national level healthy ageing programmes and policy development

Benefits for older people to participate in the advocacy process.

- Participating in advocacy supports older people to influence important decisions that affect their life and wellbeing. The design of the advocacy strategy will be more aligned to their priorities and will strengthen their ownership of the advocacy process.
- Participating in the advocacy process is empowering for the older people most affected by the issue, who usually are not included. Their participation increases their awareness about their rights and strengthens their skills and

confidence to share their views and take action with others to achieve change.

- Older people's authentic stories of their life situation and why the advocacy issue matter to them will have a more powerful impact on the decision makers, than hearing about the issues via a third person voice.

What are the steps to plan advocacy?

To achieve the desired advocacy goal and objectives a strategic advocacy plan is needed. An advocacy strategy helps maintain a clear focus, and guides the community advocacy group to plan, conduct, monitor and evaluate a strategic advocacy process.

The 6 steps to developing an advocacy strategy.

1. Identify the priority advocacy issue, goal, and objectives	2. Identify the key stakeholders and tailored messages	3. Decide on the tactics to achieve your goal	4 Finalize the strategy including M&E, budget etc.	5. Conduct advocacy activities, monitor progress	6. Evaluate results, and reflect on learning, and plan next steps
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Step 1. What do we want to advocate for, (what are the key issues)?

The first step is to understand the situation for older people, and work with them to identify their priority advocacy issues. This can be done by:

- a) Collecting available information including data about older people. Review the government policies and plans related to health and care. Review information about the health and care situation of older people.
- b) Meet individually with groups of older people, community leaders, volunteers, OPA members and local health staff to learn about their experience and the barriers they face for achieving their right to health and care.
- c) Conduct community meetings to learn more from a wider group of community members; (ensure that representatives from a diverse group of older people participate in discussions), include representatives from a mix of older age groups; older people of various ages, older women, different socio-economic groups, minority groups, persons with disabilities etc.

- d) If information about the various groups of older people in the community is unavailable, work with older people representatives to develop a map of the diverse groups of older people in the community. Then conduct home visits to explain the purpose of the community meeting and invite older people representatives to participate. Home visits also provide an opportunity to learn from older people who are home bound and unable to participate in community meetings.
- e) Plan and conduct a stakeholder planning workshop to draft an outline of the advocacy strategy. Keep the planning workshop participants to no more than 15 to 20 people, to make it easier to facilitate, and easier to have more in depth discussions. Ensure that you have representatives of the older people's groups who are most affected by the issue.
- Begin the key stakeholder workshop with introductions; present the objectives of the workshop and check the participants expectations for the workshop.
 - Provide an overview of the proposed advocacy activity.
 - Provide a quick summary of the current country/ community situation of older people.
 - Review key definitions such as healthy ageing, meaningful participation; the people furthest behind, UHC and community-based approaches to healthy ageing.
 - Discuss the issues identified for older people in the community from existing information and home visits.
 - Facilitate a discussion to identify the priority healthy ageing issues. Use a participatory method such as the problem tree analysis and objective tree method. The aim of the activity is to involve the key stakeholders particular the groups of older people to identify the key issues they want to address through advocacy.
 - The problem tree analysis involves the participants brainstorming to identify the priority issues faced by older people to achieve healthy ageing, and then selecting from the list the priority issue for advocacy.
 - This method is also used to identify the causes and effect of the key issues. The activity can be done as a big group or in smaller groups depending on the preference of the participants. Participants who are from the groups that are furthest behind might prefer to work in smaller groups until they become more comfortable with working with other participants from different groups or sectors.
 - When the participants have completed the problem tree analysis, they will work to rephrase the causes and effects statements of the key issues to

develop positive statements that can become the advocacy objectives (objective tree analysis) E.g. cause of issue “older people do not have health insurance so they cannot afford health care;” becomes “Older people have health insurance that allows them to access health care services without using their savings.”

- Next the participants will review their objectives and select the priority objectives for the advocacy strategy.
- **(See link in appendices to- UHC advocacy tools and templates and 'MSP Tool Guide. For problem tree analysis and objective tree click on link MSP Tool Guide or select other methods from the advocacy tool guide and other resource links in the appendices.**

Step 2. -Who are the key stakeholders (audiences), what do they need to hear?

- Brainstorm with participants a list of the key stakeholders who are the decision makers (people who have the decision making power for the change you want) and the key stakeholders who are the influencers (people who have influence over the decision makers), allies (the people who supports the change) and what do you need to do to work with them; opponents – (people who might be against the change and is there something you can do to get them on your side?
- Identify allies at all levels from national to local and develop strategic partnerships to increase your advocacy influence.
-
- **See appendices for links to power mapping tool and stakeholder analysis matrix tools and template section of the CSO Alliance for UHC 20230 - Health for All Advocacy kit.**

Know your key audience.

- What do they know/how interested are they in your topic?
- To whom do they listen?
- How do they get information?
- What drives or motivates them?
- What constraints might they face?
- Are there commitments for which they are accountable.

Once you know the target audience/s are, you can develop tailored messages for each target. It is important to design specific and effective messages for each group of target audience, that are relevant to them. Think carefully about what will motivate the target audience and what will create and increase their interest.

Step 3- What actions/ tactics will you undertake to achieve your advocacy goal?

- Choose your tactics. Select and mix a variety of tactics wisely as per the context and the audiences. Make sure to include tactics that will amplify the voices of older people?
- Collect and compile additional evidence, information, human stories, infographics, statistics, diagrams etc, to contribute to the design of your communications materials. Highlight the issues and propose the solutions.

Examples of tactic

- Directly engage with decision makers and influencers. Engage directly with them via meetings, phone calls and other face-to-face activities.
- Indirectly put pressure on the decision makers and influencers through public and grassroots mobilization; take your issue to the streets; using various communication media and social media to increase awareness of the issue, challenge and demand a change from the decision makers.
- Influence a wider audience via media – video clips, radio shows, blogs, letters, report on advocacy activities in local and national newspapers etc. Use social and digital media channels for influencing a broader group of people.
- Use various media radio, newspapers to reaching your core audiences with key messages; increase awareness of the issue among unfamiliar audiences and promote your organization, alliances or coalition of members advocacy work.

Examples of tactics



Presenting a written application on behalf of the community and face to face meeting with key stakeholders including government decision makers



Campaigning to promote solidarity through consultations, rally's, various community awareness, video shows, photo exhibitions etc.



Engaging in mass awareness activities i.e., walks, media events, campaigns etc.

Activity 4- Draft your strategy plan.

- What are the key opportunities/ events on the calendar, that you can leverage to influence?
- Key activities, timeline and person responsible?
- What resources do you need? People, budget, etc
- Monitoring and evaluation – goal, aim, objectives, outputs. what is working? What isn't working? Key learning? What to do next?
- It is a good idea to include your evaluation objectives and how you will measure them, during the drafting phase of the strategy plan, and not

wait until the evaluation is due. Look at your advocacy goal and objectives and decide how you will evaluate if they have been achieved.

- **(See appendices for links to examples of advocacy strategy plans and advocacy monitoring framework)**

Activity 5 Conduct activities and monitor progress.

- Use your advocacy monitoring framework to guide you. Document progress and learning on a regular basis. Involve community members in monitoring activities and reflecting on their learning on a regular basis. Consider using a community notice board community radio or community loudspeaker system to disseminate progress on implementation of the advocacy strategy, so that community members have easy access to updates and remain engaged and supportive of the advocacy efforts.

Activity 6 Evaluate and share learning.

- Advocacy initiatives are typically complex and involve several partners, often working in coalition.
- The policy process is influenced by many factors, many which are beyond your control.
- Policy change is also a long-term process. Frequently advocacy initiatives take place over long periods of time, and policy changes may only become apparent later, after an advocacy process has ended.
- The main challenge for evaluating advocacy interventions is you cannot know for certain that your actions caused a policy or other changes. You can track your activities and track changes in the decisions taken by policymakers. However, attributing the changes to your advocacy activities can be difficult.
- Ongoing monitoring and real-time evidence gathering is particularly important you're your advocacy strategy. It is also important to keep monitoring changes after the advocacy activities are completed. Even if a policy change was achieved ongoing long-term action is needed to track if the policy is implemented.

Examples of long and intermediate outcomes to monitor in advocacy.

(Adapted from Save the Children MEAL resource package 2013. Monitoring and evaluating advocacy)

Long-term outcomes	Intermediate outcomes

Change in policy	Coalition building	Influencing the policy agenda	Influencing policy maker attitudes and behaviour	Building a social movement
Change in legislation. Budgetary commitments Implementation of commitments	New or stronger networks More effective network activities	Changes in oral and written rhetoric New items appear in political discussions. Items are framed in new ways within policy arguments. Coverage of issue in the media	Key decision makers change rhetoric in public and in private. Key decision makers change knowledge, attitudes and behaviours.	Communities acquire new information. Communities change attitudes. Communities change behaviours. Communities acquire a new strength and confidence to advocate.

- Work with the community members who participated in the development of the advocacy strategy to review the objectives for the evaluation. Decide with them how you will collect additional information to measure your evaluation indicators.
- Consider requesting feedback from representatives of the key audience groups; interview older people who participated in the advocacy process to learn about their experience and their perceived benefits from the advocacy. Learn from your team and partners experiences.
- As much as possible, you should aim to collect multiple sources of evidence (anecdotal and documentary, evidence from different sources) to build a credible evidence base supporting your judgements of influence.

Sharing Your Story

- Your action at the local level can have an impact at the national and global level. Therefore, it is important to share your advocacy learning and success story widely so that others can learn from your experiences and make efforts to carry out similar activities in their communities and districts to benefit their community members.

#	Section 7 - Tools for advocacy
7.1	Example UHC template for advocacy plan
7.2	Example UHC stakeholder mapping
7.3	UHC Focus group discussion guide
7.4	UHC 2030 tools, resources, and examples policy actions
7.5	A guide for OPAs to community-based advocacy manual

Section 8. Older people's association's contribution to healthy ageing

In this section we will discuss:

- What are older people's associations?
- How do older people's associations contribute to healthy ageing?

What is an older people's association?

Community based organisations of older people are found throughout the countries and regions where the HelpAge International network of partners are active. They are most commonly referred to as older people's associations (OPAs) however depending on the country other names are used, such as: intergenerational self-help clubs; inclusive self-help group; older peoples monitoring group; older people's community, and older people's organisation.

The model of older peoples' associations has evolved over the years, informed by learning and in response to member's needs. More recently OPAs have started to leverage the benefits of an inter-generational membership with 70 % of the members being people sixty years old and over, and 30% younger (40 – 50 years of age).

The OPA model is usually set up with support from a local NGO/ CSO, who provided startup funding and organisational development capacity building. The vision for OPA's is that they will become a sustainable and self-managed community-based organisations at the end of two years of external support. The OPA model focuses on building sustainability from the start including supporting the club to develop a diverse source of funds e.g. interest from the club managed revolving fund; annual membership fees, the amount and frequency is decided by the club and its members; social development funds, which are used to support poorer members for membership fees and other emergency needs; in kind and cash funds from locally generated fund raising activities; funds from club initiated income generation activities, used for management and club activity costs and project small grants from government or non-government sources, usually after the clubs have become well established and independent.

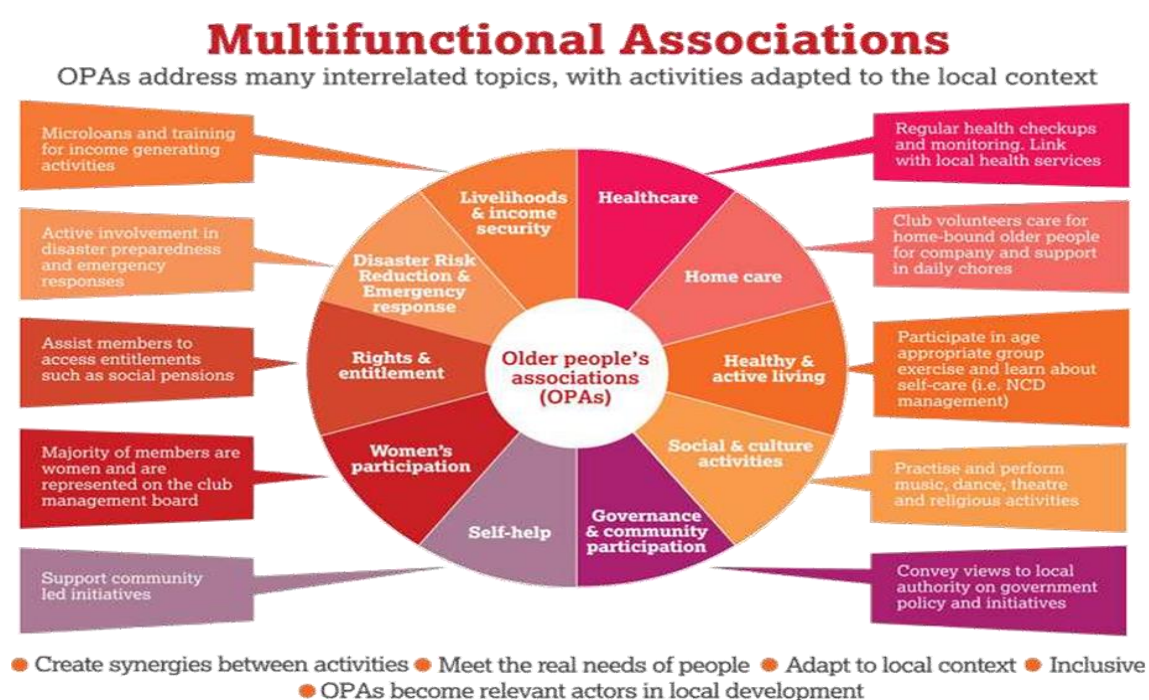
Older people's associations may also set up a network of sub national and national level.

older people associations or federations, that can represent their interests to decision makers and policy makers; participate in advocacy to influence policy,

strategy and plans for older people's issues, ensure that older people are represented, track progress for older people receiving their entitlements and network with key stakeholders for fund raising and partnerships for healthy ageing approaches.

Although the model for older people's associations is adapted to the specific context, OPAs share some common characteristics:

1. They actively engage older people, including in leadership roles. They promote members ownership and inclusive participation from diverse groups of older people from different socio-economic groups.
2. They are often multifunctional, addressing the priority needs of older people (social determinants of health such as: livelihoods, income generation; meaningful work and volunteerism; health and social care; social connection; culture activities; continuing education, rights and entitlements awareness, advocacy, gender equity, disaster preparedness, good governance and accountability).
3. They draw upon the community's existing resources, particularly the capacities of older people themselves to serve as agents of change in their family and community.
4. They seek to strengthen linkages and collaboration between the OPAs and local government leaders and services.



How do OPAs contribute to achieving healthy ageing?

The OPAs are managed by their members and work to address the priority needs of older people in their community. The multifunctional model of OPA address many interrelated issues that are important to members health and wellbeing:

- **Healthcare activities include health promotion**, lifelong learning for self-care, peer support groups, exercise groups, health screening and monitoring of members health status, rights and entitlement awareness raising and home visits to older people who are house bound for support and assistance with daily tasks.
- Social interactions and participation in cultural activities such as music, dance and artwork can help reduce isolation and support improved mental health.
- **Build livelihood security:** Older people's health and wellbeing is strongly influenced by their socio-economic status. A high percentage of older people, particularly older women live in poverty. Older people's associations can play an important role in alleviating family and community poverty by providing their members access to micro-credit, livelihood opportunities and job training skills.

Amplify the voices of older people by strengthening the linkages between older people's association structures at different levels of governance (local, sub-national and national) which provide a platform for advocacy and a space for community voices to be heard. The clubs' activities help raise awareness about the issues facing older people in their day-to-day lives.

Promote increased participation of older people in community life: OPAs promote mutual support among older people, reducing their isolation and vulnerability by creating social support networks. These can improve emotional well-being and create shared approaches to resolve family and community issues such as providing support during times of illness and organising religious celebrations.

Empower older people, promotes increased awareness of their rights, and provides the opportunity for meaningful participation in actions to advocate for their rights. OPAs play a vital role in raising awareness of the rights and entitlements of older people and improving their access to existing services. Linking up with government service providers enables OPA members to recognise that government

departments are resources for them to utilise. This builds confidence amongst older people and provides avenues for them to express their specific needs with local authorities.

Support disaster risk reduction and response: Natural and man-made disasters, such as heatwaves, floods, droughts, and earthquakes are causing increased human suffering, loss of life and financial loss each year. OPAs supported by HelpAge International, and partners employ disaster risk reduction activities such as disaster preparation, early warning systems, and relief and rehabilitation. Older people are respected sources of knowledge in their communities, providing information on traditional coping mechanisms and/or their experiences of previous disasters, which is invaluable as part of preparedness.

In conclusion OPAs are a valuable resource for older people and their community. Clubs that are multi-functional and holistic in response to the needs of the members, attract more members and generate an increased amount of funds that promote sustainability of the club.

#	Section 8 Resources for Older Peoples Associations
8.1	Older People's Associations: a briefing on their impact, sustainability and replicability
8.2	Older Peoples Associations in Asia – SANA briefing
8.3	OPA Learning Exchange Learning Report

Section 9 How to motivate and support community volunteers.

In this section we will discuss:

- Why community volunteers are a valuable resource for CBA to healthy ageing?
- How to motivate and support community volunteers

Why is volunteer motivation and support important?

Community health volunteers are widely considered a vital arm of the community health system. They provide a bridge between the community and health facility, fill gaps in provision of services particularly for preventive services such as health promotion; promote access to local health services and provide valuable communication and logistic support to local health teams. Community volunteers are often very familiar with the community culture and context, and issues faced by older people. They are aware of the people in the community who need the most support.

In many communities there is a variety of community health volunteers e.g., volunteers linked to the local health facility and volunteers who work with community-based organisations or local NGOs.

Millions of older people also contribute their time as volunteers. They bring with them years of practical life experience and maturity. Some volunteers have retired from a long career as a professional health care provider, senior leader, or skilled business manager. Others may be community men and women who have raised their family and now help to care for their grandchildren and continue to contribute to their community's development. For example, older people's associations have groups of volunteers who support various club activities such as: 'health volunteers' who provide health education, health promotion activities; support community-based health screening activities for club members; refer people at risk of disease to a health facility, follow up monitoring of older people with chronic diseases, and conduct home visits to people who are home bound etc.

To work effectively and stay motivated and energised volunteers need to have clear roles and responsibilities; the opportunity to continue to develop their skills and knowledge; be respected and valued by their community; work within a well organised structure; have the equipment and supplies they need to do their job, receive regular guidance and encouragement from their leadership and ideally be selected by the community groups they work closely with.

To ensure community volunteers are supported and valued there are several areas of volunteer management that need careful attention:

- **Volunteer recruitment** – there is often frequent turnover of volunteers especially if they feel overburdened, unsupported or undervalued. This results in the loss of trained and experienced volunteers and requires additional time and effort to identify new volunteers and train them. It is helpful to have a clear criterion for volunteer selection. The criteria should also consider inclusion to ensure that anyone who want to be a volunteer can be considered no matter their gender, ethnic group, education level, age, socio economic group, disability etc.
- **Volunteer workload** – volunteer tasks should be reasonable according to the time they can contribute. A joint workplan is helpful to allocate and coordinate the work fairly across the group of volunteers. Support for planning and monitoring their workload is important to ensure that they are not overloaded. The volunteer leader/ supervisor should ensure that volunteers are prepared and skilled for their tasks.
- **Volunteer engagement** – maintaining volunteer engagement is important for their motivation. A series of regular volunteer activities such as self-reflections, constructive feedback, sharing of experiences and skills building practice leads to better quality of teamwork and increased pride in their role and improved retainment.
- **Volunteer Recognition** - Volunteer recognition should be a part of your engagement strategy. Recognising and celebrating volunteers work, goes a long way in improving volunteer retention. Consider community recognition events with award of service certificates, study visits to learn from volunteers in other areas and opportunities for advancement within the community volunteer group is important.
- **Tracking volunteer impact** - Capturing volunteer's impact in the community is a great way to show the volunteers how much they've accomplished. Case studies, short videos, interviews with community members who benefit from the volunteer services; sharing volunteer monthly or quarterly reports with health facility providers etc are helpful ways to show the community, volunteers and stakeholders the tangible benefits of volunteers and making their role more visible.

By managing each area of volunteer work well, your volunteer group can be successfully, remain motivated and active and receive increased respect and value from their community.

Tips for recruitment of volunteers:

- Develop a clear job description. Be clear about workload, approximate hours per month for volunteer work and non-monetary incentives.
- Identify the criteria required to be a volunteer- remember to be inclusive, establish a diverse group of volunteers.
- Write a compelling description of the volunteer job opportunity and its contribution to the community. Share testimonies from current volunteers to attract people to apply.
- Request current volunteers and community leaders including health workers to share the opportunity within their community to reach a wider group of people.
- Include older people groups and other community stakeholders in the volunteer selection decision.

Tips for supervisor of volunteers:

Good supervision of volunteers is important. Supervised volunteers are not only happier, but they also perform better, leading to better outcomes for older people in your community.

Volunteer supervisors may perform some of the following tasks:

- Planning orientation for new volunteers
- Support volunteers to develop feasible work plans and monthly schedule and reporting progress.
- Communicating with volunteers regularly. Holding regular team meetings to reflect on learning, share results and problem solve.
- Provide on the job mentoring and support skills building and feedback.
- Identify the skills and knowledge needed for volunteers to do their job and track the quality of their work, providing constructive feedback as needed.
- Provide opportunities for regular learning and sharing together.
- Ensuring the safety of volunteers.
- Be available to support volunteers when they are on the job.

Tips for developing and funding your volunteer group?

Determine budget for volunteer resources and activities, and identify sources of funding, e.g., supplies and equipment, travel costs as applicable such as participating in meetings at the health facility, study tours, training costs, T-shirts, hats, bags, notebooks etc. Sources of funding may come from community funds, revolving funds, CBOs, government departments, community project funds etc.

Conclusion – good management of community volunteer groups is essential to retain, develop and expand this invaluable community resource. With good management the volunteer groups will be motivated and skilled and can successfully provide active, long-term support to their community, and contribute to the improved health and wellbeing of older people groups, especially those who are most in need of support.

Section 10. Additional community-based initiatives to support healthy ageing.

In this section we will provide an overview of:

- Age friendly communities and links to resources
- Intergenerational approaches and links to resources
- Digital technology and how it can support healthy ageing approaches.

What is an age friendly community?

All older people have the right to a healthy, dignified and independent life. Yet often their reality is that they face many barriers to achieve their right to health and wellbeing, created by the location and the environment in which they live. In both urban and rural areas infrastructure, including roads, public spaces and service facilities fail to consider the accessibility needs of older people, this prevents older people from remaining active and continuing to do what they want to do, resulting in them being increasingly isolated and inactive.

The World Health Organisation (WHO) describes age-friendly communities as being places in which older people, communities, policies, services, settings and structures work together in partnership to create an environment that support and enable us all to age well. Age friendly communities foster and support older people's functional abilities (be mobile, meet basic needs; learn, grow and make decisions; build and maintain relationships; and contribute to society).

What makes communities age-friendly?

The World Health Organisation identifies eight features of an age friendly community:

Housing

- All people have the right to adequate housing, regardless of their age or ability. Simple modifications and adaptations can enable older people to continue to live independently in their own homes. An age-friendly community supports people to make decisions about where they live, whether to stay in their existing homes, or find a new home suitable to their needs.

Social participation

- Being able to stay connected with friends and family is essential for ageing well. Age-friendly communities enable older people to take part in a range of social activities, bringing people of all ages together around shared interests.

Respect and social inclusion

- Ageism influences many of the issues faced by older people, resulting in older people being treated unfairly, not being respected and feeling excluded and their rights. Age-friendly communities challenge ageism by bringing people of different ages together and fostering positive images of ageing.

Civic participation and work

- Older people have valuable contributions to make to their community. They have diverse interests, and many older people want to continue to work or, volunteer, be politically active or participate in local groups or clubs. Supporting older people to continue working or to volunteer can provide them with an increased sense of purpose and belonging, which benefits their well-being and their local community.

Communication and information

- To stay engaged within their community older people access to information about what their community is doing. Information about meetings, social events, services and facilities should be accessible to them in suitable formats, and in places where people know how to find it. Special attention should be paid to ensuring that information is accessible to diverse groups of older people such as, people with impairments, different languages groups, low literacy level, unavailable digital technology or lack of skills to use it etc.

Community support and health services

- Accessible and affordable health and care services are crucial for older people to maintain their health and wellbeing and remain independent and active. These services need to be conveniently located to where people live, and accessible for people with disabilities.

Even with a small budget, key stakeholders including diverse groups of older people working together to pool their resources and ideas can identify small feasible actions to achieve positive changes towards a more age friendly community. **(See appendices for links to resources for taking action to create an age friendly community)**

What is an intergenerational approach?

An intergenerational approach involves groups of people from different generations working together on issues that are of mutual interest and benefit. Working across different generations to achieve a shared goal is not something new, it has been happening for generations, both informally and more formally in many contexts and countries. More often it involves older and younger people working together as equal partners on issues that affect either group or their community.

There are many benefits of intergenerational approaches including strengthening the voice of the two generations of people, achieving results by pooling the diverse and complementary resources contributed by the different generations including skills, experiences, cultural knowledge, traditional practices and wisdom, innovations, digital technology skills etc. This approach is also found to provide a good opportunity for two-way mentoring with rich learning between both generations, promoting increased knowledge and skills and enhancing communication, understanding and respect.

An intergenerational approach is very appropriate for the process of participatory development and implementation of community-based approaches to healthy ageing as discussed earlier in this guide. **(See appendices for resources to support intergenerational approaches)**

What role can digital technology play in healthy ageing approaches?

The World Health Organization (WHO) defines digital health as the use of digital and mobile technologies to support health system needs; mHealth is defined as medical and public health practices supported by mobile devices, such as mobile phones, tablet phones, patient monitoring devices and other wireless devices.

Digital technology in public health is a rapidly evolving technology with a vast array of innovative applications. It has great potential to enhance the delivery of health care services, enhance self-care skills, health literacy and self-screening of health and monitoring of health status; improve the efficiency of data management and utilisation, to identify and meet the needs of vulnerable groups.

It is acknowledged that despite the rapid developments and potential in health care technology there remains several barriers that need to be addressed, particularly for achieving sustainable digital technology for health at scale in LMICs. This includes building the essential infrastructure so that communities and individuals can experience the full benefits of digital health, such as access to reliable electricity, affordable internet services and building digital literacy

skills. Digital tools and information need to be available in languages spoken and read by the people in the target area, and gaps in basic digital literacy need to be addressed.

It is certain that digital technology for health is here to stay. It will continue to evolve and reach more people and become an essential part of our lives. The question is how we can leverage digital technology to support the achievement of healthy ageing especially for those who are furthest behind.

#	Section 9 Resources to support community initiatives for healthy ageing
9.1	WHO Age Friendly Primary Health Care Toolkit
9.2	Let's Go Guide Age Friendly Community Guide
9.3	Intergenerational Guide
9.4	SUNI-SEA Policy Brief Community Based Digital Technology for NCD screening

Appendices

1. Useful links to additional resources
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