Home care for older people

The experience of ASEAN countries

Supported by ROK-ASEAN Cooperation Fund

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Home care for older people

The experience of ASEAN countries

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Foreword

Increased demand for care and support for older people is one of the implications of population ageing, which is increasingly a concern of governments and other players in ASEAN countries. This is reflected in the ASEAN Strategic Framework for Social Welfare and Development 2011–2015, in which care and support for older peope is included as a key component.

While families continue to be primary care providers, this traditional support system needs to be strengthened in response to changes taking places in all aspects of society, especially demographic and family structures.

This report presents experience of the initiative in developing the volunteer-based home care model and promoting its expansion to address the gaps in providing care and support for older people through the ROK-ASEAN Home Care for Older People Project. The report covers its inception of the model in the Republic of Korea and the promotion process that took place in the ASEAN countries from 2003–2012. It also presents learning, key achievements and impacts of the project.

HelpAge Korea, as the lead agency in coordinating the project, would like to express its sincere gratitude to the Ministry of Foreign Affairs of the Republic of Korea, the ASEAN Secretariat, HelpAge International, the Ministry of Social Welfare, the Ministry of Health and all the implementing partners for their kind support, which led to the successful project implementation and preparation of this report.

HelpAge Korea hopes that experience and learning from the project presented in this report will raise awareness among key actors and the public and contribute to further development of policies and programmes to respond to the care needs of older people in ASEAN countries and beyond. This will ultimately improve the quality of life of older people.

Cho Hyunse
President
HelpAge Korea

In our visits to communities, urban and rural, we find increasing numbers of older people who are frail and whose needs for support in activities of daily life are not met or are met with difficulty. This relates to older people living alone or with working family members. The question is: How can these older people and their families be supported?

Needless to say, as more and more people become old, the needs for long term care grow dramatically and the need is increased by the reduced number of children who are available to support their elders. Residential homes or hospitalisation are not a solution. For the majority, it is not affordable. They are usually unnecessary and not what older people themselves want.

It is in this context that HelpAge has been promoting community-based approaches to support older people in need of care. The ROK-ASEAN Home Care for Older People Project, led by HelpAge Korea, in collaboration with ASEAN Secretariat, the HelpAge network partners and support from the relevant line ministries, developed a model of volunteer-based home care that has been adopted in the majority of ASEAN countries.

We summarise in this document the experience and learning from this project, in the understanding that it is only a piece in the general build up of a coherent, affordable and humane long term care strategy.

Eduardo Klien
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Executive summary

One of the defining struggles of the 21st century will be how to navigate the needs of a rapidly growing ageing population. ASEAN nations are faced with a 425% increase of older people over the next 35 years.[1] Economic and cultural shifts are causing the dispersal of family members across the country and region, which weakens traditional social structures for caring for older people. While older people contribute financially to their family through formal or informal labour for as long as they are able, at some point, many reach a higher required level of care. Without adequate universal pension schemes and healthcare in place to ensure a basic standard of living, older people's families and communities will find it difficult to comprehensively meet the needs of older people.[2]

Older people who are able to age in place enjoy a higher quality of life, remain in better health physically and mentally and are able to sustain meaningful contribution to their communities. In order to age in place, older people need to be enabled to care for themselves and to receive support for gaps in physical ability, psychological wellbeing and social engagement. To meet the changing needs of older people, a multi-level approach is needed. A first step in the continuum of care is basic home care. Usually family, friends and community members are the first line of home care, providing assistance with Activities of Daily Living (ADLs) such as bathing, eating, preparing meals and cleaning to older people as well as emotional and psychological support. The ROK-ASEAN (Republic of Korea-ASEAN) Home Care Model focuses on utilisation of unpaid community volunteers to assist older people.

HelpAge Korea piloted the Volunteer-based Home Care Programme (VHCP) in 1987. The government of the Republic of Korea expanded the programme nationally and integrated it into the Welfare Law for the Elderly in 1989. The UNDP selected the VHCP as a country project in 1998, during which time the training and operational manuals were revised and tested. As of 2011, VHCP was being implemented through work by 1,180 NGOs in ROK, reaching 40,000 vulnerable older people and funded by the government.

The Home Care for Older People in ASEAN Countries Project (2003–2012) was funded by the ROK-ASEAN Cooperation Fund building upon the success of the project in the Republic of Korea. The project was led by HelpAge Korea in collaboration with HelpAge International through its East Asia and Pacific regional office. It was a three-phase programme supporting all ten ASEAN countries in developing and adapting the volunteer-based home care model and in sharing and learning from each other. The implementing agency in nine countries worked with HelpAge Korea to adapt the Korean home care model to their own national context. Singapore who had a pre-existing national strategy for home care, assisted in capacity building of the partners in the other ASEAN nations.

The ROK-ASEAN home care model uses collaboration between implementing NGOs, government ministries, community volunteers, families and older people to provide basic home care help to older people in need.

Implementing NGOs are responsible for volunteer management and case management, while volunteers provide the care to older people. The government can use its leverage to make guidelines, set policies, provide funding and conduct monitoring and evaluation. The NGO, in addition to implementing the project, is then responsible to report back to the government. Upon successful completion of a pilot project, the government can facilitate the expansion of home care nationally by engaging additional NGOs for implementation. The government provides technical and financial support, while the partner NGO shares with and trains the new NGO in how to implement the home care model.

The ROK-ASEAN home care project utilised Project Advisory Committees (PAC) at the country and regional levels to guide the project trajectory within each country and to advocate for national home care guidelines. The regional PAC included representatives of the ASEAN Secretariat, HelpAge Korea and HelpAge International. The country PACs primarily included representatives of Ministry of Social Welfare, the Ministry of Health, implementing NGO partner, HelpAge Korea, HelpAge International and others including academics.

From 2003–2012, 3,697 volunteers provided basic home care to 5,080 older people through the ROK-ASEAN home care project. Most of the countries developed their own country-specific approaches based upon the Korean model.

In addition to implementing volunteer-based home care within each country, the project has advocated for national home care policy and guidelines in the ASEAN nations to promote expansion of the model. Home care policy had been in place in Thailand and Singapore and they have their own pre-existing version of home care policy and guidelines. Cambodia, Indonesia, the Philippines and Malaysia approved national home care guidelines and they are in development in Myanmar and Vietnam. The home and community care approach was also adopted in the ASEAN Strategic Framework for Social Welfare and Development (2011–2015).

Additionally, apart from the initial ROK-ASEAN home care project, volunteer-based home care has been implemented in other countries through HelpAge network members and partners.

The impact evaluation, conducted by external reviewers, gauged the familiarity, acceptability, favourability, importance and influence of the ROK-ASEAN home care project using a Likert scale administered to five target stakeholder groups. The evaluation concluded that all ASEAN member countries reported that the home care project was more than satisfactory.

According to implementing partners within each country, all stakeholders were favourably impacted by the project. The quality of life indicators of participating older people were improved. Older people also reported increased self-esteem, maintenance of existing abilities and ability to age in place. Family members were able to work more hours. Volunteers provided cost effective services. Community relationships were strengthened. The capacity of local partner organisations for conducting development projects was enhanced. Government organisations appreciated the cost-effective nature of the home care project and ASEAN has agreed to continue their support of home care.

Despite the many advances in home care among ASEAN nations over the ten years of the project, there remains much to be done in order to realise the goal of universal nationwide home care for those who need it. ASEAN governments struggle to allocate sufficient funds to the project. Implementing agencies (NGOs) may need further support and other agencies interested in expanding home care may lack capacity. National guidelines for home care in some countries are yet to be approved. Local governments need sensitisation in order to better understand and implement volunteer-based home care across communities.

The aim of this paper is to share the knowledge and experience of volunteer-based home care gained through the ROK-ASEAN home care project in order to facilitate the expansion of the approach in ASEAN and beyond.

Section 1 introduces the background of the project, the challenges of age care in ASEAN, the care needs of older people in ASEAN, national care policies and services before 2003 and ASEAN cooperation on older people issues.

Section 2 begins with the background of the ROK-ASEAN home care project including the experience of home care in the Republic of Korea. This is followed with an in-depth description of the Korean volunteer-based home care model focusing on the programmes' foundational elements. A comprehensive account of the ROK-ASEAN Home Care Project and its impact, results and limitations completes Section 2.

Section 3 includes country profiles which highlight a few of the ways ASEAN countries adapted the volunteer-based home care model to their national contexts.

Section 1: A crisis in care

I. Challenges of age care in ASEAN

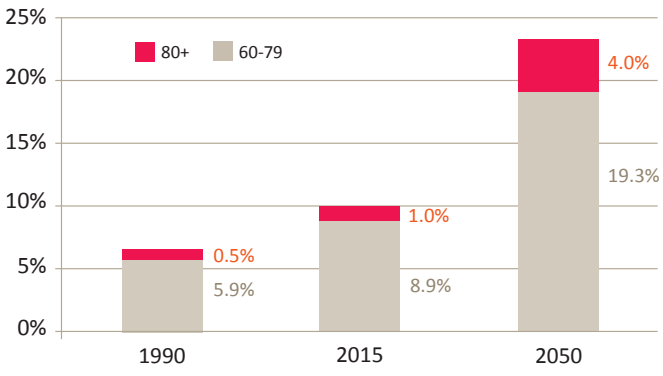
Faced with incredible growth of older populations, ASEAN nations have realised that traditional means of caregiving are not enough to meet the needs of older citizens. Therefore, finding alternative solutions to age care is of prime importance as populations age, families' capability to support older people declines and financial constraints continue to persist as a main factor in choosing care options.

Demographic changes

Mainly as a result of declining fertility rates and expanded life expectancy, by 2050 about 25% of the ASEAN population will be over the age of 60, up from 9% in 2005.[3] This is not merely a shift in proportions but is accompanied by vast population growth as well. In that same timeframe there will be marked growth in the absolute numbers of older people, from 42.5 to 180.5 million, a 425% increase.[4] The fastest growing demographic will be those over 80, the majority of whom are women and this older-old group is also the most likely to require some type of age care.[5]

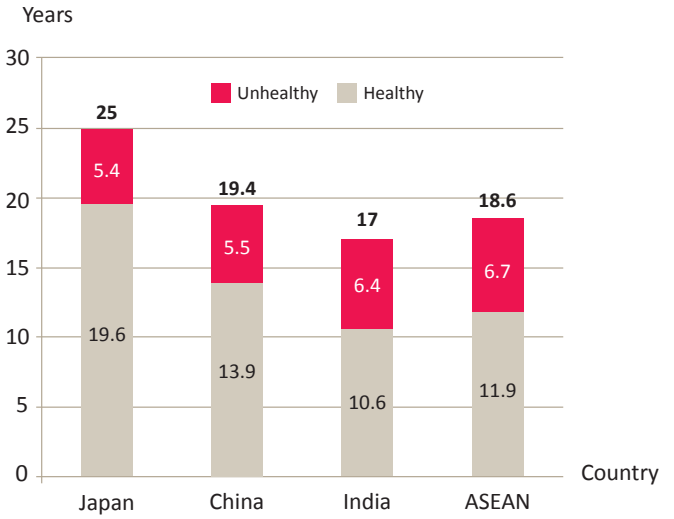
Living longer does not necessarily indicate a longer period requiring care. Ideally, a country could hope to increase life expectancy while decreasing the proportion of time spent in poor health. Nonetheless, even if the health of older people improved in the next 50–100 years, there would remain a great need for caregivers because of the decline in the potential support ratio (PSR), that is, the ratio of available caregivers to those requiring care, both children and older people.

Figure 1: Older people as a percentage of the total ASEAN population



Source: UN Department of Economic and Social Affairs (2008), http://esa.un./unpp

Figure 2: Life expectancy after 60



Source: UN DESA (Department of Economic and Social Affairs, Population Division) Population Ageing and development Wallchart 2009.

Family support

Traditionally in ASEAN nations, the responsibility for older people who require care has fallen on their family members. Multiple generations generally cohabitated in their hometown; allowing younger family members to care for ageing relatives and allowing older people to contribute to the work of family life. Additionally, communities were more stable with less migration, so that friendships and family relationships were more consistent throughout life.

Two economic realities of the 21st century are changing that former paradigm. First, ASEAN economies are becoming less agrarian and adult children often need to migrate to urban centres to find work. Secondly, more and more women are entering the formal work sector, limiting the time they have for caregiving during the day.[6] The advent of the ASEAN Economic Community (AEC) in 2015 will increase migration for work even more and across borders.

Family support of older people continues despite these changes. Remittances are sent to support older people at home from adult children working elsewhere. Many younger grandchildren remain with their grandparents while parents seek employ in urban centers or abroad. Trends show that Asians tend to stay in touch with their older parents by phone and visits whenever possible.

Still, the fact remains that cohabitation between older people and their adult children is declining and leaves a gap in the social and physical care needs of older people. This gap will only continue to grow as older populations increase and the potential support ratio declines.

Fiscal constraints

Financial challenges impact caregiving of older people on macro and micro levels. The 1997 Asian financial crisis and the 2008 world economic crisis have both impacted the economic stability of older people in ASEAN. While many economies have grown since then, they are not yet affluent enough to afford some options found in richer countries. Beyond the broader economic situation, many older people in ASEAN have been subsistence workers or farmers or have lived in poverty for much of their lives. They often have not had the chance to save enough to support themselves in old age. Instead, they must continue working as long as they are able and rely on family and community to provide for them thereafter.

In general, older people contribute financially to their families whether through working outside the home or caring for the household. However, as older people age and healthcare use increases, families often need to forfeit potential income by having a family member serve as caregiver fulltime, take days off of work or opt to work part-time to meet their family member's needs. These additional expenses of caring for an older family member can be a heavy burden. Expensive nursing homes and other institutional care for older people as found in affluent countries is an option for only a tiny minority.

Additionally, because of the rapid ageing of ASEAN populations, nations are facing the challenges of an ageing society without the benefit of wealthy economies with established welfare schemes. Universal pension schemes and universal healthcare sufficient to ensure a basic standard of living are not yet established in the majority of ASEAN countries. Low wages along with the reduced potential support ratio makes it difficult for governments to use social insurance systems which would only cover the small proportion of the labour force who had worked in the formal sector.[7]

Most ASEAN nations have limited resources to expand needed services and to make them affordable and accessible for older people. These economic pressures alongside the often unmet health needs of older people can lead, in the extreme, to older people's neglect, destitution, isolation and chronic and/or extreme poverty.

II. Care needs of older people in ASEAN

One goal regarding ageing is for older people to be able to "*age in place*", which means to remain comfortably and confidently in their own homes for as long as possible. This affords the older person with a higher quality of life as they are able to continue close relationships with friends and family. Ageing in place helps older people to remain in better health because they actively use their minds and bodies to care for themselves and contribute to the family and the community. In order to age in place, an older adult must be able to care for themselves and receive care for any gaps they cannot manage on their own.

Additionally, older people should be able to have a high level of functional wellbeing including physical, mental and social components. Thus, the care needs specific to older people fall into three main categories: physical disability, psychological wellbeing and social isolation. Difficulty with each of these is more prevalent in older people and tends to become more severe as one ages.

Activities of daily living (ADL)

Physical, mental, or social health challenges impact the ability an individual has to manage daily life or engage in the community around him or herself. Considering limitations in the activities of daily living (ADL) is one way to gauge what level of care an older person requires.

ADLs are self-care tasks that one does each day in the place of residence or outside in the community. Basic ADLs include grooming, bathing, feeding oneself, dressing and functional transfers, for example, moving on and off the bed or toilet.

Instrumental activities of daily living (IADL) are more advanced tasks which are necessary for independent living. These include managing finances, housework, shopping, adhering to medication regimens, using the phone or computer and getting around the community.

Older people may have ADL or IADL limitations for a number of reasons. Physical illness or disability may inhibit movement around the community or in the home. Dementia may limit an individual's ability to do the shopping or to take

necessary medications in the right doses at the right times. Loneliness and social isolation may make it more challenging for an older person to overcome ADL or IADL limitations, not knowing who to ask for help.

Disability among older people

Disability has often been thought of as a physical, mental or psychological condition which limits a person's activities. An alternative view, the social model of disability, places the emphasis on what functional limitations a person has as a result of their environment. Physical limitations such as difficulty or inability to walk, climb stairs, lift, bend over or balance can severely limit one. However, tools like wheelchairs, ramps and caregiver assistance can overcome those challenges. Thus, if a person is given enough support and their home and community environments accommodate them, they may continue to be highly functional when in other situations, they would not.

Older people have the highest population levels of physical disability, mainly due to chronic diseases, though in lower income countries communicable diseases and injuries play a large role as well. The World Health Organization (WHO) estimates that 43% of older people living in lower income countries have disability.[8] Moreover, prevalence of disability increases with age and older olds are significantly more likely to have a disability.[9] Prevention and management of chronic diseases may slow disability rates among older people, but given the growing older population, the numbers of those with disability will continue to rise.

Older people face age-specific mental health concerns as well. Dementia, depression and Alzheimer's are three conditions which generally develop and increase in intensity with age. The greatest number of people over 60 with dementia is found living in Asia. This trend is set to continue with the population of people with dementia estimated to increase by almost 300% from 2010 to 2050.[10]

Psychological wellbeing and isolation

Psychological wellbeing is a parameter of overall health. It refers to overall life satisfaction as well as the frequency of positive emotions. Generally, psychological wellbeing is a subjective assessment of one's satisfaction with one's life. This is measured through the experience and intensity of positive emotions over time, the lack of negative emotions over time, the lack of negative physical feelings such as hunger or pain and a cognitive appraisal of satisfaction with one's life.

Psychological wellbeing is influenced by a broad range of external and internal factors. External stress could come from natural disasters, high crime rates, discrimination or poor economic circumstances. Problems with physical health or chronic pain are known to damage psychological wellbeing as well. Personality and culture also affect a person's psychological wellbeing. Individuals have higher subjective wellbeing if they have more resilience, which is the ability to cope positively with change, shock or adversity. Another factor to consider is social support. Isolation is linked with low psychological wellbeing. Strong family relationships, cohabitation with others, having companions and confidants and participation in religious or community organisations all benefit older people.

Though the measurement of psychological wellbeing is subjective, the concept is highly valid. Research links high psychological wellbeing with quicker recovery from illness, reduced rates of cognitive impairment and healthier lifestyles. Improving psychological wellbeing is mainly achieved through increased social engagement, increased levels of exercise and increased productive activity time.

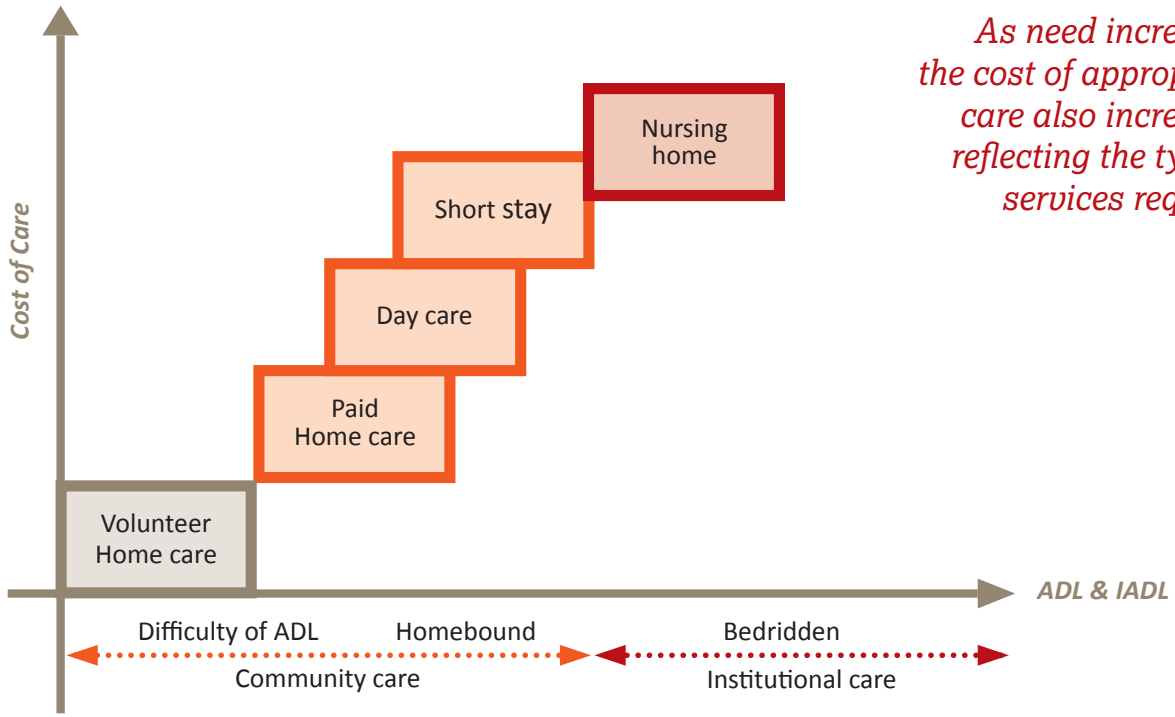
III. Continuum of care

In responding to such trends in ageing and the need of vulnerable older people for sensitive care, there is no single solution. Reliance on a range of options is necessary and those options are partly determined by the situation of each older person and the resources of each country. Some older people are mostly healthy and independent, both physically and emotionally. But some must learn to live with manageable diseases or disabilities and others with serious diseases or disabilities that require intensive care and support from others. The goal of active ageing is to keep older people as healthy and independent as possible so they can delay falling into greater dependency.

With each slip into a lower category of health status, older people become less independent and their care becomes increasingly costly to themselves, family and government alike.

To meet the need for care, families, communities, civil society and governments may provide various levels of assistance depending on their means. Generally, an older person may first require just a bit of assistance with ADLs and IADLs, a need which can be met by the family and unpaid volunteers. As need increases, the cost of appropriate care also increases (see diagram below), reflecting the type of services required. The most cost effective way of managing the increasing needs of older people is to match the care approach with the need. If there is no home care available, for example, an older person with relatively surmountable limitations may need to be moved into a costly residential care home or even a hospital. In all cases, care for older people should be appropriate to their needs and in line with their wishes, to the extent that it is possible. In the first instance, this often means care that allows them to stay in their home, where a familiar environment can reinforce their psychological wellbeing and therefore also contribute to physical health. Thus, increasing coverage of home care through the simplest and lowest-cost approach to home care is the focus of the ROK-ASEAN home care model.

Figure 3: Long-term care services



As need increases, the cost of appropriate care also increases, reflecting the type of services required

IV. National care policies and services

While families will always be the frontline of care for older people, governments are increasingly necessary to fill the gaps. This is particularly true in light of the changes mentioned above: increasing older populations, decreasing proportion of family members to older people and the fiscal constraints which limit the care older people can access on their own. All older people should have access to income security, healthcare and be granted respect from their communities. Governments can contribute to this through universal pension schemes, universal healthcare and the promotion of older people's participation in their communities. In this way, they can ensure the rights of even the most vulnerable older people.

Beginning with the United Nations' 1st World Assembly on Ageing in Vienna in 1982, the needs of older people have been highlighted on an international stage. That initial meeting resulted in the Vienna International Plan of Action on Ageing (VIPAA) and member countries were encouraged to develop national policies and programming related to older people. In 1991, the UN passed the Principles for Older Persons which affirmed rights for older people with respect to autonomy, involvement, care, self-satisfaction and esteem. During the UN International Year of Older Persons, in 1999, older people's rights were brought again to international attention with a whole year of focus on their needs, concerns and rights. In 2002, twenty years after VIPAA was accepted, the UN held a 2nd World Assembly on Ageing in Madrid, which resulted in the Madrid International Plan of Action on Ageing (MIPAA) and member countries were encouraged to work on three key issues: 1) older people in development, 2) advancing health and wellbeing into old age and 3) ensuring and enabling and supportive environment. MIPAA has had reviews in 2007 (MIPAA +5) and 2012 (MIPAA +10). All of these efforts by the UN have influenced the development of ASEAN governments' policies on ageing.

Before the 1980s, there were no national policies on ageing in ASEAN countries and only a few policies which mentioned older people as one of a list of vulnerable populations. In 1982, along with VIPAA, Thailand created the 1st National Policy for the Elderly and Singapore formed a "Committee on the Problems of the Aged" chaired by the minister of health. Between 1990–2000, several other countries in the region began to recognise the increased needs of older people. They developed some national services and policies to protect vulnerable older people and to promote the role that they play in society. In some countries, such as the Philippines in 1991, Malaysia in 1995 and Indonesia in 1998, this meant the enactment of national policies specifically for the welfare of older people. In Malaysia and Cambodia, healthcare for older people was addressed. The creation of policies did not inherently mean that they achieved success. These first actions were varied both in the scope of what they covered and in the efficiency in which they were enacted. The past decade has brought about immense growth in the policies and services provided by ASEAN nations to older people. These will be discussed further in section 2 as many of them were developed through the ROK-ASEAN Home Care Project partnerships and the advocacy work of HelpAge International and HelpAge Korea.

V. ASEAN cooperation on older people

ASEAN prioritises the concerns and wellbeing of older people as reflected in its Strategic Framework on Social Welfare and Development (2011–2015). The sectoral body responsible for the issues of older people is the Senior Official Meeting for Social Welfare and Development (SOMSWD), which meets annually and reports to the Ministers Meeting on Social Welfare and Development. The Strategic Framework of SOMSWD (2011–2015) identified 8 programme actions/activities for older people. These actions could be categorised into four thematic areas: 1) social pensions for older people in ASEAN Member States, 2) promoting active and healthy

ageing and community-care approaches, 3) promoting the establishment and development of older people's associations (OPAs) in ASEAN Member States and 4) strengthening policy and programming. In this new Strategic Framework, a Home and Community Care Programme for CLMV Countries (Cambodia, Laos, Myanmar and Vietnam) was specifically planned.

Chronologically, ASEAN commitment for the enhancement of the wellbeing and protection of older people appeared in its key policy instruments as follows. In 1997, ASEAN Vision 2020 was developed and the Hanoi Plan of Action (1999–2004) adopted as a first step in a series of actions to realise it. The Hanoi Plan of Action (Priority 4.6) mentions the need to "enhance the capacity of family and community to care for the elderly and disabled." Thus it underlined the importance of ROK-ASEAN programme on community-based care for older people as a flagship area towards the realisation of a community of caring societies.

In 2003, ASEAN identified three pillars necessary for the ASEAN Community, one of which is ASEAN Socio-Cultural Community. The Vientiane Plan of Action in 2004 (3.1.3.5&6), again reaffirmed ASEAN's decision to emphasise home care for older people. It names as a key intervention, reducing social risks faced by older people through promoting aged care services, identifying best practices in family and community-based care for older people and developing tools to measure disability and assess the health and social care needs for older people.

In 2009, the ASEAN Socio-Cultural Community Blueprint to realise the ASEAN Vision 2020 by 2015 (Action C.1.27.vi) named volunteer home-based care and all other forms of alternative family and community care arrangements as part of the strategy to promote and protect the rights and welfare of older people. In the ASCC Blueprint, there are a number of strategic objectives concerning the social protection of vulnerable people and a wide variety of actions are outlined with the view of enhancing the wellbeing for older people.

Most recently, ASEAN ratified the Brunei Declaration on Strengthening Family Institution: Caring for the Elderly in 2010. This document pledges support to active ageing and ageing in place. Specific to home care, the declaration agrees to provide support and services for community, family, volunteer and home-based care as well as to build the capacity of the caregivers themselves. Ratified in Bali in 2011 is the ASEAN Strategic Framework for Social Welfare and Development (2011–2015). This document was developed in a consultation workshop in Hanoi in 2010, along with input from HelpAge Korea, HelpAge International and Tsao Foundation. The continued growth and expansion of the home and community care model in 2011–2015 is promoted in the strategic framework under the thematic area of 'Self-Care approach to Health, Functional Independence and Active Ageing.'

Section 2: A response to care needs – ROK-ASEAN home care for older people

I. Background of ROK-ASEAN Home Care

Experience in the Republic of Korea

HelpAge Korea piloted the Volunteer-based Home Care Programme (VHCP) in 1987 after observing home care in the UK and conducting a survey of older people which showed that about 30% of Korean older people needed some type of home care. The Korean home care model of home help service, developed by HelpAge Korea founder, Mr Cho Ki-Dong, is based on trained volunteers providing social and health related care for older people in their own homes. The model was expanded nationally in collaboration with governmental and non-governmental organisations and was integrated into the "Welfare Law for the Elderly" in 1989.

In 1998–1999, the experimental project of VHCP was conducted as a United Nations Development Programme (UNDP) country project. During this time, operational and training manuals for the model were revised, tested and revised again according to feedback from the volunteers and older people involved. The UNDP country project of VHCP demonstrated that home care improved older people's emotional health and allowed the physical state of older people to remain stable rather than to deteriorate. This was measured through four main mechanisms: the life satisfaction ratio, the depression ratio, activities of daily living and instrumental activities of daily living.

More than 1,180 NGOs were subsidised by the ROK government to implement volunteer-based home care as of 2011. These NGOs provide service to over 40,000 older people.

Home care for older people in ASEAN countries, ROK-ASEAN

In June 1999, HelpAge Korea organised a workshop on home care in Seoul which provided momentum for disseminating the VHCP to the Asia and Pacific region. UNDP and HelpAge International supported the workshop which included representatives from members and partners of HelpAge network in 12 countries in the region and resulted in HelpAge International adopting home care as a regional priority.

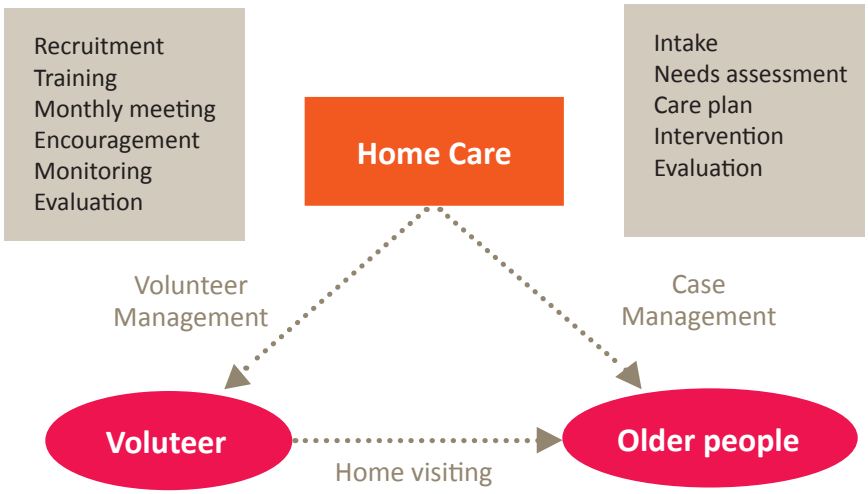
Later that year, HelpAge International conducted research on home care for older people in Asia. The HelpAge network in over 20 countries across the region were surveyed on existing home care strategies, desktop research was conducted and international researchers were interviewed. The resulting report, Ageing in My Own Place: Home Care for Older People in the Asia-Pacific Region, demonstrated that community home care and ageing in place were cost-effective and beneficial to older people, their families and their communities. The findings, including several innovative approaches to home care, were key inputs for the ROK-ASEAN Home Care Project enhancing the experience of home care in Korea.

In September 2001, HelpAge Korea hosted a second workshop, supported by ROK-ASEAN, on Home Care for the Elderly, this time for government and NGO representatives in ASEAN countries. This workshop resulted in the decision that all ten ASEAN countries would adopt a VHCP modified to their country's context.

In 2003, HelpAge Korea, in collaboration with HelpAge International, began implementing a three-phase programme supporting all ten ASEAN countries in developing and adapting the VHCP that has proved so successful in the Republic of Korea. The Home Care for Older People in ASEAN Countries Project (2003–2012) was funded by the Republic of Korea-ASEAN Cooperation Fund, whose mandate includes developing a "people-centred and socially responsible caring and sharing society." Using the Korean VHCP model as an important reference point, HelpAge Korea provided facilitation and capacity building for NGO partners and governments of ASEAN member countries to develop a home care programme in their country and to advocate for age-friendly home care policies.

In the first phase, from April 2003–March 2006, HelpAge Korea set up the project support team. The Korean model was shared with partner organisations and governments in all ten ASEAN countries. A home care model adapted to suit the local context of each country was created by the project partner in close collaboration with the Project Advisory Committee in each country, a group made up of the project implementing partner, government organisations and other concerned agencies including academic advisors.

Figure 4: The HelpAge Korea volunteer-based home care programme model



In the second phase, from June 2006–May 2009, the focus of the project was on strengthening the home care model and supporting its expansion through capacity building and formulation of national policies and guidelines. This was completed by replicating the home care model developed in the previous phase into urban and rural areas in collaboration with governmental and non-governmental organisations and promoting collaboration between governments and NGO partner organisations.

The third phase, from June 2009–May 2012, focused on improving the delivery system of the home care model and institutionalisation of governmental guidelines and policies on home care. Activities which raised awareness and strengthened networking among member states were also undertaken in all three phases.

II. The home care model

a. Aim and target group

The main purpose of the ROK-ASEAN home care approach is to enable older people who have lost the ability to fully care for themselves to continue living as long as possible in their own home and community, whether independently or with their families.

The home care approach supports disadvantaged older people who are no longer fully independent. Two broad categories of older people are targeted: those older people who suffer from illness but are managing the illness through self-caring and those who are frail, dependent and no longer in a position to fulfil their own basic needs. In most cases, older people requiring home care are not able to seek out and apply for home care services themselves, but need to be located by project staff or referred by others.

b. Care providers and services

Local volunteers are recruited by implementing agencies and matched to older people according to set criteria. They receive training tailored to the client, after which, the unpaid trained volunteer visits the older person at least once a week in their own home.

The underlying service in every project context is befriending to meet psychosocial needs. This companionship often means spending time chatting with older people who feel lonely and need emotional support. Beyond this, the type of service rendered is flexible, depending on the needs of individual older people, the preferences of volunteers and the culture. In a supportive environment, the next three most common types of services are home help, personal care and escorting the older person to a place of worship, health centre, shopping, or other place out of the home.

The ROK-ASEAN home care approach varies depending on the national context. In countries where a relatively strong and developed health service is accessible to older people, the home care approach has at its centre the social care element of befriending as well as home help, depending on what is culturally acceptable and needed. Where health service is not developed or accessible, provision of basic health services may be arranged by the project partners to complement their home care, as is the case in Myanmar, Laos and the Philippines. Though there are variations for each country, the essential elements of ROK-ASEAN home care remain consistent.

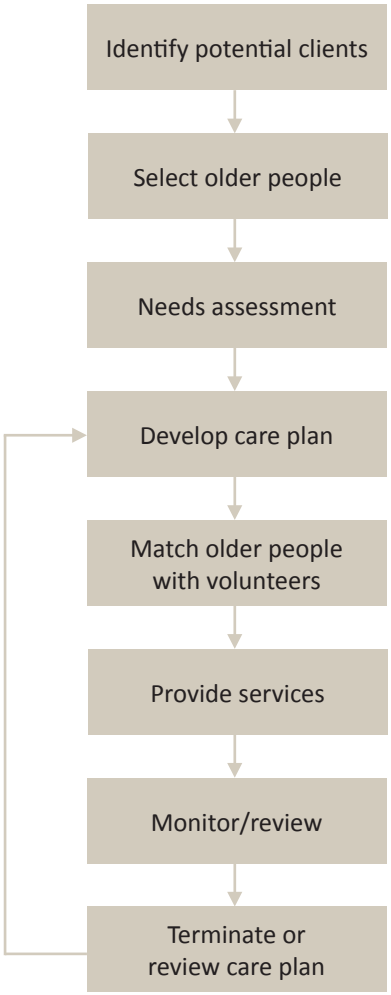
c. Implementation method

The two principal tasks of the implementing agency are case management and volunteer management. Describing those tasks is essential to understanding how home care service is practically delivered.

1. Case management

The key steps to case management which are relevant in all country contexts are illustrated in the diagram and described below.

Figure 5: Case management



Identify potential clients: A range of approaches is used by implementing agencies to identify older people who might be in need of home care assistance, from print advertising to personalised visits and phone calls. Referrals are also welcomed from community centres, medical care facilities and social welfare agencies. Oftentimes, neighbours and family members request services for older people. In Thailand, for instance, the Foundation for Older Persons' Development (FOPDEV) uses radio broadcasts, distributes leaflets and holds community meetings. In Malaysia, USIAMAS coordinates with the Department of Social Welfare and uses an existing list of older people in need of welfare support. In Cambodia, older people's associations (OPAs), community leaders, monks and project staff are used to help identify older people in need. In the Philippines, older people are identified by volunteers with support from OPAs.

Select older people: The selection criteria for older people in need of home care vary considerably across countries. However, most clients are over 60 and low-income, have difficulty carrying out daily activities due to frailty, illness, or disability and lack sufficient support. In many cases, project staff of the implementing agency select older people themselves by visiting them in their homes and using a set of agreed criteria and questionnaires. In some cases, selection is undertaken by volunteers in collaboration with OPA. The volunteer assessment is followed up on and re-evaluated by project staff. During the selection process it is vital that older people are asked if they wish to receive home care assistance, as home care is often proposed by a family member or neighbour. Where possible, to extend support to other vulnerable groups, those who obviously need care, but do not meet age criteria should be considered.

Needs assessment: Once an older person has been selected to receive home care assistance, a needs assessment is conducted. The needs assessment is normally undertaken by a member of the implementing agency team using a questionnaire. Activity of daily living (ADL) and instrumental activity of daily living (IADL) scales, along with an assessment survey, are used to measure the ability of an older person to lead an independent life.

Development of care plan: Based on the assessment, a care plan is drawn up by the implementing agency and a volunteer is assigned. During this process the services and conditions are explained to the older person, while the volunteer is trained on issues specific to the older person who they will be visiting. In some cases, older people have difficulties fully engaging in this process due to a physical or mental impairment. In such cases, it is vital to involve the main carer, but wherever possible, older people themselves need to be interviewed and included in the creation of their care plan.

Matching: Volunteers are matched to older people based on their sex, the health needs of the older person, the interests and skills of the volunteer, religion and location of both. Thus, it is important to first identify a volunteer's skills, interests and availability. Both the older person and volunteer have to be informed and agree on the exact services and conditions of the home care assistance to be provided. An implementing agency team member will usually introduce a volunteer to an older person as well as to family members or other local contacts of the older

person. This introduction process is even more important when volunteers are not from the same area, nor previously known to an older person and his/her family.

Provide services: What assistance should be provided, how often and for how long, will depend on each older person's need. Often older people require home-based care on a regular basis over a medium to long-term period. However, given that it is a volunteer service, it is vital that a volunteer's willingness and personal circumstances are taken into account and their ability to continue over a medium- to longer term period is considered. Older people are visited at least once a week and each visit lasts for at least one hour. Many volunteers visit more often if they live nearby. In some countries, volunteers visit each older person together as a group, which allow volunteers to support each other and also increase their visibility.

Monitor/review: Regular meetings between the project staff and volunteers are suggested to monitor progress, as well as to support volunteers by providing refresher sessions and psychological support. In many cases, a monthly meeting is set up. Home visits by project staff are undertaken as necessary.

Terminate or review of care plan: Termination occurs in the event of an older person's relocation or death, or due to the resignation of a volunteer if the project cannot find a replacement volunteer. If the needs of an older person change, the person's care plan is reviewed.

2. Volunteer management

The second key role of the implementing agency is volunteer management. This includes recruitment, training, matching volunteers to clients and supervising their work. Offering continued training and rewards to further improve the quality of services helps to retain volunteers.

Recruitment: The first challenge is to recruit a sufficient number of volunteers to provide home care for older people that need it. Recruitment, as with most aspects of home care, varies between countries. It can be done through community meetings, advertisements, coordination with government agencies, religious organisations, existing volunteer groups, word of mouth, or community-based organisations (CBOs) like OPAs. Once interested people respond to the call for volunteers, a clear job description is shared with them delineating the role of volunteers, expectations and conditions, required attitude towards older people and relationships to other parties. Potential volunteers are also screened using clear criteria for selection. Common criteria used in ASEAN home care are a) willingness to serve without monetary benefit and to complete an initial training, b) agreement to the job description and c) demonstrating physical and mental health sufficient to provide home care. In some countries there is an age range for volunteers (lower limit or upper limit). In Cambodia and the Philippines, volunteers are recommended to be members of OPAs.

In some countries, volunteers are recruited first and used to help identify and select older people. In other countries, older people are identified first and then volunteers are recruited to match older people's needs. As much as possible, volunteers are recruited who live in close proximity to the older people. Volunteers who live in the same community are able to visit more often and at more flexible times and have an easier time earning the trust of family members and older people.

Training: Initial training is provided to volunteers by the implementing agency. Topics covered include introduction to the concept of home care, general sensitisation to issues of ageing, common illnesses in old age, support in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) and basic healthcare and promotion. Workshops may also cover skill sessions on communication, befriending and counselling. Additionally, volunteers may be trained on local mobilisation and networking, first aid and household sanitation. As women make up for 77% of volunteers while only 71% of clients, sometimes female volunteers are matched with

male clients. Therefore, training may address male specific needs and conditions to be sure that they are not overlooked.

Training sessions are conducted by project staff with support from external sources including some PAC members. Most training workshops range from 1–5 days, but three days is normal for an initial training with additional practice sessions in some countries. Refresher sessions are provided as necessary during regular meetings with volunteers. The topics discussed mostly depend on issues requested by volunteers or identified by project staff. Some countries have organised exchange visits for volunteers to learn from other similar projects.

Volunteer supervision and quality assurance: After a volunteer is matched to an older person, visitation begins. The implementing agency is then responsible for supervising the care given by volunteers. Monitoring and support may include requiring regular reports from the volunteer on their visits, holding required meetings for all volunteers in an area and checking in with the older person to verify that they are receiving the home care they require. Project staff will also conduct home visits periodically to reassess the situation of clients and to ensure their satisfaction with the service.

In some countries, volunteers are formed into a cluster group and each group has a coordinator who will support the project team in coordinating and supporting the volunteers. They help by arranging monitoring meetings, liaising with key stakeholders in communities and service providers and other activities as appropriate.

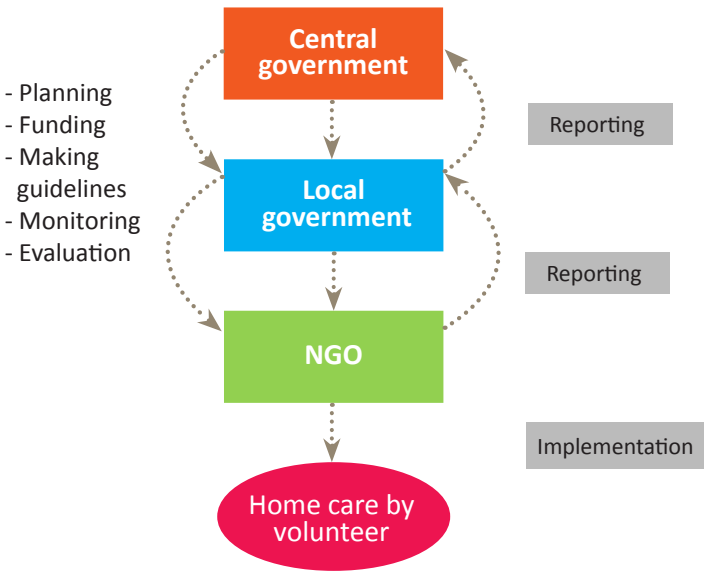
Rewards and retention: A range of activities to keep volunteers motivated and reduce drop-out are undertaken by project partners. Feeling supported by the project staff can increase a volunteer's desire to continue. One approach is for project staff to offer further training and hold regular meetings. As volunteers increase the knowledge and skills they need to give home care, the sense of accomplishment they feel links them more closely with the older people they serve and the position they hold. Project staff are also able to provide some psychological support counselling for volunteers who face strain as the older people they care for go through difficulties. Accompanying volunteers in visiting older people or organising exchange visits among volunteers is another useful tactic. Keeping volunteers informed about project activities and progress enhances a sense of contributing to a greater cause. As far as rewards, social activities for volunteers and giving certificates and awards to acknowledge their contribution are two of the main strategies that implementing agencies employ. Additional cost-free training in unrelated areas, such as income-generating activities, is another reward project partners have used.

d. Delivery system of home care

The delivery system is the organisational structure through which services are directly and indirectly carried to the clients at the community level. The structure is required to regulate the quality of service rendered and to deliver it efficiently.

HelpAge Korea recommends the government and NGO collaboration model, where governmental organisations establish social policy and support the NGO and NGOs implement as partners in the delivery of services to clients. The functions of the governmental organisation are planning, funding, making guidelines and monitoring and evaluation of home care. The functions of the NGO are implementing home care and reporting to the governmental organisation. The following diagram shows the delivery system of home care.

Figure 6: Delivery system of home care by volunteers



In practice, though each country's model is unique, three types of implementing agency are identified.

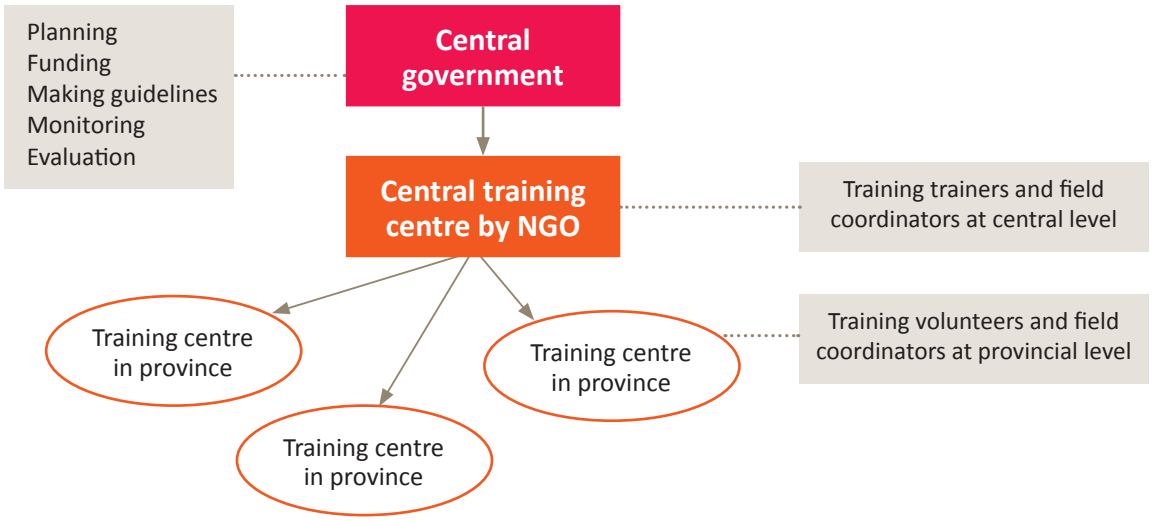
1. *NGO:* NGO, as a partner agency, mobilises community to provide home care in Indonesia, Laos, Malaysia, Myanmar and Thailand.

2. *NGO with older people's association (OPA):* The partner agency collaborates with OPAs in the communities to provide volunteer-based home care in Cambodia, the Philippines, Myanmar and Vietnam.

3. *Government in collaboration with NGO:* A community department of Ministry of Culture, Youth and Sports (MCYS), as a partner agency, implements home care in collaboration with an NGO in Brunei Darussalam.

Among the tasks of the NGO is the training of the home care volunteers and the field coordinators at the central level and from there to the community level. This action is supported by the government but implemented by the NGO. The following diagram shows the delivery system of training.

Figure 7: Delivery system of training for home care



III. Management structure and operations

Developing a successful and scalable home care model requires a multi-stakeholder approach. The ROK-ASEAN project model builds support through a multi-tiered structure, from international players to the village level. The organisational structure is illustrated through the following diagram and the roles of NGOs, the government and OPAs are described on the next page.

a. Key players at a regional level

HelpAge Korea and HelpAge International: Two international NGOs played supportive and advisory management roles in the roll-out of the ROK-ASEAN Home Care Project. HelpAge Korea (HAK) served as the lead agency for managing the ROK-ASEAN Home Care Project. HAK developed the guidelines for home care, promoted the model to ASEAN and conducted trainings and advisory sessions for the implementing agencies in each nation. HAK was also responsible for reporting to ASEAN, setting the direction of project implementation through each of the three phases and ensuring that the project progressed in each country over the ten year life of the project. HelpAge International supported the efforts of HAK through training, consulting, linking with national government organisations and HelpAge network partners in ASEAN countries, advocacy, dissemination of results in the ASEAN countries and beyond and support for fundraising. The collaboration between HAK and HelpAge International is groundbreaking for HelpAge in the region. It is the first time that a network organisation has led a regional project involving many countries and partners, with HelpAge International playing a supportive role.

ASEAN Secretariat: The ASEAN Secretariat coordinated the communication between ASEAN Member Countries and HelpAge Korea and facilitated the agenda of home care at the various meetings of the ASEAN bodies including SOMSWD+3, SOMHD+3, AMMSWD+3 and AMMHD+3. In addition, the ASEAN secretariat participated in the process of reviewing,

monitoring and evaluating the ROK-ASEAN Cooperation Project in collaboration with HelpAge Korea and HelpAge International.

Regional Advisory Committee: Once a year, members from HelpAge Korea, HelpAge International and the ASEAN secretariat met to review the progress to date, plan for the next steps and to guide the overall project objectives.

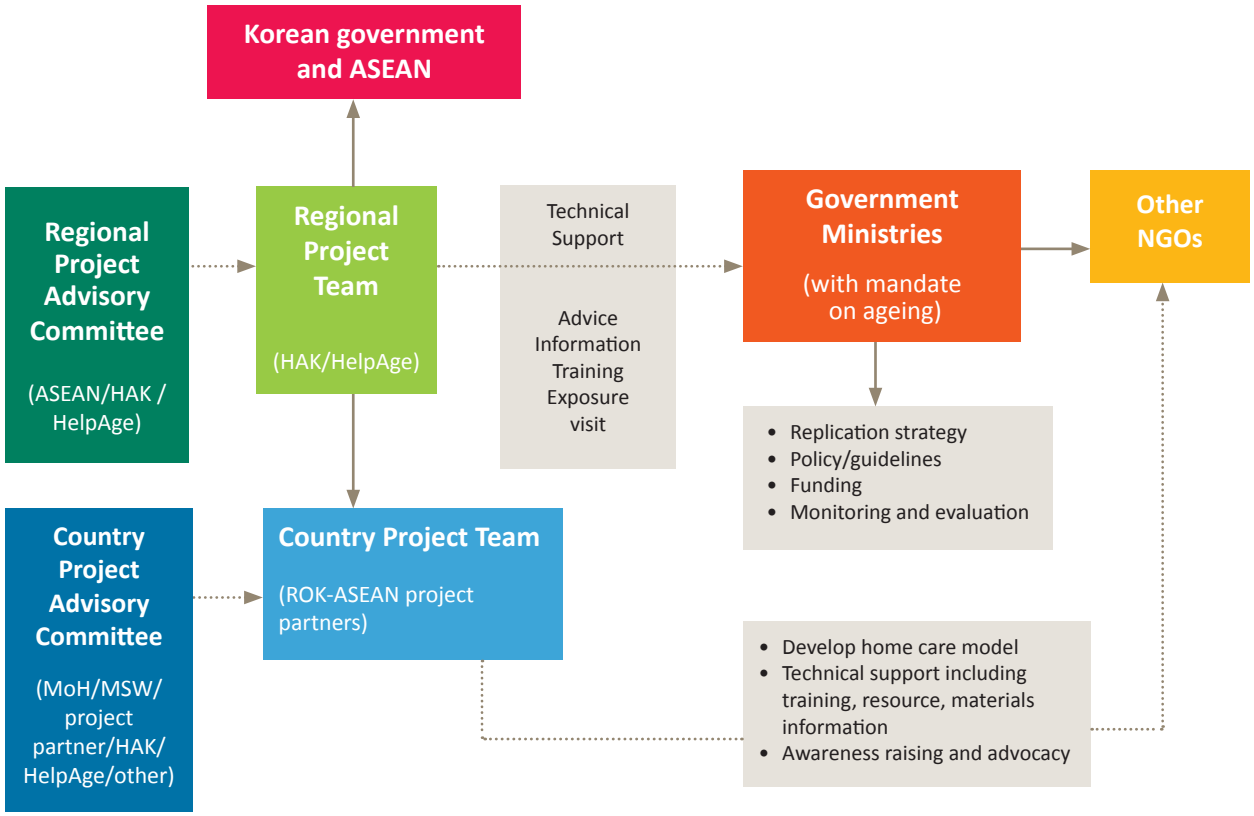
b. Key players at a country level

Volunteers: Volunteers are the frontline of service provision for the ROK-ASEAN model of home care. As of 2011, approximately 3,500 volunteers have provided volunteer home care to 4,500 older people in ASEAN. Depending on the country, volunteers visit 1-3 older people anywhere from every day to once every week. The services they offer depend on the needs of the older person, but as discussed earlier, generally include one or more of the following: befriending, home help, personal care, assistance with advanced home challenges and escorting. Volunteers are able to support older people to become aware of and access community resources and to assist them in participating in community organisations and social gatherings.

Community*:* The community participates in the home care project through supporting older people and volunteers. Informal support networks of the older people are invaluable components of the service process, as visitation by one home care volunteer can never fill all the social needs of a person. Community members including leaders and other community-based groups help with some aspects of case management and volunteer management and address other unmet needs beyond home care provided by volunteers. They often link older people to the home care project, make referrals, assist with mobilising resources and support participation of older people in community activities. The community should include home care in its development plans and allocate budget for the implementation of it.

Older people's associations: In the communities where OPAs exist, they are in a unique position to serve as an organised mechanism for meeting the care and support needs of their peers. OPAs are well-suited to liaising between the rest of the community and the older people. They advocate for and raise awareness of older people's concerns. The majority of older people are capable, with sufficient support, of effectively contributing to their community. Some become indispensable home care volunteers. They have more time compared to younger people and are unlikely to move away and look for new jobs

Figure 8: The organisational structure of home care model



after being trained. Volunteering has a positive impact on their own psychological wellbeing since it increases their social interaction. Working with OPAs and using capable older people as volunteers also reduces the dropout rate of volunteers.

Implementing agency: The implementing agency takes responsibility for developing the home care model, producing operational and training manuals, implementing home care and monitoring and reporting on the progress. Additionally, the implementing agency works with its government counterparts in formulating national policies and guidelines on home care. They also raise awareness and advocate for home care expansion and provide training and technical support to new organisations who wish to replicate the model, which could be NGOs, community-based organisations and government agencies. During the ROK-ASEAN Home Care Project, in nine of the ASEAN countries, an NGO was the implementing agency, while in Brunei, the Ministry of Culture, Youth and Sports filled the role. More information on some of the ROK-ASEAN Home Care implementing agencies can be found in the country profiles in the last section of this publication and information on case management and volunteer management is found on page 11.

National governments: National governments plays four important roles. The first is to learn from the ROK-ASEAN pilot home care project. This includes developing the national home care model in conjunction with the implementing agency in the country. The second role is to expand the model mainly through developing national policies on home care and funding expansion of the home care. A third role is to support the referral of older people to other services, as the home care approach cannot meet all of the health and social needs of older people. The last role is to monitor and evaluate regularly in order to ensure the quality of services provided.

Project Advisory Committee: The ROK-ASEAN home care approach establishes country Project Advisory Committees (PACs) as a communication channel between governmental and non-governmental organisations. The committees include a representative from the Ministry of Social Welfare and Health through the ASEAN focal point on health and social welfare in each country. In addition to linking with the two key government agencies (Health and Social Welfare), the PAC includes representatives from NGOs and academic institutions who focus on ageing issues. During the ROK-ASEAN Home Care Project, PACs were fully sensitised and informed about the home care project at regular meetings and participated in exchange visits to other countries. Their role was, therefore, to guide the pilot project, monitor and evaluate as well as to secure government support and home care policy development. In some countries, the PAC members, particularly from the academic sector, provided support on capacity building and training of project staff and volunteers. Even as the 10-year ROK-ASEAN pilot project has come to a close, the PACs in ASEAN countries continue to meet to work towards the expansion of home care in their countries.

IV. The steps of the implementation of ROK-ASEAN Home Care for Older People in ASEAN Countries

Implementation of the Home Care for Older People in ASEAN Countries- ROK-ASEAN, consisted of activities at the regional level and country level. These are some key steps taken and some steps were be concurrent and complementary to each other.

a. Activities at regional level

The first three steps were conducted at the regional level: 1) formation of a regional support body 2) grouping of partner countries 3) selection of NGO partners. After the selection of NGO partners, three more steps occurred at the regional level concurrent with and in support of the project implementation at the country level: 4) sharing the Korean Model, 5) coordination of regional events and 6) raising awareness of home care at the regional level.

STEP 1: Formation of the regional support body

- The regional project team was formed from HelpAge Korea staff and drew on their expertise in implementing volunteer-based home care with one additional recruit.
- A collaboration agreement with HelpAge International was made to establish and clarify roles and responsibility of two organisations, as HelpAge International took a supportive role.
- The Regional Advisory Committee (RAC) was established with ASEAN Secretariat, HelpAge Korea and HelpAge International representatives.

STEP 2: Grouping of partner countries

In order to minimise the difficulties of starting the project in all 10 countries at once, the member countries were divided into three groups based on their similarity in terms of capacity, needs and advancement in home care work and the start dates were staggered. This also enabled groups two and three to benefit from the experience of those who began before them.

- The 1st group was comprised of Indonesia, Philippines and Vietnam. And its first project period was September 2003–March 2006.
- The 2nd group was Cambodia, Laos, Myanmar and Vietnam. Its first project period was March 2004–March 2006
- The 3rd group was Brunei Darussalam, Malaysia, Singapore and Thailand. Its first project period was March 2005–March 2006

STEP 3: Selection of partners

- Partner organisation/s (implementing agencies) were selected in collaboration with HelpAge International and supported by the ASEAN Secretariat. In most cases, the partners were identified from the existing network organisations of HelpAge in each country. NGO partners were preferred due to the GO-NGO collaboration model, in which the NGO implements the project in the community and the government supports the project technically and financially. Initially, eight partner organisations were NGOs. As the project progressed, a government of Brunei was chosen to be a partner organisation.
- The list of partner organisations;
    - Brunei – Ministry of Culture Youth and Sports (MCYS)
    - Cambodia – HelpAge Cambodia
    - Indonesia – Yayasan Emong Lansia (YEL)
    - Laos – Lao Red Cross (LRC)
    - Malaysia – Persatauan Kebajikan *Usiamas Malaysia* (USIAMAS)
    - Myanmar – National Young Men's Christian Associations (YMCA)
    - The Philippines – Coalition of Services of the Elderly, Inc. (COSE)
    - Singapore – Tsao Foundation
    - Thailand – Foundation for Older Persons' Development (FOPDEV)
    - Vietnam – The Center for Ageing Support and Community Development (CASCD) (formerly RECAS)

STEP 4: Sharing Korean Model

Training in Korea was conducted at the beginning of each phase for the country PAC members (implementing NGO leaders, Ministry of Health, Ministry of Social Welfare, etc.) on topics relevant to that phase.

STEP 5: Learning and networking between ASEAN countries

Two types of regional events were used to promote sharing, learning and networking between implementing organisations in the 10 ASEAN countries. The events helped to enhance their capacity, raise awareness and increase visibility, which had positive effects on advocacy efforts at both regional and national levels.

- Exchange visits between countries were organised for country sub-groups. For example, in Phase 1, each of the three sub-groups met at least once a year. During the project period, partner organisations took turns hosting the visits.
- A regional conference on home care was organised at the end of each phase. The regional conference was attended by partner organisations, government counterparts and the regional advisory committee. It was also opened to other stakeholders such as academia, media and donors. It served as a forum for the partner organisations to share progress, lessons learnt and to give recommendations.

STEP 6: Raising awareness and advocacy at regional and international levels

Where possible, the Project Advisory Committee and the partner organisations as well as their government counterparts, employed relevant regional and international forums and events to share the project approach. This included:

- Regional meetings of ASEAN such as the various meetings of the ASEAN bodies including SOMSWD+3, SOMHD+3, AMMSWD+3 and AMMHD+3 and ASEAN Ministerial meetings and ASEAN NGO Forum.
- The HelpAge Regional Conference for its network in the Asia region was held once a year and currently every two years. Though the conference is mainly for civil society organisations in the HelpAge network, nearly half of the participants are from other development partners such as UN agencies, INGOs, academia, media and donors.

- Relevant regional and international events organised by other development implementing partners such as the MIPAA review by ESCAP and IFA Conference

More information on awareness raising and advocacy events can be found in the achievements and impact section on page 20.

b. Activities at country level

According to the GO-NGO collaboration model, the majority of implementation activities within the country are led by the implementing partner. After the partner is selected by the regional advisory committee, that partner is trained and supported throughout the implementation of the project. The steps at the country level, then, are: 1) Partnership agreement and formation of a project team and PAC, 2) development of the home care model through pilot project, 3) development of a national guideline for home care, 4) development of national policy/guideline and 5) expansion of the model.

STEP 1: Partnership agreement, formation of the project team and PAC

- An agreement was made between the regional level and the partner organisation to detail expectations for the partner organisation.
- A project team was formed for implementing the home care project. A project coordinator and field coordinators are recruited.
- A Project Advisory Committee (PAC) with MOSW, MOH and implementing partner was established.

STEP 2: Project orientation, planning and launch of project

- An orientation meeting on each phase was held in every country (project manager, field coordinators, government representatives). Partner organisations were assisted in developing a plan for the pilot project and ongoing support for implementation. Each year, at least one monitoring visit was conducted for each of the 10 project partners.
- A national lunch was organised in each country at the beginning of the project period to introduce the project. This also helped to raise awareness about the care needs of older people and how volunteer-based home care can help to address them.

STEP 3: Development of home care model through pilot project

- In the first phase of the ROK-ASEAN Home Care Project, each of the ten ASEAN countries, except Singapore, considered HelpAge Korea's VHCP model and then developed a home care model of their own, adapted to suit the local socio-cultural context.

In developing a model, the pilot project was conducted in select areas in each country. Based on the VHCP model, four key principles of the pilot project were:

- Volunteers are pure volunteers. No financial incentive is given, including transportation. No family members or relatives are used as caregivers. Recognition is used as the key incentive for volunteers.
- Home Care is providing care, not materials. It doesn't provide food, clothing, medical treatment, financial support etc.
- Start pilot project on a small scale. Start with 50 volunteers and 50 older people in one pilot area in order to manage it successfully. Recruit volunteers at the same village where older people live.
- Involve the government from the beginning. Involve government in the planning meeting, keep informing the government of the progress of the pilot, bring the government to monitoring visits of the project area and share both the successes and the failures.

This method was developed through the collaborative efforts of government organisations, NGOs and academic experts for the localisation of Home Care Model. The outputs of the pilot project

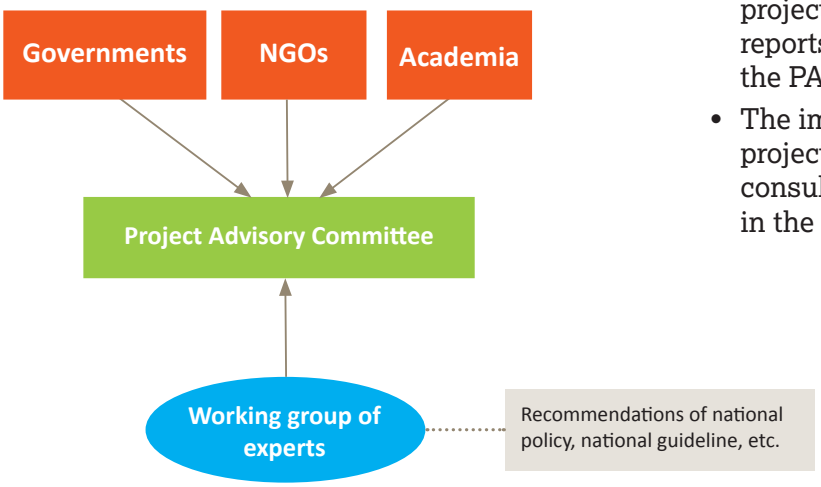
were to develop an operational manual for project staff members and to develop a training manual for volunteers suitable to the local context and using the local language.

STEP 4: Development of a national policy/ guideline of home care

The national policy/guideline is crucial for supporting expansion of the home care model across the country with support from the government, particularly in budget allocation. During the ROK-ASEAN Home Care Project, most countries started this process. Key tasks for this step are:

- A working group of experts is formed representing government, NGO and academia for making a draft of a national guideline of home care.
- A national seminar on home care is conducted to promote the draft guideline and get feedback from the participants: central and local government, NGOs, academia and the media.
- Advocacy should be emphasised throughout the process, so that the government will formally accept the draft guideline nationally.
- Depending on the local context, in order to ensure the implementation and make it permanent, legislate the programme.

Figure 9: Development of a national policy/guideline of home care



STEP 5: Expansion of the model

From the second phase of the project onwards, the main objective is to expand the home care model by replicating what was developed in the pilot project. The key strategy for expansion is to encourage the government to support funding to NGOs for the replication of the home care model into other locales. Details on how expansion was actually implemented during the ROK-ASEAN Home Care Project in the ASEAN countries can be found on page 21.

a. Steps of expansion

- Selection of the project area and new local partners
- Provision of orientation and training to the new partners and local governments
- Development of a plan for home care project expansion

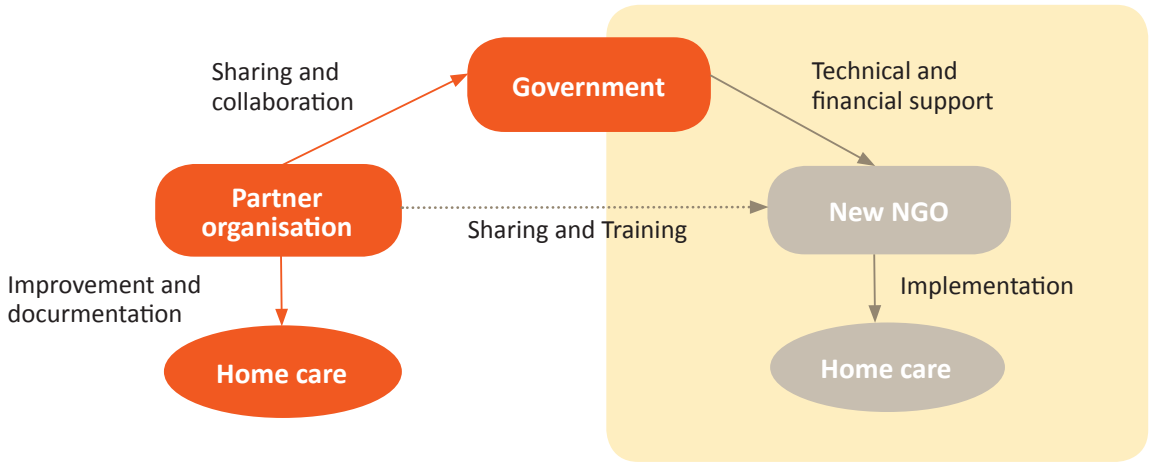
b. Requirements for successful expansion

- The guideline for implementing home care should be clear.
- Central government should mobilise funds to support the implementation of the project
- Local government should be sensitised to take initiative in supporting home care

c. Government-NGO roles

- The government provides technical and financial support for the implementation of the home care project. It also monitors and evaluates home care offered by new NGOs.
- The new NGO implements the home care project at the community level. It regularly reports the progress and financial statement to the PAC and/or government.
- The implementing agency of the pilot project provides training, technical support, consultation and shares the manuals developed in the pilot project phase.

Figure 10: The roles of government and NGO in replicating home care model



The roles of government and NGO in expansion and replication

The above diagram shows the recommended model for expansion and replication. However, replicating during the ROK-ASEAN Home Care Project period was undertaken through different approaches. In most cases, the implementing partners themselves expanded the model while supporting other interested organisations/ group either government agency or NGO including community-based organisations. In some countries, the government promoted replication through its own local structures or by encouraging NGOs to replicate without financial support.

Cost benefit analysis of home care

The Foundation for Older Persons' Development (FOPDEV), the Thailand partner organisation for the ROK-ASEAN Home Care Project, conducted a cost benefit analysis of the project in 2013. The analysis confirmed that FOPDEV's home care programme, as is, saved participating households in Chiang Mai 440,738 THB (US $14,405) in potential loss of income and 877,965 THB (US $28,696) in potential cost of hiring a private in-home care taker. Furthermore, by using a volunteer-based model, FOPDEV are able to run the programme at a cost of 539,000 THB (US $17,566) per year instead of 976,179.25 THB (US $31,906.42). This significant saving demonstrates the cost-saving outcomes of their programme and efficient use of funding. After the analysis the cost-benefit ratios of loss of family income, cost of families hiring an in-home care taker and the cost of FOPDEV paying their volunteers were 0.82, 1.6 and 1.81. Of the three cost-avoidance variables, only the first one, loss of family income, did not outweigh the home care programme costs. Of course, aside from the monetised benefits, there are a number of qualitative benefits that result from the home care programme.

The cost benefit analysis was done while the home care programme was already in a maintenance phase without the need of start-up costs. Therefore, the cost-benefit ratio for all cost-avoidance benefits remained the same over all five years. A programme requiring start-up costs would have a reduced cost-benefit ratio in the first year as there is need of more recruitment, training, administration and the like.

V. Achievements and impact of the project

Over the nine year duration of the project, much progress was made in the ASEAN nations in advocacy for and implementation of volunteer-based home care for older people. Below is a summative table of the principal quantitative elements of the project by country as of 2012. There were 3,697 volunteers who provided home care to 5,080 older people. Two countries had pre-existing national guidelines for home care, four accepted national home care guidelines and three others are in process of creating national guidelines. More detail on some countries can be found in the country profiles at the back of this document.

The principal quantitative elements of the project by country as of 2012

Country	No. of volunteer	No. of older person	Home care national guideline
Brunei	44	32	-
Cambodia	236	321	Accepted
Indonesia	541	1,212	Accepted
Laos	40	80	-
Malaysia	130	105	Accepted
Myanmar	1,224	1,404	In process
Philippines	366	867	Accepted
Singapore	-	-	Already established before the project
Thailand	118	216	Already established before the project
Vietnam	998	843	In process
Total No. of Home Care volunteers in ASEAN - **3,697**			
Total No. of older people cared by Home Care in ASEAN - **5,080**			

Note: This excludes 4,104 volunteers and 3,420 older people in areas replicated by other projects in Vietnam.

Expansion of home care in collaboration with government organisations (GO)-NGOs

The expansion of the home care project was achieved through the GO-NGO collaboration model in four countries: Indonesia, Malaysia, the Philippines and Vietnam. NGOs implemented the project, whilst financial support came from the government. However, in some cases, the expansion were funded and implemented by NGOs. In Myanmar, Cambodia and Thailand the government provided administrative support and NGOs provided funding and implemented the expansion. In Brunei, a government was the implementing partner and expansion and implementation was done by the government.

- **Brunei Darussalam:** The project was expanded into four districts, which covers all districts of Brunei, initiated by the Ministry of Culture, Youth and Sports.
- **Cambodia:** HelpAge Cambodia increased the number of areas implementing home care from 15 villages to 43 villages in Battambang province and Banteay Meanchey province.
- **Indonesia:** The Ministry of Home Affairs supported the expansion of the home care project areas to 15 provinces and set up a plan to increase the number of project areas up to 33 provinces by 2014.
- **Malaysia:** The project areas were expanded in seven areas supported by the Ministry of Social Welfare.
- **Myanmar:** The project was expanded to 73 townships with the active involvement of nine NGOs including HelpAge Myanmar Office23, National YMCA, Myanmar Red Cross Society and Myanmar Baptist Churches Union led by Ministry of Social Welfare, Relief and Resettlement.
- **The Philippines:** The number of project areas was increased to eight provinces in collaboration with local authorities and older people's organisations.
- **Thailand:** The Foundation for Older Persons' Development (FOPDEV) expanded the project areas into four districts of Bangkok and Chiang Mai in collaboration with local NGOs.
- **Vietnam:** The number of home care project areas was increased to 93 townships in 16 provinces by Center for Ageing Support and Community Development (CASCD) in collaboration with Vietnam National Committee on Ageing (VNCA) and Ministry of Labor, Invalids and Social Affairs and HelpAge Vietnam Office.

Development of national guideline on home care

A national guideline of home care was approved in three countries: Indonesia, the Philippines and Malaysia, while the project target number of countries was six. However, the approval process for a national guideline is currently underway in Cambodia, Myanmar and Vietnam as initiated by each government.

- **Brunei Darussalam:** Ministry of Culture, Youth and Sports expressed its interest in the recommendation of HelpAge Korea to develop the national guideline of home care at the project team meeting in Brunei Darussalam on July 2011.
- **Cambodia:** The Minister of Social Affairs, Veterans and Youth Rehabilitation (MoSAVY) committed to develop a national guideline of home care at a meeting with HelpAge Korea on April 2010. As a follow up activity, the guideline was drafted by the Department of Ageing and Welfare of MoSAVY in collaboration with the working group of home care and it was approved in December 2012.
- **Indonesia:** Home care was adopted as a national programme under the Ministry of Social Affairs Decree No. 67/Huk/2006 on Home Care Guidelines in 2006. Ministry of Social Affairs announced to increase the total number of home care beneficiaries up to 100,000 in 33 provinces by 2014.
- **Malaysia:** The Department of Social Welfare issued a "Guideline of Home Care" to all interested NGOs on April 2011. Further, the high level committee meeting on Senior Citizens chaired by the minister on June 2011 chose the home care project for future development.
- **Myanmar:** The development of a national guideline of home care drafted by the Ministry of Social Welfare, Relief and Resettlement is in the approval process from the cabinet of Myanmar.
- **The Philippines:** The forum on the Expanded Senior Citizens Act of 2010 and on the National Guidelines on Home Care was conducted in partnership with Davao city through the Department of Social Welfare (DSW) and Development Office and with the city councillor assigned for older people. In addition, a Memorandum of Agreement was made between COSE and DSWD-National Capital Region for partnership in the implementation of the home care programme.
- **Vietnam:** The Law for Elderly People (November 2009) incorporates various guidelines including home care and was drafted with active participation of the Project Advisory Committee members for the ROK-ASEAN Home Care Project.

Enhanced awareness on the positive impact of home care

The ROK-ASEAN Home Care Project made use of several opportunities to share its experiences of home care in the region and to spread the message across different development players. This includes national governments through relevant ministries, inter-ministerial and inter-governmental bodies such as ASEAN, multilateral bodies such as ESCAP, international organisations and academic and research institutions.

Advocacy and awareness raising activities

- The 2nd ASEAN Plus Three Health Ministers Meeting on 20 June 2006 in Yangon, Myanmar
- ESCAP Expert Group Meeting on 30 June–1 July 2006 in Shanghai, China
- HelpAge International Regional Conference on 7–10 November 2006 in Pondicherry, India.
- ESCAP High-level Meeting on the Regional Review of the Madrid International Plan of Action on Ageing (MIPAA) on 9–11 October 2007 in Macao, China
- AARP Community 50+ Asia: Building The Future Together on 23–25 January 2008 in Hawaii, USA
- The 3rd ASEAN Plus Three Health Ministers Meeting on 8–9 October 2008 in Manila, Philippines
- HelpAge International Regional Conference on 14–16 October 2008 in Bali, Indonesia.
- IAHSA 8th International Conference 'Leadership Beyond Borders' on 20–22 July 2009 at Queen Elizabeth II Conference Centre in London, England
- International Federation on Ageing 10th Global Conference on 3–6 May 2010 in Melbourne, Australia
- The 3rd ICSD Asia Pacific Conference on "Vision of Social Development in the Globalized Asia: Commonality and Diversity" Hoam Faculty House, Seoul National University on 10 – 12 November 2010 in Seoul, Korea
- ASEAN Plus Three Ministerial Meeting for Social Welfare and Development on November 2010 in Brunei Darussalam

- Asia and Pacific Alliance of YMCAs North East Asia YMCA Forum organised by Asia and Pacific Alliance of YMCAs on 22–24 January 2011 in Incheon, Korea
- Regional Forum on Elderly Care Services in Asia and the Pacific organised by ESCAP on 21–22 January 2011 at Zijin Hall, the Purple Palace Nanjing in Nanjing, China
- Sub-regional Meeting on Enhancing Long-Term Care and Social Participation of Older Persons in East and North-East Asia, organised by ESCAP November 2011 in Korea

Impact of ROK-ASEAN Home Care Project

As reported by the implementing partners within each country and the regional Project Advisory Committee, the impact of the home care project on key stakeholders was as follows:

Older people

- Older people were able to maintain their physical and mental ability to perform their activities of daily life.
- They had increased sense of self-esteem and respect, social interaction and access to services.
- They reported greater life satisfaction and improved quality of life of the poor, lonely and frail older people.
- Home care increases the amount of time older people can live at home functionally.
- There was a reduced risk of being neglected, abused and abandoned due to family's inability to effectively cope with care and support needs of older people.

Family members

- Support for family members' care of older people in the home increases successful outcomes for in-home care as older people require more assistance.
- The help of a volunteer enables many family members to work more hours and provide income for the family including older person care.
- There was improved psychological wellbeing of family members because of reduced stress from full-time care and increased ability of the family caregiver to have engagement in community activities. This was particularly true for those caring for an older family member with a high level of care needs.
- There was a reduction in family tension and conflict created by the burden of care.

Community

- There was an increased awareness and understanding of older people care and support needs, older people's concerns and exposure to their situation.
- The creation of a community forum to discuss ways to improve living condition of older people was observed.
- A strong network of organisations committed to and engaged in home and community care programmes for older people is emerging in the region. This is expected to spearhead a home care movement with and for older people in the near future.
- Volunteerism strengthens community relationships and traditional support systems, which have a positive impact on other aspects of community development and services.
- Other vulnerable groups such as people with disability and those who are chronically ill and need care and support also benefit, since volunteers, where possible, extend services to other who have similar needs.

Local partner organisations

- Organisational and staff capacity of local partner organisations was enhanced, through involvement in the design, implementation and management of innovative, location specific and culturally appropriate home care and other development interventions.
- The implementing agencies' visibility was increased through national events and engagement with key concerned agencies, which positively affected several aspects of their work including policy advocacy and fundraising.
- Stronger networking among partner organisations has led to increased sharing and learning as they support each other on home care and other areas of work.
- The implementing agencies' relationship with key government agencies was strengthened, particularly the ministries and bodies with a mandate on ageing such as the Ministry of Social Welfare and Development, the Ministry of Health and National Committee on Ageing.

Governmental organisations

- Local and national governments' awareness of and support for volunteer-based home care increased.
- The programme is recognised as a cost-effective social intervention and an integral component of the primary healthcare system. ROK-

ASEAN Home Care Project research reports on various home care programme models and the experiences and insights gathered through practical projects have given the much needed evidence to advocate for the necessary policy and programme development.

- The ROK-ASEAN Home Care Project in the region has succeeded in forging close partnerships between government organisations and NGOs working on ageing issues.

The volunteer home care model has influenced the ageing debate in the region and been shared by HelpAge International with its network members and partners in Asia and Latin America.

Impact evaluation

In addition, the impact evaluation was conducted by external reviewers. It concluded that all ASEAN Member Countries reported that the home care project is more than satisfactory. Surveys using a five-point Likert scale were given to five target groups with questions specific to that group of stakeholders. Each survey included questions on five areas of evaluation.

Target groups are older people, volunteers, family members, community members and government officers.

Evaluation areas

- *Familiarity* or knowledge of the programme
- *Acceptability* of the services from a cultural point of view
- *Favourability* or approval of the programme
- *Importance* attached to meeting the needs of disadvantaged older people
- *Influence* of the programme on promoting community involvement in caring efforts

Principles

- Every country used the same evaluation methodology.
- The evaluation was done by external reviewers.
- Sampling was done randomly except for government officers.
- The result of the impact evaluation was shared at the Project Advisory Committee (PAC) meeting.

Period: September–December 2012

Result

- As the results are scored on a scale of 1–5, any score higher than 2.5 is more than satisfactory. The average across the countries was 3.5. All countries scored over 2.5, which mean that the impact of the project is more than satisfactory.
- The evaluation reports showed average scores across areas of evaluation and target groups as Brunei (2.84), Cambodia (3.12), Indonesia (3.72), Laos (3.81), Malaysia (3.80), Myanmar (3.78), Philippines (2.77), Thailand (3.70) and Vietnam (3.72).
- In Singapore, home care is conducted differently from the ROK-ASEAN Home Care Project and did not complete the impact evaluation.

VI. Limitations and challenges

The Home Care Project has been implemented successfully in most of the countries, but limitations and challenges still exist. Representatives from the 10 ASEAN Member Countries met at the 'ROK-ASEAN Home Care Conference for Older Persons' which was held in Malaysia on 22–25 May 2012 to conclude the Home Care Project. Continuing challenges were recognised. First, home care services provided by unpaid volunteer are not sufficient for older people who are suffering from non-communicable diseases, limited mobility, or without access to an appropriate healthcare system. Second, to expand the Home Care Project nationwide, collaboration between government organisations and NGOs is required. Some barriers to this collaboration are a lack of capacity within implementing organisations, a lack of professional manpower on ageing and limited funding supported by government. Third, approving a national guideline for home care by governments and creating action plans which include it is required. However this is often delayed due to a lack of understanding of ageing issues and a limited capacity for developing policy framework by the governments. Fourth, in some countries, while national home care guidelines have been adopted by the central government, the expansion of home care is still slow. Local authorities may not understand home care and there is often a lack of budget allocation by local authorities. Fifth, collaboration and cooperation are needed between government organisations which are implementing home care projects under different ministries.

VII. Conclusion

The ROK-ASEAN Home Care Project was implemented by HelpAge Korea for nine years from April 2003 to May 2012 in collaboration with HelpAge International, government organisations and NGOs in ASEAN Member Countries with funding by the ROK-ASEAN Special Cooperation Fund. The impact evaluation report conducted by all ASEAN Member Countries says that the impact of project is more than satisfactory.

During the project period, the home care model developed by HelpAge Korea was adapted according to the country context in each ASEAN Member Country. The model was successfully expanded to other areas. In Indonesia, Malaysia, the Philippines and Vietnam, the government established home care service delivery systems through government and NGO collaboration. National home care guidelines have been approved in Cambodia, Indonesia, the Philippines and Malaysia. The process of developing national guidelines is currently underway in Cambodia, Myanmar and Vietnam.

The outcomes of the ROK-ASEAN Home Care Project were disseminated and promoted in various international conferences organised by ASEAN, UN agencies, international organisations and related institutions. HelpAge International also adopted care as one of their main strategic areas of focus.

In spite of the success of the Home Care Project, limitations and challenges still exist due to limited services provided by volunteers, lack of policy frameworks, a lack of collaboration between government and NGO and a lack of capacity in terms of implementation, manpower and budget. Therefore, it is necessary to continue to strengthen collaboration between and capacity within the involved governments and NGOs.

Complemetary solutions need to be developed to provide various services for older people at the community level to help fill other gaps in the continuum of care. To that end, HelpAge Korea, with ROK-ASEAN support, is currently implementing the community-based service for older people project in Cambodia, Laos, Myanmar and Vietnam, which addresses more advanced health and social care needs of older people.

In conclusion, the ROK-ASEAN Home Care Project has provided valuable experience to ASEAN Member Countries in home care and community based welfare policy on ageing, which contributes to the quality of life of older people. The government of the Republic of Korea's support has been essential to this project and the Korean model of home care has served the ASEAN nations as a strong foundational model for their own home care models. It is hoped that this model can be expanded within ASEAN, as well as learnt from and implemented in other countries across the globe to the benefit of millions of vulnerable older people with home care requirements.

Section 3: Country profiles

Cambodia

NGO partner and project team

HelpAge International – Cambodia Office

- Project manager (part-time)
- Project coordinator (part-time)
- Field coordinator (full-time)
- Community organisers (5 part-time)

While the project covers only the position of home care field coordinator for the implementation of home care activities, other HelpAge project team members, notably the community organisers regularly extend their support in the implementation of the ROK-ASEAN activities in the project villages.

Project Advisory Committee (PAC)

- Ministry of Health
- Ministry of Social Affairs, Veterans and Youth Rehabilitation
- Provincial Department of Social Affairs, Veterans and Youth Rehabilitation
- Village Support Group (partner organisation)
- HelpAge International- Cambodia Office
- HelpAge International
- HelpAge Korea

Note: X for project area O for known areas of home care expansion

Project areas

- Piloted area: nine villages in Banteay Meanchey (2004)
- Expanded area: six villages in Battambang in 2008 and 28 villages in 2010 (14 villages in Battambang and 14 villages in Banteay Meanchey)
- By 2012, 43 villages were covered (23 villages in Banteay Meanchey and 20 villages in Battambang).

Number of volunteers: 236

Age		Gender		Job		No. of older people taken care of by a volunteer		No. of visits per week		Total years of volunteering	
50-60	80%	M	17%	Housewife	0%	One person	0%	<once a week	0%	< 1 year	67%
60-70	20%	F	83%	Farmer	100%	Two people	29%	Once a week	78%	1-2 years	16%
70-80	0%			Student	0%	Three +	7%	>once a week	22%	2-3 years	0%
80+	0%			Small business	0%					3+ years	17%
				No job	0%						
				Other	0%						

Number of older people: 321

Age		Gender		Family status		Disease (possible to check more than one)		ADL (Activity of Daily Living)	
50-60	5%	M	21%	Live alone	28%	Hypertension	12%	No ADL limitations	81%
60-70	31%	F	79%	Live with spouse *(without children)*	17%	Diabetes	1%	ADL limitations	19%
70-80	44%					Paralysis	7%		
80+	21%			Live with family members	55%	Dementia	1%		
						Cataract	14%		
						Others	65%		

Cambodia home care model:

Integrate home care with the older people's association (OPA) mechanism

Home care is established in villages where there are OPAs. A set of services are offered to an older person in his/her own place; types of care include: (1) holistic, (2) physical (3) psychological/ emotional, (4) social, (5) spiritual and (6) environmental.

A home care subcommittee of leaders consisting of 2 to 3 members is formed under each OPA to support the implementation of home care activities and to act as case manager.

The home care subcommittee has the following role:

- following up on the activities of volunteers
- visiting older people/recipients with volunteers
- giving information to home care volunteers about various services or social activities of interest to older people
- reporting activities of home care to older people's association committee leaders and request OPA assistance for recipient(s) in need (e.g. subsidising cost of transportation to health centre, ensuring coverage during periodic food gaps, ensuring school attendance of grand children, etc.)

Volunteer-based home care

Volunteers are selected in the community to deliver the service. These volunteers are recruited through community consultations. The services they provide include: companionship and emotional support; housekeeping – cleaning, cooking and washing; personal care – assisting in eating, bathing, dressing, personal hygiene; escorting to health facilities, temple, market, bank, etc.; physical living condition improvement-sanitation, taking blood pressure and arranging volunteer doctors to visit; supporting medical treatment.

Volunteers are trained by the project staff on their role and responsibilities, communication with the older people, the ageing process and common health issues of older people. They are encouraged to join communities' regular meetings, receive annual awards and are given small gifts on special occasions.

The OPA committees recruit villagers to be the volunteer of home care through village meetings or individual invitation. The volunteers usually are those who fit with the basic volunteer criteria and live nearby to the older people. Most of the volunteers are women as most of the tasks are traditionally done by women in Cambodia.

The type of services provided by volunteers depends on the needs of the older people.

In Cambodia some of the most common tasks done by volunteers include:

- cooking
- carrying water
- contact the older people's association (OPA) and village leader when they are sick
- home visit and carry messages for the older person at home

Other services provided include:

- cleaning of house or clothes
- escorting to the *sala chortien* (village meeting place)
- transport to relatives' houses
- referral and assistance with transport to health centre
- assist with arranging a blessing ceremony when she is very sick
- assist older people to attend health camp
- provide information on health service

HelpAge encourages the OPAs to recruit younger people as volunteers but it is very difficult to keep them in the village due to migration of adult people. The volunteers that tend to remain longer in the programme are women over 50.

Validation of the model at national level

The Project Advisory Committee is following up the progress and validating the process and approach.

Impact evaluation results summary:

Areas of evaluation	Older people	Volunteers/ caregivers	Community people	Government officials
Familiarity	3.13	3.40	3.47	3.17
Acceptability	3.47	3.67	3.60	3.67
Favourability	3.53	3.70	3.60	3.77
Importance	3.37	3.57	3.67	3.60
Influence	3.50	3.60	3.47	3.87
Average of total score	**3.40**	**3.59**	**3.56**	**3.62**

Note: All the data is rounded up to the second decimal. This is on a scale of 1–5 with results between 3-4 indicating high satisfaction with the programme.

Lessons learnt

The project evaluation highlighted that the system of volunteer caregivers goes a long way towards rebuilding the trust among villagers, as evidenced by the good relationships between older people and the caregivers. This builds the image of the community as an interactive organism that cares for its members. More effort needs to be given to raising the awareness of non-OPA members in the villages. In particular, the younger generation needs to be brought into the equation.

Home care, as developed in the ROK-ASEAN model, can be a complementary service to the primary healthcare system. The health camp, a village based health consultation promoted by HelpAge Cambodia office, delivers the most basic of health educations and conducts simple screening and consultation.

The Ministry of Social Affairs (MoSVY) recognises that the home care programme is culturally acceptable and the approach is appropriate and effective. MoSVY aims to validate the approach with the endorsement of a national guideline for home care in the near future and to promote its replication throughout the country.

National home care policy

Home care approach is regarded by the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) as a good model. The MoSVY recognised that the home care programme is culturally acceptable and the approach is appropriate and effective. As a result, MoSVY has validated the approach with the endorsement of a national guideline for home care in December 2012 to promote its replication throughout the country.

Case study

Chhouk Sokhum, 53

Chhouk Sokhum lives in Ek Phnom district, Battambang province. She has a 78-year-old mother, Bou Phan, who is a participant in the home care project. Chhouk Sokhum is on ART medication and has three grown children who live far away on the Cambodia-Thai border.

The older people's association selected her mother as a home care recipient so she now has a volunteer caring for her.

Chhouk Sokhum says:

"I have time to work in another town for a few days a week and can come back to visit her (mother).

"Since my mother has a volunteer, I worry a lot less about her while I am away.

"Having a volunteer has made a huge difference to my family because I can earn a living."

Indonesia

NGO partner and project team

Yayasan Emong Lansia (YEL)

- Project manager
- Project coordinator
- Field coordinator
- Administrative staff

Project Advisory Committee (PAC)

- Coordinating Ministry of People's Welfare
- Ministry of Social Affairs
- Ministry of Health
- National Board on Population and Family Planning
- University of Indonesia
- HelpAge Korea
- HelpAge International

Project areas

As of 2012, home care projects are implemented in 17 locations at the sub-district level in 15 provinces. There are 541 volunteers serving 1,212 older people.

Map: X for project area O for known areas of home care expansion

Piloted area: Tegal Alur, West Jakarta

Expanded area:

No	Location (sub-district level)	Province	Funded by govt	Funded by NGO/ YEL
1	Cilincing	Dki jakarta	√	
2	Sleman	Di yogyakarta	√	
3	Semarang	Central java	√	
4	Aceh besar	Nad	√	
5	Banda aceh	Nad		√
6	Tangkil	Di yogyakarta		√
7	Surabaya	East java	√	
8	Sukabumi	West java	√	
9	Banjarmasin	South kalimantan	√	
10	Lampung	South sumatra	√	
11	Denpasar	Bali	√	
12	Mataram	East nusa tenggara	√	
13	Bukit duri	South jakarta		√
14	Gowa	South sulawesi	√	
15	Tasikmalaya	West java	√	
16	Garut	West java	√	
17	Samarinda	East kalimantan	√	

Number of volunteers: 80

Age		Gender		Job		No. of older people taken care of by a volunteer		No. of visits per week		Total years of volunteering	
20-29	14%	M	3%	Housewife	92%	One person	12%	<once a week	0%	< 1 year	3%
30-39	40%	F	97%	Farmer	0%	Two people	88%	Once a week	12%	1-2 years	31%
40-49	40%			Student	0%	Three +	0%	>once a week	88%	2-3 years	11%
50+	6%			Small business	8%					3+ years	55%
				No job	0%						
				Other	0%						

Number of older people: 185

Age		Gender		Family status		Disease (possible to check more than one)		ADL (Activity of Daily Living)	
50-60	0%	M	24%	Live alone	10%	Hypertension	53%	No ADL limitations	21%
60-70	35%	F	76%	Live with spouse *(without children)*	24%	Diabetes	36%	ADL limitations	79%
70-80	51%					Paralysis	5%		
80+	14%			Live with family members	65%	Dementia	4%		
						Cataract	14%		
						Blind	15%		
						Others	18%		

YEL, the NGO partner, follows the ROK-ASEAN model of volunteer-based home care. However, in the expanded areas which are financed by the government, the model has been modified to include transportation funds and lunch money for volunteers. Older people in need of home care are identified by field coordinators, volunteers and health and social workers in the area and their needs are assessed by YEL staff.

Volunteers are recruited within the communities where the older people live by a variety of methods. A one-day seminar is held to introduce the project. As with identifying older people, some volunteers are nominated by the field coordinator, community leaders and health and social workers. YEL also recruited through the existing volunteer organisations. Potential volunteers have to submit an application and are selected according to set criteria such as age, willingness and health status.

The selected volunteers receive training suitable to the needs of the older people to whom they are matched. The training is based on the module jointly developed and published by the Ministry of Health, Ministry of Social Affairs and YEL. Volunteers are generally responsible to visit two older people, each for one visit a week. There are 25 volunteers who were recruited for each location to serve 50 older people. If there are more older people in need of home care, they are placed on a waiting list. Apart from the support from the NGO, the volunteers do their tasks in close collaboration with their respective local government.

The type of services provided by volunteers depends on the needs of the older people.

Examples of some of these individualised services include the following:

- befriending (chatting)
- escorting (to health centre/hospital, attending social activity)
- massage
- basic healthcare (taking blood pressure)
- cleaning the living area of the older person
- cooking

Replication strategy

Provincial offices of the MOSA who are interested in and suitable for the implemention of the home care programe are identified by the MOSA. A seminar is organised to introduce the ROK-ASEAN Home Care model to concerned government agencies and local NGOs and a suitable local NGO is selected for piloting at the sub-district level. In each province, one local NGO is supported by the local government with financial support and guidance from the central government. This NGO must work with ageing or other social issues such as children's rights and they have to be registered with the provincial welfare office to be eligible. The financial support from the central government is for two years and the local government is expected to take it forward. Incentive to motivate local government by providing a top-up budget is being introduced.

Impact evaluation results summary:

These results are based on a 1–5 scale in which 3–4 indicates a high level of satisfaction.

Areas of evaluation	Older people	Volunteers	Caregiver	Community people	Government officials
Familiarity	3.62	3.77	3.79	3.50	3.88
Acceptability	3.69	3.92	3.80	3.50	3.80
Favourability	3.85	4.00	3.91	3.40	3.61
Importance	3.66	3.90	3.71	3.33	3.91
Influence	3.63	3.80	3.80	3.37	3.69
Average of total score	**3.69**	**3.80**	**3.80**	**3.42**	**3.80**

Challenges faced

In Indonesia, the government-funded home care services provide a small stipend to home care workers for transportation and lunch, while the ROK-ASEAN model which Yayasan Emong Lansia uses is purely volunteer. This sometimes leads to complaints from volunteers about equity. Another issue is that the older people have many more needs than the home care volunteers can meet. For example, when an older person is hospitalised, they need someone to stay at the hospital with them because of the Indonesian healthcare system demands. Volunteers are generally unable to stay all day every day. Also, many of the older people with more severe health needs such as dementia, require professional home care, but are unable to afford it. Therefore, the volunteer-based home care strategy must be paired with other care strategies to fully meet the needs of an ageing population.

Lessons learnt

Understanding of relevant policies and legislation and procedures for their formulation, are essential in policy advocacy. This information is very helpful for lobbying policy makers.

Policy advocacy is not a one-off activity; it needs continuity since policy makers often change their roles and responsibilities. Therefore, orientation with newcomers and building working relationships should be an on-going effort.

The involvement of local governments is one of the key factors for expanding coverage of the home care project. However, they often lack of motivation and the local NGO implementing the pilot project, which is initially financed by the central government, may face funding challenges. The policy of topping up budget from the central government after the initial two-year period seems to work fairly well.

Some successful strategies for retaining volunteers are to recruit female volunteers since they often stay longer than male volunteers and to mobilise additional resources to support volunteers in meeting additional needs of older people under their care. Types of activities can be decided in consultation with the volunteers to ensure that the activities address the volunteers' needs.

Involving the media has proved successful in raising awareness on ageing issues and home care needs for older people. They should always be invited to national/regional events and field visits to the project should also be arranged so that they have first hand experience. Media can be very helpful for community mobilisation as well.

National home care policy

As part of the project, an evaluation at the end of the ASEAN Home Care Project Phase 1 in 2006 conducted by an external evaluator from a well-known university was presented to the Ministry of Social Affairs. The findings showed the volunteer-based home care model developed is a useful and appropriate programme for assisting older people. This led to the formulation and approval of the National Policy on Home Care, Ministry of Social Affairs Decree No. 67HUK/2006 on Home Care. The Decree has greatly facilitated the promotion and expansion of the home care model in the country.

In the last year of the ASEAN Home Care Phase 2, the National Forum on Home Care (2009) was held. The forum served as a venue for sharing and learning about addressing older people's needs through the implementation of the volunteer-based home care model among concerned government and NGO agencies. Along with the National Home Care Policy, it is considered as one of the facilitating factors for the successful replication of the home care programme.

Case study

Rusmini, 75

My husband passed away long time ago. He used to work at a factory. I have two children, a son and a daughter, 45 and 43 years old respectively. My son works at a factory nearby while my daughter works overseas. I live with my son, but he comes home very late in the evening. I am alone during the day. I am very happy that Suci (volunteer) visits me regularly and helps me with household chores and chats with me. She also escorts me to the *Puskesmas* (health centre) and to attend spiritual and social activities, checks my blood pressure, gives me a massage and once a year I get new clothes. My eyesight is not good anymore (cataract) and I have difficulty walking (Osteoporosis, bended backbone). I feel now that have another daughter, as Suci is always there for me when I need her.

Sucihati, 40

I have four children, the youngest is in junior high school. I have been a volunteer for the home care programme since 2005. I regularly visit Ibu Rusmini, sometimes five days a week, as she is lonely and has difficulty walking. I am very happy to be a volunteer through YEL, as I have made many new friends, have been able to join lots of social activities and trainings and now know the Local Authorities. My husband fully supports my activity. Before I became a volunteer I was often sick, but now I am very healthy and physically fit. I love being a volunteer.

Myanmar

NGO partner and project team:

National Council of YMCAs of Myanmar

- Project manager
- Project coordinator
- Field coordinator
- Administrative staff

Project Advisory Committee (PAC)

- Department of Social Welfare
- HelpAge Korea
- HelpAge Intenational
- Department of Health
- Department of General Administration
- Myanmar Women's Affairs Federation (MWAF)
- Myanmar Maternal and Child Welfare Association (MMCWA)
- Myanmar Red Cross Society
- Young Men's Christian Association (YMCA)
- World Vision
- Global Vision
- National Young Women's Christian Association (YWCA)
- HelpAge Myanmar Office
- Myanmar Baptist Churches Union (MBCU)
- Caritas Thailand
- United Nation's Population Fund (UNFPA)
- Department of Social Welfare

Project areas: 64

A. Piloted areas: Hliang Thayar, Insein managed by National YMCAs

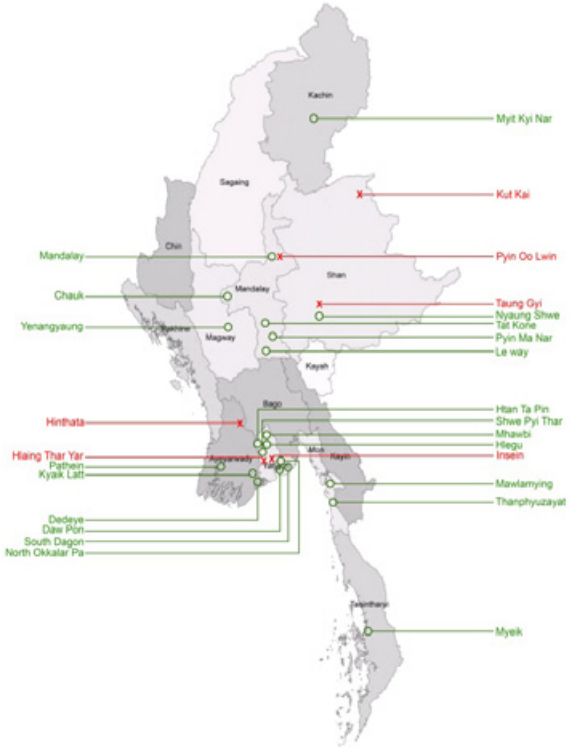
B. Expanded areas:

1. National YMCAs: PyinOoLwin, Hinthada, Kutkai and Taunggyi

2. MMCWA (Myanmar Maternal and Child Welfare Association): Mandalay, Tatkon, Yenangyaung, Chauk, DawPon, Mawlamying, Thanphyuzayat and Myeik

3. MWAF (Myanmar Women's Affairs Federation): Pyinmanar (Nay PyiDaw)

4. World vision: Pathain, HlaingThayar, Mhawbi and South Dagon



Map: X for project area O for known areas of home care expansion

5. Global Vision: ShwePyiThar, HtanTa Pin, Taunggyi, NyaungShwe, Dedeye and HlaingTharYar

6. Helpage International: Pathein, Pyin Oo Lwin and Kyite Latt

7. National YWCAs: North Okkalar Pa, Insein and Mhaw Bi

8. Myanmar Baptist Churches Union: Yangon

9. Myanmar Red Cross Society: Pyanmanar, Leway, Myitkyinar and Hlegu

Number of volunteers: 1,224

Age		Gender		Job		No. of older people taken care of by a volunteer		No. of visits per week		Total years of volunteering	
50-60	26%	M	32%	Housewife	40%	One person	56%	<once a week	17%	< 1 year	24%
60-70	25%	F	68%	Farmer	20%	Two people	11%	Once a week	29%	1-2 years	54%
70-80	24%			Student	8%	Three +	33%	>once a week	54%	2-3 years	11%
80+	25%			Small business	14%					3+ years	11%
				No job	5%						
				Other	13%						

Number of older people: 1,404

Age		Gender		Family status		Disease (possible to check more than one)		ADL (Activity of Daily Living)	
50-60	13%	M	35%	Live alone	36%	Hypertension	39%	No ADL limitations	49%
60-70	16%	F	65%	Live with spouse (without children)	14%	Diabetes	9%	ADL limitations	51%
70-80	47%					Paralysis	6%		
80+	24%			Live with family members	50%	Dementia	7%		
						Cataract	15%		
						Others	24%		

Myanmar home care model

Myanmar is unique among the ASEAN nations for the ROK-ASEAN Home Care project because in addition to its original partner organisation, the National YMCAs, the project has expanded to many areas with many implementing partners. These partners are HelpAge Myanmar Office, World Vision, Myanmar Red Cross Society, Myanmar Baptist Churches Union and Myanmar Maternal and Child Welfare Association. Older people in need of home care are identified by health officers, field officers, local authorities, volunteers from the community and the implementing NGO's project coordinator. Older people are chosen based on five criteria: frail, lonely, poor, without family support and 70 or above. Selected older people are given a needs assessment. Volunteers and older people are matched in consultation with the head of the village and leaders of the community according to commitment level, neighbourhood of the older person, willingness to serve and gender. Then, volunteers are trained according to the need of the older people with whom they are matched. Monthly monitoring by the project coordinator and reporting by the field officer helps to gauge the efficacy of the programme.

Volunteers receive training over three days on psychosocial support to older people, communication with older people, basic healthcare and hygiene, first aid and physical exercise. They are also introduced to the volunteer manual and are given guidelines for reporting on their cases. A refresher course was conducted with added topics of the history of home care and advocacy work for the national level. A national level gathering was also held for the volunteers. Volunteers were honoured annually for their service and involved in activities to encourage their continued participation. Workshops to share their experiences and essay competitions for volunteers and older people also increased project ownership by the volunteers.

The type of services provided by volunteers depends on the needs of the older people.

Examples of some of these individualised services include the following:

- companionship
- organising cultural and social activities
- cooking, washing, buying food, fetching water
- accompanying the older person to the hospital, clinic, place of worship, bank and market
- coordinating outreach healthcare services for older people such as health check-up and education

Volunteers visit older people 2–3 times a week individually. Once a month, volunteers visit older people in a group and do some health monitoring such as taking blood pressure and glucometer tests.

Impact evaluation results summary

These scores are based on a scale from 1–5. Scores from 3–4 indicate a high level of satisfaction with the project.

Areas of evaluation	Older people	Volunteers	Caregiver	Community people	Government officials
Familiarity	3.67	3.83	3.58	3.13	3.83
Acceptability	3.88	3.61	3.59	3.78	3.61
Favourability	4.00	3.73	3.72	3.70	3.85
Importance	3.80	3.59	3.69	3.57	3.80
Influence	3.87	3.81	3.54	3.67	3.68
Average of total score	**3.84**	**3.71**	**3.62**	**3.57**	**3.75**

Challenges and lessons learnt

- There is a need for a national policy, law and plan on ageing and guidelines to promote implementation of home care services.
- There are more older people who need care than can be offered home care due to financial limitations.
- Some of the older people's needs are beyond the scope of volunteers' roles and ability, which put pressure on volunteers in caring out their tasks.
- It is considered to be more culturally appropriate to have a volunteer be the same sex as older person receiving care. There is a shortage of male volunteers and recruiting male volunteers has been a challenging. This issue needs to be considered when recruiting and retaining volunteers.
- Some volunteers find it difficult to attend meetings regularly due to their work commitments. Different types of incentive depending on the local context can increase the commitment of volunteers.
- Coordination and communications between concerned agencies is improved through an agreed upon guideline and regular meetings.
- Using different mediums such as audio visual and print materials, linking with entertainment sector to raise awareness about older people's issues, including care and support needs, helped to build support from different sectors.
- Though the government has budget constraints and cannot provide financial support for local organisations to expand the model, the government can encourage national and international NGO to use their own resources for expansion, which has worked well.

National home care policy:

The national action plan on ageing and national home care guideline have been drafted. A review process to improve and finalise the two documents are being undertaken by the government, coordinated by the Ministry of Social Welfare, Relief and Resettlement. In addition, the government has expressed its willingness to advance the policy and legal framework on the ageing issue by developing a national policy and laws in the coming years.

Case study

Daw Khin Hlaing, 76

Daw Khin Hlaing is a widow and has only one son, who lives in another township and cannot look after her. She has hypertension and also cannot walk well.

Volunteer Thi Thi Aung is a 35 year old mother of two and her husband is a carpenter. Both of their parents are dead. As they are neighbours of Daw Khin Hlaing, they can take care of her like they would have their own parents. Daw Khin Hliang and Thi Thi Aung feel like mother and daughter and are quite close.

Thi Thi Aung helps out with many tasks around the house and tries to meet Daw Khin Hlaing's needs. She visits daily, does cleaning and takes care of her health. She sometimes takes her to the Pagoda and monastery to do meritorious deeds. Although her own son is unable to help her much, Daw Khin Hlaing receives love, kindness and care from her volunteer. This keeps her from feeling lonely and down-hearted. She is not worried about when she will die and she focuses on spending her last years happily.

The Philippines

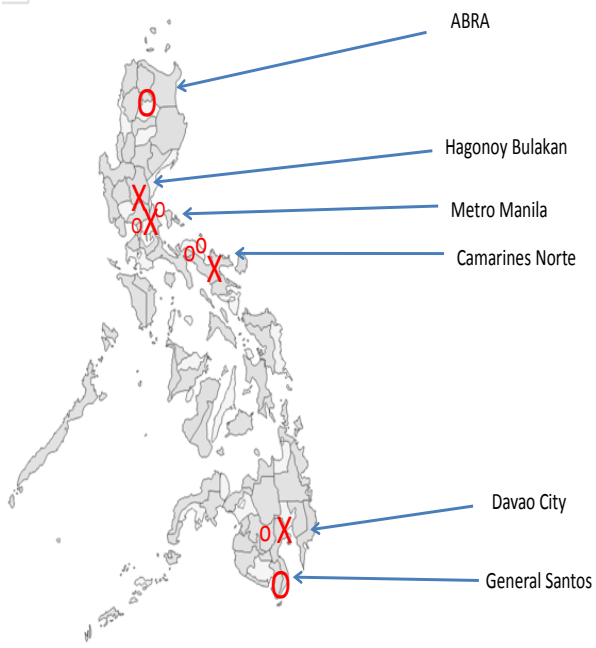
Partner and project team:

Coalition of Services of the Elderly, Inc. (COSE)

- Project manager (Executive Director)
- Project coordinator (CO Unit Coordinator)
- Field coordinators (Community Organiser - Province of Camarines Norte, Municipality of Hagonoy, Bulacan and Davao City)

Project Advisory Committee (PAC)

- Department of Social Welfare and Development
- Department of Health
- Department of the Interior and Local Government
- Philippine Society of Geriatric Medicines
- University of the Philippines Population Institute
- Coalition of Services of the Elderly



Map: X for project area O for known areas of home care expansion

PAC members in the project area

Camarines Norte	Davao City	Hagonoy, Bulacan
Provincial Social Welfare and Development Office Municipal Social Welfare and Development Office	Local government of Barangay Ma-a	Municipal Social Welfare and Development Office
Department of Health	Barangay Health Worker	Municipal Health Office
Camarines Norte Training and Educational Center	University of Mindanao	
Camarines Norte Volunteer Organizers and the Elderly Association (CNVOEA)	Barangay Ma-a Elderly Federation	Federation of Senior Citizen Affairs
Socio-Pastoral Action Center Foundation Incorporated (SPACFI)	Resources for the blind Handicap International	Office of the Senior Citizens Affairs
Public Safety and Emergency Management Office	Women's Federation	Municipal Councilors - Committee on women, children and Family - Committee on Rules, Laws and Privileges - Committee on Social Welfare
9 Parishes in the Diocese with Home Care Programme		Home Care Assistant Volunteer
		2 Concerned Individuals (Former Sangguniang Bayan Members)

Project areas

Province	No. of piloted areas	No. of expanded areas
Camarines Norte	5 municipalities	3 municipalities
Haaganoy, Bulacan	24 districts/villages	0
Davao City	1 district/village	5 districts/villages

Number of volunteers: 366

Age		Gender		Job		No. of older people taken care of by a volunteer		No. of visits per week		Total years of volunteering	
30-40	**23%**	M	**10%**	Housewife	**22%**	One person	**36%**	<once a week	**36%**	< 1 year	**34%**
40-50	**20%**	F	**90%**	Small business	**7%**	Two people	**14%**	Once a week	**26%**	1-2 years	**19%**
50-60	**24%**			No job	**49%**	Three +	**80%**	>once a week	**38%**	2-3 years	**31%**
60-70	**27%**			Others	**22%**					3+ years	**17%**
70-80	**6%**										

Number of older people: 867

Age		Gender		Family status		Disease (possible to check more than one)		ADL (Activity of Daily Living)	
50-60	**6%**	M	**31%**	Live alone	**13%**	Hypertension	**47%**	No ADL limitations	**49%**
60-70	**36%**	F	**69%**	Live with spouse *(without children)*	**16%**	Diabetes	**13%**	ADL limitations	**51%**
70-80	**36%**					Paralysis	**9%**		
80+	**22%**			Live with family members	**72%**	Dementia	**3%**		
						Cataract	**5%**		
						Others	**23%**		

The Philippines' home care model is based on the Korean model. The partner organisation, COSE, identifies older people in need of home care through older people's associations and community meetings. About 30% of older people in the communities require home care. Twenty per cent of volunteers are family caregivers and the remainder live in the communities where the older people live. Volunteers are often responsible to visit up to four older people.

The type of services provided by volunteers depends on the needs of the older people.

Examples of some of these individualised services include the following:

- monitoring of vital signs e.g. blood pressure, weight, respiratory rate, pulse rate
- conduct massage and reflexology
- spiritual services e.g. holy communion, confession, anointing the sick
- assistance to errands e.g. buying of medicine,
- home help services such as assistance in bathing, eating/feeding, hair cutting, nail cutting, house cleaning, taking medicines, etc.
- storytelling
- counseling
- physical exercise

Impact evaluation results summary

These scores are based on a scale of 1–5 with the country average of 2.72 indicating a slightly lower than satisfactory response to the overall programme.

Areas of evaluation	Older people	Volunteers	Caregiver	Community people	Government officials
Familiarity	2.74	3.00	2.54	2.78	2.67
Acceptability	2.89	2.86	2.64	2.81	2.93
Favorability	2.92	2.83	2.66	2.72	2.80
Importance	2.82	2.81	2.64	2.63	2.60
Influence	2.75	2.98	2.77	2.72	2.80
Average of total score	**2.82**	**2.90**	**2.65**	**2.73**	**2.76**

Challenges and lessons learnt

There were some challenges with implementation of the home care policies/guidelines relating to home care assistance at the local level due to various reasons

- There is no budget from the national level, so the project depended upon the budget allocation of the local government units and interest of the sitting administration.
- The majority of the home health volunteers are also home health workers. This led to a complication wherein older people expect medical services and medicines from all of the volunteers. This false expectation has left some volunteers feeling inadequate and some older people and their caregivers frustrated.
- The dropout of some volunteers, sustainability of the programme
- Promoting participation of key stakeholders such as NGOs, government agencies, academics to support the implementation.

The following factors have contributed to successful project implementation:

- Older people's organisations (OPO) coordinate home care assistance at the community level. OPO is one of the most effective mechanisms in addressing needs of vulnerable older people.
- The willingness of the community to support the project implementation and the positive response of family members on the services rendered by volunteers.
- The presence of the national guidelines on home care.
- Active involvement of PAC and openness of some local government units, NGOs and OPOs to support the programme.

National home care policy

The Department of Social Welfare and Development issued an Administrative Order No.04: Guidelines on the Home Care Support Services for Senior Citizens(HCSS) in 2010 with the objective to establish quality care for the frail, sickly, bedridden senior citizens in their own homes through their family/kinship carers and home care volunteers.

The Philippines provides a good example of how a National Home Care Policy develops. The legal history of the guideline is as follows:

A. Constitution of the Philippines 1987:

1) Article xv, *Section* 4, states that it is the duty of the family to take care of its elderly members while the State may design programme of social security for them.

2) Article XIII, Section 11 – provides that "The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the underprivileged, sick, elderly, disabled, women and children."

B. Republic Act 7876, "An Act Establishing a Senior Citizens Center in all Cities and Municipalities of the Philippines and Appropriating Funds Therefore". The law mandates the establishment of a senior citizens' center in all cities and municipalities under the direct supervision of the Department of Social Welfare and Development (DSWD) in coordination with the local government units (LGUs) concerned to cater to older people' socialisation and interaction needs as well as to serve as venue for the conduct of other meaningful activities.

C. Republic Act No. 7432 of 1991, An Act to Maximize Contribution of Senior Citizens to Nation Building, Grant Benefits and Special Privileges and For Other Purpose." The law made mandatory the granting of a 20% discount from all establishments relative to utilisation of transportation services, hotels and similar lodging establishment, restaurants and recreation centers and purchase of medicines anywhere in the country. It also exempted the senior citizens from the payment of individual income taxes. It installed the Office of the Senior Citizens' Affairs in the Office of the Mayor headed by a councilor which shall be designated by the Sangguniang Bayan and assisted by the Community Development Officer in coordination with the DSWD.

D. Republic Act No. 9257 of 2003, otherwise known as "An Act Granting Additional Benefits and Privileges to Senior Citizens, Amending for the Purpose RA 7432, otherwise known as An Act to Maximize the Contribution of Senior Citizens to Nation Building, Grant Benefits and Special Privileges and for Other Purposes. This Act, also known as the "Expanded Senior Citizens Act of 2003," benefits all Filipino resident senior citizens in the country.

E. Republic Act No. 9994 of 2010, otherwise known as "Expanded Senior Citizens Act of 2010."

Case study

My wife, Corazon, suffers from total blindness, arthritis and weakness due to old age. She commonly has coughs and colds due to sudden changes of weather. At the age of 76, her time is spent within the four corners of our makeshift house made up of light materials such as bamboo, nipa shingles, plastics, tarpaulin and laminated sacks.

Before, our main problem was who will look after our health. We can't afford to go to the doctor because we don't even have money for transportation expenses. We both need medical attention. I am also suffering from diabetes and a bad health condition. A wound below my left knee which I got from a vehicular accident more than ten years ago has not healed well.

But when Erlinda de Leon started to visit us as a home care volunteer, we felt some relief. She visits us twice a week or as often as necessary depending on our health needs.

As a home care volunteer, she always monitors our blood pressure and vital signs. She helps us prepare herbal medicines, helps my wife bathe and even provides us medicines she obtained from other sources. She evens cleans my wound and gives us advice from time to time on how to take care of ourselves. During typhoons and bad weather conditions, Erlinda informs us when there is a need to evacuate and how to get food and assistance from the baranguay. We thought that no one cares for our situation. But Erlinda helped us realise that we are still part of our community and that there are other people who care for us. Having a home care volunteer is a big help for me and for my wife.

Thailand

NGO partner and project team

Foundation for Older Persons' Development (FOPDEV)

- Project manager (part-time)
- Acting project coordinator (part-time)
- Field coordinator (1 part-time and 1 full-time)
- Administrative staff (part-time)

Project Advisory Committee (PAC)

- Bureau of Promotion and Protection of Older Persons, Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups, Ministry of Social Development and Human Security
- Bureau of Social Development and Services, Department of Social Development and Human Security
- Health Promotion Division, Department of Health, Ministry of Public Health
- Development Evaluation and Communication Office, Office of National Economic and Social Development Board (NESDB)
- Division of Public Health and Social Welfare, Department of Local Administration, Ministry of Interior
- Division of Health Promotion, Bangkok Metropolitan Administration (BMA)
- Senior Citizens Council of Thailand (SCCT), Bangkok
- Diocesan Social Action Centre, Archdiocese of Bangkok
- Thai Red Cross College of Nursing, Thai Red Cross Society
- National Health Security Office (NHSO), Bangkok

Map: X for project area O for known areas of home care expansion

- Faculty of Nursing, Chulalongkorn University, Bangkok
- Foundation for Older Persons' Development (FOPDEV)
- HelpAge International
- HelpAge Korea

Project areas

Piloted area: Four municipalities in Muang, Chiang Mai province

Expanded area: four communities Bangkok

Number of volunteers: 118

Age		Gender		Job		No. of older people taken care of by a volunteer		No. of visits per week		Total years of volunteering	
40-50	6%	M	6%	Housewife	12%	One person	44%	<once a week	53%	< 1 year	12%
50-60	36%	F	94%	Farmer	0%	Two people	30%	Once a week	19%	1-2 years	23%
60-70	42%			Student	0%	Three +	26%	>once a week	28%	2-3 years	1%
70-80	16%			Small business	11%					3+ years	64%
				No job	28%						
				Others	50%						

Number of older people: 216

Age		Gender		Family status		Disease (possible to check more than one)		ADL (Activity of Daily Living)	
50-60	1%	M	24%	Live alone	11%	Hypertension	49%	No ADL limitations	91%
60-70	20%	F	76%	Live with spouse *(without children)*	4%	Diabetes	8%	ADL limitations	9%
70-80	48%					Paralysis	8%		
80+	31%			Live with family members	85%	Dementia	1%		
						Cataract	4%		
						Others	29%		

Thailand's home care model is similar to the Korean model. The partner organisation, FOPDEV, identifies older people in need of home care through a variety of means such as community meetings and consulting community leaders and existing community health volunteers. Then, FOPDEV conducts a needs assessment created with technical support from academics. Volunteers are recruited within the communities where the older people live and receive training suitable to the needs of the older people to whom they are matched. Volunteers are generally responsible to visit two older people and occasionally go in pairs.

The type of services provided by volunteers depends on the needs of the older people and can include basic healthcare, psychological care, social care and other support. They may help with:

- personal care e.g. bathing, dressing, cutting nails
- providing food and/or personal items
- assisting older people in taking medicines
- encouraging and assisting older people to do exercise including passive exercise for rehabilitation
- coordinating with health professionals to visit older people
- organising social activities
- modifying and improving the home environment of the older person to facilitate mobility and prevent accident
- provide information on rights and entitlement and useful services
- other individualised services include the following:
- apply for official identification cards on behalf of the older person, so that the older person can utilise the card to apply for a health card and receive free health services
- provide local transportation for friends to whom the home-bound older people want to see/talk to or to take the older person to the market in the community
- seek financial and material donations through personal contacts to meet the basic needs of an older person.

Impact evaluation results summary:

This score is based on a scale of 1–5 and a score between 3–4 indicates a high level of satisfaction.

Areas of evaluation	Older people	Volunteers	Caregiver	Community people	Government officials
Familiarity	3.67	3.83	3.58	3.13	3.83
Acceptability	3.88	3.61	3.59	3.78	3.61
Favorability	4.00	3.73	3.72	3.70	3.85
Importance	3.80	3.59	3.69	3.57	3.80
Influence	3.87	3.81	3.54	3.67	3.68
Average of total score	**3.84**	**3.71**	**3.62**	**3.57**	**3.75**

Challenges and lessons learnt

- The government promotes a home care approach for which community volunteer are paid a small stipend, so recruiting and retaining unpaid volunteers is challenging as it is less attractive in terms of incentive.
- It is recommended to start by identifying older people who need care and their specific care needs, so that volunteers can be recruited based on the identified needs.
- Older people's socialisation needs can be honoured by bringing friends, neighbours and community to their home.
- While there is a range of services available for older people, it takes time to secure support for older people. Sufficient and up to date information on the referral system is required.
- Managing volunteers to provide care for older people in their home/communities requires specific knowledge, skills and particularly commitment. Recruitment and staff management has to be carefully planned, as a qualified project staff can better supervise volunteers.
- While it is vital to keep close and regular contact with volunteers, having one volunteer coordinator in each area can greatly reduce workload of a project staff and can also better serve older people and create sense of togetherness among volunteers.
- Collaborating with academics is beneficial in many aspects, such as for training staff, monitoring and evaluation and awareness raising (producing IEC materials by students for awareness raising, designing an age-friendly environment in older people's homes)
- Link with other projects and initiatives such as livelihoods projects, which can address the economic needs of older people and volunteers which is outside the project's scope and initiatives to promote volunteerism to boost morale and motivation of volunteers.
- Seek additional financial support by working with cooperate and mobilising resources by developing social business in age care. This approach can also address a high level of care needs.
- Conduct cost and benefit analysis can provide concrete evidences for promoting the volunteer-based home care approach.

National home care policy

Health and social care and services are indicated in the 2003 Older Persons Act. Advised by the National Commission on the Elderly, the Bureau of Promotion and Protection of Older Persons of the Ministry of Social Development and Human Security (MSDHS) launched the Home Care Volunteer for Older Persons in 2002 and piloted in eight provinces in 2003–2004. After its initial two years, the project was extended to one sub-district in all provinces and the local authority is expected to take it forward after the two year financial support by MSDHS. It is planned to expand to all sub-districts in 2013. However, the extent that services are provided and really meeting the needs of older people is unclear.

In 2007, Ministry of Public Health (MoPH) and MSDHS in collaboration with Japan International Cooperation Agency (JICA) developed a community-based integrated health care and Social Welfare Services Model . This has led to the second phase from 2013–2017 titled Project of Long-Term Care Service Development for the Frail Elderly and Other Vulnerable People. In parallel, the Ministry of Public Health (MoPH) launched the community –based long-term care in early 2013, but the actual implementation has not yet taken place.

The 2008–2011 Health Development Strategic Plan for the Elderly of the MoPH also addressed the long-term care needs of older people, by provided a combination of healthcare and social services within older people's home.

A result of the national social protection floor consultation hosted by ILO and the Ministry of Social Development and Human Security completed in 2012 and the report launched in early 2013 identified social care for older people as a major gap, which has led to a national assessment on long-term care for older people by ILO in collaboration with the research institute under MoPH.

Case study

Junthra, 85

Junthra is a widow. Her husband passed away many years ago. Her two sons died because of alcoholism and HIV/AIDS. Now she lives with her grandson, his wife and their three-year-old child. The grandson is the only one in the family who earns money and is a garbage collector. His wife has no job, but helps her husband sort the garbage. Junthra receives a social pension of 800 baht (US $24) per month so the family is very poor. The condition of her house in the past was so bad, with a leaking roof, no canopy around the front porch and no wall in the front section to keep out of wind, splashing rain in the rainy season and the cold in winter. This led to illness for Junthra and the whole family. The front terrace was also in the state of disrepair and molded which led to a risk of falling.

Junthra has high blood pressure. She cannot walk and needs help to move around. She can eat by herself, but cannot prepare food. She cannot see clearly and hearing has become another problem. She feels depressed from the physical limitations that prevent her even from going out for a walk so she just sits or lies at home.

Junthra has been receiving regular care from Kankeaw Maneerat, the volunteer from home care project and one of her friends. With support from FOPDEV, the volunteer and neighbours, her house has been repaired.

Her grandson does not have so much time to take care of her because he has to go out very early every morning to collect the garbage before the municipal garbage trucks will take it away. After bringing back the garbage, it must be separated before selling. So he has almost no time for his grandmother.

Janthra's grandson said:

"The volunteer from home care helps me a lot. Because of her help, I can use all of my time to work without having to worry about my grandmother.'' His wife added, "It is a big burden for me to be a house wife and to take care of a sick grandma along with my own small child. The volunteers help to reduce my burden, so I have more time for taking care of my child and helping my husband's job. It also reduces my stress because I have some free time to rest. Moreover, they also bring food and milk for the grandma and my child almost every week. If someone donated adult diapers to the foundation, we get it for her too. We need it, but we have no money to buy.

"Our volunteer always comes together with her friend because our grandmother can barely helpherself and the volunteer needs a helping hand. They are so kind. They help my grandmother a lot, giving her a bath, washing her hair, changing her clothes, combing her hair and cutting her nails." Finally, she added that, "I want this project to go ahead. It is good for my grandma who cannot go out. She wants someone to visit her and talk with her. It is a way to rehabilitate her mind towards the end of her life."

Vietnam

NGO partner and project team

Center for Ageing Support and Community development (CASCD, former RECAS)

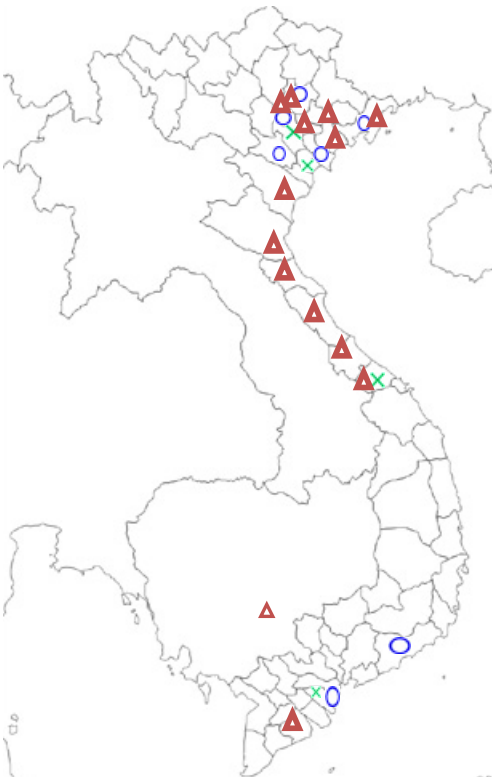
- Project director
- Project coordinator
- Assistant coordinator
- Administrative staff

Project Advisory Committee Members:

- National Assembly
- National Committee on Ageing
- Vietnam association of the Elderly
- Ministry of Labour, Invalids and Social Affairs
- Ministry of Health
- Vietnam Red Cross
- Center for Development and Consultancy
- Vietnam Women Union
- Academia: Former Prof. At Military hospital 108

Project area:

The project was piloted in 11 wards/communes in Hanoi Province and in three wards/communes in Hai Duong Province. The project has been expanded/replicated in a further 15 provinces within and beyond the ASEAN home care project. There were 5,120 volunteers who were trained to provide home care assistance to 4,263 frail older people in the following provinces: Hanoi, Hai Duong, Thai Nguyen,Nam Dinh,Quang Binh,Hoa Binh,Thanh Hoa,Nghe An,Ha Tinh,Quang Binh,Quang Tri, Ben Tre, Thua Thien Hue, Hcmc, Vung Tau and Khang Hao.



Map: X for project area O / for known areas of home care expansion within ASEAN home care project and beyond

Number of volunteers: 998

Age		Gender		Job		No. of older people taken care of by a volunteer		Total years of volunteering	
<50	7%	M	31%	Housewife	14%	One person	70%	< 1 year	20%
50-60	40%	F	69%	Farmer	48%	Two people	23%	1-2 years	40%
60-70	42%			Student	2%	Three +	7%	2-3 years	18%
70-80	10%			Small business	10%			3+ years	22%
80+	1%			No job	5%				
				Others	33%				

Note: It is difficult to confirm the visits/week as the visits depend on the need of older people. As most volunteers live near to the older people house, they can make a "visit" or just pass by to check in on the older people. Sometimes more than one VL take care of a older people and they can make a planned "visit" or just "a drop in". So the "visit" or "drop in" by volunteer/week cannot be confirmed with accuracy. It can often be evaluated as "daily" or "more than one/week."

The no. of years of volunteering depends on the year of commencement of the project in the commune. In general, the number of year equals the duration of the project at the commune. There has been some drop out but not much.

Number of older people: 843

Age		Gender		Family status		Disease (possible to check more than one)		ADL (Activity of Daily Living)	
50-60	4%	M	31%	Live alone	26%	Hypertension	26%	No ADL limitations	47%
60-70	19%	F	69%	Live with spouse *(without children)*	21%	Diabetes	13%	ADL limitations	53%
70-80	41%					Paralysis	14%		
80+	36%			Live with family members	53%	Dementia	13%		
						Cataract	11%		
						Others	23%		

Note: This data is not complete. Therefore, totals in each column do not add up to the sum. It is for this reason, that percentages are not used for the data on older people in Vietnam.

Home care in Vietnam has several unique features. First, there are more volunteers than older people, so more than one volunteer visits the older person. They generally live in the same communities as the older people so they are able to stop by their homes frequently throughout the week. Case management of older people is carried out by the commune coordination board including local authorities and social organisations (Red Cross, VWA, VAE, etc) with CASCD consultancy. Funding for services provided to the older person comes from several sources in addition to the NGO. The local authority funds special events and some material repairs to homes and the like. The coordination committee also organises donations from wealthy community members to meet the physical needs of the older people. Volunteers are recruited by the coordination committee and receive training on home care, healthcare, psychology of older people and the rights of older people in Vietnam.

The type of services provided by volunteers depends on the needs of the older people.

Examples of some of these individualised services include the following:

- house keeping
- bathing
- dressing
- cooking
- gardening (sometimes farming in case older people has land given by the commune)
- organising religious events
- knowledge of older people rights according to law on older people

Impact evaluation results summary

Areas of evaluation	Older people	Volunteers	Caregiver	Community people	Government officials
Familiarity	3.50	3.75	3.50	3.45	3.40
Acceptability	3.57	3.80	3.65	3.55	3.95
Favorability	3.60	3.90	3.75	3.75	3.85
Importance	3.53	3.75	3.65	3.60	3.80
Influence	3.73	3.95	3.70	3.80	3.85
Average of total score	**3.60**	**3.85**	**3.65**	**3.60**	**3.75**

Limitation and challenges

There is a need for improvement in the close coordination between the concerned government line ministries particularly MOLISA and MOH and non-governmental counterparts in the replication of the home care model.

There is a need for an appropriate mechanism for financing the implementation and expansion of the home care model, in particular for volunteer-related costs.

A weak reporting system at the commune level due to low education level and insufficient means, causes challenges for project monitoring.

Lessons learnt

- The development of relevant policies and regulations greatly contribute to the success of the implementation of home care projects.
- Collaboration between central, local governments and non-governental organisations should be promoted so that they can complement each other and the PAC at the national and local levels is one of the mechanisms that can be useful.
- Working with media such as television, radio and newspaper can help raise awareness among the general public on the ageing issue in general and some specific issues related age care, which positively impacts the promotion of home care.
- The volunteer-based home care model is socially and culturally appropriate, complementary to other types of care services and suitable for the economic condition of Vietnam.
- This model recognises and responds to older people's desire and preference for continuing living at own home and community.
- It is cost effective and is potentially sustainable since it promotes people's participation through volunteerism and can be managed by local people and organisations.

National home care policy

After the development of the national plan of action for the elderly 2005–2010 in 2005 and of the Law on the Elderly (39/2009/QH12 dated 23/11/2009), many Decrees and Circulars on the elderly have been issued by various Ministries such as MOLISA, MOH and MOF , which included the implementation of home care for older people or for programmes that complement and facilitate its implementation.

- Decree 06/2011/ND-CP dated 14/01/2011 on the implementation of LAW on the Elderly
- Circular 17/2011/ TT-BLDTBXH dated 19/5/2011 on dossier of social allowance, funeral cost and reception of the Elderly in Social Protection Establishments
- Circular 21/2011/TT-BTC date 18/02/2011 on management and use of budget for healthcare, long life congratulation, long life wishing ceremony, reward for the elderly .
- Circular 127/2011/TT-BTC dated 09/09/2011 on reduction of fee for the elderly in visiting historic sites, museums, etc.
- Decree 06/2011/ND-CP dated 14/01/2011 guiding the implementation of Law on the Elderly - Care for older people (Chapter 4–20 Articles)
- Circular 17/2011/TT-BLDTBXH dated 19/05/2011 Dossier for Community Care, elderly establishments, funeral fee, budget... Responsibility of related organisms
- Circular 21/2011/TT-BTC: Budget related to the care, rewards, healthcare, visits, etc.
- Circular 35/2011/TT-BYT dated 15/10/2011 on Health Care of the elderly (Health care facility, responsibility, healthcare at home, chronic diseases
- Circular 71/2011/TT-BGTVT dated 30/12/2011: Reduction of fee for the elderly in public transportation

Case study

Chin, 95

Chin is a widow since 2000. She is now blind and lives alone without children or relatives. Long ago she and her husband had adopted a child, but unfortunately, he died at young age.

Nguyen ThiBuoc is a 60-year-old woman who lost her parents when she was a child. She was married once but her husband left her when she could not get pregnant.

In 2003, when the home care pilot project started, MsBuoc joined as a volunteer and has continued as a home care volunteer since then. She said:

"You know, Chin does not have a child and I do not have parents. We are now like mother and daughter. I feel like my mother has come back to live with me and I enjoy it!"

Endnotes

1. United Nations, Department of Economic and Social Affairs, Population Division (2011). World Population Prospects: The 2010 Revision, Volume I: Comprehensive Tables. ST/ESA/SER.A/313.http://data.un.org/Data.aspx?d=PopDiv&f=variableID%3a33 (Oct. 1, 2011). Data compiled by HelpAge International.

2. Alfred Chan Cheung Ming, Sheung-Tak Cheng, and David Phillips. The Ageing of Asia: Policy Lessons, Challenges. Global Asia Journal, vol 2. No. 2, Fall 2007. http://globalasia.org/articles/issue3/iss3_11.html (accessed 13 May 2013).

3. United Nations, Department of Economic and Social Affairs, Population Division (2011). World Population Prospects: The 2010 Revision, Volume I: Comprehensive Tables. ST/ESA/SER.A/313.http://data.un.org/Data.aspx?d=PopDiv&f=variableID%3a33 (Oct. 1, 2011). Data compiled by HelpAge International.

4. Ibid.

5. Ibid.

6. Mujahid, Ghazy. P*opulation Ageing in South and Southeast Asia: Current Situation and Emerging Challenges*. Papers in Population Ageing No. 1. UNFPA. 2006. http://www.globalaging.org/agingwatch/events/funds/ageingasia.pdf (accessed 13 May 2013)

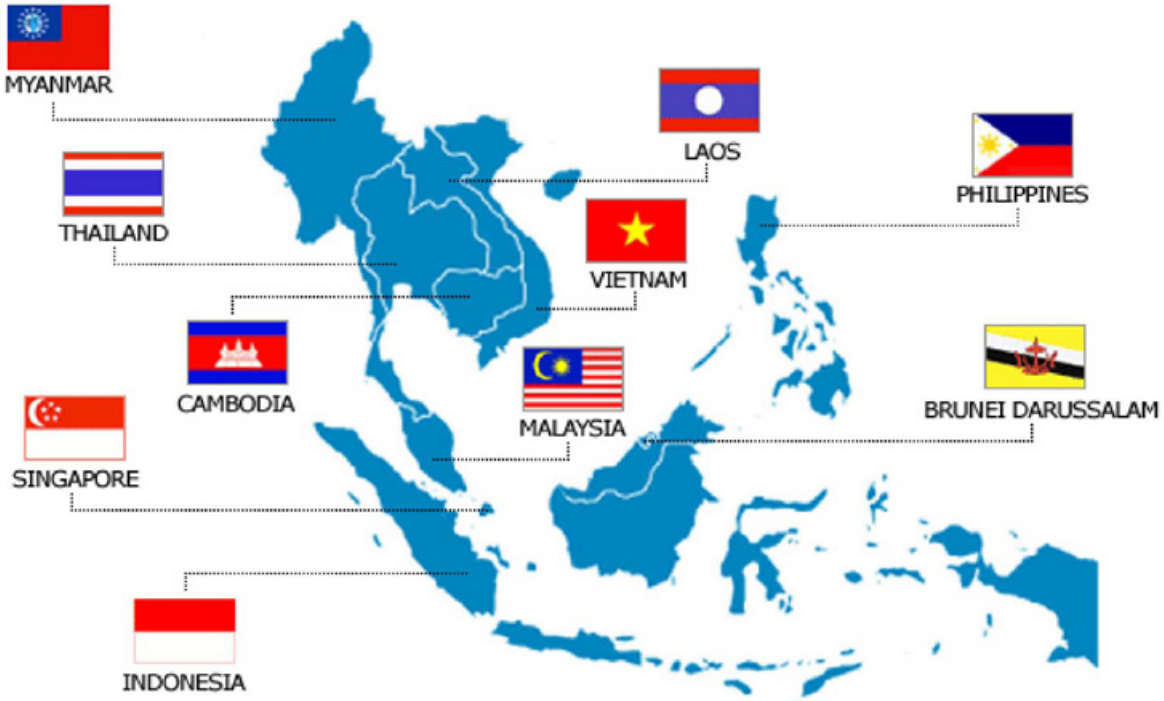
7. Alfred Chan Cheung Ming, Sheung-Tak Cheng, and David Phillips. *The Ageing of Asia: Policy Lessons, Challenges*. Global Asia Journal, vol 2. No. 2, Fall 2007. http://globalasia.org/articles/issue3/iss3_11.html (accessed 13 May 2013).

8 World Health Organization. *World Report on Disability 2011*. World Health Organization and World Development Bank. http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf (accessed 13 May 2013).

9 Mujahid, Ghazy. *Population Ageing in South and Southeast Asia: Current Situation and Emerging Challenges*. Papers in Population Ageing No. 1. UNFPA. 2006. http://www.globalaging.org/agingwatch/events/funds/ageingasia.pdf (accessed 13 May 2013).

10 World Health Organization and Alzheimer's Disease International (2012). *Dimentia: A Public Health Priority*. http://apps.who.int/iris/bitstream/10665/75263/1/9789241564458_eng.pdf (accessed 10 May 2013).

ASEAN Member Countries



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