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SOCIAL INCLUSION

# Community Development and Preventative Care With Older People: New Values and Approaches

**Edited by** Fiona Verity, Frances Barker, Mark Llewellyn, Simon Read, and Jonathan Richards

**Volume 12**

2024

Open Access Journal
ISSN: 2183-2803

Social Inclusion, 2024, Volume 12
Community Development and Preventative Care With Older People: New Values and Approaches

Published by Cogitatio Press
Rua Fialho de Almeida 14, 2° Esq.,
1070–129 Lisbon
Portugal

Design by Typografia®
http://www.typografia.pt/en/

Cover image: © PIKSEL from iStock

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Available online at: www.cogitatiopress.com/socialinclusion

## Table of Contents

**Reflections on Community Development, Preventative Care, and Ageing**
Fiona Verity, Frances H. Barker, Jonathan Richards, Simon Read, and Mark Llewellyn

***Pirnilu Nintipungkupayi*** **(Everyone Is a Teacher): Keeping Old People's Spirit Healthy Through Education**
Jennie Buchanan, Daisy Ward, Elizabeth Marrikiyi Ellis, Jan Turner, and Dave Palmer

**Ageing in Place, Healthy Ageing: Local Community Involvement in the Prevention Approach to Eldercare**
Chiara Lodi Rizzini, Franca Maino, and Celestina Valeria De Tommaso

**A Scoping Review of Older LGBTI People's Experiences of Homecare**
Mel Duffy, Giovanni Frazzetto, Anthony Staines, Anne Matthews, James Geogheghan, Collette Gleeson, Claire Mooney, James O'Hagan, and Sean Vail

**Supporting Older Adults' Social Inclusion and Well-Being in Neighbourhoods: The Social Hub Model**
Anniriikka Rantala, Outi Valkama, Rita Latikka, and Outi Jolanki

**A Community Project to Supplement Social Care Services**
Frances H. Barker and Mollie Roach

**Older People Reimagining and Envisioning Preventive Care Through Land Acquisition: Evidence From Rwanda**
Albert Irambeshya

**Implementing a Senior Community Care Model: An Italian Top-Down Cohousing Project and Nursing Home**
Isabella Riccò, Claudia María Anleu-Hernández, and Adele De Stefani

**Dancing With Care: Promoting Social Inclusion Among Older Women in China Through a Novel Preventative Care Model**
Chun Xia, Jia Xu, Jianzeng An, and Jianwen Ding

**Preventative Social Care and Community Development in Wales: "New" Legislation, "Old" Tensions?**
Simon Read, Fiona Verity, Mark Llewellyn, Gideon Calder, and Jonathan Richards

Social Inclusion
2024 • Volume 12 • Editorial 8007
https://doi.org/10.17645/si.8007

EDITORIAL

Open Access Journal

# Reflections on Community Development, Preventative Care, and Ageing

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**Submitted:** 12 December 2023 **Published:** 25 January 2024

**Issue:** This editorial is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

## Abstract

Recently there has been a chorus of demands to "re-imagine" social care. Community and faith-based organisations, policy, and academic communities are engaged in discussions on issues such as human rights for older populations, the future of residential care, how to better support family/community care, and strengthen local place-based community development. Moreover, the Covid-19 pandemic has added new urgency to this mission, galvanizing developments for change and collective action and exposing public troubles of endemic system failings, prevailing discourses of ageism, tensions with health systems, and limitations of market models of care and support. Prevention is a central social welfare principle in many countries. It is associated with policy and practices that aim to meet social care needs early and is explored in this thematic issue.

## Keywords

ageing; community development; human rights; inclusion values; old age; preventive care; principles

## 1. Introduction

In the UK context where we are located, recent calls to "re-imagine" social care often talk about a need for "radical change," "transformation," and "system reorientation" (see, for example, Charles et al., 2018; Church of England, 2022; Cottam, 2021). These calls are animated by concerns about failings in state and market provision and service demands and by moral arguments about how we might best live collectively and meet human rights (Charles, et al., 2018; Cottam, 2021; Church of England, 2022). At a time when people are still experiencing the effects of the Covid-19 pandemic and now interlinked economic crises, formal social care systems (e.g., offering domiciliary or home-based care, community care and support, residential and nursing home care, or social work) are stretched and struggling, with implications for care and caring relationships (Cottam, 2021; Wallace et al., 2023).

The focus of this thematic issue is community development in preventative care with older people. We see preventative care to be many interconnected personal, interpersonal, and community practices. Held (2006, p.39) writes in her work on the ethics of care that care is a “practice and value. The practices of care are of course multiple, and some seem very different from others.” Preventative care clearly involves something practical, but also supports health, well-being, social networks, and relationships within conducive social, economic, and physical environments. Government and statutory services influence infrastructure that impinges on health and well-being and can facilitate community initiatives and social development.

Within our framing of prevention are community development approaches and care models. These are driven by the urgencies, motivations, and visions of older people in their cultural communities and places, and so are collectively focused. There are many perspectives on community development. The definition within the 2004 *Budapest Declaration of Community Development* places emphasis on actions and processes for “strengthening civil society,” “active citizenship,” and communities organising for the change and policy directions they seek (Craig et al., 2004). In this community development approach, human rights and social inclusion values are fundamental.

While applied in the context of complex social issues, discourses of prevention are well established in the realm of public health (e.g., tertiary, secondary, and primary prevention). However, as North American writer Rapoport (1961) noted many years ago, translating the unified view of prevention associated with public health into the realm of social services and social support is inherently problematic. We see that this remains the case, particularly in thinking about “what is being prevented,” “how is prevention enacted,” and “whose interests are served” (Read et al., 2023). It will depend. The values informing government agendas in social care prevention are contested and contradictory (Curry, 2006; Marczak et al., 2019; Verity et al., 2021), and can be overshadowed by the immediate concern or crisis responses, for example, to reduce hospital demand (Gmeinder et al., 2017).

## 2. Themes in This Thematic Issue

Ageing populations across many countries have placed older people central in concerns about the sustainability of state-based social care provision. Much of the contemporary emphasis on prevention takes these demographic shifts as a departure point, with formal care systems that are already under considerable strain predicted to worsen over coming years due to diminishing workforces and growth in the numbers of those with complex care needs. In different parts of the world, the discourse of prevention for older people incorporates ideas of independence, interdependence, remaining in one’s own home or place, and resilient or resourceful place-based communities. Informal or unpaid aspects of care associated with families, friends, and other social relationships are also emphasised.

The articles in this thematic issue cover situations and research in many different parts of the world, as explored in the following sections.

### 2.1. Different Nations, Different Opportunities

Several articles throw light on what is happening regarding care in parts of the world, namely Australia (Buchanan et al., 2024), China (Xia et al., 2024), Italy (Lodi Rizzini et al., 2024; Riccò et al., 2024), Wales, UK (Barker & Roach, 2024; Read et al., 2024), Finland (Rantala et al., 2024), and Rwanda (Irambeshya, 2024). They give an idea of the background and cultures across these different countries, and their prevalent care systems. The care solutions adopted are influenced by history and beliefs, available resources, and dominant patterns of power and inequality. At the root of all, is the care provided by family, friends, clan, tribe, or "community." As countries face changes in economic and social factors, this type of care faces different challenges that statutory services and civil society must try to meet.

### 2.2. Investigation

Articles describe some of the measures taken to assess, investigate, and understand the nature and extent of social care problems across these different nations, as well as the success, or otherwise, of efforts to mitigate them. Subjects covered include providing home-based care in isolated mountain regions (Lodi Rizzini et al., 2024), the application of social hubs (Rantala et al., 2024), a senior community care model (Riccò et al., 2024), older LGBTI people's views and experiences of homecare provision in the context of "predominantly heteronormative" health and social systems (Duffy et al., 2024), and community-focussed prevention initiatives (Read et al., 2024).

### 2.3. Applications

Additionally, these articles describe either existing practices that support and help older people in their communities, or practical steps that have been or might be taken to address perceived needs. These are useful approaches and models that can be adopted and adapted to suit individual situations. Culturally relevant ways to link and share knowledge are covered between older people in Indigenous populations and younger people (Buchanan et al., 2024), through dancing and social connections for older women (Xia et al., 2024), in more inclusive social hubs (Rantala et al., 2024), in community development within a nursing home and cohousing project for older people (Riccò et al., 2024), and within a place-based volunteer service developed by local people (Barker & Roach, 2024). Duffy et al. (2024) call for a re-imagining of inclusive home care for older LGBTI people where there is cultural humility and respect for the importance of home, and awareness of histories of oppression and inequality for LGBTI communities. Riccò et al. (2024) remind us about the "practical and symbolic aspects" of community and that community-building processes take time and critical awareness.

## 3. Our Reflections

Our research and evaluation activities as a team have been informed and guided by the principles-focused evaluation approach (Patton, 2018). At the start of any work, we are encouraged to reflect upon our values and how the principles that flow from them will inform our strategies and activities. We applied Schön's

(1984) “double loop learning” method to look behind and under our thinking to discover important factors and considerations. The range of articles in this issue is wide and the researchers have been informed by a number of theoretical models. However, as we consider all the research and discussions that flow from the findings, we wonder if three “deep world views” are hidden, underlying the ways in which services for older people have been planned, commissioned, and measured in recent years.

Firstly, “neoliberalism” is considered to have had a significant impact on societies around the world since the 1980s (Gilles, 2011; Vallier, 2022). Priorities, values, and policies have been informed to a greater or lesser extent in many aspects of society (Becker et al., 2021; Gilles, 2011). In a study investigating the health and well-being impacts of neoliberalism, Becker et al. (2021, p. 947) note that:

> It could be argued that neoliberalism will generally be beneficial because this ideology encourages individuals to strive for self-actualization, personal growth, and happiness....However, it can equally be argued that individuals are harmed by neoliberalism because this ideology promotes competition and, in the process, undermines people’s sense of solidarity and social security....In fact, under neoliberalism, economic disparities are seen as accurate reflections of differences in hard work and deservingness and the neoliberal age has seen a corresponding rise in inequality.

They conclude that:

> It actually appears be [sic] harmful to health because it can create a sense of being disconnected from others, as well as being in competition with them, in ways that feed feelings of loneliness and social isolation. (p. 962)

These findings fit with our concerns in our context of Wales, UK, that the principle of “voice and control,” a core component of social services legislation, focuses attention on the “I” in *what I want* at the expense of the “we” in *the communities we are a part of* (Llewellyn et al., 2023).

The second “hidden” source of values and principles is the hegemony of rational utilitarian decision-making. Philosopher Martha Nussbaum published a detailed critique of this approach that we find relevant as we read and think about the articles in this thematic issue. In 1995 she wrote of four factors that are applied to data and decisions, against which we set our observations:

| Nussbaum's factor | Our observations |
|---|---|
| Commensurability: The economic utilitarian mind reduces qualitative differences to quantitative ones. | People analysing data and making decisions may ignore, fail to notice, or describe what matters to each person in the complexity of the lives that they are living. |
| Aggregation of data “from individual lives.” | This approach is found in many red/amber/green spreadsheet reports on the average values of a group without recognising that, for each person in that group, their own responses are what matters to them. |

| Nussbaum's factor | Our observations |
|---|---|
| Maximising: Finding a solution to every problem by "sum-ranking." | There is danger in thinking that more of something must be better. Assumptions are made that every person wants the highest score or rating for every category. People make their own choices about what matters to them and what they may compromise about one component of their care in order to benefit from more of another one. |
| Exogenousity: Seeing human beings as counters in a mathematical game. | The expectation that what matters to decision-makers and what should be counted can be determined by outside experts who claim to know best. The articles in this thematic issue show why this needs to be challenged. |

Source: Based on Nussbaum (1995, p. 14).

The third "world view" that we find relevant is the insights from disability research and ethics (Shakespeare, 2013) that relate to underserved or excluded populations. The articles in this thematic issue demonstrate the variety and complexity of people's lives, their communities, cultures, experiences, expectations, and the challenges faced by historically shaped inequalities and oppression. They also highlight a theme of fear and mistrust of statutory services and experiences of discrimination and disempowerment. Riccò et al. (2024) argue professionals can "act as community development practitioners" and create spaces (dialogic and physical) and processes for this approach, whilst Read et al. (2024) suggest the need for a "deftness" in working within governmental systems that can privilege other values and interests.

## 4. Conclusion

The themes running through the articles in this thematic issue explore the role of older people in societies and community-based supports for "ageing well." The discussions confirm what research into preventative care has repeatedly shown: People need people, and the closer these people are to their places, "community," friends, or families where there is support, the better it is. For everyone—older person or otherwise—involvement in a "community" can be positive for their physical, mental, and social health, although we acknowledge this is not always the case. Local initiatives can activate a huge human resource and need not necessarily be expensive. These articles reinforce the importance of values and principles, and that invaluable community development processes can be slow, delicate, and complex. We have found this editorial process rewarding and stretching of our own thinking and imaginations as we learned from the initiatives and studies you will read about in this thematic issue. We recommend them to you.

*Ageing Well*

We want to age in OUR place, wherever that may be.
It could be in Rwanda or a cottage by the sea.
It could be Alpine mountains, or off the beaten track,
It could be in a city, or Australian outback.

We know our way around it, we know the people there.
Our friends, our pets, our children, neighbours, those who care.
We know the way of life there, the way the people think.
And should our memory falter, we still will have a link.

We want to be a part of things, to plan and to take part.
To sing, to dance, to talk or walk — what's closest to the heart.
To read, to write, if still we can, and watch things on TV,
And have some other folk around to chat of things we see.

And if we can't be in our home, we want to be close by,
With carers who become our friends and miss us when we die.

Frances H. Barker

## Acknowledgments

We thank sincerely the contributors to this thematic issue for working with us in preparing this edition, for their thoughtful and inspiring articles, and the time and expertise given by reviewers. We have been especially grateful for the assistance and flexibility of *Social Inclusion*'s editorial staff over the time this publication project took shape.

## Conflict of Interests

The authors declare no conflict of interests.

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**Social Inclusion**
2024 • Volume 12 • Article 7541
https://doi.org/10.17645/si.7541

ARTICLE

Open Access Journal

# *Pirnilu Nintipungkupayi* (Everyone Is a Teacher): Keeping Old People's Spirit Healthy Through Education

**Jennie Buchanan [1], Daisy Ward [2], Elizabeth Marrikiyi Ellis [2], Jan Turner [3], and Dave Palmer [1]**

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**Submitted:** 18 August 2023 **Accepted:** 21 November 2023 **Published:** 25 January 2024

**Issue:** This article is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

## Abstract

In the Ngaanyatjarra Lands of desert Western Australia, older people are being encouraged to participate meaningfully in student education. This initiative is being led by two of the authors of this article, senior Ngaanyatjarra women, both of whom work with the Ngaanyatjarra Lands School with its campuses in eight remote communities spread over hundreds of kilometres. Elderly men and women, some of whom are residents in the Ngaanyatjarra Aged Care home (Ngaanyatjarra Health Service, 2021), are eagerly participating in the planning of bush trips, gathering their traditional resources, seeds, grinding stones, bush resins, recalling stories, songs, and dances—as they prepare for the bush camps with students. During the camps the schoolteachers step back and the elderly lead in what is known as two-way science. At first glance, this work may look like it is simply focused on the educational needs of students with senior Yarnangu acting in a supporting role. However, this article will demonstrate the continuous connections and responsibilities, laid out in the *Tjukurrpa* (the Dreaming), between the old and the young, to their ancestral lands. It sets out how according to "*Tjukurrpa* thinking," the principal way to provide good care is by helping senior people remain *on country* with family, pass on their knowledge to younger people, and thus keep strong languages and *kurrunpa* (people's spirit) alive.

## Keywords

Aboriginal Australian; Central Australia; inter-generational respect; *Tjukurrpa*

## 1. Introduction

In the Ngaanyatjarra Lands in the desert of Western Australia, Old People have a long history of participating meaningfully in young people's education. It is important to note that, in these regions, the Aboriginal English term "Old People" is used as a mark of respect and authority. The initiative to be described is led by two of the authors, senior Ngaanyatjarra women, both of whom work with the Ngaanyatjarra Lands School with its campuses in eight remote communities spread over hundreds of kilometres. Senior men and women eagerly participate in bush trips, gathering traditional resources, seeds, grinding stones, and bush resins, while recalling stories, song, and dance. During the camps, the schoolteachers step back and the elders lead in what is known as two-way science.

At first glance, this work may look like it is simply focused on the educational needs of students with senior Yarnangu (Aboriginal people from the region) acting in a supporting role. However, the camps also build social connections and follow processes laid out in the *Tjukurrpa* (the Dreaming). This provides an important way to help senior people visit country with family, pass on their knowledge to younger people, and thus keep strong languages and *kurrunpa* (people's spirit) alive.

This article allows readers to see, hear, and get a feel for what happens when senior people take on "up front" roles as educators in "on-country" learning for students, schoolteachers, Aboriginal rangers, and other *maliki* (visitors). It describes activities that see senior people being involved in work that has them being carers and cared for. It also provides a case study of how to bring younger and older people together to support each other's wellbeing and sustain cultures that have long valued the elderly. This allows us to understand how people might see their identities and roles move from being "the aged in care" to "educators of young people."

## 2. A Few Words on Writing Together

The article is written in a way that some will see as unconventional. In part, this is because "Western" ways of writing are strange to Yarnangu whose systems of coming to knowledge are much more grounded in narrative, dialogue, or conversational styles and situated in the specific contexts of places in their *ngurra* (traditional country). It is also because this piece of work emerged out of a set of relationships rather than university-based research projects. Finally, the article draws upon a mix of sources including a film that was commissioned by the Ngaanyatjarra Lands School, photo records of the camp, the direct participation in a two-way science camp by four of the authors, narratives of Daisy Ward and Lizzie Ellis recorded specifically to help illuminate what went on during the camp, and many hours of reflective discussion by the authors. In June 2021 four members of the writing team participated in the camp and were involved in filming by Fat Lizard Films who were commissioned by Ngaanyatjarra Lands School and the Western Australian Department of Education. The resulting film has been cleared by the school and those Yarnangu who were present to be made publicly available, particularly for those interested in two-way science and working to support the future of Yarnangu young people. The film titled *Pirnilu Nintipungkupayi: Everyone is a Teacher* (Turner, 2023) is the second film across a trilogy examining the work of the school as it incorporates Yarnangu education content and processes into its curriculum.

Daisy Tjuparntarri Ward is the senior Yarnangu educator and Lizzie Marrkilyi Ellis is the Yarnangu curriculum writer for the Ngaanyatjarra Lands School. Both are Yarnangu and grew up in the Lands. Jan Turner is an anthropologist and filmmaker who has spent considerable time on the Lands and working closely with Daisy and Lizzie. The film narration was unscripted. Daisy and Lizzie viewed the film and each provided an explanation of the content. Jan edited the final narration with ongoing feedback from Lizzie, Daisy, and others from the school who were present during the camp. Jennie Buchanan was a member of the film crew and worked with Lizzie in providing a reflective process for teachers to analyse their own learning from the camp. Dave Palmer has been working with the team for several years and is an independent director of one of the local Aboriginal corporations.

Importantly, all of the authors are related through time and cultural affiliations. Although Daisy and Lizzie are Yarnangu and Jan, Jen, and Dave are Walypala (non-Aboriginal people), all are considered either sister, brother, or sister-in-law according to Yarnangu conventions. This reflects the fact that Daisy, Jan, and Lizzie have been sisters for over 30 years, and Jen and Dave have been invited to take on various roles over the past five years and are treated by Daisy and Lizzie as brother and sister-in-law.

This article did not emerge out of a research project conducted as part of a research institution. Rather it came from two main inspirations. The first was the documentary of the two-way science camp, produced through a collaboration between the school, Fat Lizard Films, Daisy and Lizzie, and with assistance and the blessing of all present. This served as "data" and helped shape the structure and content of this article. The second was a desire for those involved (including senior women) to talk about elements of the two-way science approach that are concerned with passing on knowledge and keeping people healthy across the generations. This aspiration is shared by all the authors. The work is part of a larger agreement between those involved to support Yarnangu wellbeing and help prepare others who may seek to do this in the future. In this way, the article represents part of an ethical practice of working across cultural borders to articulate what respectful practice might look like. In this specific case, the following ethical processes were followed: regular conversations between the writers to check that cultural safety was not breached; co-authorship; drawing upon material (the film and photos) that had been cleared by the school and those present for publication; and checking the work against Yarnangu written and filmed sources.

We have decided to follow a Yarnangu practice of moving between *tjuma* (a rich description of events as they occurred) and *yitingka* (diverting and making aside remarks by thinking, showing, and sometimes explaining what is behind the events). While this does not follow the rules of some academic journal writing, we believe this brings the reader more fully into the cultural and physical experience of the work being described. In this way, we invite the reader to shift their position from reading and feeling the *tjuma* (story) to understanding the *yitingka* (context and analysis).

## 3. *Tjuma*: Setting Up for Two-Way Science

*Pirnilu Nintipungkupayi: Everyone is a Teacher* is a film that offers a condensed story of a two-way science trip based out of Warakurna in the Ngaanyatjarra Lands. The story starts with vehicles following behind a Ngaanyatjarra Lands School bus. The vehicles are bumping along a single track through bush ten or so kilometres northeast of the remote community of Warakurna in Central Australia. The bus contains a precious cargo of Yarnangu students, young people, and elders along with school teaching staff. In the convoy of four-wheel drive utes (utility cars) and cars are also Aboriginal rangers, other *maliki* (visitors), and people from a distant Aboriginal community.

The vehicles travel through low spinifex grass bathed in soft golden sunlight. The landscape has been shaped over many thousands of years by mosaic fire work practices. This includes the magnificent deep red ranges of Purli Yurliya (the Rawlinson Ranges). Prior to leaving the Warakurna community, *maliki* have been sung into safety by Daisy and other senior women. This process is part of old Yarnangu governance practices that ensure care and safety for people as they travel.

On the bus, and in the vehicles in front and behind, experienced and well-honed eyes are looking for goanna and other food sources. It is the Old People who have the knowledge of the seasons, habitats, and right times for seeking out food sources and making fire. Old People regularly sang out to *tjitji* (children) to keep a lookout, ever ready to stop and reach for their mobile kits of self-sufficiency in the desert (bags, knives, sticks for digging and stunning, and blankets for warmth).

When we arrive, a drone camera is launched to offer us a bird's eye view of things being set up. Daisy and other senior people choose where everyone should camp. Senior ladies walk through the bush, exchanging observations with loud and joyful voices, one with her blankets on her back; "this is a good spot here….Look at the *waru* [firewood]!" They carefully set up windbreaks, choosing soft sand for sleeping.

There is much laughter and instructions in *wangka yuti* (everyday language). Students lay out their swags side by side for warmth. Minky blankets are shaken and set down on school swag mattresses so that a wonderful sea of colours spread across the site. These warm blankets are as soft as animal fur, but made of synthetic polyester fabric, mimicking the plush texture of mink fur but at a much more affordable cost.

Older young people work with four- and five-year-old students, shovels in hand. They smooth away the prickly spinifex bush or dig a little *waru* (fire) place. It is all hands on deck as the camp comes into being. A central tent and a blue ground tarpaulin peek out from under two gazebos set up as food preparation and learning spaces sheltered from the raging sun. Later in a post-camp reflective workshop facilitated by Lizzie and Jennie the schoolteachers confess to being confused and baffled, unused to camping, to not giving the directions, and unaware of the cultural and educative significance of carefully setting out where people sleep.

This work is reliant on senior ladies who possess a deep knowledge of kin and family relationships, people's proximity to areas of origin, opportunities for learning, food resources, the wind and weather, access to wood and shelter, and esoterica associated with safety. This is critical to doing things "the right way."

## 4. *Yitingka*: Who Are Yarnangu and Where Are the Ngaanyatjarra Lands?

Yarnangu is the term used to describe Australian Aboriginal people who come from and often reside in the communities of the desert regions in the far eastern part of Western Australia. Some readers may know of *Uluru* (Ayers Rock). This is approximately 300 kilometres to the east. Ngaanyatjarra Lands include approximately some 250,000 square kilometres (about the size of Victoria or the whole of New Zealand). Approximately 2,000 Yarnangu live in eleven remote communities across the Lands (Ngaanyatjarra Lands School, 2023).

Most Yarnangu maintain a rich cultural heritage, holding onto their language, laws, and systems passed down over thousands of generations. Many of the senior people are amongst the first wave of those who moved from the bush between the 1930s and 1970s into mission life in Warburton. These people have never lost contact with their *ngurra* (traditional country), living close to where they were born and continuing to visit and carry out important customs and practices. The main language spoken is Ngaanyatjarra, though many also speak other Western Desert languages such as Mantjiltjarra, Pitjantjatjara, Pintupi, Luritja, and Ngaatjatjarra (Brooks, 2019).

Yarnangu continue to hunt and gather and fulfil their obligations to carry out men's and women's "business" and take young people "through" various special processes of education and induction. The role of the Old People is to teach young people about *Tjukurrpa* and traditional ways of living and conducting themselves. This includes a strong emphasis on processes such as singing important songs, passing on *tjukurrpa* (stories and accounts of knowledge) painting, *tjanpi* (grass) weaving, and *purnu* (artefacts, tools, and instruments of power) making (Turner & Ellis, 2023).

As has always been the case, Yarnangu *kanyilya* (hold, carry, and teach) their children and young people very carefully (Ngaanyatjarra Lands School, 2023). For Yarnangu, there is nothing more important than their love for *tjamu* and *kaparli* (grandchildren). The word "love" is not just a feeling, it is everything to them. Yarnangu love their young people with all their heart, just like their *kaparli* (grandmothers) always loved them when they were young.

Several of the senior people involved in this story are now residents of the facility Kungkarrangkalpa Aged Care. This is the only specialist care accommodation on the Ngaanyatjarra Lands and is located in the Wanarn community, 100 kilometres northeast of Warburton (the administrative centre of the Lands). *Kungkarrangkalpa* means Seven Sisters, an important *Tjukurrpa* story that people share across much of the desert (National Museum of Australia, 2023). Kungkarrangkalpa Aged Care has been built and is managed by the Ngaanyatjarra Council, the Yarnangu-governed corporation responsible for all remote communities across the Lands. Kungkarrangkalpa is an 18-bed facility that provides a home for older people with low-level to high-level care needs (Ngaanyatjarra Council, 2011). Although people in Kungkarrangkalpa are often not living with their families they are still on *ngurra*, close to *tjukurrpa*, culture, and *kurrurnpa* (the living spirits of others). Also important is that living here allows them to be close to other activities that help keep them healthy. For example, staff from Warakurna Artists visit fortnightly to assist residents in maintaining cultural strength through their arts.

## 5. *Tjuma*: Learning By Doing

On the first morning as people awake, students are laughing and having fun, dogs bark, and we hear the voice of a schoolteacher saying: "Let's go! We are going to look for honey ants." Within minutes the sounds change to those of digging in the sand.

There are yellow acacia flowers blooming amidst the low branches as students, teachers, Aboriginal rangers and senior ladies start to dig and test for ant activity. Some of the Old People have done an earlier walk around to note the likelihood of finding honey ants. Daisy tells us that this is "how we get honey out...how we teach about finding the nests...the kids are so happy!" Emphasising this point, we hear squeals when ants are found; "Come this side, that's right." In the excitement, cries of "*walkamunu!*" (good, great) are heard. Lizzie points out that "everybody is watching; others are giving instructions on how to, where to dig, and...finally...the nectar."

The word “nectar” is said in a reverent tone. This sweet honey comes by with hard physical labour and strong intellectual knowledge. “Nectar” also serves as a wonderful metaphor for the way things are happening *on country*. This is precious work, outside the bounds of school sites and aged care homes.

What is most striking is the sheer physicality of the task. Most take a turn digging but it is a few people who dig to the source. One senior lady from the Kungkarrangkalpa Aged Care facility led this. Dogged and eager, she dug and instructed the younger students. She involved girls in collecting the ants for sharing. She was a superwoman on that day, exerting massive energy and strength, taking seriously her cultural obligations as an educator.

Digging for *tjarla* (honey ants) is crucial in Yarnangu deliberate practices associated with education and care, simultaneously a way of “taking care of our Old People,” by supporting them to take care of students. It also allows senior people the opportunity to teach students the “right way,” showing younger people how to take care of themselves in the bush if they were ever to get lost or need to survive away from their community. It also teaches deeper things about conduct for life. In *Tjukurrpa* thinkin there are layers of meaning with many everyday activities standing as metaphors for other elements of life. To dig for ants is not simply about satisfying one’s sweet tooth. It also introduces *tjitji* in how to take instruction in a respectful way.

At one point a young girl takes a honey ant and holds it in the palm of her hand. As Daisy notes, “she is really happy to teach her teacher how to eat and get the sweet part out of the ant.” Lizzie adds that in this way the schoolteachers are brought into the learning too. Schoolteachers are shown where to grasp the ant and how to access the sweet bubble of nectar on its body without eating the wrong bits. One teacher spent some time in a nervous state, repulsed by the idea of eating an ant. It is a joyful moment for everyone when she yells: “OH YUM! OH MY GOODNESS! IT’S QUITE STRONG AS WELL.” In this moment the teacher becomes the student.

The visiting ranger team is also excited to try this delicacy. There are no honey ants in the region where they come from. They know how special it is and appreciate the chance to learn and have a taste. They dig and watch, recording the process on digital devices (smartphones and tablets) to share with families back home. When they return, students will take what they have learned in the Yarnangu context and weave it into the state-driven curriculum. This is how two-way science works, starting with Yarnangu language, knowledge, and educational forms, and then bringing in Western science. The reach and value of senior people’s role in education are multiplied, challenging discourses that construct the aged as a drain, as needy, and of minimal value (Deslandes et al., 2019).

## 6. *Yitingka*: Being on *Ngurra* (Country)

This work occurs on *ngurra* (country). As is the case across remote Australia, the business of teaching children and young people is inseparable from country. This is because “country is literally and symbolically an extension of family and self” (Palmer, 2012, p. 46). The nexus between Old People, the generation of grandchildren, learning, and being healthy reflects long-established ontological traditions that connect the health of country, the health of persons, and sustaining knowledge across the generations (Palmer, 2012, p. 46). Rose et al. (2002, p. 14) put it beautifully when they explain:

> In Aboriginal English, the word “country” is both a common noun and a proper noun. People talk about country in the same way that they would talk about a person: They speak to country, sing to country, visit country, worry about country, grieve for country and long for country. People say that country knows, hears, smells, takes notice, takes care, and feels sorry or happy. Country is a living entity with a yesterday, a today and tomorrow, with consciousness, action, and a will toward life.

Here *ngurra* (country) is a sentient being, able to feel, act, respond and interact with Yarnangu. As Palmer (2012, pp. 46–47) observes, this means that the process of education on *ngurra*:

> Not only involves the young and their living Elders “going along together,” it also demands a shared relationship with Elders and ancestors long passed away, but still living as spirits on country. Important here is the conception that the living and the dead are an integral part of the maintenance of life.

Not surprisingly, doing this work on *ngurra* makes Yarnangu feel happy and strong.

## 7. *Tjuma*: Cooking *Tjanmarta* (Bush Onion)

Later people sit on *ngurra* in the shade of the school bus. Next to this is the jaunty bright blue ute, sparkling against the bright reds, greens, and azures of the country. Spare swags, bags, and other gear rests in the carry tray of the ute. It is a fabulous windbreak offering a space where a circle of elderly ladies sit and work. They speak *wangka yuti* (everyday language) as they sit by their fire. They are positioned in a crescent that allows each to see what is happening and to look out at the gathering of students and visitors. Grandmothers are teaching and *tjitji* are ready to learn.

One of the ladies puts her hand into a large tin that holds the *tjanmarta* (bush onions) next to a well-tended fire with a good bed of ashes. Lizzie explains that bush onions can be collected in this country but these are a special gift from Ntaria (Hermannsberg) over 800 kilometres east, on the road to Alice Springs in Western Arrarnta country. This is a good reminder that Yarnangu are involved in far-reaching relationships often across distances that would see Europeans travel across three or four nation-state borders.

The students and visitors are shown the *pirti*, a wooden “container” that holds these tasty treats. The same container is used to dig into the ash to reveal the hot sand to cook the bush onions. The Yarnangu teachers speak out:

> *Tjitji*, there…try that.
>
> *Yuwo*…yes!
>
> *Munta yuwa*…oh, like that.
>
> *Walykumunu*, *walykumunu*…great, wonderful!
>
> *Nuntu*…you!

As Lizzie observed in her commentary on the documentary of the camp, “this is how we cook. This is how our ancestors cook. This is the teaching and learning classroom. The campfire.” The senior ladies continue continue to roast the onions. As a team, the educators offer their lesson. “*Ninti*…” implores Daisy as the students become quiet. Kids are then given bush onions to eat. Each different voice and instruction occurs in *wangka yuti* (language). The clear voice of another senior lady names the bush onion: “*Tjanmarta*…oh, that’s a big one…*yuwo*. Another look, *nyuntu look*….David [name of child]…*ninti*…*mapitja*…keep going.” The students are handed a cooked bush onion each and shown how to remove the skin to get to the creamy bulb inside. Students intensely watch the movement of their elders and each other as they rub their hands together to find the warm white onion. It is an image of great nourishment for all involved.

## 8. *Yitingka*: What Is *Tjukurrpa*?

To understand this story of community work with Yarnangu it is important to visit the idea of *Tjukurrpa*. Just as the practice of “aged care” is rooted in discourse, traditions, and knowledges of care, health, and medicine, this example of Yarnangu “social inclusion” is deeply shaped by *Tjukurrpa* and *Tjukurrpa* thinking.

As Lizzie, Daisy, and Jan have said elsewhere, *Tjukurrpa* is real (Turner & Ellis, 2023, p. 8). It is not simply a series of stories, folk tales, or mythology. Rather *Tjukurrpa* is the basis of all Yarnangu knowledge, the culmination of information, wisdom, and intelligence from the desert. Indeed, *Tjukurrpa* as a system of knowledge came into being long before contemporary Western thought and knowledge systems were taking shape (Turner & Ellis, 2023).

Imagine being given the task of trying to gather and capture the entire body of knowledge that is on the scientific record. Imagine if we narrowed this to knowledge made since the Enlightenment. The task would still be enormous even if we further limited this to a single discipline. Now imagine the totality of that knowledge being placed in a database called the *Tjukurrpa*, a culturally defined database that incorporates knowledge amassed over thousands of years (Turner & Ellis, 2023).

When Yarnangu talk about *Tjukurrpa*, they are referring to what non-Yarnangu sometimes call the Dreaming, or the Dreamtime. In other parts of Australia this is given a different word, for example: *alcheringa* (Arranda), *Jukurrpa* (Warlpiri), or *Bukarikara* (Karajarri). The *Tjukurrpa* is central to all Yarnangu lives. It is everything and all-encompassing and usually refers to the relationships between rules of conduct, for living and taking care of country, family, language, and future generations; teaching, learnings, and stories; the time when great events occurred that set down teachings for the future; something held inside and with each person, literally, intellectually, spiritually, and symbolically as part of one’s body; the past as it is now and continues to be; and the foundation for practices and how one acts as respectful Yarnangu (Turner & Ellis, 2023).

*Tjukurrpa* is important when understanding the worlds of senior Yarnangu. As they age, Yarnangu become more knowledgable for the totality of *Tjukurrpa* both as a body of knowledge and knowledge embodied. The most knowledgeable of elders know how everything relates, from the past, the present, and the future, across different regions, and on the earth’s surface as well as from deep in the earth and up into the cosmos (Turner & Ellis, 2023).

When Lizzie and Daisy speak about *Tjukurrpa* they also describe it as something Yarnangu hold in their bodies. This happens in a variety of ways: in their behaviour and conduct, language and the various speech registers people use with one another, the way they relate to themselves and the universe, and of course, the way people take care of their *ngurra*. It is also literally inside their bodies, felt and made manifested in different parts of their anatomy. Some speak of this existing in one or more spirit animals, or *Tjukurrpa* beings that get carried in their bodies (Turner & Ellis, 2023).

Some ancestral *Tjukurrpa* beings are involved with day-to-day activities and their details are more open and accessible to the young and newcomers. Other *Tjukurrpa* beings are involved with life and death and their details are only revealed to persons with great maturity.

As Lizzie explains elsewhere, the word for totem is also *tjukurrpa:*

> Each person was something before they were born, that is in a "pre-life," and this is their totem….You have to be respectful of your individual totem—for example, by not eating it. Should you eat it, it would be like eating yourself and you would become sick because you have been disrespectful to your own totem. (As cited in Kral & Ellis, 2020, p. 17)

Daisy similarly says: "It's in our body—our totem. That's what's keeping me strong. That's what happens when they are born, that *Tjukurr* goes into them" (as cited in Turner & Ellis, 2023, p. 24). Another word for these spirit beings is *Kurrurntatja*. *Kurrurntatja* have a level of agency, entering and leaving human bodies, precocious, brazen, wilful, their personalities informing that of their human host. They are not static, but rather constantly able to move (Turner & Viegas, 2023).

## 9. *Tjuma*: Mapping Country

Lizzie describes another session on the camp where the Aboriginal rangers team steps in: "The rangers joined here, they talked about two-way science and what they do in their role in looking after country." One young man works with the rangers and the filmmakers, starting a drone from the ground and up into the air. We watch as a high school student begins to draw in little children to this activity. Lizzie notes: "In the two-way science approach with the older students teaching the young students, there are no white teachers in sight." This is a continuation of what the elders have set up, the Yarnangu way of doing things, giving Yarnangu primacy.

People then move to an area where a large canvas painting of approximately three by four metres is rolled out on the ground. It acts as an aerial map created by men and women for a ranger team based 250 kilometres away. It is created in the style of western desert acrylics famous across the globe. It holds an encyclopedia of knowledge for the area. Daisy draws all present to sit, watch, and listen to senior people talking about the map. This is an important story and the role of the storyteller is also important. Also critical is the part this has in student's learning, setting out how one should behave, people's obligations, and the dangers associated with misadventure and carelessness. The map is also used to identify important places in the stories. Students hear accounts of families going out hunting, success with catching *kuka* (meat), of trips in Toyotas to look for *ninu* (bilby). This educational event is shared by a group of 30 people, aged three through 80.

Lizzie explains additional elements in the storytelling associated with the mapping exercise:

> While we carefully examine the details on the painted map Old People talk about places associated with particular bush foods. The rangers then join in by pointing out what they do in different areas featured on the map.

Together with other senior people present the painter controls how much is shared and with whom.

More serious educational activities are mixed with play. According to Daisy, this is how it has always been and one reason the students are happy to learn. Lizzie notes that "students have moments set aside for leisure, as fun is important, so the Bush is the student's learning classroom and also where they play." This means that the soundscape of the desert is rich in the joyful mixture of peals of children's laughter and playing sounds as games are conducted. Adults keep an eye on things and there is much encouragement, but little interference. While this happens, the older ladies sit down and talk about their childhood growing up in the bush. Clearly the playful rendition of learning, the sounds of joy and the youthful energy all act as a mnemonic that assists in the process of remembering for those senior people, some of whom suffer with dementia. Initially it is impossible to tell this having watched their animated rendition of story-telling and the part they all play in providing additions to other stories being told.

For the involvement of these senior ladies to be possible, several "practical health" care matters are built into the arrangements for the camp. Beds, portable commode chairs, sanitary products, support with specialist medications and diabetes testing are all provided. Basic needs are met in a dignified manner. In addition, there are plenty of able bodies to assist with camp set up, keeping wood in supply, food delivery, and preparation.

## 10. *Yirna Kamu Pampaya Tjukurrpaku Ninti Purlkanya Mularrpa* (Old People Are Very Knowledgeable About *Tjukurrpa*)

All of this keeps senior people feeling healthy. As mentioned, this is partly because this work occurs on *ngurra*, in conditions where many grew up and lived when they themselves were young. The Old People are in places undertaking activities and consuming food and water that is clean, nutritious, and where family are in immediate proximity. This is directly felt in the body and physical health of people. As one senior man explains elsewhere:

> When old people look at things in the bush, they feel it with their body as well. They feel the country when old spirits that are still in the country enter their body. When they see each rockhole, they can feel the rockhole…and surrounding country. The families from that country who are there in spirit become happy and touch the people who are alive spiritually. The people who are alive feel the country and feel proud. (Lyall Giles as cited in Kral & Ellis, 2020, p. 132)

It is this feeling that comes from being on country that senior people so intensely love experiencing. They are doing what all see as their obligation, educating and caring for their grandchildren. They share in *wangka yuti* (language), reliving early memories in guiding young people as they were guided by their grandparents. They are also spending time at places of spiritual significance, not rushing to get to a destination, and experiencing the *tjukurrpa* with all the senses possible.

There is ample evidence from other non-Yarnangu sources that in remote Australia senior people are critically important. According to King et al. (2009), senior people's involvement in the passing of culture is important given the massive and detrimental effects of communal trauma on younger people. They are central to the maintenance of cultural continuity so that their grandchildren have anchor points to the identities and systems their family has inherited (Varcoe et al., 2010). A range of research projects have demonstrated the efficacy of involving elders in community health initiatives (Muhunthan et al., 2017). This reflects that crucial role of elders that exists in traditional systems (Dunn, 2004). This continues today with most communities looking to their elders for guidance in matters such as governance, conflict resolution, land management and cultural transmission (Lewis, 2011). Additionally, senior people play important roles in community solidarity and holding things together, helping others deal with racism, trauma, and the effects of colonisation, helping build a better resourced community, and safeguarding identity (Busija et al., 2020, pp. 519–520). Clearly elders fulfill many important roles here (Busija et al., 2020).

## 11. *Tjuma*: *Kirti* (Making Spinifex Glue) and Night-Time

In another session, Daisy leads a demonstration of making *kirti*. She starts with placing lumps of termite mound on a grinding stone on the sand: "*Kirti* comes from the spinifex, *kirti* is a super glue." Students, teachers, rangers, and others watch as another senior lady crushes the hard nodules of termite mound to reveal the spinifex resin. Spinifex (Triodieae) is the tough hummock grass that grows across the desert, a kind of "porcupine grass" with sharpened leaf blades (Ausemade, 2023).

In the documentary Daisy shows us the grinding stone, *walu* and *tjiwa* (a small rock) she is about to use to crush the spinifex. Again, the work prompts much excitement, voices of curiosity, of respect—"wow, *yuwo*, *walykumunu*"—and cries of encouragement as the students gather around. While one elder shows how we make *kirti*, other elders describe the process: "*Wangka pirni*...lots of talk, *kuliya*...listen up...*wantinta*...where now?...*walykumunu*...good one, strong one." The session ends with the students clapping the good work as the hand-processed *kirti* is shown and passed around.

Later that evening learning and other activities continue when Craig, the school principal, issues instructions to play a game of spotlight: "So, you got to try and sneak up on me and try and tag me without me seeing you. If you get me, you all win. If I see all the kids, I win. *Palya*?" Students' voices shout: "*Yuwo*...yes!" The images of torch lights flash in the dark. There are glimpses of children and spinifex bushes lit by torch beams. The light animates a different atmosphere. Lizzie notes:

> In two-way science the night-time is for learning as well....When the night-time comes, they are out, playing, story-telling, bedtime stories or little games to make kids feel tired so they could go to sleep early.

By this time the Old People are snuggled in their swags, some on camp cot beds for extra comfort. This is important as aging hips and bladders mean getting up more than once or twice at night. It is perhaps strange for western care providers to think of "aged" women and men in the desert communities regularly sleeping on the ground in the outdoors. However, here this is what it means to be healthy.

The teachers and staff had made sure the Old People had a good feed for dinner. Their campfire has a billycan with black tea leaves on the boil throughout the day and night. Greedy cups (large enamel cups) are nursed closely, next to each swag as people settle for sleep, beanies on heads to keep out the desert cold. The various little dogs that have been a big part of the camp are next to each person. They, along with the central campfire still burning gently, will keep people warm and safe. The sounds of the students playing the last of their night games ring out through the night. This is a little bit of *ngapartji ngapartji* (reciprocity) for the earlier night-time stories. Students reciprocate the healthy environment gifted by the Old People. How can the ladies not sleep well when they hear joyful children doing the things they did when they were little?

## 12. *Yitingka: Wanytjapurinypa Tjukurrpanya Kamu Tjukurrpa Kulintjanya Ngarala?* (How Is *Tjukurrpa* and *Tjukurrpa* Thinking Important?)

As those who have often received the most induction (lifelong learning) into the *Tjukurrpa* and *Tjukurrpa* thinking, senior people are the most knowledgeable. They understand the laying down of customs, laws, and rules of conduct. The lifelong accumulation of this *tjukurrpa pirna* (Tjukurrpa thinking) as well as their careful nurturing of its transmission across the generations is critical to older people's health and status. This is so in several ways.

*Tjukurrpa* sets out that those with the most knowledge and rights are those who have the greatest obligations and responsibilities. Elsewhere, Daisy explains about lay (*yara*):

> Under our law, the traditional owners are responsible to look after the land and look after the *Tjukurrpa*. If a *Tjukurrpa* place is damaged, we, traditional owners, will be upset and sad. It's like they are doing it to our bodies—the feeling is like cutting us in half. The people holding the *Tjukurrpa* will get really sick and might even finish [die]. (As cited in Turner & Ellis, 2023, p. 53).

At every part of the lifecycle of Yarnangu, senior people, particularly the grandparents of the young, are those who set out how the young ones move through different stages from baby to elder (Douglas, 1959/2020, p. 5). As Lizzie describes, this begins in childhood:

> I learnt from an early age, when my siblings and I were told stories by our parents and grandparents, at dusk, many of them from the *Tjukurrpa*....We learnt that the rules of our society are linked to the origin stories that are embedded in specific locations in the country and along the "songlines"....We learnt that there were places we could not go into. We also learnt that there were things that could or could not be touched or taken. And we quickly learnt that there were harsh consequences for breaking the rules....We did not learn all this knowledge in one day—it happened gradually throughout our childhood, our teenage years and into our adult years. (As cited in Kral & Ellis, 2020, pp. 16–17).

Lizzie also notes:

> This is what Ngaanyatjarra people call *tjamuku* and *kaparliku yara*—grandfathers' and grandmothers' law....Through the [Ancestral beings] encounters, actions and words, the law, that is, the "right ways of being," the "right ways of doing" and the "right ways of communicating" evolved. (As cited in Kral & Ellis, 2020, pp. 15–16).

To breach these protocols of behaviour is to incite ill-health. In part, this is because the rules of *Tjukurrpa* set out conducts that help keep spiritual forces in balance. When these rules are not followed, even when a breach occurs in ignorance, negative forces can be released, troubling events can occur, and ill-health to individuals and communities can be unleashed. Being able to contribute in this way brings great satisfaction to the Old People. Others may call this the practice of generativity, of giving something back to younger generations. This brings a sense of meaning and fulfillment in older people's lives (Tanaka et al., 2020, p. 1428).

## 13. Conclusion

On the final morning of the camp, students and adults gather as Daisy and several other Old People sing to all. Teachers, non-Yarnangu, and Indigenous visitors join in as best they can, humming and moving their arms as Daisy demonstrates. The students join in and swing their arms in time to the communal goodbye and safety song whereby visitors are sung safely home. Daisy explains that song is critical in keeping people safe and well, particularly as they travel home: "We are saying goodbye to the Fitzroy ladies and the others."

The title of the film recording is *Pirnilu Nintipungkupayi: Everyone is a Teacher*. The title signifies the importance of everyone contributing to education. However, in this situation, it is the Old People who are the central players in the maintenance of *Tjukurrpa*. This is because they have special talents and skills in helping young people experience *Tjukurrpa*.

During the camp, all enjoy an embodied experience of *Tjukurrpa*. They eat and are nourished by the "nectar" of the ants, in many ways the nectar of the *Tjukurrpa*. They watch as *kirti* (spinifex resin) is fashioned into a ball for ease of carrying. Students hear songs sung as guests are welcomed and farewelled. Students touch and are touched as they are painted in preparation for dance.

As Daisy points out, similar rituals of education and cultural transmission have been built into the rules for conduct over thousands of generations:

> Grandparents and their grandparents...have been passing on that knowledge and skills to the younger generations...the people have to hold on to that *Tjukurrpa* and keep passing it on to future generations because it's not an empty wasteland—it's full of sacred places, it's full of stories, it's full of memories, that they haven't forgotten, they've still got it [and] they want the younger people to get that knowledge. (As cited in Sackett, 2014, para. 294).

This is how Old People, many of whom will soon move on and into the *Tjukurrpa*, have their identities, roles, and experiences confirmed, shifting from being constituted as "the aged" to being "educators." They become the conduit that helps prepare others to live a good life as Yarnangu (the motto of Ngaanyatjarra Lands School), drawing the living and "dead," the past and the future, the learned and the learning together.

In some of the Western literature, the term "aging in place" has been used to describe the importance of people remaining in the context of their homes and families. Often it refers to living in one's community rather than in residential care (Australian Institute of Health and Welfare, 2013, p. 2). Perhaps we could think about this story as one example of "aging in *ngurra*," of a thoughtful and practical way of supporting senior Yarnangu to age "at home, in community, on-country, with country, and into the *Tjukurrpa*."

## Acknowledgments

Thanks to Ngaanatjarra Lands School for working with us to tell this story.

## Conflict of Interests

The authors declare no conflict of interests.

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**Social Inclusion**
2024 • Volume 12 • Article 7438
https://doi.org/10.17645/si.7438

ARTICLE

Open Access Journal

# Ageing in Place, Healthy Ageing: Local Community Involvement in the Prevention Approach to Eldercare

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**Submitted:** 27 July 2023 **Accepted:** 6 November 2023 **Published:** 25 January 2024

**Issue:** This article is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

## Abstract

The increase in ageing societies is posing new and urgent societal and political challenges to meeting people's medical, personal, and social needs in old age. Ageing should not be considered a uniform phase of life and at least three phases should be distinguished: (a) silver age, (b) the mildly frail age, and (c) those at risk of dependency. Policy tools and logics should prevent and support specific needs in a life-course approach and the preventive approach is seen as among the most useful interventions, with a baseline objective to promote ageing in place, minimize the institutionalization of care, and prevent psychophysical deterioration by supporting older people and their families through tailor-made approaches and policies. Our study focuses on the project Invecchiare bene/Bien vieillir (ageing well) funded by Interreg Alcotra France–Italy and implemented in the Valleys of Monviso in northern Italy. The project targets older people living at home in mountainous areas, where healthy ageing is difficult due to chronic diseases and social isolation. This article presents an analysis of preventive-based interventions and services that promote innovative ageing policies and investigates the involvement of the local community and how it can lead to the deployment of new preventive measures. The research covers the direct impact on the health and living conditions of the recipients (older people) and innovation by the local care model (among social workers and the local community). Qualitative (documentary analysis, semi-structured interviews, and focus groups) as well as quantitative (questionnaire and secondary data analysis) methods were used.

## Keywords

active ageing; ageing in place; community building; local welfare; older population; preventive approach

## 1. Introduction

Western societies are currently dealing with the rapid ageing of their population. This has become a central issue in policymaking as new concepts, programmes, and services to fulfil the expectations of the older population—as well as service providers and policymakers (Iecovich, 2014)—are being developed. Two concepts have been dominating both the scholarly and public debate: active ageing and ageing in place. According to the World Health Organization (WHO, 2002, p. 12), active ageing is “the process of optimizing opportunities for health, participation, and safety to improve the quality of life of people as they age.” Active ageing adopts an inclusive view of late-life health, capable of capturing the full range of factors that—beyond types of care—can positively influence the life course of the older population. The goal is to prevent the deterioration of health among people in their old age through the development of policies and services that enable the individual to consciously choose an ageing path more appropriate to their needs and motivations. Older age is a transitional period when people experience changes not only in physical health, but also in social roles (e.g., retirement), and successful ageing has been empirically defined to include a low probability of disease and disease-related disability, a high level of physical and cognitive functioning, and active engagement in life (Carr et al., 2013).

Alongside successful ageing and healthcare prevention, there has been a steady increase in the discussion of ageing in place in recent years. Ageing in place involves developing services and facilities that allow older people to stay in their homes or chosen environments for as long as they can as they grow older. Mainstream scientific and public discussion has underlined how most older people prefer to age in place rather than relocate to another place or residential care facility, as ageing in place allows them to maintain their independence, social engagement and networks, as well as to remain in a safe and comfortable environment (Whitney & Keith, 2006). Empirical studies have underlined how older people wish to stay in their homes as long as possible, but their demands are influenced by policies and their own individual needs (Means, 2007). Most older people are attached to their independence and prefer to live in the environment with which they are most familiar (Vermeij, 2016). Independent living also contributes to maintaining a sense of self-esteem and self-reliance (Milligan, 2009). In this framework, ageing in place means growing old in one’s own home rather than in an institution (i.e., nursing home). It also means living independently in old people’s homes and communities safely, autonomously, and comfortably regardless of age, income, or functional limitations (WHO, 2017). Broadly speaking, to age in place is to continue to live in the same “place” as always (Löfqvist et al., 2013).

This article focuses on the project Invecchiare bene/Bien vieillir (ageing well; hereafter INCL) funded by Interreg Alcotra France–Italy and implemented in the Valleys of Monviso in Piedmont, northern Italy (Agostini et al., 2023). It is based on primary sources such as original data collection (survey, semi-structured interviews, and focus groups; see Section 2) from the monitoring and evaluation activities conducted by the Observatory on Second Welfare and develops those results within the framework of an ongoing discussion, in the literature, about active ageing and ageing in place. INCL specifically targeted older people living at home in mountainous areas, where the possibility of ageing well is at risk due to chronic diseases and social isolation.

The literature recognizes a wide variety of definitions of social isolation. Biordi and Nicholson (2009, p. 97) defines social isolation as “an individual’s distance, psychological or physical or both, from the desired or necessary network of relationships with other people. Thus, social isolation takes the form of a loss of positioning within a group." More specifically, two dimensions of social isolation have been identified: a subjective dimension, which is a perceived deprivation of one's social resources, such as companionship or social support (and is thus closer to the concept of loneliness); and an objective dimension, which includes a lack of contact with others due to contextual factors (e.g., reduced social network size, rare social interaction, or lack of participation in social activity). Risk factors leading to social isolation can be psychological (e.g., a depressive state), physical (e.g., chronic illness), or, indeed, social (related to inequalities, economic or cultural aspects, transportation, social activities, etc.; see Biordi & Nicholson, 2009; Nicholson, 2009). Social isolation is therefore distinguished from loneliness, which relates to a subjective and negatively experienced discrepancy between the quality and quantity of existing relationships and a person's desires or standards regarding those relationships (Machielse, 2015). One can feel lonely while not being socially isolated. Nevertheless, the two concepts are related: Loneliness can be conceived of as a risk factor for social isolation because persons who deal with prolonged feelings of loneliness often see their social network shrink (Machielse, 2006); both loneliness and social isolation affect the physical and mental health and health-related behaviours of older people (Choi et al., 2015; WHO, 2021). Both problems are amplified in mountainous areas, which are experiencing depopulation, the closure of commercial and community activities, and lack of transportation (see Section 2).

Concerning the current debate on services for older people and ageing, INCL has at least two main points. The first is understanding its target (older people) and the relative specificity of its needs and services. There is a growing awareness of how the people that comprise the "older population" are profoundly diverse among themselves and how the needs of people in their old age vary as they grow older and as physical, cognitive, and mental complications occur. Indeed, not all older people are in a state of non-self-sufficiency or are passive recipients of services: Some of them actively participate in social life and can be a resource for the entire community (Longo & Maino, 2021).

The life-course approach is a concept that has become widespread in rethinking the logic of intervention to support the older population. Looking at the long phase that begins with retirement (from age 65/67 onward), it is possible to identify three subgroups corresponding to the three main stages of old age: the silver age (aged 65–74), the mildly frail age (aged 75–84), and people at greater risk of non-self-sufficiency (aged 85 and older). These three profiles ideally reflect the exacerbation of needs related to increasing age. Ageing is characterized by an increase in the risk of frailty, disability, and sedentary conditions, the risk of social isolation, and depression. The likelihood that an older person may fall and injure themselves also increases. The three profiles must therefore be associated with different goals, tools, and services that better reflect the differentiation of care needs and responses (Maino & De Tommaso, 2021).

The transition from active life to non-self-sufficiency goes through different stages characterized by increasing frailty, which is largely also related to the condition of social isolation and loneliness to which older people are increasingly exposed (Maino & De Tommaso, 2021). The role of local welfare thus becomes that of supporting—through caretaking—older people from one stage to the other. It is thus a matter of flanking restorative interventions (which aim to offer answers to manifest needs) not only with preventive interventions (which aim to postpone the non-self-sufficient phase as long as possible) but also with "proximity" interventions based on "light" services that go beyond prevention and look to the well-being of older people. This third type of action is in line with the most recent transformations in local welfare, which increasingly focus on the promotion of a model variously defined as proximity and community-based through generative and capacitating approaches. What these definitions have in common is the centrality of the community and the idea that territories are systems in which "first welfare" actors (public agencies) compete with "second welfare" actors (third sector, for-profit and non-profit entities, and also ordinary citizens) in the production of interventions aimed not only at responding to and preventing needs but also at promoting well-being in a broader sense (Longo & Maino, 2021; Maino, 2021). In other words, thinking about older people, it is necessary to combine care and assistance with preventive interventions and activities that can promote mobility and sociality, as well as autonomy inside and outside the home, to delay physical and cognitive decline as much as possible. Achieving this goal requires identifying the multiplicity of needs of individual older people and adopting specific and necessarily multidimensional interventions.

The second point of the INCL is related to community development, an alignment whereby individuals who are part of a community are committed to working together in the process of community evolution (Walter & Hyde, 2012). The active participation of local actors—public, for-profit, and non-profit or families—is aimed at innovating local public policies via renewed forms of local community participation. The final aim is to establish "structured" pathways of community empowerment to restore bonds of trust, sharing, and assumption of a community perspective that goes beyond individual interest; to strengthen the capacity of residents, associations, and organizations (private and public) to promote positive change through the creation of social ties among people; and to leverage spontaneous mechanisms of aggregation and mutual recognition that are based on the adoption of collective behaviours inspired by mutual responsibility (Berloto, 2021; Longo & Maino, 2021).

This study, therefore, investigated the impact of the INCL project on both older people ageing in place (and, indirectly, active ageing) and community development. The remainder of this article is divided into four sections. The next section outlines the research questions and methods. The third section briefly presents the background, objectives, and phases of the project. The fourth section focuses on the analysis of the direct impacts on the health and living conditions among the project's recipients and the local model innovation of care (i.e., on social workers and the local community). Conclusions are presented in the fifth section.

## 2. Research Question and Methodology

Starting with the results of the monitoring and evaluation activities, our analysis answers two research questions: How has the INCL project's model of care improved the health and living conditions of older people? How has the project fostered innovation in the local model of older people care (i.e., regarding community development)?

The research was structured into two parts. The first part investigated the impact that the INCL—as a typical project in the field of ageing in place—could have in fostering the transition from active life to non-self-sufficiency while mitigating and preventing dependency, as well as the role of local welfare in supporting older adults from one phase of life to another. The first part of the research interweaves and illustrates three dimensions: (a) the project's main characteristics and goals; (b) the experiences of both individual older adults and social workers to analyse how effective the project was in relation to its intended objectives and recipients’ satisfaction; and (c) the factors facilitating or hindering the project’s success to determine areas where it could be improved.

Data collection was conducted via the monitoring forms filled out by operators at the beginning of the project (61 forms), an online structured questionnaire that professionals filled out for each of the recipients whose projects were still active as of 7 September 2022 (52 questionnaires). Each questionnaire collected data on specific analytical dimensions (personal health and well-being, interpersonal skills and sociability, housing, daily life, relations with territorial services) and focused on four parts: achievement of the objective of the project; satisfaction among older adults with the activities; difficulties encountered by the operators; and services/activities that should be enhanced and/or included. Each questionnaire was completed by the professionals who managed the individual projects. The professionals carried out the evaluation (and related completion). This choice was intended to compensate for the difficulties that older people may have in completing the questionnaire on their own and, on the other hand, to enhance the overall view of the project’s effects, which could be offered by the operators involved in the activities. Moreover, six in-depth semi-structured interviews related to relevant case studies were conducted to delve into the factors that facilitated the success of the intervention. The interviews concerned six older women and men involved in the INCL project who were signalled by the members of *gruppi integrati di presa in carico* (GIPIC, groups composed of different professional figures, such as social workers, nurses, health workers, and professional educators in charge of providing care to older people) for their good level of participation in the project activities and because they were able to talk about their experience clearly and comprehensively.

The second part of the research investigated the impact that INCL—as a typical project promoting community development—could have in experimenting with new forms of participation by public and private actors at the local level. The analysis focused on (a) the characteristics of the services that the INCL model provided in the face of a substantially new target (frail older adults with a non-severe clinical picture), (b) the intervention model implemented to run these services and its effects on the social workers, and (c) the improvement of local care services generated by INCL. This part of the research was carried out based on the analysis of project documentation and by making use of qualitative methods such as in-depth interviews and six focus groups. The interviews involved members of the technical project committee, while the focus groups addressed the six GIPIC teams supporting the valleys targeted by the intervention.

## 3. INCL: Project Description and Goals

This article analyses the model of the intervention tested within the INCL project, implemented between June 2021 and September 2022 in a partnership led by the Consortium Monviso Solidale (CMS) in collaboration with the Local Health Enterprise of Cuneo (ASLCN1) and the Cuneo Social Welfare Consortium. CMS is a public body established by the will of 58 municipalities and is responsible for the associated management of social and welfare services. INCL is part of the PITER Terres Monviso Integrated Territorial Plan and is funded by the European Regional Development Fund, Interreg Alcotra Programme 2014–2020. INCL involves a territory that includes, in Italy, the mountain community Valli del Monviso (composed of Varaita, Po-Bronda, and Infernotto) together with the three mountain unions of Valle Grana, Valle Maira, and Valle Stura; in France, the project involves the local communities of the Guillestrois–Queyras, Serre–Ponçon, and Ubaye–Serre–Ponçon municipalities. This section illustrates the project’s background and context (Section 3.1) as well as its dimensions, goals, and phases (Section 3.2).

### 3.1. Background and Context

INCL is a project that promotes ageing in place, or "the ability of older people to live in their own homes and communities safely, autonomously, and comfortably, regardless of age, income, or functional limitations" (WHO, 2017, p. 6). The project targeted older people whose possibility of ageing well was at risk due to health issues and the social isolation derived from living in mountain villages. While the processes of physical and cognitive deterioration, as well as the feeling of social exclusion, are typical of ageing, one's specific context exacerbates the living conditions of older population: Consider, for instance, scarcely populated villages far from city centres, poorly connected to them—if at all, and the resulting difficulty in accessing social, commercial, health services. The "INCL territory" shares common sociodemographic trends. In recent years, this area has suffered a slow—but progressive—demographic decline, determined by the constant depopulation of the high valleys, mainly due to the geographical marginality of the mountain territory, the lack of job opportunities, and the scarcity of services in rural areas. Further social dynamics are linked to the persistence of a digital divide between urban and rural areas, which has spread a deep disadvantage for those living in marginal areas where access to digital services remains limited. However, while the socioeconomic context seems more fragile in the higher villages, the social relationships are also stronger. Indeed, community and neighbourhood social ties are more present and effective in small towns and upper valley areas, where all community members know each other and there is a constant monitoring of the situation of the more fragile and isolated individuals. The reference persons are doctors, pharmacists, and social workers, but neighbours and relatives are also ready to report situations of criticality or distress. While active ageing activities in some territories had never been attempted, in others (Valle Varaita and Valle Grana) they were successful, especially with the involvement of volunteers. Moreover, during the Covid-19 lockdown (in 2020 and 2021) in Val Varaita, older people were taught to use new technologies to, for example, send SMS, make video calls and send emails, using both tablets and mobile phones.

### 3.2. Core Goals, Dimensions, and Phases

INCL had two main objectives: (a) to implement an innovative mode of taking care of older people with identified physical and cognitive frailty (and, thus, a quasi-severe clinical profile) and (b) to test, albeit on a small sample compared to the width of the recipients in the main target, an individualized plan of care, allowing the older people and the whole local community to identify social needs while co-designing possible responses. The project involved 61 beneficiaries: 36 women and 25 men, aged 60–95 years (28 of them were between 80 and 90 years old). Half of them did not have any caregivers. Most of the beneficiaries enjoyed a good level of independence in activities of daily living and instrumental activities of daily living. They had minor health problems but needed support for therapy/care management. Beneficiaries of the INCL project had no economic problems but experienced loneliness (reported in 70% of cases) and needs related to the partial and progressive loss of their autonomy. Of the beneficiaries, 21 lived in inadequate housing (e.g., with architectural barriers or no hot water) and 13 in partially adequate housing (e.g., isolated or in need of housekeeping).

There are two main dimensions at the core of the project. The first involves the design of policy tools specifically calibrated to the project's priority target, notably frail older people (Maino & De Tommaso, 2021). The second requires innovation of the local model of care through the deployment of intersectoral (thus involving multiple policy sectors) and multidimensional interventions, aiming to intervene simultaneously for the different needs of older people and in the direct participation of local communities with a view towards community building (Zazzera, 2021) and proximity welfare. In fact, Maino (2021, pp. 50–51) defines proximity welfare as:

> A set of co-defined public–private interventions and measures that aim at sharing welfare among people within the same community. It starts from a shared reading of needs and common goals, providing for the advocacy of the local actors involved….It involves the enhancement and promotion of formal and informal territorial networks (composed of public actors, private actors, associations, and citizens) which attempt to respond to local and shared social needs.

To select the appropriate model to achieve these objectives, the implementation of the project was preceded by an accompanying activity (lasting about six months and conducted with the support of an external consultant) that led to the creation of the GIPIC in charge of providing care to older people. INCL established a GIPIC for each territorial area involved in the project—a total of six teams, three of which were active in the Cuneo area and three in the Saluzzo area. Each GIPIC met, on average, every three weeks to carry out its activities. In addition, collective meetings were held between GIPIC teams to discuss, among operators, the local best practices and specific training activities—that is, the management of health issues, the professional skills required to work in multidisciplinary teams, and the socio-relational strategies necessary to promote dialogue with older people.

The local intervention of the GIPIC teams consisted of two phases. The first, carried out between July and September 2021, concerned the definition of "individual projects," i.e., a project for each older person, tailored to their needs and resources. It included the following steps: (a) assessment of the older person's needs and the recognition of the services/activities with which they were already provided; (b) the identification of the professional figures that could manage the individual project; (c) the identification of the objectives of the individual projects (groupable in the macro area of health and well-being, interpersonal skills and sociability, quality of housing, everyday living and continuing relationships with local social services); (d) the definition of the services and activities to be implemented, which had to contemplate the participation of the three sectors (health services, social services, and the local community), and the implementation timeframe (maximum 9–12 months); and (e) the identification of the indicators useful in evaluating the fulfilment of the stated objectives.

The second phase, carried out between September 2021 and September 2022, encompassed the project implementation—and related services—envisaged by the individual projects. The main services concerned improvement of autonomy, health monitoring, prevention of loneliness, personal and house hygiene, transport, and grocery shopping services. Aside from health and social services, the local community was directly involved in the activities. The involvement and cooperation between the local community and public services in a structured programme were one of the main innovations of the project. Community members were asked to activate a territorial network able to care for older people and prevent their social isolation with several activities (e.g., community lunches, musical evenings, out-of-town trips, art and photography workshops, home reading). From a community-building perspective, these activities often involved other older people in the area, including "more active" older people and retirees, with free time and willingness, who proposed the activities and took on the burden of organizing and leading them. These activities required strong coordination with social welfare consortiums, public administrations, and voluntary associations. The ASLCN1 also asked to participate directly in local meetings to combine aggregative activities with moments of health prevention such as the “Health Education in Pills”—a health education opportunity managed by the ASLCN1 and based on a playful mode of learning.

## 4. Analysis of Results

This section presents and analyses the results. Section 4.1 presents the data about the recipients, while Section 4.2 presents the results from the perspective of operators and service providers.

### *4.1. Services: Assessing Effects on Health and Living Conditions Among Recipients*

This section presents data collected via the monitoring surveys filled out by operators at the beginning of the projects (61 recipients) and a structured questionnaire only addressed to recipients whose projects were still active as of 7 September 2022 (52 recipients). Although the subject of the questionnaire was the recipient, the evaluation (and related completion) was carried out by the operators. The project addressed frail older people affected by mild physical and cognitive decline (i.e., the partial loss of their independence) who were socially isolated. Most of the individual projects focused on improving autonomy (49), followed by health monitoring (39), prevention of social isolation (35), and maintenance of personal and household hygiene. Fewer projects addressed the provision of transport (15) and grocery shopping services (14; see Figure 1). The most common interventions involved the ASLCN1 (55 individual projects), followed by social services (49) and the local community (33). However, social services and the community are the two fields in which professionals invested more hours per recipient.

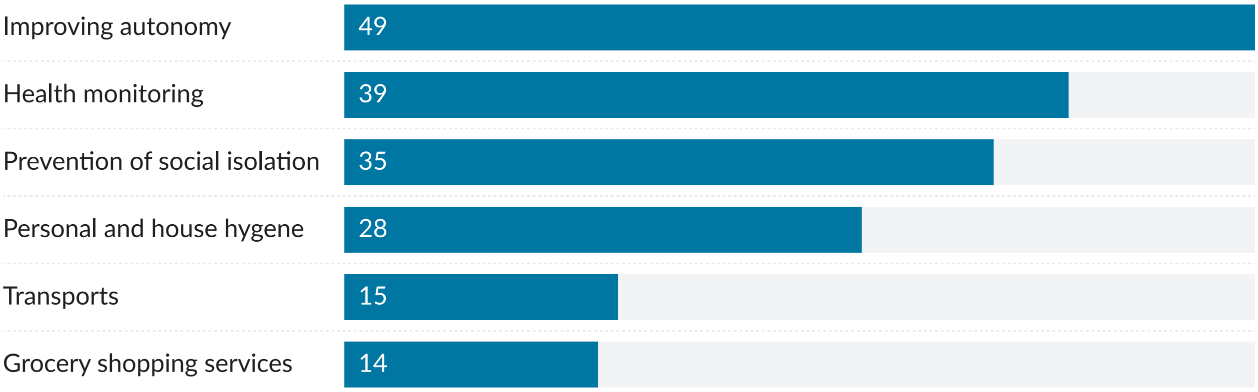

**Figure 1.** Frequency of individual projects launched per areas of project intervention.

On the one hand, the project achieved very good results overall for personal health and well-being, particularly with respect to the objective of “encouraging a proper use of therapeutic procedures” (e.g., taking medications), which was rated fairly or very effective in almost all cases where it was implemented. The sphere of interpersonal skills and sociability, on the other hand, was controversial, representing both the project’s main opportunity and criticality, although the experience was evaluated positively overall. Indeed, the project was rated fairly/very effective in “promoting socialization by reducing the risk of isolation” in 64% of cases, but also not very or not at all effective in 36% of cases. For 72% of respondents it was fairly or very effective in “maintaining/improving interpersonal relationships,” although for 28% it was little or not at all effective (Table 1). Activities and services that relate to personal health and well-being, such as "activities/services to monitor health status" and "help with the correct taking of medications and the correct use of medical devices," were the most appreciated by older people (Figure 2). Judgements on social activities were also rather fragmented: They were not at all or little appreciated in 48% of the cases for which the activity was carried out (with 24% not appreciating it at all) and fairly/very much appreciated in 52% (Figure 2).

**Table 1.** Recipients' assessment of achievement of the project's main objectives.

| Objectives | Not effective at all | Hardly effective | Fairly effective | Very effective |
|---|---|---|---|---|
| **Personal health and well-being** | | | | |
| Promote proper personal hygiene | 3% | 27% | 32% | 38% |
| Encouraging the proper use of therapeutic procedures | 0% | 3% | 61% | 37% |
| Promoting proper nutrition and hydration | 0% | 33% | 48% | 19% |
| Promoting adequate mobility | 2% | 36% | 33% | 29% |
| Initiate/enhance personal autonomy | 0% | 28% | 53% | 19% |
| Maintain/improve the quality of life of the older person | 0% | 10% | 65% | 25% |
| **Interpersonal skills and sociability** | | | | |
| Promoting socialization by reducing the risk of isolation | 5% | 31% | 27% | 37% |
| Maintaining/improving interpersonal relationships | 4% | 24% | 39% | 33% |
| **Quality of housing** | | | | |
| Creating a more comfortable and safe home environment | 3% | 35% | 35% | 27% |
| Promoting adequate hygiene in the dwelling | 4% | 42% | 31% | 23% |
| **Everyday living** | | | | |
| Facilitating the handling of paperwork/commissions/shopping | 3% | 6% | 54% | 37% |
| Facilitation of transport | 9% | 26% | 26% | 40% |
| **Relationship with local social services** | | | | |
| Improving the trust of older people in operators | 2% | 2% | 29% | 67% |
| Guiding older people to available services | 2% | 7% | 27% | 64% |

On the side of interpersonal skills and sociability, both goals of the activities—promoting socialization by reducing the risk of isolation and maintaining/improving interpersonal relationships—were rated as hardly effective (31% and 24%) and fairly effective (27% and 39%). These activities were highly appreciated among recipients (43%), although 48% of them declared that they were not at all or only poorly satisfied with these activities (Figure 2).

Another important issue for the project, which aspired precisely to encourage older people to stay in their own homes, was housing. The goal of creating a more comfortable and safe home environment was not achieved, or was achieved poorly, in 38% of the cases, while that of promoting adequate hygiene of dwelling was not achieved in 46% (Table 1); hygiene activities/services related to the home were poorly appreciated by 48% of participants—almost half (Figure 2). This result can be explained, first, by the difficulty of being supported by strangers in personal care and living environment activities—reported in 15 cases—which was slightly more prevalent among those who are quite autonomous and probably have more difficulty accepting the help of an external, unknown caregiver. Finally, it should be noted that 21 recipients lived in inadequate housing (e.g., with architectural barriers or without hot water); 13 lived in partially adequate housing (e.g., isolated or in need of housekeeping), where making the environment more comfortable and safer would require restructuring interventions.

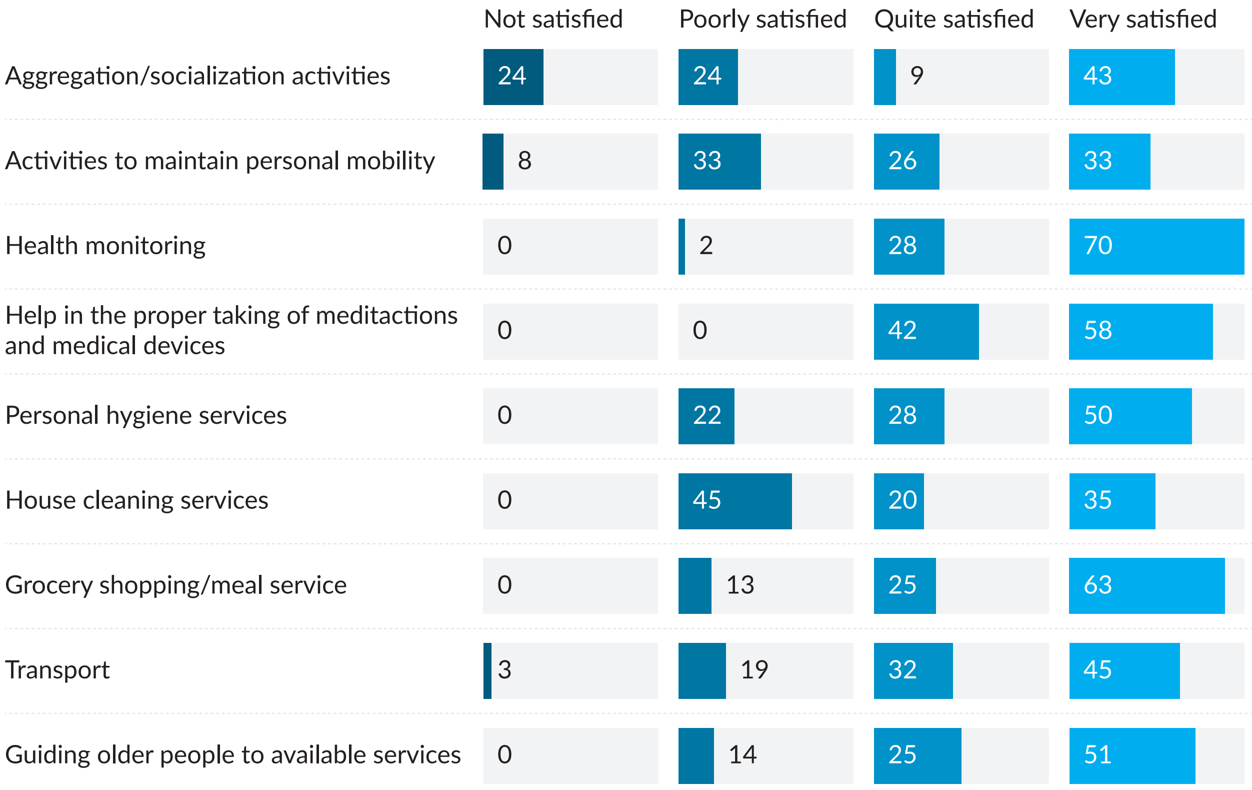

**Figure 2.** Rate of satisfaction with activities/services among older people, in percentage values.

In the daily life sphere, the project was effective in facilitating the handling of paperwork/commissions/shopping, which was rated positively in 91% of cases, and quite good in the facilitation of transport—the transportation service received a negative rating in only 22% of cases (Table 1). The shopping/meal service was also highly appreciated, receiving positive ratings in 88% of the cases for which this activity was carried out (Figure 2).

Regarding the relationship with local social services, the project achieved excellent results (although the figure may be conditioned by the fact that the operators carried out the assessment). The goal of improving the trust of older people towards operators was considered to have been achieved in 96% of cases (Table 1). In this sense, a very delicate stage was the engagement of people in old age who had not connected to the services before, as revealed in the interviews. In this regard, emblematic is the case of one interviewee who recounted that she was initially wary because she thought she had been "hooked" by social services to be taken away from home. The objective of addressing older people towards the services available in the area was achieved in 91% of cases (Table 1). These activities were fairly/very much appreciated in 86% of cases (Figure 2).

Obstacles reported in 26 cases (half) concerned reluctance to participate in social/collective activities or to leave home for 20 cases (Figure 3). Another factor that emerged from the interviews was older people's desire to protect their independence, a sentiment often conditioned by the presence of close relatives. Although with some difficulties, as mentioned above, social/collective activities and services were appreciated and—according to interviewees—considered beneficial, because they allowed respondents to get to know new people. Furthermore, when asked what services/activities should be improved/strengthened, the most needed was strengthening aggregation and socialization activities, reported in 30 cases—more than half. This response was given mainly by those who are fully or fairly autonomous (about 60% for both combined), further confirming that, for socialization activities, there is a need to invest precisely in this target group, which emerged as the most critical.

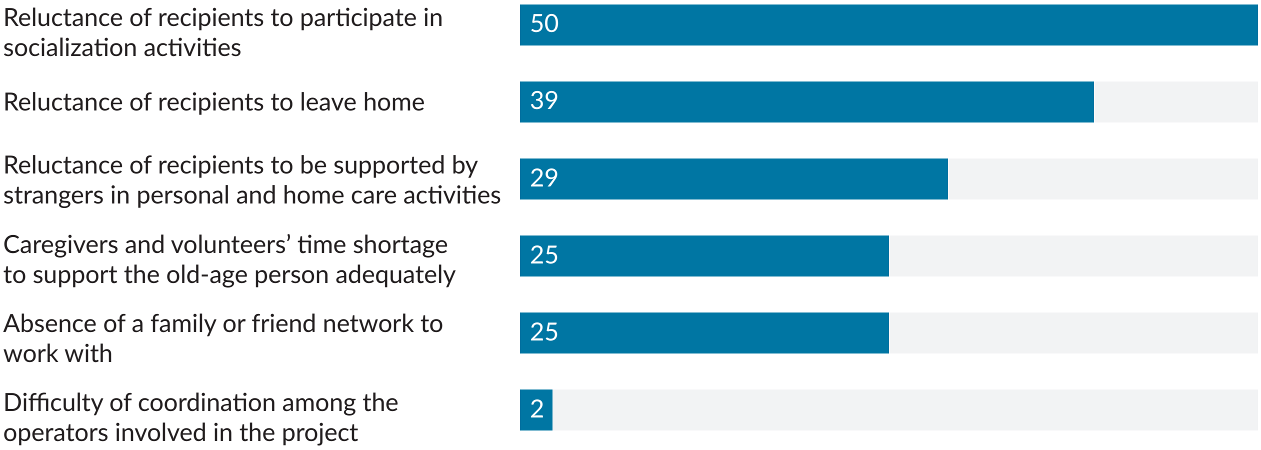

**Figure 3.** Difficulties experienced by the operators involved in the project.

Finally, regarding the services that could be strengthened/included, older respondents underlined the need to invest in socialization activities (58%), transport services (44%), and improvements in the number of paid social workers (35%) and volunteers (33%). A small quota—2% of respondents—asked for assistive home automation tools (Table 2).

**Table 2.** Services/activities that should be strengthened and/or included.

| | N | % |
|---|---|---|
| Aggregation/social activities | 30 | 58 |
| Transport services | 23 | 44 |
| Number of paid social workers | 18 | 35 |
| Number of volunteers | 17 | 33 |
| Volunteers' skills | 5 | 10 |
| Telemedicine | 5 | 10 |
| Social care | 4 | 8 |
| Paid social workers' skills | 1 | 2 |
| Nursing caretaking | 1 | 2 |
| Assistive home automation tools | 1 | 2 |
| Other | 9 | 17 |

### 4.2. Networks: Assessing the Innovation of the Local Model of Care for Older People

The innovations introduced through INCL have had significant impacts on how care is provided, on the professionals' work, the management of services for older people, and the construction (or consolidation) of territorial networks. The innovative target group—which involved frail older people—was associated with integrated caretaking on three fronts: health, the social sector, and community. The project adopted a multisectoral perspective and aimed at social and health integration: The GIPIC teams brought together practitioners with social and health skills and volunteers, and the projects focused on objectives and interventions that covered both sectors. Most projects involved the integration of ASLCN1, social services, and the local community—or two of these together.

While there are long-lasting structural issues at play (Longo & Maino, 2021), in Italy, as in many other countries, integrating health and social care services has become a central aim of welfare policies (Tousijn, 2012). Two important factors have acted as the main drivers of change: the growing number of people affected by multiple and chronic diseases who require more holistic care (Tousijn, 2012) and the de-institutionalization and de-hospitalization of social and health services to contain costs and keep people as much as possible in their own home and community (Burau et al., 2009). Third sector—mostly, voluntary—organizations have long offered support services to older people to fill existing gaps in public provisions. The various institutional actors involved in healthcare and social care are now being asked to cooperate, providing a proper institutional framework for more effective and efficient care. New models and structure are needed to coordinate, merge, and foster new processes that have been separate for a long time: Members of different professions are expected to integrate their work practices (Tousijn, 2012).

This is the case of INCL. This local innovation allowed for a multidimensional response to both manifest and hidden old-age needs, which tended to be neglected by traditional social services. Social and healthcare integration would not have been possible without establishing GIPIC teams (see Section 3). Teamwork was a valuable experience for the operators for several reasons. First, the synergy with professionals from other areas allowed them to reflect critically on their internal capabilities, while minimizing the routinization of professionals' tasks from a learning perspective. In one interviewee's words:

> This model is certainly valid. It should be more and more like this, more and more networked. When I think about professional diversity, the fact that she [points to another colleague] is from a different cooperative than I am, I find it very enriching. We are often used to building comfort zones that teamwork forces us out of. You can also put yourself in the other operator's shoes because it is not necessarily the case that if you have been doing it for 30 years then you do it well or you always have to do it that way. Still, you can also learn from others. (Social worker, CMS, translated from Italian)

On the one hand, the INCL process guaranteed a deeper understanding of the individual and contextual situations of people in their old age in the area, unveiling their neglected needs. On the other hand, it shared an emotional—more than professional—burden in caring for complex individual situations, improving both professional care and the lives of individual older people. The absence of volunteer workers in the GIPIC teams (because they were involved only in the implementation phase) was considered a limitation because they would have facilitated the identification of needs, given their close relationship with older people living in the area. As reported in interviews, the role of volunteers is central in defining population needs because they are actively involved on the ground 24/7. Voluntary associations have—and should continue to have, based on the prospect of social and health care integration—a key role in taking care of older care recipients.

However, two shortcomings—and, therefore, areas for potential improvement—emerged. The first concerns strengthening human resources—that is, the number of operators and volunteers involved (about the latter, the need to improve their skills was also reported). The second concerns the fact that accompaniment has improved the social relations for older people, but their volunteer network has often been limited to the closest neighbourhood. Hence, there is a need to enhance community involvement to achieve proximity welfare that can widen the network of "caregivers" for mildly frail older people. In any case, the innovations generated by the mode of work in GIPIC teams have improved the quality of services offered to older people: The holistic approach to the person makes it possible to observe latent and manifest needs. In addition, intervention time was reduced, because professionals could carry out their tasks more quickly by working together in synergy:

> With INCL, we carry out a comprehensive assessment of the person through the team, which has different professional skills within it. This allows us to understand their needs and situation. Before INCL, we used to respond to specific requests. Now we try to understand, for example, if the older adult needs a meal, if he has a health situation that is better to keep under control, for example, because he has diabetes….So the nurse does her part, the social worker does hers…and if we see that the person has needs related to socialization, then we activate the educators and try to structure specific moments. So, the assessment and the responses are 365 degrees. (Child and families social service manager, Technical Project Committee, CSAC, translated from Italian).

Finally, INCL also had an impact on territorial networks, consolidating them where they were already present or promoting their construction where they were not. This has been possible for two main reasons. The first is that, through collaboration with local public and civil society, INCL practitioners have become a point of reference for the community. According to some interviewees, INCL fostered mutual helping relationships among older people. Socialization activities made it possible to bring together people with shared needs who otherwise would have never met on their own.

The second is that the project promoted the building of relationships between the mildly frail older people in charge with other older people in the area who participated in the animation activities. In any case, the development of community activities was strongly conditioned by the pre-existent development of local networks: In valleys where networks were already built, the implementation of territorial animation was easier; in valleys where they were not already in place, sometimes the territory welcomed and promoted INCL's actions, while in other cases institutions and local realities were reluctant to support the project and the GIPIC teams. Social and healthcare integration developed an extensive local network. Respondents reported that the GIPICs fostered a great stimulus to community development:

> If we look at the territory, the networks activated are a great asset. For example, if tomorrow there were no more GIPIC, I know that the social worker is still there, who has seen the mayor many times for this project, who knows the nurses, and so on….The volunteer who goes today to bring the groceries or who anyway sees the shutter down but knows that the older person is there and rings the doorbell…these relationships have been created over time, and when you create the relationship, automatically you create the network. (Project manager, CMS, translated from Italian)

Changing local conditions have affected the likelihood of people becoming involved in community development while working to improve humanistic aspects of community life. While citizen participation is not synonymous with community development, it is a means to realize the humanistic elements of community development through compelling involvement by public and private actors to foster self-help efforts among all segments of the population (Dillman, 1983). As we delve into the conceptualizations of community inherent in the theories of community development, Phillips and Pittman (2015) point out that, within this theoretical area, communities are, first and foremost, a group of people and the ties exist between these individuals. It is territory per se—not only because of its physical texture and boundary definition but also because it hosts a series of social actors and resources, both tangible and intangible—that determines its facticity and it is the relationships between these actors and objects that constitute its identity (Goldenberg & Haines, 1992).

## 5. Conclusion

In the field of old-age policies—more specifically, ageing in place—INCL focused on promoting home care by adopting a multidimensional, and proximity approach. The project has tried to address the issue of ageing by considering it not only from the point of view of better management of needs that have already occurred but also of risk prevention through early identification and care provision for fragile individuals. The initiative has, therefore: (a) attempted to broaden the perimeter of care from the individual family or the "older people–caregiver–family triangle" to the broader territorial community of reference; (b) sought to mobilize a plurality of public and private resources, both formal and informal, that the community can make available; (c) introduced new professional figures, fostering community and proximity welfare (Lodi Rizzini & De Gregorio, 2021; Maino, 2021) through the reinforcement of tailor-made responses; (d) created new services (or reformed existing ones) and/or created (or adapted) physical spaces dedicated to older people to facilitate their relational opportunities; and (e) in line with Maino and De Tommaso (2021), fostered the development of more coordinated interventions between socialization and response to ageing-related needs.

This approach was translated into goals and consequent activities and services that focused on promoting health and independence in and out of the home, as well as creating an "older people-friendly" environment. The project efficiently facilitated physical mobility inside and outside the home; the meal supply service and help with grocery shopping were also highly appreciated. This latter is an essential achievement because proper nutrition is a prerequisite for healthy ageing (e.g., preventing diabetes, cardiovascular disease, and obesity), but inaccessible in mountain villages that, given the scarce presence of grocery stores, can be considered "food deserts" (USDA, 2009). Because the project sought to encourage older people to stay in their homes, an important aspect concerned housing quality, especially regarding hygiene and creating a safe and comfortable home environment. On this point, the project has not been very effective, which requires further attention. Even if there are "structural" reasons the project could not have changed (older people often live in obsolescent buildings with architectural barriers), other elements could be addressed, such as the difficulty—reported by some beneficiaries and operators—for older people to let "a stranger" into their house, which could be overcome by intervening in social relationships and mutual trust. Finally, the effect on the development of relations and the contrast of loneliness was controversial, representing both the project's main opportunity and area for improvement—however positive the overall assessment was. The difficulties encountered can be traced to the attitude of older people towards participating in aggregative/socializing activities, leaving their homes, and, at other times, being determined to protect their independence.

Integrating the social and health dimensions improved the quality of services because it provided operators with a complete picture of older people's situation and allowed submerged needs to be brought to light, enabling a holistic approach to the older person's well-being. Working in teams was a valuable experience for professionals: The confrontation and fostering of a holistic approach allowed them to learn and improve their work. A second aspect of interest is the aggregative activities and related community involvement. Thanks to the provision of these activities, the project fully promoted the shift from traditional "on-demand" welfare to proactive welfare (Longo & Maino, 2021). The first describes the user's (i.e., the recipient) and individual demands for welfare services. Recipients manifest their needs by applying for welfare services. The second one refers to a proactive, own-initiative welfare services approach in which social services analyse, know, and identify (new) social targets and implement social services to tackle their needs. This is a multidimensional analysis of needs that involves proactive scouting, user orientation, and user accompaniment. This transition had already begun in the territory. For this reason, the responses were differentiated in all of the valleys that took part in the experiment. In some valleys, a developed network facilitated the implementation of INCL, while in others, a local network still needs to be created, although the local community got involved anyway. In others, however, there was a certain reluctance among the institutions and local actors or of the older people. Beyond the peculiarities of each context, the project has generated essential legacies because of the results achieved and because it shows how individual local projects can represent real laboratories for social innovation. The need for a "sense of community" was recognized as the need to create networks and social relationships among people within a community context, not necessarily in the sense of community as a group of persons living in an area, thus generating "communities of purpose" (Mannarini, 2004). Proximity—and community-based approaches—align with these purposes to reduce the distance between citizens and (public and private) services.

## Acknowledgments

We thank all the professionals, public workers, experts, and old-age recipients involved in the INCL project. We would also like to thank Chiara Agostini, Ester Bonomi, and Alessandra Motta for co-conducting this research at Percorsi di Secondo Welfare (https://www.secondowelfare.it). Finally, we want to thank all reviewers for their kind comments and suggestions.

## Conflict of Interests

The authors declare no conflict of interests.

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**Social Inclusion**
2024 • Volume 12 • Review 7402
https://doi.org/10.17645/si.7402

**REVIEW**

Open Access Journal

# A Scoping Review of Older LGBTI People's Experiences of Homecare

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**Submitted:** 17 July 2023 **Accepted:** 3 October 2023 **Published:** 25 January 2024

**Issue:** This review is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

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## Abstract

Amidst the global growth of the ageing demographic in the world, an inclusive assessment of the care needs of the older lesbian, gay, bisexual, transgender, and intersex (LGBTI) population is receiving increasing attention, especially in view of reported health inequalities for these minority groups and the position of their sexual orientations and gender identities within a predominantly heteronormative health and social system. This literature review aims to identify and analyse previous research on older LGBTI people's views, experiences, and perceptions of homecare provision. We searched the CINAHL, Medline, and PsychINFO databases and found a total of 337 records. After an eligibility assessment, 12 studies were selected, comprising 11 qualitative studies, and one mixed methods study. Under an overarching theme of fears of discrimination and of receiving suboptimal care, we further categorised our findings in the following three interlinked subthemes: (a) disclosure of gender identity and sexual orientation; (b) emerging meanings of LGBTI-competent care; and (c) recommendations for improved quality of LGBTI-friendly services. The overall surfacing outcome of our analysis of the participants' experiences described in the studies examined is an aspiration for homecare services ensuring quality of holistic, person-centred care that recognises this population's distinct set of requirements, including knowledge and consideration of their histories of inequalities and oppression. Wider awareness about the need to re-imagine more inclusive care for the LGBTI community has the potential to improve services and practices, reduce access barriers, and prevent inequalities.

## Keywords

ageing; healthcare; homecare; LGBTI; prevention; scoping review

## 1. Introduction

With the ageing demographic growing worldwide, the specific health requirements of the older lesbian, gay, bisexual, transgender, and intersex (LGBTI) population are receiving increasing consideration, as is the need to ensure the provision of adequate care prevention for this minority group. This reflects the much wider and deeper discrimination and marginalisation experienced by the LGBTI population, in the cis-normative and heteronormative social arrangements which surround their lives and extend to all aspects of home, family, and work life.

Indeed, members of the LGBTI community face inequalities throughout their life trajectories that are harmful to their physical and mental health and have repercussions on their approach to and experience of healthcare (Zeeman et al., 2018). In comparison to the heterosexual population, sexual minority older adults tend to disproportionally suffer from several chronic health conditions, ranging from lower back and neck pain, cancer, and a weakened immune system to cardiovascular disease, such as stroke, heart attack, and angina pectoris (Fredriksen-Goldsen et al., 2017). There is also a higher prevalence of anxiety, depression, and substance use disorders among this population (Yarns et al., 2016). Older LGBTI people's encounters with health and social care services are repeatedly pervaded with experiences and perceptions of homophobia, heteronormativity, and attitudes that tend to ignore or overlook their sexuality and identity (Kneale et al., 2021; Stinchcombe et al., 2017). Studies have shown that sexual minority groups experience or perceive spaces of care as customarily privileging heterosexuality, for instance, through obliviousness to their sexual lives, use of heterosexist language or absence of non-straight cultural references during communal social activities, and by the non-acknowledgement of same-sex relationships and routine reinforcement of traditional family models (Westwood, 2016; Willis et al., 2016). While this is well documented, especially in the context of long-term, residential facilities, the preference for which is comparatively low across both the heterosexual and non-heterosexual populations (Buczak-Stec et al., 2023), it is less so for other aged and social care settings, such as homecare.

Homecare, or domiciliary, services can cover attendance to nursing and medical needs as well as assistance with personal care and housekeeping. They offer those who avail of them the advantage of being supported in their own home where they can retain a higher level of privacy, autonomy, and independence, as well as a sense of safety and security that arises from attachment to a familiar space and connection with neighbourhoods and social supports, such as family and friends (Holmberg et al., 2012; Wiles et al., 2012). Receiving care in the home is more than just benefitting from the provision of support services from an expert professional. It is also a meeting between a stranger and the domestic environment of an individual with distinct health and social care needs, and with a unique biography, the integrity of which needs to be maintained. The visit of a homecare professional to an LGBTI household entails not only knowledge of and attendance to specific health and care requirements of given members of the LGBTI community, but also respect for the variety of their ways of life and consideration of the needs that may arise from both past and present circumstances of being LGBTI.

To help illustrate the specificities of older LGBTI people's lived realities of receiving homecare support services, and contribute to expanding the attention on the need to improve health prevention measures for this population, in this scoping review we examined relevant literature through the frame of the following questions: "What are older LGBTI people's views and experiences of homecare, especially in terms of faced disparities and inequalities?" "What are the attributes of LGBTI-congruent homecare that emerge from these views and experiences?" and "What can be learnt to build a vision of LGBTI-friendly homecare?"

## 2. Methods

These three databases were searched for records up to the third week of May 2023, with no time frame restrictions considering the potential scarcity of studies conducted on the topic explored: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, and PsycINFO. These were chosen to ensure a broad reflection of studies across the nursing, health, medicine, and psychology domains of publication. Keywords and combinations were employed consistently across the different databases and were grouped under the four themes of (a) views and experiences, (b) ageing, (c) homecare and ageing in place, and (d) LGBTI groups.

To select records for the review, we used the following inclusion criteria: peer-reviewed primary research studies published in English; studies that explored homecare experiences of LGBTI older people, among whom at least half were aged 50 and above (this age limit was chosen because older LGBTI people aged 60 or above are often a hidden population within the context of research recruitment, given their history of not disclosing their gender and sexual identities); studies that employed qualitative, quantitative, or a mixed methods approach. We excluded: studies that were not about LGBTI older groups, non-primary research articles, such as reviews, and editorials. For analysis, records were transferred onto MS Excel sheets. After duplicate removal, titles and abstracts of the records were screened for eligibility according to inclusion criteria. Eligible full-text articles were then retrieved and further evaluated, after which the final list of selected articles was examined for an in-depth analysis. We did not carry out a formal quality appraisal of the individual studies examined. With our initial research questions in mind, to reach our findings we followed a narrative synthesis approach, broadly similar to a methodology previously used in health research (Brien et al., 2010), that allowed interpretation and description of both the qualitative and quantitative data examined. For each article, specifics on study design, sample, national context, and methodology used were extracted, and descriptions of findings were summarised. An inductive analysis recognised the recurrence of elements and produced relevant clusters of topics and was followed by an integrative synthesis and assessment of its soundness across the various studies, resulting in the identification of subthemes.

Aware of the continuous and inclusive evolution of the terminology to describe the LGBTQIA+ community, to refer to it in general, in this article we chose to employ the acronym LGBTI. Our choice originates from the consideration that it might better reflect the groups familiar to and the relevant terminologies used by the community's older generations, whose experiences and realities of diversity are at the centre of our study. Sometimes, we also use the terms "sexual minorities" or "sexual minority groups." All care has been taken to refer to the identity groups of the studies examined with the appropriate original description terms.

## 3. Findings

### *3.1. Articles Found*

A total of 337 articles were recovered: 82 through CINAHL, 123 through Medline, and 132 through PsycINFO. Following duplicate removal, titles, and abstracts of 215 records were screened for eligibility. After this assessment, 21 full-text articles were retrieved and examined. Nine articles were further excluded because they did not examine homecare services or, in the case of studies employing quantitative methods, because it was not possible to extrapolate data on homecare services from a larger pool of data on general health, social, and aged care services. Twelve articles were ultimately selected for the review, published between 2010 and 2022 (see Figure 1). Eleven were qualitative, employing either interviews, a town hall meeting, or focus groups. One, which was also the most recent, was a mixed methods study that combined a survey and follow-up interviews. Five studies were conducted in the USA, four in Canada, one in the Netherlands, one in Wales, and one in Australia (see Table 1).

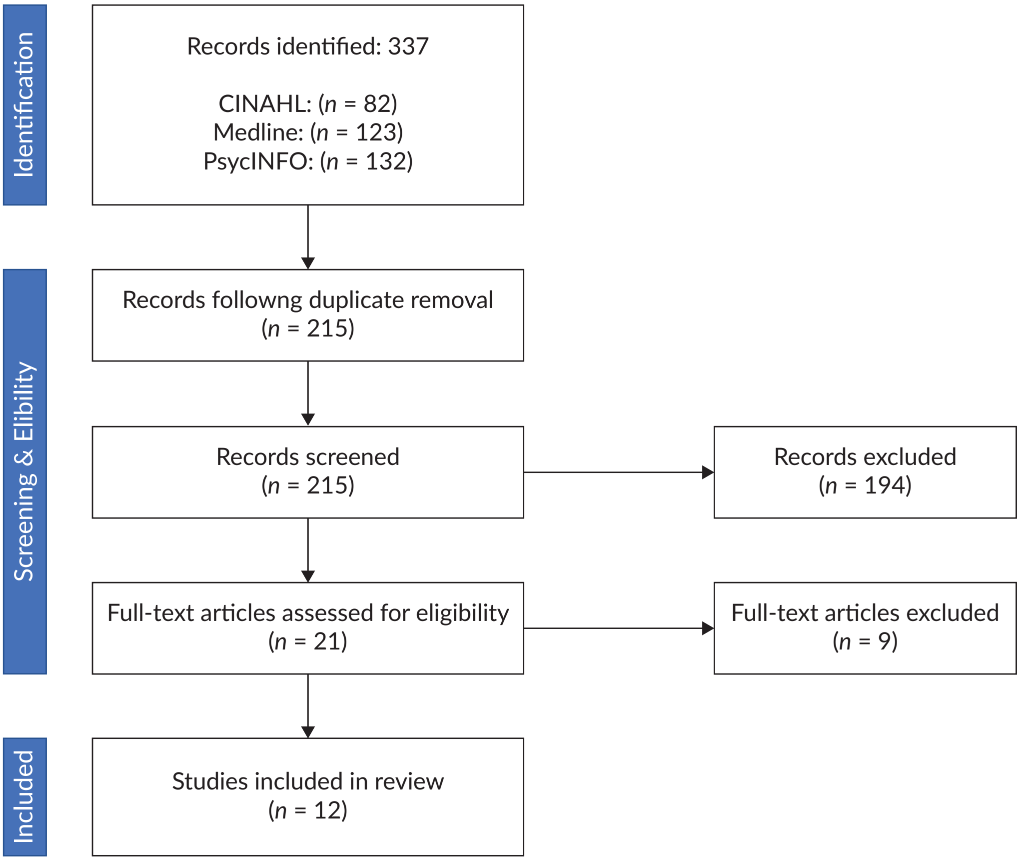

**Figure 1.** Flow diagram of search and selection of articles.

### *3.2. Fears of Discrimination and of Receiving Suboptimal Quality of Care*

Through an analysis of the selected studies, the prevalent theme among older LGBTI people's views and experiences of accessing and receiving homecare services is a fear of discrimination, homophobic mistreatment, and poor quality of care, which was often rooted in incidents of stigma and prejudice this generation faced in the past, at a time when many of them might have had to live their identities in secret and endure attitudes of intolerance and periods of social exclusion. This is exemplified by a community-dwelling participant (sexual identity and gender unspecified) in the least recent of the studies examined:

> I'm afraid to have a stranger in my home, someone who may be very anti-gay, and then what if they find out about my life and now they're in my home regularly, and could somehow take advantage or mistreat me? (Stein et al., 2010, p. 429)

**Table 1.** Summary of articles included in the review.

| No. | Author(s) | Sample summary | Research design | Themes |
|---|---|---|---|---|
| 1 | Boggs et al. (2017) | No. of participants = 73<br>Demographics only available for interview participants ($n$ = 29; participants could indicate more than one option)<br>16 lesbians; 2 bisexuals; 1 straight; 9 gays; 2 transgenders; 1 queer; 20 females; 9 males (participants could indicate more than one option)<br>Age range 40–79<br>8 white; 1 Hispanic; 1 African American ($n$ = 10)<br>Context: USA | Qualitative (focus groups, town hall, interviews) | Fear or experience of discrimination; support and community |
| 2 | Butler (2018) | No. of participants = 20<br>20 lesbian women<br>Age range 66–86<br>All primary participants identified as white<br>Context: USA<br>6 additional participants were informal caregivers, age range 62–76 | Qualitative (interviews) | Fear or experience of discrimination; quality of care; support and community |
| 3 | Butler (2017) | No. of participants = 20<br>20 lesbian women<br>Age range 66–86<br>All primary participants identified as white<br>Context: USA<br>11 additional participants were 6 informal caregivers, age range = 62–76 and 5 homecare workers, age range = 44–69 | Qualitative (interviews) | Fear or experience of discrimination; identity disclosure; quality of care; support and community |
| 4 | Dunkle (2018) | No. of participants = 31<br>16 lesbian women, 15 gay men<br>Age range 54–80<br>87% white; 3.2% Asian; no other races represented; no partcipant reported being Hispanic or Latino; race not indicated by three participants.<br>Context: USA | Qualitative (focus groups) | Fear or experience of discrimination; identity disclosure; support and community |
| 5 | Furlotte et al. (2016) | No. of participants = 12 couples (4 male same-sex couples and 8 female same-sex couples); 1 partner identified as transgender.<br>Age range 39–75<br>The majority of participants identified as white, Caucasian, Anglo-Saxon, European background; one participant identified as Chinese-Canadian<br>Context: Canada | Qualitative (interviews) | Fear or experience of discrimination; identity disclosure; quality of care |

**Table 1.** (Cont.) Summary of articles included in the review.

| No. | Author(s) | Sample summary | Research design | Themes |
|---|---|---|---|---|
| 6 | Grigorovich (2016) | No. of participants = 16<br>7 lesbians; 2 lesbians/queers; 1 lesbian/queer/dyke; 1 bisexual; 4 gays; 1 woman-loving-woman<br>Age range 55–72<br>No race/ethnicity data available<br>Context: Canada | Qualitative (interviews) | Fear or experience of discrimination; quality of care |
| 7 | Grigorovich (2015a) | No. of participants = 16<br>7 lesbians; 2 lesbians/queers; 1 lesbian/queer/dyke; 1 bisexual; 4 gays; 1 women-loving-woman/*femme*<br>Age range 55–72<br>Ethnicity/race (self-identification, open-ended category): Jewish (2); Anglo-Irish (1); Dutch (1); English German (1); Chinese/South Asian/Caribbean/ Caucasian (1); French Canadian (1); English Canadian (1); Hungarian/English (1); Welsh (1); British (1); Scottish/Irish (1); English/Irish (1); French Acadian/Aboriginal (Micmac) (1); Aboriginal (1); Aboriginal (Dene) (1)<br>Context: Canada | Qualitative (interviews) | Fear or experience of discrimination; identity disclosure |
| 8 | Grigorovich (2015b) | Number of participants = 16<br>7 lesbians; 2 lesbians/queers; 1 lesbian/queer/dyke; 1 bisexual; 4 gays; 1 woman-loving-woman<br>Age range 55–72<br>12 identified as having a White European background; 1 participant identified as a woman of colour; 3 participants identified as Aboriginal<br>Context: Canada | Qualitative (interviews) | Fear or experience of discrimination; quality of care; support and community |
| 9 | Hoekstra-Pijpers (2022) | No. of participants = 115 (survey); 10 (follow-up interviews)<br>Age range 68–88 (interviews)<br>3 lesbians; 2 bisexuals; 5 gays<br>No race/ethnicity data available<br>Context: Netherlands | Quantitative and qualitative (survey and follow-up interviews) | Fear or experience of discrimination; identity disclosure; support and community |
| 10 | Stein et al. (2010) | No. of participants = 16<br>Age range = 60–84<br>4 lesbian women, 12 gay men<br>Age range 60–84<br>14 participants were white; 2 were African American<br>Context: USA | Qualitative (focus groups) | Fear or experience of discrimination; identity disclosure; support and community |

**Table 1.** (Cont.) Summary of articles included in the review.

| No. | Author(s) | Sample summary | Research design | Themes |
|---|---|---|---|---|
| 11 | Waling et al. (2019) | No. of participants = 33 | Qualitative (interviews) | Fear or experience of discrimination; quality of care; support and community |
| | | 19 lesbian women, 14 gay men | | |
| | | Age range 60–80 | | |
| | | As mentioned in the "Discussion" section of the article (p. 1258): "Most participants were of Anglo-Celtic background" | | |
| | | Context: Australia | | |
| 12 | Willis et al. (2018) | No. of participants = 29 | Qualitative (interviews) | Fear or experience of discrimination; meaning of home; support and community |
| | | 19 lesbian women (some also identified as gay); 9 gay men; 1 participant identified as a "cross-dressing" bisexual male | | |
| | | Age range 50–76 | | |
| | | All participants were white (26 of British descent) | | |
| | | Context: Wales | | |

Within this overarching theme, we further identified the following three subthemes, through which we structured the review in an attempt to illustrate a comprehensive picture of the elements making up the vision and experience of homecare emerging across the studies examined: disclosure of gender identity and sexual orientation, emerging meanings of LGBTI-competent care, and recommendations for improved quality of LGBTI-friendly services.

### 3.2.1. Disclosure of Gender Identity and Sexual Orientation

Deciding to reveal one's gender identity and sexual orientation to care providers surfaces as a common and meaningful step along the experience of receiving homecare support as an LGBTI person.

For most LGBTI people, the choice of this type of disclosure is a dilemma faced constantly. Within the specific framework of accessing healthcare, the consequences associated with coming out are assessed against the risk that the revelation may result in the receiving of low-quality care or jeopardise the establishment of a relationship of openness and trust with the care worker.

Across the studies examined, the range of choices spanned from viewing disclosure as a useful or essential condition for care, or only necessary according to given circumstances and in case of medical relevance, to deciding to avoid it completely (Butler, 2017; Dunkle, 2018; Furlotte et al., 2016; Grigorovich, 2015a; Hoekstra-Pijpers, 2022; Willis et al., 2018).

Over 80% of respondents to a survey indicated revealing their identity to care workers, with the disclosure almost invariably enhancing the quality of their interaction (Hoekstra-Pijpers, 2022). For many users in another study, not being able to be out to providers meant a preference for not accessing the services (Dunkle, 2018). A male gay participant based his choice of coming out on his status as a survivor of the HIV/AIDS pandemic:

> In my mid-30s I lost all of my friends to AIDS. Every. Last. One. Of. Them. And I had a large circle of friends. I think at this point, and pardon my language, I basically said fuck it. This is who I am. I'm a survivor. God knows why. And I'm gonna live a proud and open life. (Dunkle, 2018, p. 446)

In one study that included the disclosure experience of older lesbians, including lesbian couples, one partner in a couple summarised their decision to reveal their sexual orientation and relationship status by affirming the unwillingness to put up with intolerance: "I set boundaries, when they first come into the house or on the phone, saying up front that we were a lesbian couple and that we did not want anybody saying anything negative" (Butler, 2017, p. 387).

The middle option of disclosing one's identity if it came up or according to circumstances, often resided in the idea that one's sexual identity was not considered relevant for the caregiver–user rapport, and there was no need to make it known (Butler, 2017; Furlotte et al., 2016). In some cases, this position hinged on the participant's relationship status, with singlehood, though not unvaryingly, being a reason not to disclose one's identity (Butler, 2017; Grigorovich, 2015a).

The choice not to disclose sexual orientation involved having to "pass" and often consisted of deliberate actions of "straightening up" or "de-gaying" the home, by hiding clues that might give identity away, such as putting away items like books, DVDs, or Pride symbols (Butler, 2017; Furlotte et al., 2016; Willis et al., 2018).

Concealing or disclosing one's identity surfaced as a component of an "expenditure of energy" involved in navigating a heteronormative healthcare system, with the effort comprising in general having to keep a degree of alertness for slight or discrimination, to monitor and tame negative or uncomfortable reactions, as well as having to always teach or appease others (Furlotte et al., 2016; Grigorovich, 2015a). A participant stated:

> You learn to bury your feelings and honour theirs in the hope that they'll meet you halfway. It becomes your job and yours alone to explain, ignore, to forgive over and over again....You're always the one who has to, you know, soften the corners, make things right. (Furlotte et al., 2016, p. 439)

Some have argued that the search for and implementation of common procedures in healthcare to facilitate the disclosure of gender identities and sexual orientations, could be guided by whether it provides users with a range of capabilities, in other words, enables or impedes their attainment of a wide-ranging health, including plain medical benefits, emotional health, and bodily autonomy (Toze et al., 2020).

### 3.2.2. Meanings of LGBTI-Competent Homecare

Overall, the emerging meaning of homecare that is congruent to LGBTI older people entailed the recognition of the needs arising from the vulnerabilities and challenges of belonging to a sexual minority.

In a study investigating the meanings attributed to home, rurality, and place among a group of older lesbian, gay, and bisexual participants, concerns were expressed at the possibility of receiving homecare support, particularly in relation to the unknown views and mindsets of the visiting care professional, with the home being considered as a safe and affirmative space where to be able to express their identities (Willis et al., 2018).

Described as being in line with principles of the feminist ethic of care, the following attributes were recognised as ensuring quality of care in a study conducted among a group of participants predominantly identifying as lesbian women: attentive and responsive, competent, and actively enabling comfort (Grigorovich, 2016). As voiced by both participants who received medical support, personal care and housekeeping assistance, attentive care meant that it was focused and tailored to their specific needs, it was carried out according to their requirements and preserved their autonomy by engaging them in the decision-making. The participants described receiving care as a vulnerable condition and considered the providers' responsiveness to their feedback and readiness to involve them in the direction of the care provision as mitigating their feelings of vulnerability.

Providing competent care bore a dual connotation. On one hand, care professionals needed to show knowledge, preparedness, and technical expertise in carrying out their job. On the other, they also needed to offer emotional and relational competence, which, given the isolation endured by many of the participants through ill health or disability, would also work as a form of social support. A 57-year-old participant stated:

> Well to me, there's two kinds of homecare. There's the physical care that you get when you get the help in the shower, the laundry is done for you, the housecleaning. And the other type of care is how the caregiver relates to you as a human being, as a person, and how caring they are of you. Quality homecare is somebody I can get along with, who treats me as a "normal" human being, treats me with respect, treats me with understanding and caring. (Grigorovich, 2016, p. 112)

The experience of homecare required providers to guarantee users' comfort, while also showing their own in delivering assistance. The participants' description of comfort included being at ease with an outsider coming into their home and performing care but extended specifically to feeling safe amid fears of discrimination or mistreatment in relation to their sexuality. Not only did the participants want reassurance that the providers did not show ostensible homophobia, but they also wanted providers to withhold judgments about their identities, recognise the realities of their households, such as partnerships and family, and display sensitivity towards their history of oppression.

The need for building a reciprocal feeling of comfort between users and providers was similarly illustrated by participants in another study, conducted with older lesbian and gay couples who were asked to communicate their opinions about the prospect of utilising homecare services or entering a long-term care facility (Furlotte et al., 2016). Participants voiced their preference for providers who, besides not expressing prejudice, could also understand users' reservations about obtaining care from a non-LGBTI person and showed regard for their ways of life, while behaving toward them with a genuine approach that signalled acceptance inconspicuously. Among the participants' views in this study was also the articulation of a contrast between wanting to be cared for like any other user while in parallel being seen as a lesbian or gay person with distinctive needs, in search for what belied that uniqueness:

> In some ways, I'm tempted to say that the answer is "no," that we don't need anything different. Except I think there is something wrong with a "no" because the context is different….There might be nuances that need smoothing or that they need to work on. (Furlotte et al., 2016, p. 440)

Qualities such as maturity, the ability to listen, dependability, and competence counted for the establishment of good relationships between care recipients and homecare workers in another study conducted with a group of lesbian women participants, some of whom also developed friendships with their care workers outside the professional connection (Butler, 2017, 2018). Some, but not all, members of the same cohort expressed the preference to be cared for by other lesbians (Butler, 2017), as did some women in another study, with one motivation being:

> I'd like to have [younger] lesbians…just to know that the people who were caring for you, you had the same connection with them that we have with all our lesbian friends, you know, just that you don't have to explain yourself. (Willis et al., 2018, p. 913)

Overall, the data suggest that many of the features of homecare advocated by the participants align with attributes of homecare also wished for by non-LGBTI groups, namely qualities of a holistic, person-centred dimension of care that acknowledges the individuality, dignity, and autonomy of the older person, and that is also based on respect, trust, and communication (Höglander et al., 2019; Holmberg et al., 2012; Sundler et al., 2020). In addition, however, these studies jot a picture of an LGBTI-congruent care that guarantees equality through difference, by emphasising the necessity for the care to recognise the totality of the distinct lived realities of sexual minority older adults, including, for instance, the acknowledgement of their histories of social exclusion.

### 3.2.3. Recommendations for Improved Quality of LGBTI-Friendly Services

Common among the recommendations for the creation, or strengthening, of LGBTI-inclusive home support services, was the need to ensure adequate training for health workers and care providers.

In one study, participants voiced the need for improved training across all levels of healthcare, and the importance of service providers taking responsibility to educate themselves about the LGBTI community and acknowledge that users' past experiences of maltreatment result in loss of trust (Dunkle, 2018). Better education was regarded as a prerequisite for leadership in reaching LGBTI older people and creating welcoming environments, as expressed by a gay male participant:

> I don't believe we should have to do all of the work. We've been talking about doctors here…all these highly educated people.…I don't understand why they don't understand the umbrella is this big [extends arms wide] not this big [shortens arm extension]. (Dunkle, 2018, p. 448)

Training was considered essential considering the vulnerability that homecare entails and, as expressed throughout the studies, how traumatic it would be to experience homophobic attitudes or mistreatment. A lesbian female participant expressed this necessity:

> They have to be educated to come into a lesbian home and feel comfortable. These people that come into your home must be educated in diversity. I would call ahead and ask and if they are not open to serving the lesbian community, I'd say no thank you. (Dunkle, 2018, p. 448)

The adoption of adequate language and terminology that, for instance, did not assume heterosexuality and acknowledged non-traditional support circles surfaced as a relevant facilitator for the attainment of a quality of care that is comfortable for both caregivers and homecare recipients (Grigorovich, 2016; Hoekstra-Pijpers, 2022). Thirty-eight percent of respondents to a survey conducted in the most recent of the studies thought that the language employed to address them, or the questions they were posed by the caregivers, did not adequately apply to their circumstances. Among them, more than half envisaged being more receptive if the care workers used wordings that were more neutral (Hoekstra-Pijpers, 2022). Within the context of language and terminology employed, participants also lamented the lack of diversity and inclusivity in forms and documents, such as the absence of options to indicate sexual orientations or mentions of partners other than legal spouses (Dunkle, 2018).

Other suggestions centred around strategies for care providers to signal the inclusivity of their services, through the increase of visibility and representation, which was also seen as a way to reach people not open about their sexuality (Dunkle, 2018). These included, for instance, the establishment of a reliable resource centre dedicated to LGBTI ageing, lists of LGBTI-friendly providers and services available, or the use of Pride symbols, such as rainbow flags and stickers, or images of non-heterosexual couples on services brochures and advertisements (Boggs et al., 2017; Dunkle, 2018). A female lesbian participant stated: "If I were sitting in a waiting room and filling out a form that acknowledged me, and seeing a reflection on the wall of our senior community, [it] makes a difference—creates a welcoming environment" (Dunkle, 2018, p. 449).

Finally, another common experience described by ageing LGBTI participants across several of the studies examined was the need to specifically connect with, or receive support from, other older LGBTI people and have access to safe environments and neighbourhood or other community activities (Boggs et al., 2017; Furlotte et al., 2016; Hoekstra-Pijpers, 2022; Waling et al., 2019; Willis et al., 2018). A sense of belonging to community is of significance to older people's experience of identity and lifestyle (Phillipson, 2007). Sexual minority groups are more likely to live on their own and to have friends at the core of their social and support circles (Brennan-Ing et al., 2014). In one study, not being able to consistently rely on family or friends for help was described as a factor impacting the choice to access or the circumstances of complementing homecare support (Grigorovich, 2015b).

A female lesbian participant from one of the studies expressed how mutual support among the gay community resided in an exercised habit of having to rely on each other to build strength in the face of adversity: "Historically we've all taken care of ourselves, going back even to pre-AIDS. It's always been us that's taking care of us" (Dunkle, 2018, p. 449). Participation in LGBTI community events and activities, however, was not experienced homogeneously. In the most recent of the studies examined (Hoekstra-Pijpers, 2022), around 75% of survey respondents (especially those open about their sexuality) participated in community activities. Among those who did not, meeting too few people their contemporaries, and fear of ageist attitudes were the motivations for not attending for 40% and 20% of them respectively. Participants in another study showed ambivalence about how welcome they felt in their community, with some expressing they did not feel at ease either with younger members of the community or with their heterosexual peers (Boggs et al., 2017).

## 4. Conclusions

The purpose of this review was to identify in the available literature aspects of homecare salient to the views, perceptions, and experiences of older LGBTI adults.

Overall, the outcome of our analysis points to converging narratives of perceived or endured inequalities vis a vis the position of this group's sexual identities and orientations within a largely heteronormative social care system. While not all study participants' views and experiences of homecare examined in this review were negative, as observed elsewhere (Smith & Wright, 2021), the predominant theme among them was a lingering fear associated with risks of homophobia, discrimination, and intolerance that would compromise the preservation of their identity as well as the quality of care received.

Our findings comprise descriptions of identity disclosure dilemmas, states of vigilance in anticipation of slight or mistreatment, language and communication inadequacies, as well as calls for an inclusive care environment and connection to a supportive community. Taken altogether, these accounts outline receiving home support as a complex and not always unproblematic dimension with potentially non-negligible effects on this population's course of health. The cultural distress paradigm proposes that the delivery of care that is not congruent to patients' unique perception of what the obtained care should entail elicits a detrimental response with physiological and behavioural manifestations (also related to the experience of an imbalanced power dynamics in the patient–provider rapport), that may aggravate illness, impede healing, compromise access to and utilisation of health services, and cause allostatic load (DeWilde & Burton, 2017). According to this model, therefore, to avoid any of these damaging consequences, it is necessary within the context of LGBTI-specific health and social care to take into consideration this group's own accounts of what constitutes a regimen of care that fits their requirements.

The meaning of what constitutes LGBTI-congruent care emerging from our analysis of the existing literature comprises properties of person-centred care that align with experiences observed in the non-LGBTI population. These include the safeguarding of an older person's dignity, autonomy, and independence, and the establishment of a rapport of trust, respect, and good communication with the caregiver (Hoeglander et al., 2019; Holmberg et al., 2012; Sundler et al., 2020). However, what transpires as specific to the sexual minority experience among the narratives examined is an aspiration for the attainment of a delicate balance between being treated as everyone else and being recognised as individuals with a distinctive set of requirements that includes knowledge and consideration of their histories of invisibility and inequality. The experiences described in the studies reviewed point to the vital need for better training for healthcare workers, and to the necessity for shifts in organisational culture among homecare providers towards inclusion and diversity. A recent integrative review of research on healthcare workers' perceptions of sexual minority adults has found that 70% of participants in the studies examined expressed feelings of unpreparedness to care for this population and demands for better training (May & Crist, 2023). An evolving discourse in health and social care education is suggesting a need to move beyond cultural competence and toward the attainment of "cultural humility." Some of the motivations for advocating such a shift are premised on the view of cultural competence as primarily "content-oriented" and focused on advancing a carer's knowledge, self-confidence, and efficacy when interacting with diverse groups of care recipients (Lekas et al., 2020). This approach poses the risk of operating with a meaning of culture that is stagnant, places the authority of its definition on the providers, and assumes a series of fixed perceptions shared by a given social group, potentially generating stereotypes and disregarding issues of intersectionality. By contrast, cultural humility is considered “process-oriented” and based on a care provider’s self-reflexivity and willingness to create a provider–recipient rapport that is power-balanced, an enduring commitment to learning, and respect for care recipients’ own expertise of their cultural and social circumstances (Lekas et al., 2020).

Improving health prevention for any given vulnerable group involves not regarding it as a homogenous entity, but accumulating diverse knowledge of their specific health needs. Studies in geographical gerontology underline the value for health professionals in granting places of care, including homes, similar diversified attention. A home should not be considered as a mere “container,” but as a multi-faceted and evolving, social process, inseparable from how it is understood and experienced by its occupiers, and from a variety of contexts, including a historical one (Wiles, 2005). Older LGBTI people’s sexualities are inherently linked to their homes, which they can edify as safe spaces (Gorman-Murray et al., 2022). By way of an example, a study conducted with older gay men living in London showed how participants can display their identities through materialities that in subtle, or more overt ways, reflect how they see themselves and would like to be seen and can work to queer heteronormativity and challenge oppression (Pilkey, 2014). The narratives from our analysis suggest a similar ambition for the safeguarding of this nuanced dimension and a desire for equality.

This review presents several limitations. The small number of studies recovered through our search reveals a scarcity of research in this field, but at the same time undermines the breadth and soundness of the interpretations and conclusions derived. Another limitation of our study is the absence of a formal appraisal of the quality of the studies examined, which affects the significance and applicability of the findings (Brien et al., 2010; Grant & Booth, 2009). Furthermore, our findings are relative to groups that are in large part white, Western, and English-speaking. The experiences of homecare discussed, therefore, are representative of a homogenous section of the population and do not reflect those of other racial and ethnic minorities, or other groups vulnerable to prejudice or intolerance, which may be dissimilar. They also do not reflect the realities of older people living in national contexts with limited or absent rights for LGBTI individuals, for whom access to, and experience of, health and social care services may be significantly compromised. An important limitation of this study is that it does not include homecare experiences of transgender and intersex individuals, who, we acknowledge, present unique health and social care needs that are distinct from those of cis members of the LGBTI community. It would be important if future studies in this field could shed light on how the groups not represented in this review experience homecare.

Despite the limitations listed above, our work has the potential to contribute to promoting awareness about the need to envision a more holistic and inclusive quality of health and social care for LGBTI older adults and to prevent inequalities.

## Funding

This work is funded by the Irish Research Council COALESCE Research Fund—Collaborative Alliances for Societal Challenges, grant number COALESCE/2022/277.

## Conflict of Interests

The authors declare no conflict of interest.

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**Sean Vail** grew up in the heyday of LGBT+ culture, born in 1959 on the Canadian/American border. From Dallas to Hollywood and LA to Boston, America was the place to be gay in the 70s and 80s. Sean moved to Bantry, West Cork in 1991 to join his family businesses. Moving to Bantry was like going back to 1950 America where tolerance and acceptance of LGBT+ people hadn't developed yet. Now retired from physical therapy, Sean focuses much of his time on psychosocial issues within marginalised communities and continues to develop opportunities for the over-60s rural LGBT+ population.

**Social Inclusion**
2024 • Volume 12 • Article 7431
https://doi.org/10.17645/si.7431

ARTICLE

Open Access Journal

# Supporting Older Adults' Social Inclusion and Well-Being in Neighbourhoods: The Social Hub Model

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**Submitted:** 26 July 2023 **Accepted:** 19 October 2023 **Published:** 25 January 2024

**Issue:** This article is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

## Abstract

In recent years, many Finnish cities and municipalities have aspired to develop services that support older adults' well-being and social inclusion. This study focuses on the Social Hub model, a local social innovation developed in the city of Tampere. Social hubs operate on a neighbourhood level, providing free-of-charge service coordination and counselling, group activities, and meeting places for social gatherings. This study aims to look at whether this kind of local innovation can support older adults' well-being and social inclusion. The sociomaterial perspective and multidimensional model of well-being (the having–doing–loving–being approach) provided theoretical and analytical guidelines to examine older adults' experiences and perceptions of social hubs. The qualitative interview data was collected among people living in service housing, senior housing, or ordinary housing in the proximity of the social hubs studied. Face-to-face and "go-along" interviews with 19 older adults aged between 57 and 96 were analysed with theory-driven content analysis. The results showed that the hubs are a valuable local resource for older adults, providing free services, accessible and appealing shared spaces, and activities that promote social well-being, physical activity, creativity, and autonomy. The hubs serve as important gathering points for older adults in the neighbourhood, fostering community-building among citizens residing in different types of housing. The results highlight the importance of acknowledging well-being as a multidimensional phenomenon. The Social Hub model provides one practical tool to support older adults' well-being and social inclusion by offering various kinds of resources and social and cultural activities.

## Keywords

aging in community; having–doing–loving–being; HDLB model; older adults; Social Hub model; social inclusion; sociomateriality; suburban neighbourhoods; well-being services; well-being

## 1. Introduction

Developing age-friendly cities and supporting older adults to age in place have become global public and social policy goals (Buffel et al., 2012). Recently, the focus has increasingly shifted from the home to community-centric approaches (Ahn, 2017; Wiles et al., 2012). New concepts such as "aging in community" (AIC) emphasise and expand the understanding of place beyond the home to include the community and neighbourhood levels (Thomas & Blanchard, 2009). Previous research on models supporting AIC has explored community-dwelling facilities, retirement villages, the village model, and naturally occurring retirement communities (Grant, 2007; Greenfield et al., 2013; McDonough & Davitt, 2011; Parniak et al., 2022; Scharlach et al., 2012). In this study, we focus on a local social innovation, the Social Hub model, which is a local innovation developed to support community building at a neighbourhood level. We investigate older adults' experiences and perceptions of social hubs in the frame of the "HDLB model" (i.e., the having–doing–loving–being approach; see Allardt, 1976; Hirvilammi & Helne, 2014). The study aims to assess whether and how this kind of local innovation can support older adults' well-being and social inclusion.

There is some evidence of the connections between neighbourhood environments and older adults' well-being (Besser et al., 2017; Yen et al., 2009). Older adults' well-being and quality of life are related to the quality and depth of their social relationships and their engagement in neighbourhood social activities (Gardner, 2011; Grant, 2007). Furthermore, infrequent social contact with neighbours and a weak sense of "neighbourhood belonging" are associated with more loneliness among older adults (Nyqvist et al., 2016). According to the literature, social inclusion may be promoted by overcoming physical and social barriers that prevent older adults from participating in their communities and accessing societal resources (Scharlach & Lehning, 2013). The material environment and its physical characteristics are particularly significant in this context. For instance, it has been found that the transportation infrastructure and accessibility to social connections and services are associated with enhanced social inclusion (Bigonnesse et al., 2018; Luoma-Halkola & Jolanki, 2021; Mahmood & Keating, 2012). There is also a growing drive to integrate digital solutions into well-being services and loneliness prevention (Czaja, 2017). Digitalisation may enrich older adults' lives in multiple ways, but it can also widen the gap between digitally included and excluded older adults (Pirhonen et al., 2020). Neighbourhoods and communities that facilitate older adults' social interaction and participation can help reduce health risks related to social isolation and loneliness (Courtin & Knapp, 2017; Coyle & Dugan, 2012). Taken together, previous research highlights the importance of addressing AIC and older adults' social inclusion in the context of accessible living environments, community, local services, digital participation, and well-being.

In this study, we apply a sociomaterial perspective to study the well-being and social inclusion of older adults. This means that we take the stand that the social and material levels are inevitably related and mutually influential, as Orlikowski (2007, p. 1437) argues: "There is no social that is not also material, and no material that is not also social." Recently, increasing importance has been given to applying sociomaterial perspectives in well-being research (Andrews et al., 2014; Duff, 2014; Fox & Powell, 2021). Fox and Powell (2021) note that, within the literature, addressing the relationship between spaces and well-being, a common distinction is made between the physical and social dimensions of geographical location. The authors argue that the distinction between material characteristics of spaces and the social effects arising from the individuals who occupy those spaces might create an artificial separation between what is considered "natural" (material) and "cultural" (social). As a result, one of these aspects—social or material—may receive intentional or unintentional preference when examining interactions between spaces and well-being (Fox & Powell, 2021, p. 226). The sociomaterial perspective strives to avoid this dualism by acknowledging that well-being is not solely influenced by either social or material aspects, but rather by the interplay between them, meaning that a person's well-being is shaped by the dynamic interactions between social aspects (e.g., social interaction, relationships, community) and material aspects (e.g., physical environment, infrastructures, resources). There is only limited evidence available on the role of local well-being services in supporting older adults' well-being and social inclusion from a sociomaterial perspective. Our study adds to the literature by providing insight into a local well-being service innovation from this perspective. In the analysis proper we draw from the multidimensional conception of well-being, the HDLB model (Allardt, 1976; Hirvilammi & Helne, 2014), which offers a novel approach to well-being services research.

## 2. The Social Hub Model

Many Finnish cities and municipalities have aspired to develop service models that aim to support the well-being of older adults and facilitate social interaction (Ministry of the Environment, n.d.). These efforts have been prompted by a health and social care reform that transfers responsibility for healthcare, social welfare, and rescue services from municipalities to well-being services counties. Municipalities remain responsible for primary health promotion, whereas the newly-formed counties will provide secondary and tertiary health promotion (Agerholm et al., 2023; Sote-uudistus, 2022). This study focuses on the Social Hub model (*Lähitori-malli* in Finnish) developed in the city of Tampere. These social hubs are funded by the public sector and produced jointly by the well-being services county of Pirkanmaa, the city of Tampere, and non-profit organisations.

In the city of Tampere, social hubs provide free-of-charge service coordination and counselling, activities such as chair exercising, handicrafts, games, singing groups, and other community events including concerts and art exhibitions. Most hubs also provide restaurant and cafeteria services. Activities are organised by professional "hub staff," including coordinators and physiotherapists, or by volunteers or representatives of non-profit organisations. The hubs are usually open weekdays from 9 AM to 3 PM all year round. Spaces at the hubs include lobbies with seating areas, meeting rooms for group activities, and restaurant and cafeteria areas. There are also rooms for service coordination and meetings with staff. Free newspapers and computer use are available. In total, there are 13 hubs in the city of Tampere, located in the city centre and the suburbs. In this project, we studied three hubs in suburban neighbourhoods. The size of the buildings where the social hubs were located varied. Each hub had a large meeting room with the capacity for 50–85 people and smaller meeting rooms for 10–20 people. Buildings, meeting areas, and surrounding environments were accessible. Lobbies and yard areas were spacious with wide footpaths and several seating areas. All studied hubs operate within the premises of service housing where service coordination and counselling, group activities, social gatherings, and restaurant and cafeteria services are produced by a non-profit organisation. All studied hubs offer hairdressing services that are produced by private entrepreneurs and one of the hubs also offers a chiropodist service.

The hubs are intended to support older adults to continue to live meaningful and independent lives in their living environments and to prevent social exclusion and the need for stronger services. The Social Hub model combines social and welfare services, group activities, and social gatherings and is produced in cooperation with different sectors, making it a unique social innovation worthy of examination.

## 3. Theoretical Framework: The HDLB model

We structured our analysis around a multidimensional model of well-being: the HDLB model (see Table 1 for an overview). This model is based on Allardt's (1976) theory of well-being, according to which well-being is composed of the three welfare dimensions of having, loving, and being. The dimension "having" refers to the need for basic material and economic resources. "Loving" refers to a longing for connective social relations with others and "being" refers to a sense of autonomy, self-actualisation, and wholeness. Hirvilammi and Helne (2014) have further elaborated on Allardt's original model and added a fourth dimension: "doing," which refers to the need to engage in meaningful activities such as hobbies. While Allardt regarded "doing" as part of "being," the distinction made by Hirvilammi and Helne (2014) emphasises human activities as a source of well-being. Allardt's theory was very much ahead of its time in recognising the impact of environmental factors on well-being. Helne and Hirvilammi (2015, p. 172) also underline the importance of understanding well-being not only as an interpersonal phenomenon but also as a connectedness to the physical environment and non-human entities. Together, the four dimensions of well-being make up the HDLB model.

**Table 1.** The HDLB model.

| Having | Doing | Loving | Being |
|---|---|---|---|
| Material & economic resources | Hobbies | Local communities | Sense of autonomy |
| Housing & transportation | Social & political action | Society | Creativity |
| Natural resources | Education & learning | Family & friends | Self-actualisation |
| | Nature activities | Other species & nature | Physical & mental health |

Allardt's framework was originally designed for survey use, whereas Hirvilammi and Helne were concerned with developing a model of ecosocial well-being that strives to identify the interdependencies between personal well-being and social and ecological systems. In aging research, Allardt's theory has been used to study older adults' mobility (Hjorthol et al., 2010), unmet activity needs and well-being in later life (Nordbakke & Schwanen, 2015), and aging in Norwegian communities (Blekesaune & Haugen, 2018). The HDLB model has not been previously used in aging studies. Helne and Hirvilammi (2022) have studied young unemployed adults' discourse on well-being by adapting the HDLB model to the analysis and Obeng et al. (2023) have used the HDLB model to interpret well-being outcomes of nature-based interventions for young people in precarious situations.

Neither Allardt (1976) nor Hirvilammi and Helne (2014) have discussed aging and the changing needs and life situations that might emerge in later life. Blekesaune and Haugen (2018) have acknowledged this issue and utilised Allardt's well-being theory by adapting different dimensions (having–loving–being) to better fit older adults' lives. This was done by shifting the focus to aging and the changing needs and life situations of older individuals. Blekesaune and Haugen link the dimension "having" to older adults' access to resources and facilities within their living environment. The authors relate the dimension "loving" to older adults' experiences of attachment, belonging, and social relationships. Blekesaune and Haugen note that many older adults do not participate in the workforce, which is why older individuals need to find new venues for self-actualisation ("being"; Blekesaune & Haugen, 2018, pp. 234–235). Retiring from work might increase the meaning of other activities such as hobbies and volunteering, which is why these kinds of leisure activities are highlighted in our analysis through the dimension "doing." Hirvilammi and Helne (2014) also highlight the connectedness to the physical environment and non-human entities, which is why we analyse the dimension "loving" not only as older adults' experiences of social relationships with other people but also as connectedness to material surroundings. Following the work of Blekesaune and Haugen (2018) and adapting the HDLB model to fit older adults' everyday lives, we have used the HDLB model as an analytical tool to study older adults' perceptions and experiences of the social hubs in Tampere and to find answers to the question of whether and how social hubs can support older adults' well-being and social inclusion.

## 4. Materials and Methods

### *4.1. Participants*

We conducted thematic interviews with older adults ($N = 19$) living in three suburbs of Tampere. Fifteen participants were female and four were male, ranging in age from 57 to 96 years. All participants lived alone. Twelve participants lived in service housing, five in ordinary housing, and two in senior housing. In Finland, service housing refers to housing that provides on-site services (e.g., daytime personal care and meal services) and accommodation. Senior housing refers to a residential building that offers rental or ownership apartments specifically designed for older adults. Unlike service housing, senior housing complexes do not typically have on-site staff or services. In this study, the service housing units were located in the same buildings as the social hubs. Senior housing units were located in the proximity of the social hubs. An overview of the participants is presented in Table 2.

**Table 2.** Overview of the participants.

| Pseudonym | Age | Gender | Housing type: service/senior/ordinary housing | Social hub ($N = 3$) |
|---|---|---|---|---|
| Leena | 73 | Female | senior | Hub-1 |
| Jaakko | 69 | Male | service | Hub-1 |
| Ismo | 57 | Male | senior | Hub-1 |
| Eero | 70 | Male | service | Hub-1 |
| Irma | 72 | Female | service | Hub-1 |
| Toini | 87 | Female | service | Hub-1 |
| Alma | 68 | Female | ordinary | Hub-2 |
| Anna | 81 | Female | ordinary | Hub-2 |
| Elsa | 85 | Female | ordinary | Hub-2 |
| Viola | 77 | Female | service | Hub-2 |
| Roosa | 79 | Female | ordinary | Hub-2 |
| Sylvi | 76 | Female | service | Hub-2 |
| Hilja | 77 | Female | ordinary | Hub-2 |
| Kaija | 78 | Female | service | Hub-2 |
| Elisa | 86 | Female | service | Hub-3 |
| Saara | 96 | Female | service | Hub-3 |
| Vuokko | 86 | Female | service | Hub-3 |
| Laila | 92 | Female | service | Hub-3 |
| Eino | 92 | Male | service | Hub-3 |

The participants were recruited in collaboration with the hubs' service provider (Sointu Senioripalvelut). We delivered a presentation about the research and collected a list of people interested in participating. We then contacted all participants to arrange interviews. Before the interviews, the participants received information about the project and the voluntary nature of the research. They also received a data protection report and signed an informed consent form. Ethical approval for the study was granted by the Academic Ethics Committee of Tampere University.

### 4.2. Interviews

Thematic face-to-face interviews were conducted in the participants' homes or on the premises of the social hubs. The themes covered social relationships, perceptions of living environment and services, everyday routines, and use of technology. The interview themes were based on the ideas coming from the multidimensional AIsola Research Project 2021–2022. The AIsola project studied loneliness and social isolation from the perspective of social psychology, gerontology, architecture, and technology. The themes were chosen based on the research objective to gain a rich understanding of older adults' everyday lives and living environments. The interview guide is presented in the Supplementary File. The interviews lasted between 31 and 238 minutes and were audio recorded and transcribed. One of the transcripts covered only parts of the interview due to the poor quality of the recording.

Go-alongs were conducted after the face-to-face interviews. They lasted between 20 and 90 minutes and were conducted up to three times based on the participants' interests. The route and length of the walks were decided by the participants. We mostly walked outside along streets and in parks, but sometimes only in indoor spaces. Field notes were taken during the interviews. We also collected additional data by photographing our observations and places that were meaningful for the participants. The field notes and photographs were transcribed into ethnographic field diaries. In this study, we used the data from the face-to-face interviews and the field diaries. Most of the photographs were taken elsewhere in the neighbourhood, not in the social hubs, and therefore were not included in this analysis. All interviews were conducted by the first three authors of this article.

### 4.3. Method of Analysis

To organise and make sense of the data, we conducted a theory-driven content analysis based on the HDLB model (Krippendorff, 2004). The data was organised with Nvivo. In the first round of the coding process, all descriptions of the hubs were searched from the data. In the second round, the descriptions were identified and coded into four categories: "having," "doing," "loving," and "being." After coding, the transcripts were transferred to Excel where they were organised into a table of contents following the categories of the HDLB model to check the coherence of the coding. This process allowed us to systematically go through the data.

## 5. Findings

The findings are structured around the HDLB model and illustrated by extracts from the data. The names appearing in the extracts are pseudonyms and the letter "I" refers to the interviewer. The extracts were translated from Finnish into English by the authors. Some excerpts are condensed for readability. Omitted text is marked with an ellipsis (…). In some places, the authors have added information to clarify the context of the talk. These explanations are given in square brackets.

### *5.1. Resources and Accessible Spaces ("Having")*

The interviewees extensively described the services and activities available at the social hubs. The hubs were something that the participants *had* in their living environment, contributing to the dimension "having." Below, Viola refers to the different supervised activities available and stresses that this is not common in other residential settings. Similar remarks were also made by other participants:

> Viola: …so yes, we have all kinds of supervised activities here, which you wouldn't have in an apartment block or a detached house.

One advantage of the hubs discussed in the interviews and go-alongs was that they were conveniently located within walking distance, meaning there was no need to travel to the city centre, as Roosa describes:

> Roosa: The social hub offers lots of, like, culture. I was just looking at the programme for November and there are art exhibitions and music and so—when you live nearby, I'm not the sort of person who would go to the city centre to a concert, a bit too lazy to go to the movies or anywhere—so this is really nice because it's all so nearby, and all the events are during the daytime.

Both Viola, who lives in service housing, and Roosa, who lives in ordinary housing, describe the hubs as a local resource that brings value to the neighbourhood and enables cultural experiences, for instance. Similar comments were also made by other participants. Many of them appreciated the proximity of the hubs and having access to face-to-face services and counselling on weekdays.

One important material and spatial feature was the easy accessibility of the hubs and their immediate environment, as highlighted in Jaakko's remark:

> Jaakko: This is a great place in terms of environment.
>
> I: Yeah. Do you also mean the location or what's around here?
>
> Jaakko: I mean the surroundings that you can easily move around.

Some negative comments related to the built environment were made during the go-alongs. A few participants said they had difficulty crossing doorsteps with mobility aids. Those with mobility difficulties, such as Saara, who lives in service housing, expressed frustration at the physical challenges that hampered her movement at the hub. Some also referred to slippery pavements around the hubs in the wintertime. The findings related to the dimension "having" highlight the importance of ensuring a physically accessible and safe environment within and around the hubs to cater to the needs of older adults with differing abilities.

### 5.2. Activities and Involvement ("Doing")

All participants were involved in a varied range of group activities offered by the hubs. The frequency of participation ranged from daily to once or a couple of times a week. Participants living in service housing tended to visit the hubs almost every weekday, whereas most of those living in senior or ordinary housing visited less frequently, one to three times a week.

The opportunity to continue old hobbies through the hubs' organised activities held significant importance for some participants. The hubs provided a space for participants to continue their long-standing interests and maintain a sense of continuity in their lives. Many expressed a desire to engage in familiar activities such as gymnastics, singing, or physical exercise. Laila talked about keeping up her regular gymnastic exercises:

> Laila: …and what I do is gymnastic exercises. There, that's my hobby.
>
> I: Where does that happen, where do you exercise?
>
> Laila: Usually in the big hall [of the hub], on the first floor…
>
> I: So this is something you like to do, something you've done regularly?
>
> Laila: Yes, right, really since I was a child.

Participants also described their involvement in self-organised groups. These groups, such as TV clubs, knitting circles, and exercise groups, connected older adults based on their shared interests and abilities. Below, Jaakko talks about the TV club and his role as facilitator in the club:

> Jaakko: Yes, for us living here, for them I'm a kind of "Jack of all trades," I switch on the television and search these things [programmes] on the internet. We've watched together, Matti, Annikki, Aune, and Tuija. We watch something on the telly every day.
>
> I: Right, so what kind of programmes do you show them?
>
> Jaakko: I search them on the internet.
>
> I: Okay. And how did this habit start?
>
> Jaakko: It just came [laughs]. I don't know.
>
> I: Yeah.
>
> Jaakko: The others don't know how to use them, so that's why they come to me.

Similar descriptions of self-organised groups were found in other interviews as well, indicating the participants' enthusiasm to engage in activities of mutual interest. Often these groups had grown out of activities taking place in the hubs and, in this sense, formed a natural extension of the hubs' activities. Some participants said they would have wanted to see the hubs open their doors during weekends. Self-organised groups seemed to satisfy this need by providing a forum for get-togethers outside the hubs' opening hours.

Participants took an active part in both organised and self-organised groups but expressed a preference for on-site activities over virtual groups. Toini expressed her frustration at the technical difficulties she encountered in online groups:

> Toini: …but now these [singing groups], they're quite poor because often the programme comes through the television and there's so much interference, it can be blank for a long time.…Like yesterday, we had this programme and it's impossible to join in when it keeps breaking up.

Virtual groups lacked the same appeal as face-to-face groups, and Toini was not the only participant to report problems with online connections. Analytically, online activities can be categorised as both "having" and "doing." The hubs provide access to computers and online groups, contributing to the dimension "having," where digital devices can be understood as a material resource supporting older adults' digital participation. Digital devices also play a role in hub activities ("doing") as part of the hubs' programme was organised virtually during the data collection. According to our analysis, the participants preferred face-to-face participation over online groups, indicating that sharing the same physical space affords stronger social connections and a greater sense of physical presence.

### *5.3. Social Relations and Connectedness ("Loving")*

Social interaction played a crucial role in the participants' lives. The various social encounters and activities offered by the hubs allowed participants to engage in meaningful interactions. In the field diaries, hubs were described as an "arena where one can meet friends." According to our interpretation, shared spaces were important for meeting the need for connectedness. Hubs served as common living rooms in the neighbourhoods, facilitating social contacts and providing a practical way for older adults living in service housing to connect with those living in ordinary or senior housing. Participants reported forming new connections with people they met in the hubs' environments, as described by Viola:

> Viola: …and of course you get outsiders here as well. For this morning, when we had our "move your joints" group, there were five of us in total, two of us, and three "from outside." So now I know these people as well because we've played *mölkky* [a yard game played in Finland] in the summertime.…But it's nice when we get outsiders. That's how you get to know them. I don't know at all where they live; apparently somewhere nearby.
>
> I: Right, so these social contacts, they are mainly in the shared spaces?
>
> Viola: Yes, these that we have.

These new friendships seemed to contribute to a sense of belonging and enrich the participants' social lives.

We found that participants met other people in shared spaces even though they lived in the same service block or as neighbours in senior or ordinary housing. Visiting other residents' apartments was extremely rare.

Although this can be attributed, in part at least, to Finnish culture where neighbours tend to interact mainly in public spaces, the result emphasises the meaning of shared communal spaces where people can easily meet each other. Below, Sylvi underlines the importance of interacting with other people in the hub's lobby. The dynamic nature of the community ensures that there is always someone to engage with:

> Sylvi: The chairs are always full in the evening and we talk and chat about all sorts of things. Sometimes you get different people so that if someone is missing there is always someone else. But that you get to see other people and exchange a few words, that's a surprisingly big thing. Sometimes I sit and listen to them talking and it's nice just to listen. Then they will argue about something or, you know, you can say it's normal living.

Hilja also explained how social connections in the hub and upcoming events can help reduce feelings of loneliness:

> Hilja: ...it's nowadays, this loneliness. And when you spend a lot of time alone, sometimes your imagination starts running wild and makes things up, things that are not at all hard but your head makes them hard when you're alone and thinking. We humans are like that. But thank God there's this social hub and these meetings at our clubroom where I can meet people once a week. So that there's something.

The dimension "loving" refers to individuals' longing for social relations, not only with other people but also with other species and nature. In our data, the presence of familiar environments, memories related to landscapes, nature, and aesthetic appeal had a positive influence on participants' connection to their surroundings. One of the studied hubs was located next to a lake, which was an important and familiar landscape for many people, loaded with memories from the past.

Our results related to the dimension "loving" highlight the importance of the hubs for social interaction. The analysis emphasises the role of social engagement, the formation of new friendships, and the emotional connection that participants establish with their material environment.

### *5.4. Autonomy and Self-Actualisation ("Being")*

Participants explained that they were involved in the hubs' activities based on their own interests, motivations, and schedules, indicating a sense of personal agency and choice. Most of them talked about making choices as to which activities to attend and which not to attend. As there is no obligation to participate and no fees are charged, the hubs can facilitate older adults' independence and autonomy. Vuokko exemplified this freedom of choice by describing how she had started to make her own meals at home rather than use the hub's restaurant services:

> Vuokko: I used to go out to eat for a very long time, and then I just felt that I needed to do something. I've always been, let's say, active, I haven't been able to stay still and do nothing for very long at all. I mean, I have nothing to do here and I don't have my own garden, so I decided that, and now I've been making my own meals for more than two years.

Based on our analysis, self-organised groups contributed to supporting older adults' autonomy and self-actualisation by providing a platform for smaller groups to come together based on their shared interests and skills. For example, the handicraft groups, both supervised and self-organised, provided opportunities for creativity and self-expression. Activities such as knitting or crafting fostered creativity and allowed participants to maintain and develop their personal skills. The handicrafts produced were often put on display at the hubs as a concrete reminder of shared activities. Irma remarked during her go-along interview that the handicrafts hanging on the corridor walls brought the place to life. Some participants described how they had volunteered to organise community events such as rummage sales. Others talked about assisting in group activities; Viola mentioned how she had helped the tutor of the singing group by handing out songbooks. For most informants, taking on an active role and opportunities for self-actualisation played an important role in participation.

Another significant motivation for engaging in group activities, especially chair exercises and games, was the desire to maintain one's functional ability, remain physically active, and address the challenges associated with the aging body. Below, Jaakko talks about how activities like bingo and physical exercise helped him maintain his functional ability:

> I: Right, so, are bingo and exercise group activities that you attend weekly?
>
> Jaakko: Quite regularly. It sort of helps maintain your functional ability a bit when you go to play.

Participants actively pursued their interests and made choices that were aligned with their individual needs and preferences. Therefore, it can be argued that the hubs provide an environment that supports older adults' autonomy and self-actualisation ("being"), allowing them to explore their potential and remain physically active.

## 6. Discussion

The participants in our study regarded social hubs as valuable local resources that offer shared spaces for social encounters, facilitate interaction with one's social and material environment, provide activities that promote physical activity and creativity, and allow for independence in choosing when and how one wants to participate. The hubs were viewed as important community assets that contributed to the overall well-being of local neighbourhoods. The results highlight the significance of social and material aspects in understanding the meaning of the hubs for older adults living nearby.

The results concerning the dimension "having" underscore the importance of physical accessibility to services in the neighbourhood. This is in line with earlier findings on older adults' social inclusion and age-friendly living environments (Bigonnesse et al., 2018; Mahmood & Keating, 2012; Scharlach & Lehning, 2013). It is worth noting that socio-economic aspects were not prominently discussed in the interviews. This might indicate that in Finland, people are used to having access to public well-being services that are provided for a nominal fee or free of charge.

All participants took part in different kinds of *doings*, including activities organised by the hubs and self-organised groups. These activities contributed to the construction of daily routines and provided opportunities for continuing existing hobbies and starting new ones. Meaningful and appealing activities also reduced the amount of time that people spent alone in their apartments, which for some meant feeling less lonely. Covid-19 accelerated the shift to virtual care and social support. The results of this study indicate that well-being services have social, spatial, and bodily meanings for older adults. Even though virtual connections can contribute to satisfying social and emotional needs (Czaja, 2017), our analysis points to the importance of physical face-to-face interactions. Similar findings were reported by Pirhonen et al. (2020).

One of the key findings of our study concerns the ability of social hubs to serve as gathering points for older adults living in the neighbourhood, fostering social interaction and community-building among older citizens residing in different types of housing. The hubs provide spaces where older adults can form meaningful social bonds and neighbourhood networks. Informal interactions and networks within places can be important for older adults' everyday lives and well-being (Gardner, 2011). By creating opportunities for connecting with others and meeting the needs related to the dimension "loving," social hubs help reduce social isolation and loneliness.

Our findings related to the dimension "being" highlight the active role of older adults as agents who are willing to participate in community activities and organise their groups and initiatives. The results underline the importance of autonomy, self-actualisation, and creativity in participation. Scharlach and Lehning (2013, p. 114) propose a developmental perspective on social inclusion for older adults, encompassing participation in activities that are valued throughout one's life, including non-labour-related contributions. Based on our study, social hubs can facilitate valuable opportunities for self-actualisation in old age by providing places for social participation. By actively engaging older adults, the hubs can better meet the diverse needs of the older population, leading to a more inclusive approach to social inclusion and AIC.

The results generally align with the literature on AIC (Blanchard, 2013; Thomas & Blanchard, 2009), to which we add that local well-being services can facilitate community-building in suburban neighbourhoods by offering a social and material environment that supports older adults' social inclusion and well-being. Developing new ways of involving older adults in the social life of cities is an important task for urban development (Buffel et al., 2012). The Social Hub model appears to be a promising model in supporting AIC, and it can also contribute to making suburban neighbourhoods good places to age.

While the findings of this study provide valuable insights, it is important to acknowledge some potential limitations. The sample size was relatively small, and the participants were white and predominantly female. This may limit the generalisability of the findings to more diverse populations of older adults. Additionally, data collection took place during the Covid-19 pandemic, which could have influenced the participants' experiences and perceptions. However, most of the social restrictions were lifted at the time of the interviews. Future research should aim to include a more diverse range of participants to gain a deeper understanding of the experiences of older adults living in suburban neighbourhoods. In addition, it would be beneficial in future studies to collect systematic data on participants' health status and socio-economic background to gain a better understanding of the interaction between individual and social factors influencing well-being and social inclusion.

The HDLB model applied in the analysis was originally designed for survey use (Allardt, 1976), whereas Hirvilammi and Helne (2014) set out to develop a model of ecosocial well-being. In this study, the model provided a framework for understanding the dimensions "having," "doing," "loving," and "being" within the context of a local well-being service model. The HDLB model provided a useful tool to analyse the Social Hub model and AIC from a sociomaterial perspective. Even though the different dimensions of well-being can be analytically separated from the data, the dimensions and their sociomaterial characteristics need to be understood as intertwined in older adults' everyday lives. For example, forming social relations ("loving") takes place in physical space, where the characteristics of the space affect the formation of social ties, and social interaction affects how individuals engage with the material environment. In older adults' everyday lives, material characteristics, such as accessibility of the place and close location of resources ("having"), play a crucial role in the formation of social ties ("loving"). Accessible and available places and material elements also affect activities ("doing") and self-actualisation ("being"). For example, in Jaakko's interview, where he talked about the TV club and his active role as a "Jack of all trades," the interaction between social and material aspects was clearly pronounced. The material aspects, such as television and the shared space offered by the social hub, together with the social interaction taking place in the TV club can be seen as a sociomaterial practice, where material environment and resources affect social behaviour (the TV club); vice versa, the social interaction and decisions made in the TV club affect how the participants of the club engage with the environment and its material elements (e.g., TV). In the context of this study and the results, social hubs can be understood as networks of multiple human and non-human relations (Duff, 2014; Fox & Powell, 2021) that affect older adults' well-being and social inclusion. More empirical research is needed on the relations between the dimensions of well-being to develop the HDLB model and its adaptations further.

## 7. Conclusions

Based on our analysis, we argue that social hubs have an important role in providing preventive care at a neighbourhood level and in supporting older adults' social inclusion. The results provide valuable insights into the efforts of professionals and stakeholders to develop community-based models aimed at promoting the well-being of older adults. In conclusion, the findings of this study highlight the significance of social hubs as local resources that can support the well-being and social inclusion of older adults. Providing local well-being supporting services, fun and meaningful activities, and shared spaces for social interaction can promote aging in the community and foster the overall well-being and social inclusion of older adults.

### Acknowledgments

We are grateful for all the participants who gave their time and made this research possible. We also thank Sointu Senioripalvelut and the social hubs' personnel for their cooperation during the data collection. We appreciate the valuable comments we received from the editors and two anonymous reviewers.

### Funding

This study was enabled by the resources and funding provided by the AIsola Project 2021–2022, funded by the Intelligent Society Platform INSO Profiling Area at Tampere University, Finland, and by the Centre of Excellence in Research on Ageing and Care (CoE AgeCare), funded by the Research Council of Finland.

### Conflict of Interests

The authors declare no conflict of interest.

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Social Inclusion
2024 • Volume 12 • Commentary 7896
https://doi.org/10.17645/si.7896

COMMENTARY

Open Access Journal

# A Community Project to Supplement Social Care Services

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**Submitted:** 28 November 2023 **Accepted:** 28 November 2023 **Published:** 25 January 2024

**Issue:** This commentary is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

## Abstract

Solva in West Wales, UK, is a small community with about 700 people on the electoral roll. In 2013, Solva Community Council faced the fact that things were not going well for the elderly in our village. Many had to leave home and go "into care." They didn't want to go and we didn't want to lose them. A community councillor at that time, author Mollie Roach, did some research and decided that the village could look after its own. A small working party including first author Frances Barker was set up to plan the way forward. The original idea was not a volunteer service. We wanted to set up a local domiciliary care service, where the carers would live locally and not have to spend their precious time travelling between wide-spread destinations. We soon found that there were several administrative and monetary barriers in the way of setting up such a scheme, especially for a small community. Registration needed money and qualified people. and the "rules" were such as to prevent rather than encourage individual response to individual circumstances. However, we could see that there was a need for a local volunteer service. It is disturbing when you discover you cannot go up a ladder and change a light bulb. It is devastating when you are told you cannot drive anymore because of an eye problem. It is worrying when you cannot take the dog for a good walk or collect your prescription because of arthritis. All these problems are under the radar of statutory services. This is a gap that can be alleviated by a local community-based volunteer scheme. Solva Care evolved with a paid co-ordinator to mediate between volunteers and those needing help. We are now getting closer to the original idea, doing our best to integrate domiciliary and social care, working with agencies, private carers, families, and individuals, as well as continuing to run the volunteer service.

## Keywords

community integration; local action; rural area; village activities; volunteer service

## 1. In the Beginning

Our starting point in 2013 was a report from a community councillor concerning the difficulties experienced by the elderly of the community in trying to secure adequate care. Older people found it difficult to stay in their own homes, remain part of the community, and the Community Council considered the idea of setting up a local care company to meet a local need. It was decided to take the idea to the community; to find out if there was a need and the nature of that need. A survey was devised and distributed to every house. Eighty-five percent of the surveys were returned, and the community was very much in favour of the idea. Analysis of the responses told us who was already receiving care, from whom, how much, and how it was financed. We also found out who would be willing to volunteer to help with social care. At Solva Care, we have never had fewer than 30 volunteers. We were fortunate to have a supportive Community Council. They helped with financing the survey and with our early financial problems. A survey would be a useful starting point for every community since every area is different and will have different assets available and different needs.

Our next step was to acquire some funding to put the ideas into practice. We decided that we needed to pay a co-ordinator. Research carried out showed us that projects wholly reliant on volunteers tended to fail after a while. The situation is volatile and the volunteer organiser finds the load very heavy. A paid co-ordinator gets to know the volunteers and their preferences and can distribute the work equitably, getting the right person helping the right person. In this way, friendships and patterns develop and no one need be overloaded. Our co-ordinator also secures training for our volunteers and organises an “away day” for them each year. She makes sure that people are being helped and encouraged to attend existing activities in the village such as coffee morning and luncheon club, and initiates new activities and events such as the regular Friday Club.

Solva Care started off as serving only the Parish of Solva and Whitchurch; we have tried to keep to this fairly small area despite requests from people further afield. They are very welcome to come to our village activities and we help as much as we can, but we prefer that the local, personal touch is maintained. *Small is beautiful*. With this commentary, we hope to inspire and encourage other communities to set up their own schemes, suitable to their particular requirements.

## 2. Progress

The volunteer service provided by Solva Care has slowly evolved and is now fully integrated into village life. We were able to get a two-year grant from the National Parks Sustainability Fund and thereafter obtained a five-year Big Lottery grant. The Big Lottery representatives were impressed with what we were doing and subsequently gave us a further grant to research how our model could be spread to other communities. The research group produced a toolkit that sets out how we proceeded and what we learnt. It is available in hard copy and online (https://www.solvacare.co.uk/our-research). Co-operation with other communities is still in progress. We have had other smaller grants to investigate the “direct payment” scheme and are being approached by research groups with particular projects in mind.

Because the volunteer scheme is now an integral part of our village, we would hate to see it have to come to an end for lack of funding. We are therefore taking measures to become more self-sustainable and are building up the reserve fund whenever we can. In addition to grant money, revenue also originates from donations, legacies, and fundraising events. We have also started a pop-up shop that sells donated goods at low prices, saves them from landfill, and puts some funds into Solva Care and other village assets like the play parks and Memorial Hall. We need to be able to plan ahead and are in negotiations with our Local Health Board, our County Council, and the Welsh Assembly Government in our efforts to secure a permanent funding base.

We have learned much over the five years that we have been operating and have become aware of the wider needs of the community as a whole. Responding to individual needs has made us aware of the group needs that might exist in communities. In helping solve the problem for one individual or family, we become aware that the problem might exist, unspoken, for others too and can devise ways of meeting that need, if and when people seek help. We have always enjoyed the full support of our Community Council and they are represented on our Trustee Board. The Covid crisis confirmed our community spirit and our willingness to work together. During the Covid crisis, we met with the Community Council every week so that we might all be fully aware of any local difficulties. We work closely with our local surgery, holding a drop-in session every Friday (prior to Covid), and are working with the Community Council and local groups to support the development of a preventative approach to health, social care, and well being that covers everyone, not just the elderly. We have found that this preventative approach extends our understanding of “well being” to include all aspects of daily life, not just health and social care. To this end, we also work closely with our local community and activities groups, third-sector groups, the social services, and the hospitals that serve this area.

The co-ordinator and her assistant (also paid) keep abreast of developments in social care and benefits and are ready to help people in these areas. It is not easy to secure domiciliary care and we have compiled a list of local privately employed carers, so that we can respond when asked for help.

We find that being able to respond immediately to individual needs is much appreciated. The “top down, one size fits all” approach, which is what we currently have from the County Council, the Health Board, and the Welsh Assembly Government, responds in general to the group rather than in particular to the individual. Local communities can respond more swiftly to individual needs.

On the research side, we are supporting two local communities seeking to set up their own similar projects and a Ceredigion Community also seeking to establish community care. There is also a local example of the successful establishment of a fully domiciliary care scheme.

Communities differ in their makeup and in what assets are available to them. Not all town and community councils are willing to take the lead and there are communities of age, interest, and place. That being said, Covid showed us that community groups can get together to respond to local needs and such groups could continue to respond to social needs when the health crisis ended.

We have not had much success in getting individuals to take the direct payment option when considering social care. Under this scheme, in place of a care package, funds are paid directly to the individual, who can then pay for the services they need. The bureaucracy of the system seems to cause more concern than the freedom offered by being in charge of one’s own care. We are, however, seeking to encourage individual carers in the community to work in small groups to offer care to two or three individuals living in the area. This approach may help secure more integrated domiciliary and social care on a local community basis.

## 3. The Future

Working closely with agency and private carers goes some way towards creating the holistic, integrated response to care provision that we were unable to provide at first. We were keen to stay local and the costs involved in setting up and running a care agency made it impossible for us to contemplate it. However, we are now considering the possibility of securing funding to set up a domiciliary care agency that will operate across the whole of the peninsula, covering several communities. A locally based care company would be of real benefit to those needing care. Locally based carers could be employed and travel times would be reduced. We could also offer support to any communities interested in establishing a social care project similar to Solva Care, to work jointly with the domiciliary carers, and to provide a much more integrated response to individual needs.

We have found that the work of Solva Care has made our community more aware of itself. Many houses here are second homes and holiday lets, and many neighbouring communities have lost their surgeries, schools, shops, and bus services. We have a Community Land Trust in Solva, which has secured funding to build houses to let and for local people; and though most of our youngsters travel to school, we still have our shops, our surgery, a post office, play areas, a bus service, and public houses. Solva Care has shown us that we can work together to achieve our aims; it has boosted our self-confidence and given us a belief in the power of the local community.

## About the Authors

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**Social Inclusion**
2024 • Volume 12 • Article 7483
https://doi.org/10.17645/si.v12.7483

ARTICLE

Open Access Journal

# Older People Reimagining and Envisioning Preventive Care Through Land Acquisition: Evidence From Rwanda

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**Submitted:** 31 July 2023 **Accepted:** 8 January 2024 **Published:** 25 January 2024

**Issue:** This article is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

## Abstract

This article presents findings about older people reimagining and envisioning preventive care through land acquisition in the Karongi district, Rwanda. My primary objective was to understand how land acquisition constitutes a means for older people's preventive care arrangement. Ethnographic data were collected from 15 older people's households. Empirical findings indicate that land scarcity makes it a coveted resource that attracts care around older people possessing it. Those unable to use their land rent it out to someone else who accepts to use the land and share the harvest equally with the owners. Furthermore, caring relationships between the landowner and the land user go beyond sharing the harvest to provide other forms of caring practices, such as assistance to access health care, firewood, and water provision, as well as helping older people sell their harvest. Renting out the land displays the image of an older person actively engaged with the community and who attracts caring practices using the land. Besides, land acquisition is the basis for intergenerational care negotiation, as expectations to inherit the land encourage children to care for their older parents. Thus, this article shows preventive care that is happening outside the realm of the Western biomedical model, but rather within an imagined model of owning an asset that benefits older people, their kin, and the community.

## Keywords

community care; intergenerational care; land, older people; preventive care; Rwanda

## 1. Introduction

In Rwanda, state-led care for older people is limited to those formally employed in public or private institutions. Only 7% of older people are covered by a pension scheme (MINECOFIN, 2009). Those in the informal sector have to resort to family support when in need of care. However, socio-economic changes make family care for older adults unreliable or insufficient to cover older people's needs (Sabates-Wheeler et al., 2020). The decline in family support for older people results in the young generations' competing needs and insufficient means to respond to their own needs and those of their parents (Aboderin, 2006). The gradual decline of intergenerational support for older people makes it uncertain. This is what Sabates-Wheeler et al. (2020) qualify as fragile support from children to parents. In reaction to this situation, older people do not assist helplessly in the face of this situation; they rather imagine how they would be cared for when in advanced old age. It should be noted that the notion of retirement does not exist in older people's communities in rural settings, especially those in the informal sector not covered by a pension scheme (Guven, 2019). More senior people continue to work on their land to ensure their daily subsistence until they are frail (NISR, 2015b).

Frailty is a crucial stage that leads to increased vulnerability in old age and requires more claims for care (Yang & Lee, 2010). Thus, it is wise to think about care at this stage and to be prepared to face it earlier. Preparation for old age includes thoughts and activities about how to age well (Sörensen et al., 2021). Envisioning preventive care in advanced old age requires adopting strategies to make care possible and proactively deciding how to live in old age (Hou, 2019). One of the strategies some older people in the Karongi district use is acquiring and maintaining land, which they see as a way of preparing to live well through advanced old age. This consideration incites us to research the relevance of land in older people's preventive care in rural settings in Rwanda. Preventive care in this article is not envisioned in terms of disease prevention and health screening practices (Drewes, 2013); rather, it is conceived in terms of strategies to attract care practices in the future and simultaneously avoid social isolation. Among the actions oriented to attract care in rural areas in Rwanda is land acquisition. For the land to play a role in attracting care around older people in their frailty stage, kinship, as well as the surrounding community, are vital in enabling an age-friendly environment that allows them to access resources needed for their everyday living.

It is worth mentioning that land is scarce in Rwanda. More than 60% of the rural population has less than 0.5 hectares of land (Musahara & Huggins, 2005). In the context of land scarcity, land is a desired asset that attracts social networking from various angles. Research indicates that access to land in Rwanda is not given to everyone; a quarter of the Rwandan population is landless, and this issue will continue to grow (Musahara & Huggins, 2005). Land scarcity makes Rwanda a unique case study where land is paramount in attracting caring practice for older people. This article contributes to the care debate by showing that preventive care in agrarian society goes beyond the biomedical Western model to include the accumulation of assets to draw on when in need of care. In this regard, older people who own land expect to benefit from caring practices. Caring for older people goes hand in hand with showing them dedication and attachment, and carrying out activities on their behalf that they cannot do themselves (Van der Geest, 2002). Doing an activity for someone relates to what Sadruddin (2020) calls, in her article on ageing and dignity in Rwanda, "care of the small thing" that gives older people dignity.

Furthermore, research on ageing in Rwanda indicates that social changes such as demographic, health, social, and economic forces are at the foundation of the looseness of family ties (Davis et al., 2019). From this perspective, older people have to think about alternative agencies through which they can navigate their preventive care. The article aims to explore how land acquisition and maintenance constitute a strategy for preventive care in advanced old age. In this regard, some questions need to be raised. How do older people mobilise kin and community care around them through their land possession? What types of care are older people entitled to when they become frail? How do kin and community benefit from caring for frail older people? The article uses older people's narratives about their lived experiences in their socio-cultural settings to reflect on these interrogations and to provide an empirical-based answer. Apart from that, throughout this article, an older person is understood drawing on the Rwandan older person policy that defines older people using social and chronological age. Social age determines an older person by changes in social roles and functional or psychological and intellectual abilities. In contrast, for chronological age, an older person is any person who is 65 years and above (MINALOC, 2021). In Rwanda, an older person is not only determined by chronological age, as is the case in other cultural settings where old age is determined by the age of retirement (Apt, 1996). Furthermore, the concept of care is used following Van der Geest's (2002) definition, which considers care as an assemblage of emotional and practical performance relating to the manifestation of concern, dedication, and attachment on the one hand and carrying out activities for others who, for physical or emotional reasons, are unable to do so.

## 2. Theoretical Framework

This article draws on previous studies conducted on old age care, which have investigated elderly care from various perspectives. Care has been debated from different points of view. The Marxist feminist perspective considers care as unpaid care work accomplished by women within the household, while paid activities belong to the male breadwinner (England, 2005). Feminist scholars portray care as a positive dimension of our lives that the capitalist and patriarchal order has socially devalued. It can be conducted in a way that rewards rather than penalises women. Caring activities give a woman a certain status and contribute to forming a woman's identity (England, 2005). In the same vein, disability studies examine care in terms of power relations between caregiver and care receiver; the latter should be considered an active actor (Thelen, 2015). The work of Hochschild (1995) contributes to the care debate by categorising it into warm and cold, traditional and modern, as well as public and private. However, Thelen (2015) rejects these divisions. She suggests overcoming the narrow focus and looking at care as embedded in a larger institutional framework and within different temporalities. In the same perspective, looking at care broadly allows us to understand different angles of care as an activity, a service, a social relation, and emotions, summarised in "caring for" and "caring about" (Alber & Drotbohm, 2015).

Several scholars have contributed to the care debate from various contexts. In Asia, care has been a subject of much discussion; Laurence Cohen analysed family care in Muslim and Hindu families in India and its impact on their health, especially pathological dementia and the social construction that derived from it (Cohen, 1998). Along the same line, Lamb (2020) examines successful ageing in India and North America and shows how it differs between the Euro-American and the Indian perspectives. While the Euro-American view considers successful ageing the ideal of independence, the Indian view focuses on interdependency within the family. Besides, people become elderly caregivers to older people by practising rituals of care, which are repetitive practices that achieve effects through correct performance (Aulino, 2016). On the African continent, elderly care has been the subject of many scholarly investigations. Van der Geest (2016) analysed family care for older people in rural Ghana and concluded that families would struggle to provide good care to their ageing parents. In the same perspective, the decline in family care for older people in Southern Ghana makes the latter express curiosity for Western care facilities, which they consider like schools where they can meet their colleagues (Coe, 2018). While in Ghana older people wish to live in retirement homes, in the Democratic

Republic of Congo the existing retirement homes are not fully operational. The elderly in such care facilities are those socially rejected or accused of witchcraft (Pype, 2018). Besides, older people in Tanzania provide care to older people. This testifies to the failure of intergenerational reciprocity, which makes older people create new options for action and space within generations (Pype, 2018).

In Rwanda, the 1994 genocide against the Tutsi has reconfigured the carescape, where older people are obliged to provide care to older people as some have lost all their family members (Sadruddin, 2020). Furthermore, the genocide made some elderly childless, others widowed, and deprived of traditional family care (Davis et al., 2019). Even for those with children, the economic hardship coupled with the difficulties in sustaining their livelihoods fragilise the social support from children to parents (Sabates-Wheeler et al., 2020). All these changes in elderly arrangements call for thinking about attracting other forms of caring practices. This article focuses on land acquisition to attract various forms of care.

To a certain degree, older people feel secure when they have their land and do not worry about the way they would be cared for in old age. In her research on Benin, Alber (2018) shows that buying pieces of land and keeping them constitutes one of the strategies older people use to arrange their retirement despite being in the informal sector. Preparing for retirement makes older people position themselves in terms of care at the late phase of their lives when there is no state support. In rural areas, land serves not only as the basis for food production but also as a place of belonging and attachment (Manzo, 2003). Moreover, land is becoming progressively more important in old age care since it is the basis for rural livelihoods. It also serves as the area where older people interact with kin and community and define their caring relationship experiences (Manzo, 2003). People's attachment to their space is materialised in a strong feeling of belonging to a geographical setting that emotionally connects them to where they have experienced their social and economic living throughout their life course (Rubinstein & Parmelee, 1992). Economic life relates to investments and other economic activities, while social life involves constructing social networks that extend to the community neighbourhood. Older people's investments, especially buying land for future use, constitute a preventive care strategy. Alber (2018) indicates that older people prepare to live in old age by buying land because this is a source of caring resources after they have ceased working. From this perspective, older people's foresightedness for future care is a way of imagining preventive care.

Preventive care is commonly conceived as a set of measures to prevent diseases or injury (Drewes et al., 2012). For older people, preventive care also includes contributing to the goal of healthy ageing, the maintenance of independence, and well-being by preventing or postponing disability or social isolation (Drewes, 2013). In the context of this research, it seems appropriate to focus on well-being and preventing social isolation. In countries like Rwanda, particularly in rural areas, where the professionalised care for older people is quite inexistent, reflecting on preventive care goes beyond preventing diseases and includes measures adopted to access resources and care necessary for living through old age until the end of one's life. It is much closer to the feeling one has of being cared for when in advanced old age; the feeling of having planned for life in advanced old age (Alber, 2018). To make this preventive care function and achieve the expected results, there is a need for kin and community interventions. Kin's care falls within the perspective of intergenerational reciprocity. Community intervention in older care practices relates to social networking. Older people do not live in isolation; they live with other community members who help them to engage in social activities. Continuous interactions with neighbors enhance a shared emotional connection and increase one's feeling of belonging in the community (Chavis & Wandersman, 1990). Older people's interaction with neighbours resonates with the community development's values of combating social exclusion, poverty, and discrimination. These values enable community members to create social and economic wealth that helps older people deal with social and economic changes in their society (Cavaye, 2001). The social and economic changes push older people to reconstruct their social networks regarding which their material and relational resources may shape more or fewer results (Bramanti, 2022).

Moreover, older people's material and social resources enable their routinised interactions with the community. The community's closeness to older people favours an old-age-friendly neighbourhood environment that allows access to caring practices and successful ageing (Rugel et al., 2022). This article uses a life course perspective to reflect on how older people's assets, like land, connect to preventive care. The life course perspective is a theoretical orientation in the study of lives. It is a sequence of socially defined events and roles that the individual enacts over time. These events and roles potentially shape the present and the future (Giles & Elder, 1998). It postulates that individuals construct their life course through their choices and actions embedded and sharpened by history and place over time within lived interdependent lives (Elder et al., 2003). Applying the life course perspective to preventive care enables us to understand how older people's land-acquiring experiences link to caring practices by kin and community. Thus, the actions and choices of older people through their life trajectory shape their care at an advanced age. The article argues that to apprehend how older people imagine and envision preventive care, we should focus on the timing for acquiring land and how it connects to the lives of kin and the surrounding community in a determined social-cultural setting.

## 3. Methodology

This article draws on ethnographic data collected during fieldwork in Rwanda from December 2020 to March 2021. Drawing on Murchison (2010), ethnography is a research strategy that allows researchers to explore and examine the culture and societies that are a fundamental part of the human experience. Ethnography helped me to study older people in their social settings and capture their experiences in mobilising caring practices through land possession. Besides, this article is part of a research project on the social protection of older adults in Rwanda. The Directorate of Research and Innovation in the College of Arts and Social Sciences of the University of Rwanda has approved this research. Before conducting interviews, all informants had to give their informed consent orally, and interviews were only conducted with those who consented to participate in the research. In-depth interviews were conducted in Karongi district, one of the thirty districts that compose Rwanda. The choice for this district was motivated by the fact that it is among the Rwandan districts with a high proportion of older adults, 5.6% of the total population, against the national proportion of 4.9% (NISR, 2015a). In addition, in my previous visits to the District, I have observed various initiatives of older people to care for themselves. The article explores the strategies used by older people for their preventive care. It specifically focuses on land acquisition as an asset highly coveted in a community where most people rely on the land for their everyday livelihood. The Rwandan population and housing census indicate that 82% of the older people aged 60 and above reside in rural areas and have agriculture as their economic activity (NISR, 2023). Informants were selected purposively based on the fact that they possess more than one piece of land and make that land productive through others. In this regard, fifteen older people were selected, including six women and nine men. The informants' age ranges from 78 to 92 years; these are older people who are frail and unable to cultivate their land by themselves. In-depth interviews were conducted with the selected informants at their houses. The interviews focused on the older people's lived experiences in terms of land possession and caring practices. Each selected informant received my visits at least three times. The visits helped me socialise with informants, build rapport with them, and get immersed in the field. As Malinowski (1922) indicated, to truly understand the local inhabitants one must live with them and observe their lives and cultural accounts. In addition to the interviews and participant observation, field notes were used to capture information not collected by interviews. Interviews were recorded and then transcribed and translated from Kinyarwanda to English, which helped the researcher to familiarise and immerse with the data. Data were analysed using the thematic analysis method. This method helped the researcher identify, analyse, and report patterns or themes embedded in the interviews (Braun & Clarke, 2006). From this perspective, systematic analysis of the entire data set led to the identification of repeated themes across the data set, which relate to the land's usefulness in preventive care as well as to the meaning and experiences that informants have of these themes. To ensure confidentiality, all informants are given pseudonyms when quoting them in this study. Furthermore, cases presented in this article are for those who consented to participate. In this perspective, the meaningfulness of the case study does not reside in the number of cases but in what the case tells us about society as a whole (Burawoy, 1998).

## 4. Empirical Results

### *4.1. Planning for Preventive Care*

"A walking stick in old age is cut earlier and kept far from the reach of everyone," said Anastase, an older man, 81 years old. Anastase gave this statement when he explained how land constitutes an asset that helps older people plan for their preventive care. He had bought three pieces of land in his village when he was in his active age. During that period, he purchased crops from his neighbours and sold them at the local market. This activity helped him to mobilise money so that he could buy the land he has now. He did not acquire his three pieces of land at once but kept buying them one by one as his income increased. He did not think about selling his land again because he knew that his land was the walking stick in his old age. This land acquired earlier is the source of livelihood in his old age as it is the one, he uses to produce food for his family.

Another informant, Adela, managed to get land and keep it to serve her in old age. Adela is an older woman of 92 years old. She earned two pieces of land she uses together with the land around her house to produce various crops that she needs daily. She said: "I can't run a shortage of food because my land is there to give me the food I need."

Adela is happy that she has the land that allows her to have food that lasts from one agricultural season to another. It is worth mentioning that, in rural areas, those who do not have enough land to produce food are likely to experience food shortages. Thus, land constitutes a precious means of food production for Rwandans, particularly for rural older adults who secure their food security through their land (Takeuchi & Marara, 2011).

With renting out her land, Adela cannot beg for food. She put her story this way:

> I have sufficient food all the time and cannot beg for it as those without land do. It is good to think about your old age when you can do something to prepare for it.

Adela explained that she bought the land from selling the crops she grew on the land surrounding her house. She kept saving money until she purchased the first piece of land and the second one.

In the same perspective of selling crops to get land, Alphonse, another informant in the Karongi district, bought land using the money from selling coffee beans. Alphonse is an older man, 79 years old. He had a coffee plantation that generated an income for him at every harvest season. He used that money to buy pieces of land in different locations in his village. He explained that his land is a kind of savings for his old-age livelihood. Like other informants, Alphonse uses his land to produce foodstuffs, and whenever he needs money to respond to different needs, he sells a part of the land to get the money he needs. Nevertheless, he is convinced he cannot sell the whole land as he will bequest it to his children.

Contrary to Alphonse, who got land from the sale of coffee beans, Kaberuka got land from the money he earned from his work. Kaberuka is an older man, 81 years old. He worked for several years as a casual worker in road maintenance. As a casual worker, he did not have a work contract, and he was not entitled to the pension scheme as his employer did not contribute to the social security fund. However, he managed to prepare for his old age with his little salary. He bought two pieces of land that he is now using to respond to his needs. According to Kaberuka's narrative, he did not want to save money in his bank account because land kept increasing its value while the money in the bank kept depreciating. He said: "Land has a value that is constantly increasing; so, I saved my money on buying land rather than depositing it in a bank account where its value decreases yearly."

In the same vein of the land value, another older man of 84 years, Matabaro, said: "The land is an asset that keeps increasing its value and rescues you when you do not have enough strength to cultivate it."

The cases presented above show that some older people not entitled to retirement benefits try to create an alternative, which is buying land that they use to respond to their old age needs. Thus, buying land is an act of sightedness to envision preventive care. Through land acquisition, older people I talked to in rural areas of Rwanda adopt measures to prevent the lack of care and plan for their well-being in advanced old age. The land is not only a means for food production but also for attracting care from the surrounding community.

### *4.2. Attracting Community Care Through Land Acquisition*

Older people participants in this study report to attract community care through their land. These narratives made the researcher explore how older people entice care from the community through their land possession. In the Karongi district, older people use the surrounding community to make their land productive. An old woman explained that she rented out her land to her neighbours, who agreed to share with her equally the harvest, what she called in Kinyarwanda *hinga tugabane*, which means "cultivate we share":

> With *hinga tugabane*, my neighbours cultivate my land and grow the agreed crop, and then I share with them the harvest.

Another informant said: "When I give my land to my neighbour to grow crops, I get in return the foodstuffs through sharing the harvest with them."

The problem of land scarcity made land a highly demanded resource in rural areas in Rwanda, as most of the population depended on land for their survival. Thus, those without land seek it from those possessing it, which makes the *hinga tugabane* practice commonly used. An older man of 79 years explained it as follows:

> In this region, the land is not enough for all people to produce the food they need, so my neighbours without land come to me to ask for land during every agricultural season. I [always have] someone to use my land.

From the quote above it is clear that land is becoming scarce. According to the district development strategy, 77.7% of households own less than 0.99 hectares of land, while 85.2% of the population is in the agriculture sector (Karongi District, 2019).

The practice of *hinga tugabane* is not only limited to sharing the harvest between the landowner and land user, but it also extends to assisting when in need. Some informants explained that as follows:

> When I was sick, my land user accompanied me to the hospital and kept visiting me during the two weeks I was admitted to the hospital. He brought food and drinks whenever he came to see me.

> My neighbour, who uses my land, besides providing me with foodstuffs, brings me water and firewood and helps buy products from a market located far from here.

> When I share the harvest with my tenant, he helps me sell a part of it to the market, and I get money to buy other products.

Land allows older people to create caring relationships with their surrounding community, while people without land have access to it through the *hinga tugabane* practice. Thus, community development based on neighbourhood mutual support arises from social and economic caring practices (Kokos, 2001). Moreover, older people and community members come together to solve their problems in mutually beneficial relationships: Those without land access it and produce the food crops they need, while older people, unable to cultivate their land, benefit from their harvests to improve their own well-being.

It is worth mentioning that land acquisition does not only attract community care but also constitutes an asset that connects generations in a caring relational practice.

### 4.3. Land Holding to Enhance Caring Relationships Among Kin

Land is an important asset for the family in an agricultural-based economy society. The prominent way of land acquisition in rural areas in Rwanda is from parent to child through donation or inheritance. From this perspective, some older people with land benefit from their children's care as they expect to inherit the land. One respondent reported:

> I will bequeath my land to my children [and] they will care for me, as they know they will inherit the land. But when you don't have land, children run away from you in search for their land.

Another informant said:

> When you have land, it is for your children, who will inherit it at your death. They have, in return, to care for you to avoid you giving the land to any other person, or selling it.

In their lifetime, a parent has the right to donate land and property to someone other than the offspring. When children do not care for their older parents, they lose their advantage over their parent's property when the latter decides to dispose of their property as they want, without worrying about careless children.

It is worth mentioning that land serves not only as children's inheritance but also as a place of rest after death. As one older man put it: "At my death, the burial ceremonies will be organised on this land. This is the land of our ancestors that has passed from one generation to another."

In rural Rwanda, land plays a significant role in funeral rituals. An informant explained it as follows:

> It is not good for an older person to die without bequeathing land to their offspring. On their last day, a child who buries [a parent] is given a piece of land. If you don't have land, people will criticise you for not having managed to leave something behind.

From the above narratives, having land and keeping it is used to be cared for when alive but also on a person's last day. It also prevents older people from being shamed by the community when they die. Older people in this study are proud to have land to leave to their children. An older woman expressed her satisfaction:

> I am happy that I have land to leave behind for my children. A good parent always thinks about their children and is proud to bequeath something to them. But when you consume all your property, people will consider you a greedy parent who has forgotten his children.

Another informant said: "I am proud to have land to leave to my children. I have fulfilled my duty, and I will die happy."

The decision to keep land throughout one's life span is a means of arranging for preventive care and preparing for the bright future of one's descendants. Furthermore, land constitutes an asset that strengthens caring relationships between kin members.

## 5. Discussion

This article builds on qualitative data and explores how older people envision preventive care through land acquisition. To achieve this aim, we focused on the lived experience of 15 older people in the Karongi district. While preventive care is often envisaged in terms of preventing various diseases and injuries, the empirical results indicate that in rural settings, preventive care goes beyond medical aspects to include the accumulation of resources to draw on when in need of care. The valuable resource that older people focus on is the land, an asset that attracts different forms of care when they are becoming frail. Thus, the cases presented here testify to a paradigm shift in understanding preventive care. Therefore, preventive care has to be envisioned, taking into consideration socio-economic settings that reflect the everyday living of individuals. Through owning land, some older people benefit from material, financial, health, and emotional care practices embodied in the *hinga tugabane* practice. The shift in caring practice is related to constant care adaption to the changing circumstances (Drotbohm, 2015). Caring practices through *hinga tugabane* fill the family care gap threatened by socio-economic changes. In this regard, drawing on Thelen (2015), care becomes an open-ended process connecting the giver and the receiver in a practice that satisfies socially recognised needs.

Preventive care in this study materialises in the everyday living conditions in a rural setting, where securing food and having the means to access health care services are among the primary needs many older people strive to satisfy. In this regard, land possession makes interviewees in this study be cared for by their tenants regarding food provision or assistance to access health care services. Some people in the Karongi district acquire land through inheritances or by buying it from others. The land passes from one generation to another through inheritance and constitutes an asset that connects generations, as children expect to get land from their parents. From that perspective, land serves as the basis for care negotiation between children and their parents, as parents have the right to bequest the land to those who care for them. Research on kinship relations in Rwanda indicates that children who did not show absolute respect to their parents or did not act in their interest lost the favour of receiving a good inheritance (Pontalti, 2018). This could generate tensions and conflicts among family members, especially between those who inherited small patches of land and those with ample land. Land ownership is traditionally the main form of self-insurance in a traditional peasant society (Freiberg-Strauss & Jung, 1988). In managing preventive care in advanced old age, timing matters. Older people interviewed in this study know that they have to imagine living their advanced age while they are still active and able to acquire land. This resonates with the life-course theory, which contends that in the development of an individual’s life paths or life trajectories, timing plays an important role and stands as a central element to the life-course perspective. There are three kinds of live timing: individual time, generational time, and historical time, which influence the individual’s positions and societal roles (Mitchell, 2003).

Besides, the increasing value of the land over time is a motivating factor for some older people to imagine their old age in terms of land holdings. Those aware of the depreciation of money kept in a bank account opt for land as an asset of increasing economic value. It should be noted that the main ways of acquiring land in Rwanda are inheriting it from the parents or buying it. However, regarding inheritance, not everyone can inherit the land from his parents. As Musahara and Huggins (2005) indicate in their research on land reform in Rwanda, a quarter of the Rwandan population does not own land. Furthermore, most of the rural population has less than 0.5 hectares of land, which is not susceptible to subdivision according to the Rwandan land law. Thus, land scarcity makes acquiring land well before old age an illusion for some people. Unless they buy it from others; otherwise, they have to resort to the *hinga tugabane* practice for their survival. Regarding access to land through purchasing, this depends on the land market dynamism. As the population increases, land demand and its financial value also increase. Research indicates that land can double its price between two successive sales (Baldwin et al., 2019). This is because land is the main livelihood asset for the rural population, and farming is the main occupation for rural inhabitants. Thus, buying land requires mobilising financial resources as people compete to buy land on sale (Bizimana, 2011). The value of the land is determined by its size and location. For example, land with access to public roads is more expensive than land without access to the road or exposed to landslides. There is no regulation about the price of the agricultural land. The seller and the buyer bargain about the price until they agree on the convenient price. Once the sale contract is signed, the seller and the buyer go to the nearest land administration office to register the transfer of land rights and pay the required transfer fees (Baldwin et al., 2019).

Moreover, land for older people is a social place that allows them to sustain a sense of belonging and extend their social networks. In their research on older people and their social space, Wiles et al. (2009) indicate that older people attach great importance to the place where they live and give it a sense of belonging, attachment, and well-being. In that spirit, older people keep their land and feel proud to leave it to their children as a legacy. Land possession brings care not only in the lifetime of older people but also at their death in funeral ceremonies. Thus, land becomes a commodity that has symbolic, economic, and social value. It connects the living to the dead through inheritance and burial and establishes a person's sense of belonging in place (RISD, 2013). It is these values that go beyond kin to expand to community members to strengthen caring relationships.

Older people's social networking with their land users provides not only a kind of security but also an assurance to get food and income from the sale of foodstuffs. This kind of security that elderly landowners have echoes preventive care imagined earlier in their life course when still active. The insurance and security older people enjoy through their land resonate with the walking stick cut earlier and kept far.

The relationships between older people, landowners, and their surrounding community relate to community development values. Older people who agree to give up their land to their neighbours contribute to their well-being by allowing them to produce foodstuffs. As land is scarce in Rwanda, accessing it constitutes a reliable means to secure a living in rural settings where most of the population relies on land for their survival. Interactions between older people and their community enhance their social engagement and promote their well-being. Similarly, the community helps older people to access resources, like food and health care, needed to maintain their quality of life. Thus, the community creates an age-friendly environment that promotes healthy ageing, social participation, and ageing in place. This kind of support for older adults is rooted in the cultural value of mutual help that is prominent in the Rwandan community. This mutual help revitalises community engagement in caring practices that benefit both older people and community members.

## 6. Conclusion

Preparing for preventive care is a goal in the life course of the older people interviewed in this study, that they strive to achieve when still active. Older people who participated in this study imagine preventive care through land acquisition. Land is, at the same time, a physical and social space that connects them to their kin and the community. The article argues that preventive care is to be envisioned depending on the social-cultural context of a given community, expressed in their everyday living conditions and community values. Thus, acquiring land throughout the life course and keeping it increases the likelihood of being cared for by the surrounding community and kin. As indicated in the older people's narratives, land has expanded beyond the economic sphere of a means of production to become a way to envision preventive care in advanced age. The interactions between older people and their neighbourhood over land use stimulate community development based on satisfying mutual needs of getting food and shared emotional bonds and support. When older people become frail, they lose their physical power but remain with the social power of mobilising the community around them for the use of their land and share equally with them the harvest. Despite the achieved results, this study is not free from limitations. The first limitation was the limited prior research studies on elderly care in Rwanda. This literature gap made the researcher look at available literature in contexts other than Rwanda. Furthermore, the Rwandans, in their culture, do not like to disclose their personal information to an outsider, even less information related to asset possession. This led the researcher to spend time with informants and build rapport with them to get the needed information. The article analysed older people's preventive care arrangement in a rural area and it cannot be claimed to be exhaustive; therefore, we recommend that future research focus on preventive care in urban settings to explore older people's caring agencies and their interrelatedness.

## Acknowledgments

I want to give special thanks to the Bayreuth International Graduate School of African Studies (BIGSAS) at the University of Bayreuth for financial support and their promotion of junior fellows researching African studies.

## Funding

This research was funded by the Bayreuth International Graduate School of African Studies.

## Conflict of Interests

The author declares no conflicts of interest.

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Social Inclusion
2024 • Volume 12 • Article 7404
https://doi.org/10.17645/si.7404

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# Implementing a Senior Community Care Model: An Italian Top-Down Cohousing Project and Nursing Home

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**Submitted:** 17 July 2023 **Accepted:** 13 November 2023 **Published:** 25 January 2024

**Issue:** This article is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

## Abstract

Not ageing in place is an increasing reality for many older Europeans. For several decades societies have applied different care models in developing initiatives to provide safe and age-friendly spaces. This article presents the community care model implemented by the Italian service provider ISRAA in Treviso (Italy) in one of its nursing homes and senior cohousing projects. The aim of our study was to analyse this senior community care model and find out how residents have responded to it. Participants were both the older adult residents in the two ISRAA facilities and professionals responsible for their social attention. A qualitative methodology was used: questionnaire, interviews, and focus groups with professionals and care facility residents. Results reveal the care philosophy implemented, residents' experiences, the main barriers to creating a community, and how this model could be improved by following community development principles, with the older people's help, participation, and engagement. The conclusions highlight the importance of applying principles of self-determination and social inclusion in a preventive care model for the senior community. In addition, a key factor in promoting community development is for professionals to act as community development practitioners and to allow older adults to be part of the change.

## Keywords

ageing; care; cohousing; community; community care; elderly; gender; nursing home; social inclusion

## 1. Introduction

This article addresses the topic of community development within a residential care setting for older people to support their well-being. The rise in life expectancy and subsequent increase in the population aged over

65 in European countries (Corselli-Nordblad & Strandell, 2020) calls for actions that maintain individual well-being for as long as possible. This consideration is particularly relevant to the Italian case. In Italy, 21.4% of the population are aged over 65, of which 7.7% are over 80 (ISTAT, 2022), making it the country with the oldest population in Europe (EUROSTAT, 2023). In this article we refer to the concept of community development both "as a participatory process by which communities of place, identity or interest grow and change; [and] as a practice of stimulating and supporting communities to participate in change" (Banks et al., 2023, p. 2). According to Kam (1996), in response to the social and political changes in contemporary society, a community work approach can be a useful way of transforming old people from passive clients into active and empowered individuals with a positive self-image. It is effective in strengthening older people's contact with the community, eliminating their negative self-image, protecting their rights, and increasing their capacity to influence policymaking.

Considering older adults as active members of society and providing them with the tools (spaces, networks, activities) for their inclusion in social life are crucial elements to consider in social care prevention policies. In this regard, new housing environments are required for the ageing population that invest in preventive solutions, self-care, and rehabilitation within the community (Pennestrì et al., 2022). A related issue to consider is the public perception of care and residential facilities for older adults, such as nursing homes. These institutions still carry a stigma in our societies and are considered oppressive, dehumanising places detached from the surrounding social context, often exclusively associated with illness and death. Similar stereotypes are frequently extended to residents, who are perceived as physically or mentally impaired, disabled, ill, unproductive, inactive, isolated, and unmotivated (Dobbs et al., 2008; Kornadt & Rothermund, 2011). A paradigm change is needed to reverse this way of thinking, which first implies challenging the taboo associated with old age. Change must come from a political position that coordinates a network where the public, the private sphere, and the community are woven together to promote shared responsibility (Martínez-Buján, 2019).

An increasingly viable alternative to the problem of social exclusion is cohousing, understood as "a form of community living that contains a mix of private and communal spaces, combining autonomy and privacy with the advantages of community living" (Riedy et al., 2017, p. 1). The cohousing approach has been implemented in northern Europe since the 1980s (Pedersen, 2015) and involves a way of living both "apart and together" (Brenton, 2013). According to Durrett and McCamant (1988), one of the main characteristics of cohousing is the presence of collaborative lifestyles and a democratic, non-hierarchical decision-making process. These authors are referring to bottom-up cohousing, which are communities created, designed, and managed by their residents (Arrigoitia & Scanlon, 2015; Riedy et al., 2017), often with shared values or based on a commitment to a central ideology (Korpela, 2012). However, not all cohousing in Italy has this structure. According to Durante (2011), cohousing is an umbrella concept that includes a variety of experiences (*condomini solidali*, ecovillages) previously embedded in different categories, which were incorporated into this concept once "cohousing" became a buzzword in public discourses on housing and social policies. Considering this, the experience we present here is a top-down cohousing or "institutional mediation cohousing," a term used by our informants. It refers to a place where the residents' opportunities for choice and autonomy are reduced to a minimum, that is, all the main decisions on forming the groups, participatory planning, legal assistance, and building the community and its rules are mediated by the institution that guides and oversees the constitution of the cohousing (Bianchi & Roberto, 2016). This is the type of cohousing managed by the Italian service provider ISRAA (Istituto per Servizi di Ricovero e Assistenza agli Anziani), which we discuss in this article.

The objective of this article is to present, discuss, and analyse the senior community care model implemented by ISRAA using the findings of the AGORAge: Ageing in a Caring Community project, based on the following notion of community as a reality that necessarily requires people's participation in one or several processes, a participation that generates elements or psychological components of identity or belonging (Zuñiga Ruiz de Loizaga & Arrieta Frutos, 2021).

### 1.1. From the Community to Community Care

This research is framed within the concepts of community and care, which we introduce separately before analysing them together under the concept of "community care."

The concept of community has a long theoretical history in the social sciences and has been used as an analytical category in many studies since the 19th century. One of the first notable contributions in this respect is that of the German sociologist F. Tönnies (1887/1979), who distinguished between the concepts of community and society. Community, he argued, was mainly found in limited social spheres (family, neighbours) and was characterised by the coincidence between "individual will" and "collective will," while society was based on the domain of "arbitrary will," a mechanical formation in which individuals are not linked to each other (Galli et al., 2005). Subsequently, other authors have focused on the relationship between community and solidarity, highlighting the difference between mechanical solidarity, typical of so-called simpler societies, and organic solidarity, typical of complex societies (Durkheim, 1893/2016); or on the holistic character of the community as a "human whole" where members live for and as a result of the community (Redfield, 1965).

Throughout the 20th century, the community became a classic object of study in anthropology, initially within the framework of the colonial model, centred on the primitive/indigenous–civilised binomial, and then turning its attention to peasant communities (Trapaga, 2018) or, in the Italian context, to the subaltern population (Cirese, 1973; De Martino, 1949).

With the rise of feminism from the 1970s onwards, people began to speak of community in different terms, breaking with previous oppositional categories and binding the concept of community with that of care. Domestic work and the naturalisation of women's role as carers were debated (Dalla Costa, 1972; Gerstein, 1973), and the community began to be critically considered as a vertical space that helped to reproduce the subaltern position of women (Vega Solís et al., 2018). Care eventually became an analytical category linked to Marxist feminist studies that postulated the centrality of women's role as reproducers of the labour force, essential for the development and sustenance of the capitalist system (Federici, 2004).

In this article, we refer to the concept of care as the set of practices necessary to sustain life, that is, the physical and emotional well-being of all people in any social context (Pérez Orozco, 2014). Talking about care implies talking about a system of provision, and we are interested in knowing how the community is positioned in this respect. In the care diamond model (Razavi, 2007), devised by feminist economics to identify the institutions involved in providing care, the community is already partially included through its identification with the non-profit sector (which includes voluntary and community provision). However, recent studies propose replacing the figure of the diamond with that of a pentagon, identifying the community itself as one of the key elements, in addition to the state, the market, the third sector, and the family (Zuñiga Ruiz de Loizaga & Arrieta Frutos, 2021).

Following this premise, our research is framed within the concept of community care as a heterogeneous set of practices that involve different actors and different degrees of commitment. These practices may refer to self-managing processes, to the extended family, or the collaboration with or intervention of institutional services provided by the state or by private organisations (Vega Solís et al., 2018). Specifically, community care can be related to the material dimension (which includes maintenance and provisioning tasks), the relational dimension (relating both to accompaniment in difficult moments and to sharing moments of socialisation), and, finally, the domestic-corporal dimension (which involves direct contact with the person and assistance; (Bodoque-Puerta & Sanz Abad, 2021).

### *1.2. Context*

Borgo Mazzini Smart Cohousing (BMSC) began with an open consultation launched by the service provider ISRAA in 2014 to collectively explore social and architectural possibilities with the citizens of Treviso. This initiative was aimed at members of the population aged between 65 and 80 who still lived independently, and intended to offer an alternative solution to nursing homes that would combine a high level of autonomy with soft support and protection provided by the organisation. The cohousing model was therefore identified as a model that could reconcile these instances and, within this framework, the community dimension was seen as a key feature to counteract isolation, encourage forms of mutual support and care, stimulate active participation, and help to sustain mental and physical well-being. The project saw the light of day in 2018 and the cohousing facilities currently consist of six restored historic buildings, which residents and professionals call "houses," each one divided into single apartments and equipped with common spaces. The buildings are in an area of Treviso's historic centre named Borgo Mazzini, from which the cohousing takes its name. From an architectural point of view, BMSC can therefore be defined as "diffuse cohousing," since it consists of several properties distributed across the area, only some of which are spatially contiguous. ISRAA also has extensive experience in service and assistance provision to older adults and in senior care facilities, and currently owns four nursing homes in Treviso. Casa Albergo (CA, a guesthouse) is one of them, based in the city centre in the same area where cohousing is located, home to 167 residents, 42 of whom have some degree of dependency. CA and BMSC are currently involved in a plan of progressive integration in the surrounding area, with the dual intention of creating a living environment that is welcoming and caring for older people even outside their walls and facilitating the spread of a new representation of ageing, also conveyed through the use and experience of spaces. With this in mind, three newly renovated rooms in one of the cohousing buildings will be made available to the public, aiming at putting the bases for the creation of an extended neighbourhood community.

## 2. Methodology

The methodology was mainly qualitative. Participants were the older adult residents in ISRAA's facilities and the professionals responsible for their social care (see Tables 1 and 2 for the sample details). Fieldwork was carried out from September 2022 to January 2023. The research techniques selected were considered optimal to meet the objectives. The following activities were carried out:

- Six semi-structured interviews (Int) were conducted with older residents to explore their experiences and sense of belonging to the neighbourhood, their relations with the other inhabitants, and the reasons why they chose to live there. The selection was based on a preliminary open questionnaire administered to 13 CA and BMSC residents, which provided us with general information on their relationship with the neighbourhood, their socio-biographic backgrounds, and their disposition to be interviewed. The interviews were conducted by one of the authors who works at ISRAA and had come into contact with the residents previously. This was an advantage, as the interviewees felt confident enough to talk because she was familiar.

- An open questionnaire (Qp) was administered to five ISRAA professionals to learn their views on the relationships between the people living at CA and BMSC, the impact of Covid, and the residents' activities both inside and outside the two facilities.
- A focus group (FGp) was set up to investigate the ongoing process of building a community incorporating CA, BSMC, and the neighbourhood. The four ISRAA professionals who participated—a psychologist, a community nurse, an educator, and the CA coordinator—were selected as they had the most contact with users. It was conducted by two of the authors.
- A focus group with eight residents (FGr) from CA and BMSC was conducted to discuss the bases for and barriers to creating a caring community. A community map was used as an operational tool to introduce and address the link between spaces and relationships. The map represented the area of Borgo Mazzini and contained only the main topographical elements, such as the names of streets and squares, and the principal landmarks. The intention was to provide a neutral instrument so as not to influence the participants, who were invited to indicate their points of reference, such as the commercial and recreational establishments they frequent as part of their daily itinerary, or the places where they feel comfortable and like to spend time.

**Table 1.** Characteristics of the residents' sample.

| Code | Age | Place of residence | Activity |
|---|---|---|---|
| Res 1 | 80 | Cohousing | Interview |
| Res 2 | 75 | Cohousing | Focus group |
| Res 3 | 81 | Cohousing | Interview, Focus group |
| Res 4 | 79 | Cohousing | Interview, Focus group |
| Res 5 | 75 | Cohousing | Interview |
| Res 6 | 84 | Nursing home | Focus group |
| Res 7 | 80 | Nursing home | Focus group |
| Res 8 | 84 | Nursing home | Focus group |
| Res 9 | 86 | Nursing home | Interview, Focus group |
| Res 10 | 86 | Nursing home | Interview, Focus group |

**Table 2.** Characteristics of the professionals' sample.

| Profile | Sex | Age | Years working at ISRAA | Activity |
|---|---|---|---|---|
| Community manager | Male | 30 | 3 | Questionnaire |
| Community nurse | Female | 47 | 17 | Questionnaire, Focus group |
| Professional educator | Female | 35 | 7 | Questionnaire, Focus group |
| Facility coordinator | Female | 54 | 5 | Questionnaire, Focus group |
| Psychologist | Female | 49 | 13 | Focus group |
| Trainee | Female | 20 | 2 months | Questionnaire |

### 2.1. Ethical Considerations

The research was conducted in accordance with the Declaration of Helsinki for human research of the World Medical Association and was approved by the ISRAA data protection officer. Participation was voluntary and participants were previously informed about the purposes of the study and gave their informed consent to participate. The data collected were anonymised to protect their identity.

### 2.2. Analysis

A qualitative approach was taken to collect narratives from the interviews and the focus groups, all of which were digitally audio recorded, transcribed in Italian for text-based analysis, organised, and coded (Leavy, 2014; Taylor & Bogdan, 1987). Participants' discourses were analysed inductively by all three authors in regular team meetings. Users' and professionals' opinions were differentiated and crosschecked to ensure consistency. One of the authors had previously constructed categories according to four main variables: motivations for moving to ISRAA's facilities, inside and/or outside relations and activities, community conception, and barriers to creating community. The same author pre-coded (Saldaña, 2009) the narratives by isolating quotations related to the main research objectives to identify patterns and similar experiences and opinions. Then, after sharing with the other authors and receiving their feedback, a second round of coding was carried out to collectively produce a conceptual framework for further analysis. This method of analysis allowed us to compare perceptions, identify relevant common and differing issues, and obtain a comprehensive understanding of the data to reach general conclusions. The quotations used have been translated into English for this article.

## 3. Results: ISRAA Philosophy of Care

### 3.1. Choosing a New Life Project

The process by which people access a care facility is important to understand further community building and development. In the case of ISRAA's facilities, this procedure involves two meetings: The first is between the future resident and the social worker and addresses mainly formal aspects; the second involves the whole team and assesses the person's existing autonomy and suitability for access. The accommodation is then assigned, and the future resident can spend a month in the facility to find out if this new reality is what he or she is looking for. Right from the start, the fact that the person is embracing a new life project is considered, but it is also made easier for the person to understand whether they might feel at ease in this setting:

> What we always say, and what I say every time I make an assessment, is that this doesn't want to be a place where you lock the door and throw away the key. We have a lady who stayed with us for a year and a half, and then she decided that it was no longer for her. She took a flat nearby, she comes to have parties with her friends here. (Educator, FGp)

The educator's words go to the heart of the idea that living in ISRAA's care facilities is not always for everyone, and it is not necessarily a permanent arrangement. For this reason, they are given the chance to experience the project and ascertain whether it suits them or not. There are several reasons why people decide to move into one of ISRAA's care facilities. As mentioned above, a minority of residents have some degree of dependency.

Other people apply when their partner passes away or when they realise that they no longer want to or can manage a home on their own:

> I don't have any relatives, so I came here because I had 25 stairs to climb, I had a big house with a garden, and I wouldn't have changed it at all. It was just that, suddenly, I realised I wasn't drinking wine anymore because it was too heavy to carry up, I was throwing the sheets out of the window to wash them, I was limiting what I did because I was starting to struggle [to climb the stairs]. (Res 3, FGr)

In this regard, the ISRAA professionals are keen to point out the importance of older adults' autonomy, understood not only in the physical sense but also in terms of decision-making. According to one respondent, "the institution is not the panacea for all ills; it's an institution made up of people, where there may be errors; but there are not only requests to solve problems, we also sit down together and solve them" (psychologist, FGp). The involvement of the subject in decision-making and the expectation that the person is willing to cooperate is therefore the basis of this new experience of life.

### *3.2. Key Elements of the ISRAA Senior Community Caring Model*

Giving a voice to older adults and caring for their well-being in a broad sense are key elements for the ISRAA staff, who emphasise the need to spread what they call the philosophy of care. This expression underlies the concept of what the team understands by caring: "Learning to go beyond labels, caring absolutely, with kindness, with compassion, with a genuine acknowledgement that there is suffering, because sometimes there is a lot of it, but also with the genuine willingness to alleviate it" (psychologist, FGp). The idea is to understand care from different perspectives, including above all the notions of empathy, sensitivity, proximity, and inclusion. In this framework, the person must be placed at the centre:

> We are not talking about older people, but we are talking about people who are cultivating their own life projects and their own autonomy. We are there and we are part of their life project choice, but to the extent that they want to include us. (Educator, FGp)

It is crucial to bear in mind the importance of interdisciplinary collaboration and trying to understand the needs of older people in a broad sense, as they have "not only health care needs" (psychologist, FGp), but also social, emotional, or material needs. As a result, part of the professional work is to personalise the attention to and care of the person, as expressed by one of the nurses:

> If I do an activity and [only] two people take part in it, but those two people like it...then the activity continues. That's how it is, at least I really feel free to make proposals....That's certainly because this is an organisation that allows us to do that. (Nurse, FGp)

Even though the residents of a care facility tend to be perceived as a group, as a community, they are individuals, each with their characteristics, habits, thoughts, and plans. This is important "because, in a nursing home, it can happen that you lose sight of the fact that everyone is a person, a unique individual" (educator, FGp). Providing several kinds of activities and giving residents the chance to choose or propose what they would like to do is another important part of the philosophy of care, as highlighted by the coordinator:

> On the one hand, there are the activities proposed by ISRAA; on the other hand, the idea is to accommodate the wishes of the residents and support them, so we offered gym classes with a teacher who we paid for a couple of months and they liked her, so they started paying her directly, self-managing [the activity]. The third kind of activities are those managed in a completely autonomous way. (Coordinator, FGp)

ISRAA thus proceeds by proposing activities and carrying them out when they receive a positive response from the residents, sometimes even pushing for autonomous management (especially in the case of the cohousing), and acting as an incubator for spontaneous proposals from the older people themselves. To support encounters between residents, activities are open to both CA and BMSC residents, regardless of where they take place.

### 3.3. From Inside to Outside: Opening the Community to the Neighbourhood

Ideally, this philosophy would not be limited to ISRAA spaces but extended to the whole neighbourhood in which these people live, through processes of integration, interchange, and collaboration that enable older people to maintain a role and be recognised in society. In this respect, the work on the community map showed that there is already a connection between residents and the surrounding neighbourhood, as expressed in the following quotation (Res 7, FGr):

> Researcher: Why do you go to this pharmacy and not the other one [which is closer]?
>
> Res 7: Because I knew her mother and her grandfather and I get attached to people; now her daughter is there. She is also close by, logically, but yes [the reason is that] I know everyone.

It is also interesting to note that several points of reference are located within the CA and BMSC premises, such as the terrace or gardens where they like to sit and chat. A continuity between inside and outside can therefore be detected in the residents’ individual geographies. In this regard, the location of the housing is of great value to residents, as it naturally facilitates contact with the neighbourhood:

> [The street where we are] is the centre of all the events: cycling, marathons, carnival, market. Everything starts from here and we thank God that we are in a central place. (Res 6, FGr)

However, the relationship with the surrounding area is not limited to these locations. Some members of the care facilities’ communities are involved in weekly activities with the neighbourhood shopkeepers, as explained by one of the professionals:

> And that’s why we’re grateful to the girls in the bar opposite, who allow the lady to go and clean the tables. Because this lady is so happy to clean the tables. And then, let’s say, indirectly some of us [referring to ISRAA professionals] go there for a coffee, and thank the girls or ask: “I haven’t seen that lady [referring to one of the residents], how is she?” Even if this seems like a very basic thing, this is important. (Psychologist, FGp)

Interaction with the territory also involves proposals put forward by the residents themselves. For example, in the winter of 2022, a group of BMSC residents decided to make figures for the nativity scene together with a professional painter and a craftsman. A procession through the neighbourhood was organised by one of the residents:

> My intention is to start at CA [with the 14 nativity scene figures] with people who want to come, including those in wheelchairs. Then we'll go to the garden where the nativity scene is set up. (Res 3, Int)

The garden she talks about belongs to one of the cohousing buildings and is open to the public.

By encouraging an open, dynamic community that is integrated with the surrounding neighbourhood, the ISRAA staff are aiming to break down stereotypes of care facilities as bleak places of suffering and isolation. The intent behind this approach is therefore to build a caring community encompassing the CA, the BMSC, and progressively, the surrounding neighbourhood.

## 4. Residents' Experience

### *4.1. Basis of a Community*

Any discussion of caring communities must be based on an understanding and interrogation of the concept of community in relation to the nursing home and cohousing.

According to the nursing home residents, the daily sharing of activities and routines is what makes them feel part of a community the most. As one resident puts it: "You eat together every day. You're together every day" (Res 10, Int). But this does not mean that residents have to associate with everyone. In fact, the formation of subgroups in a community and an unwillingness to accept new members seem totally normal, especially when it could be interpreted as a "forced" community since people have not chosen to live with each other, as in the case of our study:

> Afterwards, you choose them [the people], we are a little group. We chat and play cards. There was this lady who wanted to join our group, with the three of us, and some of us didn't like her so much. I said "let's try," and she is so much fun. (Res 10, Int)

Socialising is, therefore, another fundamental element of a community; in this regard, some people chose to live in the nursing home because they knew they would be able to establish relationships there, as one resident pointed out: "I came here to feel good, to meet people, to do cultural things, to socialise" (Res 6, GFr). There are others who do not necessarily need continuous interaction: "I don't want any obligations either way. In a nutshell, as many pleasures as you like but nobody too clingy" (Res 9, Int). In spite of this, the residents recognise the institution's efforts to encourage a community through numerous proposals: "There are courses, shows, birthday parties I take part in....It's a community" (Res 9, Int). Some cohousing residents were also positive about how stimulating they found the place, as manifested in the following quote: "There is life. Me, coming from a place where there's nothing, here I've got a new life because I like people, I like to talk" (Res 2, GFr). A similar sentiment was shared by another resident: "Here I have more life because they involve you and I let myself be involved. Everything they do interests me and I go see it" (Res 4, Int).

In sum, the numerous organised activities, the chance to socialise, and the everyday life in a care facility (in the case of CA) may be considered key elements for developing a community.

### *4.2. Barriers to Creating a Community*

It is important to note that we found discrepancies between the CA and BMSC residents, starting with differences in the types of users:

> People in the cohousing were not people who had thought about moving into a nursing home, or who had to make a choice that conflicted with the stereotypes held by their family and friends. With them, we began a project to explore slightly different methodologies related to community development, and we started from the question of desires and commonalities. (Coordinator, FGp)

Thus, the idea of community is experienced and perceived differently in the two living contexts. The sense of community within the nursing home seems to be more evident and deep-rooted, as these people live within the same context, have room neighbours, have meals together, and carry out activities on the premises. Community, therefore, comes out of everyday practices. In this regard, the CA staff provide the conditions for the residents to create ties, some closer than others, both with the other residents and with the professionals, although this inclination to create bonds also depends on their health status and their personality, as one of the employees pointed out: “In general, people with a higher level of autonomy and prosociality manage to establish more positive relationships with other residents” (community manager, Qp).

The cohousing inhabitants, on the other hand, were less enthusiastic about relationships in the facility, complaining that many people are not interested in participating in community activities, as reflected in the following quote: “There are people who don’t participate and don’t even look out of the windows” (Res 4, Int). They also point out the lack of frequent relations: “Regarding the kind of relationships we have, I would say they are very good, because when you get along it is good, but you don’t really hang out that much” (Res 1, Int). And, finally, some expressed disappointment:

> For me, cohousing is small blocks where we try to live together to perhaps recreate the relationship we had elsewhere, for example, like the one I had where I lived before for forty-four years, that is difficult to replicate. (Res 3, FGr)
>
> In June we went for a week at the seaside…there were eight of us. We left in two cars, we were happy, so much so that after coming home I was sorry because [there] you were eating together, then you sat outside for a while, then someone went for a rest, then you were on the beach in the evening.…But in short, when you’re here, you’re alone (Res 5, FGr).

The data we collected show that some people did not find the community they were looking for in this model. They may have met new people to spend time with and do activities together, but they do not feel like a community in the place where they live. Other people are content to live in a place that offers certain services and care, but basically continue to have the same life they had before; in other words, they may not be interested in being part of a community, or may not have the time to devote to community building, as one of the residents commented: “We struggle because those who have the head for it [referring to community building] have so many commitments” (Res 5, Int).

In addition to the complaints related to the differences in residents' needs, some residents noted how the spread of Covid-19 had slowed down the community-building process initially envisaged by ISRAA. This is not only due to the forced isolation, but also because the people who initially moved to the cohousing were severely affected by the side effects of the pandemic, as highlighted by the following quotes:

> Covid was big trouble for everyone, but especially for an old person. It stole two years of our lives. (Res 1, Int)

> In these two years we haven't aged two years, we've aged five years. (Res 5, Int).

In other words, two years for an old person is not the same as two years for younger generations, and the impact of the pandemic was harder for them.

Moreover, one aspect that should not be underestimated, which was mentioned several times, is the lack of a place where all the cohousing and, potentially, nursing home residents could meet together. Some of the houses have taken the initiative to create their own micro-community, which the layout of the buildings and the shared garden allow for; this encourages contact between residents: "On Thursdays they play bingo in the other block, maybe because there are eight of them, which is quite a lot" (Res 5, Int). However, other housing blocks, also part of the cohousing, are more isolated: "There is no meeting point, no place, not even three benches arranged [next to each other]" (Res 3, GFr). This situation is currently being addressed as part of the renovation of a new section mentioned above, with three common spaces for the residents of all the housing blocks.

Lastly, both CA and BMSC residents would like to have more direct contact with the institution in order to express their needs: "What is missing is a person who can step in to see how it works, and what is needed" (Res 10, Int). Or they would like to be more involved in community building:

> For me it is not a community, not because [the buildings] are separated, but because they are not managed to be a community....For example, they could use the talents of [Res 4, who is an artist], they could even ask me [to help them in the management of some activities]. (Res 3, Int)

What emerged is the need to be listened to by ISRAA or to be able to participate directly in the construction of the care model.

## 5. Discussion

The study describes and analyses the senior community care model ISRAA implements in its care facilities. The model is intended to be an alternative to both the classic nursing home and the traditional bottom-up cohousing models, since it attempts to create a broader community encompassing the residential environments and, potentially, the neighbourhood community. The philosophy of care underpinning the work of ISRAA's professionals is based on the principles of self-determination and person-centred care and on a representation of the older person as a complex subject, not flattened by age or specific health conditions. This philosophy is reflected in the professionals' efforts to find solutions together with the residents. Their aim is to go beyond simply providing a service to a "user," by also proposing activities and initiatives that can contribute to increasing their quality of life and well-being in a broader sense (regardless of the number of people involved), and by motivating them to create new networks, thereby encouraging residents to be proactive and seeing them not as users or patients, but as individual people. However, implementing processes designed to change the structural conditions of a community always requires long lead times, engagement, and efforts, as well as constant negotiation, as it involves social actors with different characteristics, needs, and expectations.

As the results of our study show, not all residents feel part of a community. The simple fact that a group of people coincide together in a certain place does not make a community; someone needs to take charge of managing and reproducing the community. In this regard, Covid-19 certainly did not help, striking at the start of the community-building process, just two years after the cohousing opened. In addition, some of the residents involved in the process of cohousing ideation from the outset and who were catalysts of community-building dynamics have left. Moreover, not all the residents are genuinely interested in playing an active role in the community. Several people are satisfied with the daily care provided by the institution and the exchanges with other residents (however frequent they may be). Others recognised that being part of a community is not the main reason why they moved into ISRAA's care facilities.

Returning to Tönnies' (1887/1979) initial binomial, what may be happening here is that a group of people who used to live in society has moved on to live in a community (or an attempt at a community), in some cases trying to replicate—with little success—what Gardner (2011) calls the "natural neighbourhood network," and in others, continuing along the lines of their previous life based on a more individual than a communitarian model. There are also notable differences in the representation and expectations of the community between the cohousing residents and the nursing home residents. In CA the notion of community derives mainly from the practices and routines of living together and it is not put forward as a core characteristic of this housing solution. In contrast, the community dimension is a founding principle underpinning BMSC. In this regard, cohousing could, in part, be understood as a model of intervention developed to tackle social isolation and loneliness. Consequently, expectations about the community dimension and its centrality (perhaps more symbolic than practical) can differ significantly between the two contexts. This factor should also be considered when analysing the divergences in the residents' opinions.

One of the main problems that emerged is the organisation of the spaces, which is not conducive to residents doing shared activities together. Rather than a single building, the cohousing consists of several apartments that, although close to each other, are not in the same complex. Because of this layout, some people feel excluded from social life or consider that theirs is not favoured. In this regard, Keller Garganté and Ezquerra Samper (2021) highlighted the importance of informal encounters to community building, since cultivating personal relationships creates the necessary space to generate reciprocity and cement mutual support beyond formal mechanisms; this sometimes happens in the nursing home but not in the cohousing. Although the creation of new common spaces is a good starting point in this regard, the difficulty in building a community for the cohousing project may persist if these spaces are not, at least partially, self-managed by the residents with the support of the institution.

The senior community care model ISRAA is working towards could be improved by considering some key issues in terms of community development and citizen participation. The participatory process should always be contextualised and understood at different levels following the desires and situations of the people involved. For some of the residents who participated in our study, being part of a community and self-determination simply mean having the freedom to decide not only when and how to be involved in activities, but also having the choice not to actively participate in community building. In contrast, for other residents, "the sense of place and belonging is articulated through the availability and accessibility of facilities and opportunities for active living, social participation and meaningful involvement in the community" (McCall et al., 2020, p. 30). These people should be given the possibility to participate in community change. To this end, professionals should act as community development practitioners not only by encouraging and supporting the community to participate in activities but also to participate in the change by taking a cue from other collaborative housing initiatives, such as the Solidaria Cohousing in Ferrara (Durante, 2011), or the Santa Clara cohousing in Malaga, Spain (Keller Garganté & Ezquerra Samper, 2021) that, as self-managed cooperatives, take full responsibility for the management of spaces and services. Although residents often consider this aspect to be rewarding, they also find it very tiring and regard it as a job (Fernández Arrigoitia et al., 2023). In this case, the residents should not be burdened with all the community management, but they could be involved in developing and reproducing it, which would imply more direct contact with decision-making in the institution. For this reason, top-down cohousing offers a good opportunity to relieve residents of the burden of full self-management, while guarding against any regression into complete institutionalisation.

A first crucial step in this direction could be setting up a board of directors, or commission, chosen by the inhabitants themselves, which would consider the residents' needs and proposals and could act as a mediator with the institution. This community commission would oversee what García et al. (2021) called "gaseous" care, which involves the emotional management of individuals and the group, and the reproduction of the community. Finally, a closing note concerns the broader process of building an open community by gradually including the neighbourhood. Although among the residents of BMSC and CA the relationship with the surrounding area tends to be positive and several initiatives have been launched in this regard (some arising from the residents' own spontaneous suggestions), in practical terms this openness and integration has been only partially initiated. As a result, the idea of an extended community seems to be in its infancy and is probably still perceived as too abstract, especially by those living in CA, for whom the community is more a consequence of the living conditions rather than an expectation, as is the case for many older people living in the cohousing. Yet this model of community has now emerged as a goal, as a future development plan mainly overseen by professionals and by a small number of residents.

## 6. Limitations

It is important to state that the sample of older people involved in the study consisted exclusively of women. The main reason for this is the prevalence of women residents, which in turn reflects the higher life expectancy of the female population compared to the male population. This difference was to be expected, given the context and general demographic characteristics. The residents and staff also offered additional explanations for the predominance of women in the sample: firstly, men are far less inclined to get involved and take part in activities; and secondly, the professionals also attributed this lack of engagement to the poorer health or particular life conditions of the older men. Another limitation to bear in mind is the relatively small number of residents involved in both the BMSC and the CA, which obviously reflects just a partial view of the multiplicity and complexity of experiences, expectations, and opinions of the residents. A larger number of participants would undoubtedly have provided a broader and more multifaceted picture of the situation.

## Acknowledgments

We would like to thank all the people who participated in our research, especially the residents of Casa Albergo and Borgo Mazzini Smart Cohousing, and the professionals at ISRAA. Special thanks go to Yolanda Bodoque-Puerta, Verónica Anzil, and Mireia Campanera, members of the AGORAge project.

## Funding

AGORAge: Ageing in a Caring Community is one of the 10 pilots financed by the COESO: Connecting Research and Society project, which has received funding from the EU Horizon 2020 Research and Innovation Programme (2014–2020) SwafS-27–2020: Hands-On Citizen Science and Frugal Innovation, under grant agreement no. 101006325.

## Conflict of Interests

Author Adele De Stefani is an employee of ISRAA. She is employed in the unit devoted to EU projects and innovations and is not part of the team working at Borgo Mazzini Smart Cohousing and Casa Albergo. Her position in the organisation had no impact on the findings of the research but exclusively facilitated making contact with the target group during the fieldwork.

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**Social Inclusion**
2024 • Volume 12 • Article 7463
https://doi.org/10.17645/si.7463

**ARTICLE**

Open Access Journal

# Dancing With Care: Promoting Social Inclusion Among Older Women in China Through a Novel Preventative Care Model

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**Submitted:** 31 July 2023 **Accepted:** 13 November 2023 **Published:** 25 January 2024

**Issue:** This article is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

## Abstract

This article examines how a new form of preventative care provision—dancing with care (DWC)—promotes social inclusion among older women in China and explores whether DWC can be regarded as an effective way to address the challenges these older women face in improving their social inclusion and achieving a healthy lifestyle. Our study demonstrates that various dimensions of DWC play a vital role in addressing the difficulties these older women encounter in their struggle to end their own social exclusion: These dimensions include levels of happiness, social network involvement, access to social support in "preventative care terms", and the role of own's grandchildren as a means to social bonding. Various dimensions of DWC align with the concept of preventative care for older women in urban communities. Using semi-structured interviews in selected "DWC communities" located in southern China, this article demonstrates that DWC contributes to addressing older women's social inclusion by providing preventative care. In addition, we also performed an empirical data analysis that included institutional regulations for DWC design and implementation, publications by DWC communities, and academic research focused on DWC communities. DWC proposes an appealing path for older women to actively engage with and within their community. Furthermore, it offers valuable insights into the potential of a new model of preventative care and our conclusions will serve as a reference for enhancing social involvement among older individuals globally.

## Keywords

China; dancing with care; older women; preventative care; social involvement

## 1. Introduction

Community care for older adults has long been a point of contention (G. Huang et al., 2022). Specifically, conflict exists between policymakers and older people over care support, needs, and issues related to one's personal choice and possible arrangements within care service clusters, among specialists, and in light of available services in a community (G. Huang et al., 2022; Tomioka et al., 2016). Much of the recent discussion relates to the provision of preventative care for older people, particularly women (Jerliu et al., 2014); and while the Chinese government does support older individuals with preventative care at the policy level (National Health Commission & National Office on Aging, 2020), the demand for such preventative care services in China have augmented in the face of an increasingly aging population and in an effort to improve people's health and promote healthier lifestyles. At the same time, the impact of low fertility rates in China, a decrease in family size, and the three-child policy have increased the need for older women (as grandmothers) to assist with the responsibility of family care.

Due to the need for family care support and the expectation of intergenerational care services, from the year 2000 to 2022, many women over 60 followed their adult working children and moved to urban communities (Du et al., 2019; Liu et al., 2022). However, as newcomers with insufficient time and energy to rebuild their social networks, such women found themselves isolated in their new communities and passively excluded from their former familiar social network (Liu et al., 2022). They faced challenges to their own social inclusion and were hampered by feelings of unhappiness and loneliness, by health conditions that were often the result of age (thus with no pressing medical treatment), and this resulted in their exclusion from—and inability to create—social networks (Zhong & Peng, 2020). A usual strategy for improving this situation is addressing such challenges faced by older people through a social capital theory approach and the basic dimensions of trust, networks, and norms (Bourdieu, 1986; Gray, 2009; Norstrand & Xu, 2012). This article sustains the notion that social capital theory provides a pathway to deal with these challenges; grounded in the Chinese context, it provides an alternative theoretical basis on which to establish a new model for preventative care provision to foster older women's energy and keep them relatively involved in their community and potential social networks.

The article promotes a new form of preventative care provision—dancing with care (DWC)—and examines how this enhances feelings of social inclusion among older women in Chinese urban communities. In exploring whether DWC is effective in promoting a healthy lifestyle for older women, we will specifically emphasize the following dimensions: (a) levels of happiness and (b) social network involvement, (c) access to social support for preventative care services, and (d) the role of own's grandchildren as a means to social bonding. The article will first present the background upon which DWC developed in China (Section 2), followed by the analytical framework (Section 3) and method approach (Section 4) used in our study. The empirical analysis (Section 5) presents the findings of this new design for preventative care provision and, based on the interviews, discusses the degree to which it could contribute to older Chinese women's social inclusion in urban communities. Section 6 is the conclusion.

## 2. The Past and Future of DWC

The concept of DWC was developed based on early definitions of "community care," such as those put forward by the Chinese Social Welfare Department and the Chinese Quality of Life Programme (Lee et al., 2018; Tang, 2015; Xu & Chow, 2006); it is also closely aligned with concepts described in the United Nations Convention on the Rights of Persons With Disabilities (Wu et al., 2019). Broadly speaking, community care (a) involves an accommodation that is adequate, appropriate, and accessible to the individual in need of care, from a range of options ordinarily available to the wider population; (b) enables individuals in need of care to choose where they should live, with whom, and how, at least to the greatest possible extent; and (c) finds the resources for them to successfully participate in their community (Tang, 2015). Drawing from these basic principles, a new care-friendly community service for older people emerged in China that established preventive care as its key area of intervention (National Health Commission & National Office on Aging, 2020) and found in *dancing* a means to promote healthier lifestyles.

The basic aim of preventative care is to identify and deter health issues from developing and thus promote early disease prevention, which is more cost-effective than medical treatment (Maciosek et al., 2017). Preventative care services include general physical examinations and selective programs designed to detect illnesses in the population (Wang et al., 2019). Some preventative care services are fully funded by government budgets, whereas others are treated as an integral part of disease management regimens and are covered by medical insurance schemes (Maciosek et al., 2017; Wang et al., 2019). In China, literature has shown that the promotion of preventative care also influences the use of preventative care among the population (C. Huang et al., 2016; Lee et al., 2019), which prompted the Chinese government to promote DWC as a new model of preventative care provision in urban communities to improve older people's health and, we argue, enhance their social inclusion (see also Mi, 2016).

Over the last few decades, DWC has been a legal, openly organized preventative care practice (National Department of Sport, 2017a, 2017b). What we call "DWC communities" (communities that have embraced this practice) differ from traditional communities in that they can obtain financial support from local governments by organizing DWC competitions, which are a good way to encourage older people to engage with DWC while simultaneously promoting the practice. DWC communities and activities are encouraged and organized throughout China, particularly in South China, by the Chinese central and local governments (e.g., Ren & Liu, 2022). Participants usually join DWC activities in the form of nonprofessional dancing, such as folk, modern, street, and Latin dance, with high-decibel and rhythmic music, after dinner (National Department of Sport, 2017a). Participants may also join DWC activities and dancing schedules on weekends and during their leisure time.

DWC is believed to be beneficial to the physical and mental health of older people while contributing to remedying some of the difficulties that older people face, namely concerning their social involvement in the community and feelings of loneliness and unhappiness (Mi, 2016; Yang & Yuan, 2016). Such challenges notably afflict women and researchers have argued that regular participation in DWC activities may effectively reduce depression levels in postmenopausal older women (Gao et al., 2016). Specifically, physiological function, emotional function, mental health, and social function may be significantly improved in older women who take advantage of DWC practices compared to those who do not (Mi, 2016).

A second challenge women confront in old age is the lack of social networks. Reforming one's social networks in an urban community is especially difficult for older adults without effective social support as most are usually considered "neighbor strangers": Older adults may live close by to one another and in the same building but they hardly know each other (Yuan, 2019; Zhong & Peng, 2020). In addressing this obstacle, research findings suggest that older women who actively participate in DWC activities within their community receive more support compared to those who do not (Ou et al., 2022). Furthermore, it has been observed that older women with poorer healthcare conditions or greater potential care needs receive even more support within the DWC network (Yang & Yuan, 2016).

A third difficulty faced by older women is that they require preventative care but are sometimes unable to access effective community services. Older people with preventative care needs differ from those with other types of care needs (e.g., long-term care) as most preventative care does not require urgent medical treatment (Gao et al., 2016; Li, 2016). An analysis of the promotion of DWC has demonstrated that older people—and older women specifically—benefit from DWC "as preventative care" in that it satisfies their emotional needs, promotes continuous physical mobility, facilitates information exchange, and increases their sense of happiness in life (Yuan, 2019).

Overall, people have a lower chance of communicating and forming social connections in an urban environment (Zhong & Peng, 2020), but older women have reported that feelings of loneliness can be relieved by participating in DWC activities (Ou et al., 2022). For older women, DWC allows them to express their feelings with dancing partners (Yuan, 2019), which is another way DWC can be seen as an effective way to promote social communication within a community (Yang & Yuan, 2016).

As suggested in the literature, a useful approach to address challenges to the social inclusion of older women and ensure that their preventative care needs are met must involve the development of practices that intervene "as preventive care." This is the core objective of China's DWC (Ou et al., 2022; Yuan, 2019) and our detailed discussion will hopefully highlight the usefulness of this new form of preventative care and how it impacts social inclusion.

## 3. Analytical Framework

A central challenge for Chinese society is the rising number of older women moving into urban communities due to family care responsibilities, which often increases their isolation from past and potential social networks (MacLachlan & Gong, 2022). Based on social capital theory (Bourdieu, 1986), trust, networks, and norms have become basic dimensions in understanding the formation and use of social capital in today's society—and tackling social problems related to old age from the perspective of social capital theory is a common strategy (Norstrand & Xu, 2012). However, in China, social capital comprises a relatively stable social network that usually exists in neighborhood relationships until people's living patterns change (Meng & Xue, 2020). Older women moving into urban communities due to family care responsibilities, thereby removing themselves from familiar social networks and contributing to their own social exclusion, is an example of such changes in pattern (Shui et al., 2021). Nevertheless, we argue that the original three dimensions of social capital theory can help explain the challenges that older women face in achieving social inclusion and provide a new theoretical basis to respond to these challenges.

Social capital theory's trust dimension, for instance, asserts that older people may question their trust in unfamiliar people, especially in urban communities, due to a lack of efficient communication. Consequently, they tend to block themselves out from their community, which leads to unhappiness and social exclusion. The network dimension helps explain why older people may experience less social support because they lack an effective social network. The norm dimension helps explain how older people's use of social capital changes along with variations in their family members and the relationship they establish with one another, in particular the changing role of younger generations in the family.

Different aspects of DWC may align with these dimensions of social capital theory in how they address older Chinese women's feelings of unhappiness, loneliness, exclusion, and their inability to access community services. Our analysis, however, expands beyond a social capital theory approach and focuses on how DWC influences one's levels of happiness, social network involvement, and access to social support for preventative care services, as well as places grandchildren as a means of social bonding.

We primarily focus on DWC practices implemented in 10 pilot DWC community projects in the Anhui province and will discuss the degree to which DWC can inspire future Chinese preventative care provision models considering current challenges faced by older women and the results of establishing DWC in urban communities.

First, we measured whether access to DWC contributed to positive changes in happiness among older women and found that participating in DWC activities could indeed increase their levels of happiness if its design encouraged older women's participation; otherwise, it would be ineffective. Access to DWC as "preventative care" could be social network-exclusive if participation in DWC activities was selective (i.e., targeted at specific groups of local people or people within a certain social network) and strictly social background-tested (i.e., requiring continuous living experience in the community or as per the recommendation of other DWC participants); otherwise, it would be inclusive. In preventative care terms, social support concerns the extent to which older women feel assisted, both psychologically and personally; our findings show that women felt mostly confident of the support of their DWC companions, who provided them with practical, informal support, specifically to those with more urgent needs. A final aspect that we considered was how grandchildren can be a means to social bonding, since older women find in them a motivation to socialize with other DWC participants.

By looking at DWC as a means of preventative care provision, we question how older women's need for social inclusion can be met while accommodating their preference for remaining in an urban community, and with their families, for as long as possible. Our study does not focus on sustainable funding sources for Chinese DWC initiatives, which have been studied previously (Gao et al., 2016). Though all residents (including middle-aged residents) are encouraged to participate in DWC activities, most participants in DWC activities in our study were older women, mainly because the most prevalent form of DWC is dancing, which is more easily accepted by women than men in Chinese society (for a gender comparison see Yuan, 2019).

## 4. Method

In addition to the fieldwork (interviews), we also performed an empirical data analysis that included institutional regulations for DWC design and implementation—including government statistics and local regulations in the Anhui province (Isoaho et al., 2021) and academic research focused on DWC communities (e.g., Ou et al., 2022). The analysis included, when available, data on the prevalence of DWC communities in targeted provinces in China, the progress of DWC communities, any information on how (and how many) older women access DWC in their local communities, whether they receive any support by participating in

DWC activities, and to what extent the government or social organizations promote DWC activities. Data about China in the years 2017–2023 were collected and reviewed by a research team from Anhui Normal University. These researchers were asked to describe DWC communities in terms of size, form, organization, staffing, location, and participation. A template was used in the data collection to retain all data sources. These were carefully examined to assess, as much as possible, their internal consistency and locate any variations between different sources.

A series of in-depth semi-structured interviews were conducted with older women in 10 DWC communities in the Anhui province, South China (see Table 1). We used a snowballing approach in two cities—Wuhu and Hefei—to select these DWC communities (see also Bhutta, 2012). In Wuhu, officials from the Wuhu Civil Affairs Bureau were asked to recommend two DWC communities that met the following criteria: (a) were located within the jurisdiction of the selected city; (b) had official community documents supporting DWC activities and practiced continuous DWC activities for more than one year; (c) had at least one non-profit organization (NPO) joining the organization of DWC activities, lasted for more than one year, and had had continuous DWC activities in the past six months; and (d) had community staff and heads of NPO organizations who are willing to actively participate in the research. Interviews were then undertaken in a total of five selected/recommended DWC communities. Interviewers followed the same procedure in Hefei.

Fifty-five responses were included in the study. Those interviewed included eight representatives from official or government positions at the regional and local levels, seven community staff members in charge of the development of DWC, 39 representatives of DWC communities, and one academic (see Table 2). We contacted residents based on the following inclusion criteria: They had to be female and older than 60; had to be living in the community for at least nine months, have participated in DWC activities in the past six months, be able to clearly express their views, and be willing to participate in our research after understanding its purpose. With the support of community staff and NPO leaders in each community, we randomly selected residents who regularly participated in DWC activities via WeChat group: We divided users into multiple WeChat groups, deleted duplicate residents based on their usernames and avatars, and randomly selected 12 candidate residents. We then randomly selected one person from these 12 selected residents; if they refused to participate in our study, we randomly selected another one from the remaining 11 residents. This process was repeated until four residents were selected from each community.

Interviewers comprised well-trained university students with elevated interview skills and over two years of experience conducting resident interviews. All interview questions were prepared by the research team. The Declaration of Helsinki was strictly followed. The research plan was submitted to and approved by the Ethics Committee of the Anhui Normal University (AHNU-ET2023089). During the implementation phase, we respected the dignity and decision-making rights of each respondent, informed them of the research purpose in advance, and obtained their informed consent before conducting the research. We focused on protecting the respondents' wellbeing. As the main interview subjects of this study were older women, time and location were arranged following the respondents' requirements to ensure their convenience, privacy, and safety. In addition, when we interviewed 13 women aged over 70, community doctors accompanied us to answer any possible emergency; doctors didn't directly participate in the interviews and were on standby in the waiting room. No public health problems were reported during the interviews.

**Table 1.** Data collection from DWC communities.

| DWC communities | Location | Population (thousands) | Community description |
|---|---|---|---|
| WZY | Yijiang region, Wuhu | 24 | The community encompasses approximately 0.87 square kilometers. It is a relatively new community, established about 10 years ago, with mostly commercial housing and some resettlement housing. |
| WHC | Yijiang region, Wuhu | 9 | The community encompasses approximately 0.17 square kilometers. It is a relatively new community, established about 14 years ago, with commercial housing only. |
| WSH | Yijiang region, Wuhu | 4 | The community encompasses approximately 3 square kilometers. An old community, established about 30 years ago, it comprises mostly resettlement housing and some self-structured housing. |
| WXG | Jinghu region, Wuhu | 11 | The community encompasses approximately 1.1 square kilometers. It was established in 2006, with mostly commercial housing and some resettlement housing. |
| WFH | Jinghu region, Wuhu | 12 | The community encompasses approximately 0.7 square kilometers. It is an old community e,stablished about 30 years ago, with mostly resettlement housing and some self-structured housing. |
| HBH | Baohe region, Hefei | 8 | The community encompasses approximately 0.7 square kilometers. It was established about 15 years ago with all commercial housing. |
| HWG | Baohe region, Hefei | 7 | The community encompasses approximately 2.0 square kilometers. It was established about 21 years ago with resettlement housing and some self-structured housing. |
| HQL | Yaohai region, Hefei | 85 | The community encompasses approximately 20.1 square kilometers. It was established about 22 years ago, with mostly commercial housing and some resettlement and self-structured housing. |
| HWL | Yaohai region, Hefei | 11 | The community encompasses approximately 0.3 square kilometers. It was established about 18 years ago with commercial housing only. |
| HJX | Shushan region, Hefei | 17 | The community encompasses approximately 0.9 square kilometers. It was established about 30 years ago, with mostly commercial and some resettlement housing. |

**Table 2.** The interview respondents.

| Interviewee | No. | Average age | Female (percentage) | Average years involved with DWC | Chronic disease (percentage) |
|---|---|---|---|---|---|
| Officials | 8 | 42.0 | 37.5 | 14.8 | — |
| Community staff | 7 | 35.9 | 71.4 | 9.3 | — |
| Scholars | 1 | 52.0 | 0 | 19.0 | — |
| Older women | 39 | 68.9 | 100 | 6.7 | 51.1 |

Reports from each interview were prepared in Chinese, translated into English, and crosschecked using professional language editing services. The reports from the interviews were thematically analyzed and initially coded based on the following interview topic guide:

- What were the most impressive *changes* and *advantages experienced* by older women due to—and in their involvement with—DWC?
- What changes were there concerning older women's *social involvement*, including how they got to know more people, understand their community, and participate in other social activities with peers from DWC practice?
- What were the *care barriers*, if any, in the development of a community living? To what extent do peers from DWC help older people with *care needs* and share their experiences with examples?
- To what extent have peers from DWC contributed to *sharing* medical care *information* or utilizing medical services?
- Who or what were the facilitators of the development of DWC communities, in terms of government and policy?

Focus was placed on variations in the extent to which DWC contributed to the social involvement of older women in their community, as well as on the DWC dimension that was developed based on social capital theory.

Overarching themes and subthemes were identified for each of the listed topics. Three members of the lead research team focused on community living read and coded the reports, and all themes and subthemes were collated into one document (preserving the identification of each community). Any aspect that didn't immediately fit into one of the initial themes was also recorded along with quotations, in case it proved useful in illustrating any key points. The second and third authors collated all the subthemes for the final synthesis. Changes experienced due to support received from DWC practice was one of the topics for which most information was available; in such cases, themes and subthemes were summarized. Interviewees from the same community often raised similar themes, for instance, they usually mentioned that peers from DWC practice help older people with care needs and share their experiences. All quotations provided in this article are illustrative and respondents are not identified.

## 5. Analysis and Findings

### 5.1. Happiness

In our interviews, older adults were asked about their social interactions and levels of happiness before and after participating in DWC activities. Compared to their state of mind before they began participating in DWC projects, respondents reported a positive increase in happiness and provided significant examples. An older woman respondent said that the happiest time of her day was dancing with partners at DWC activities. For DWC participants, happiness is a consequence of sharing an emotional experience and finding someone to talk to:

> Happiness: I would not say it's a factor, but I can feel it when I am with my peers in DWC. No. I am not lonely, and I have someone with whom to share my feelings.

Another respondent, a leader in a DWC team, found that the happiness she felt after participating in DWC was extremely high, something she had seldom felt before:

> I organize the dancing team every evening and send messages about our arrangements through the WeChat group. This was the first time I felt I could do something meaningful that I liked. I voluntarily offer my support to team members facing difficulties.

Family care responsibilities that were being undertaken before respondents joined DWC activities continued well after that, and highly efficient family care work was profound in older women. One DWC participant expressed herself in the following manner:

> I was here [in the city] to take care of my granddaughter, for whom I had to cook and take to kindergarten because my daughter and son-in-law were busy. I felt exhausted by family work before DWC. Afterward, I found that many of my DWC peers shared similar experiences with me. I feel emotionally supported and see myself more positively, with better quality sleep.

This relatability increased their desire to participate in the community. Another participant stated:

> At first, I was afraid that they [DWC peers] would push me out. However, they are friendly with me. Dancing makes me have regular dinners and better sleep, and I feel happier and healthier [than before].

Dancing felt like a daily enjoyment, as one participant explains:

> My husband danced with me every evening. We both felt happy and healthy, as it was obvious that we did not need to visit doctors so often. I felt an unexpected relaxation....No, [dancing] is not a task; it is rather an enjoyment that we should have.

Respondents continuously reported positive experiences of happiness and health improvement. The reasons for this are complex, but key factors include their increased social involvement/connection, psychological support from their peers, and enhanced physical mobility. Some DWC participants even mentioned activities outside the DWC project such as nurturing the neighborhood’s cats or scheduling online shopping, which had a strong impact on their feelings of life satisfaction and self-worth:

> Sometimes, they [DWC peers] talk in the WeChat group about helping cats find their hosts and invite us all to save hungry lost cats around the community. I was happy to join them. I feel like peers in DWC were another family in which I could be recognized as a friend.

Older women had frequent contact with their neighbors because they felt happy about participating in DWC activities. During the interviews, many respondents regarded DWC interactions positively, which increased their desire to contact other people outside DWC practice, particularly neighbors. For example, a participant expressed:

> I refused to have more contact with neighbors because I felt isolated from these young people...but eventually, I helped our neighbor by treating their young boy to a meal when they had an emergency. I felt happy to help them, and we were not “stranger neighbors” from then on.

### 5.2. Social Network Involvement

A possible reason why happiness generally increased after participating in DWC activities is that respondents rapidly established a social attachment with their community through dancing. As a participant stated:

> People care about others and interact with them, so it is a reality that they can see. You can see it, in reality, every evening, outside the window in the summer, and even in garages when it rains, and in online chats.

As more and more older people joined DWC practice, most of them feels that it is easy to connect with their peers, as stated by DWC team member:

> We have new participants all the time, our dancing team has reached over 50 [people]. There were only 10 participants at the beginning….Although new members are not familiar with us, we come to know them quickly because [they] were one of our peers.

A sense of social involvement in DWC communities is established by the organization of extensive social activities by dancing members, as per institutional regulations for DWC design and implementation. In some instances, networks are formed that are quite extensive, and stable communities support the development of additional activities, which promotes far-reaching networks. As stated by one participant:

> It is possible to travel for a short time with peers in the dancing team, as in one-day travels nearby on weekends. I feel safe doing so and we also have each other's backs when people face difficulties or challenges.

Social interactions vary according to the intensity of the interpersonal connection. Community organizations encourage older women to socialize by promoting a communal concern for each other's well-being; through DWC, older women are instilled with unprecedented confidence. One respondent, who expressed concerns after having moved to an urban community, acknowledged:

> Our community supports DWC and formed an organization by building community dancing activities. They [the DWC team] stated that this was a preventative care service for older people. I was included without difficulty and felt integrated with the DWC team members. I think [there was] an easy connection.

Communication through dancing activities forms a social bridge that strengthens the community, with residents being closely connected and sharing similar goals in their daily lives, such as improving their health and staying active. On the other hand, while residents were generally open-minded, their awareness of being included in the community and their desire to support others was also a reflection of institutional regulations. The aim of DWC communities is to improve older people's health through novel preventative care activities—like dancing—instead of forcing them to perform regular medical checks. Policies encourage older people to find psychological support by joining DWC projects while publicly proposing ideal social involvement expectations. However, respect for the individual's desire is maintained, as one of the representatives at the local level explains:

> Residents are free to join DWC and financially support [these activities] in the community, but we do not knock on people's doors to spread news or push them to participate.

One community staff member stated:

> We observed that most older women who joined DWC activities spontaneously found a suitable team by first trying to follow the music during or after dinner. Next, they engaged with the team, followed by further communication with other dance teams.

### *5.3. Social Support for Preventative Care*

A strong social involvement among DWC participants resulted in older women feeling supported and more confident in their daily lives. As a consequence, it became more common for them to support each other with regular health checks and while visiting doctors. One DWC participant stated:

> Members of the dancing team encouraged me to undergo health checks twice a year since I have heart problems. I felt supported and turned my negative attitude into visits to doctors, since I saw what they had done in practice.

This often resulted in direct instances of residents providing practical and informal support, particularly to those with urgent needs, as stated by another respondent:

> I suggested that our dancing members who are nurses offer blood pressure checks to peers in the DWC team….We all help each other out, and if I am not feeling fine, I can also phone some of them.

Support also varied from a psychological to a personal one:

> I was upset due to a health problem [and] doctors seemed to do nothing besides persuade me to rest….So it was friends from the dancing team who visited me and helped me with [my] terrible emotional conditions.

Some community staff also reported communicating with facilitators to improve the space allocated to DWC practice and promote preventive care activities:

> Our dancing space was organized by the community, but it was a blank square without grass. There was no outside light. We suggested that the Community Hall improve lighting and support us by building public exercise equipment residents could benefit from. Although it took them two years to do so, our DWC team members [now] have more options to exercise in the same space where we dance every day.

### *5.4. The Role of Grandchildren*

Caring for grandchildren is an important element within Chinese society, and older women in DWC communities engaged significantly with their peers by relating to each other's care work for the younger generation:

> Well, I send my grandson to school and bring him home after school every day, so I am familiar with other "grannies" who do the same. Sometimes, I go to the supermarket with other "grannies," as we both need to cook for our family.

Grandchildren also play a role in the social bonding of older women, with grandmothers either getting together when their grandchildren play outside or helping each other with picking up children from school. One DWC participant stated:

> [Two of us] organized a support schedule....All grandchildren were from the same kindergarten. Each of us is responsible for picking up two children every two days, taking them to the playground, and monitoring their safety. The other is responsible for cooking dinner. We take turns.

One DWC participant expressed the social value of including her grandchildren in her socialization process:

> I feel that my grandchildren give me an incentive to connect with others because many people do so. You just feel that you must. If you hesitate, people ask if you want to do so.

## 6. Discussion

### *6.1. A Supportive Agenda for Old Age*

As presented in the existing literature (e.g., Chen et al., 2021), DWC can be considered a key element in a supportive agenda for old age. Designed as a new form of providing preventative care support, it gives residents a high level of control over their lives. That said, it's important to acknowledge that, due to its structural design—specially geared toward older women—DWC is only available to residents with mobility. Consequently, residents with poor health conditions who require home care services are excluded. DWC is popular because it promotes the social inclusion of older women and helps maintain/improve their psychological health, instead of traditional preventative care models that only endorse regular medical checks and screenings. Although preventative care agendas have long been developed worldwide, the Chinese DWC concept is the first to offer both lifetime physical and psychological support concerning the health of older women in the Chinese context. Its popular Chinese name is *guang chang wu*.

### *6.2. Social Connection*

Participating in DWC activities can increase one's sense of belonging, improve life satisfaction, increase social trust, promote positive and healthy lifestyles, and improve social recognition among older women. These traits are also reflected in the "trust dimension" of social capital theory. Social interaction with dancing partners also promotes self-realization among older women, while improving their subjective well-being. In addition, older women rely on their peers in DWC to obtain emotional support and life information, which is conducive to alleviating loneliness, thereby reducing their psychological dependence on family members. The willingness of older women who participate in DWC to become involved in its social support network can redirect their need for support from their original family to society. This encourages them to interact with a single, pluralistic social network, thereby reinforcing the "network dimension" from social capital theory. Non-relative social groups or organizations, such as DWC, can provide emotional communication and psychological safety for older women, improving their life satisfaction and quality of life. Moreover, DWC helps form social connections with mutual care services, which differs from traditional healthcare and long-term care concepts. The "care" in DWC refers to preventative care attitudes, including both physical and emotional support, and participants of DWC are both care service providers and receivers in the Chinese context. Nevertheless, we argue that the development of this Chinese preventative care provision was somewhat influenced by the strong familial relations inherent to Chinese traditional culture. This could be regarded as the empirical practice of the "norm dimension" from social capital theory. This may explain why older women are willing to move to urban communities with their adult children to provide family care services for the next generation.

### *6.3. Social Activity and the Prevention of Disability*

Our analysis indicated that participation in DWC was necessarily associated with feelings of desire to participate in social activities. DWC seemed to infuse older women with a willingness to engage in social interaction and improve their physical and mental health conditions, which might decrease their chances of potential disability problems. DWC is sufficient to meet older adults' needs and maintain their sense of self-promotion, thereby avoiding the negative effects of self-exclusion. We observed that DWC participants rapidly developed a sense of being active while aging. This was a positive experience for most older women. Our analysis also suggested that the rapid formation of a sense of a DWC community was at least partly dependent on the fact that Chinese social policy supports this form of community development at the regulation level, while local governments promote development by positively implementing such policies.

The level of support experienced by the participants appeared to rely on their feelings of connection in the DWC community. Despite a general feeling of mutual concern for each other's well-being, it would not be accurate to say that all older women felt included in the DWC community. Our interviews revealed that older women were part of a constituent of residents who maintained a willingness to improve their health condition and decrease their chances of becoming disabled. These women often took the initiative to "involve" themselves in different ways in the DWC community. While DWC communities promote social cohesion and everyone looking out for each other, they are no substitute for urgent medical care services.

## 7. Conclusion

This study provides an overview of a new form of preventative care in China in urban communities—DWC. It aimed to explore whether DWC can be regarded as an effective way to solve the challenges that older women face in improving social inclusion and maintaining a healthy lifestyle. This study argues that different dimensions of DWC interact with those established within social capital theory, and contribute to the response to these challenges—which include happiness, social network involvement, social support for preventative care services, and regard of grandchildren as a means to social bonding—while adhering to the development of the preventative care that older women definitely need in urban communities. The findings reveal that DWC contributed to promoting healthy lifestyles of older women while exploring a new definition of preventative care. Specifically, it helped to promote happiness and social involvement, build support for preventative care service delivery, and regard grandchildren as a social bond. The DWC community contributed greatly to addressing older women's physical and psychological preventative care needs and desire for social involvement. DWC communities can serve as a reference for international community development and contribute to preventative care management in the future. However, this study also has limitations. First, it focuses only on one form of Chinese preventative care, DWC. Other forms of preventative care, such as brisk walking with care, should be explored in future research. Second, we believe that additional social groups, such as older men, middle-aged men, and middle-aged and younger people, should be included in future research of DWC. Gender differences should also be included in future research because it is important to explore the impact of gender on preventative care outcomes through DWC.

## Acknowledgments

We thank our student research assistants for their support in the data collection: Hui Zhu, Kong Teng, Junpeng Chen, Wenwen Yan, Jieyu Miao, Mengqi Long, Ziling Lu, Qianqian Zhang, and Meiyin Hu.

## Funding

This article was made possible due to funding from the National Social Science Fund (grant number 23BSH086). The role of this funding body is to support the design of the study and the collection of data.

## Conflict of Interests

The authors declare no conflict of interests.

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**Social Inclusion**
2024 • Volume 12 • Article 7448
https://doi.org/10.17645/si.7448

**ARTICLE**

Open Access Journal

# Preventative Social Care and Community Development in Wales: "New" Legislation, "Old" Tensions?

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**Submitted:** 28 July 2023 **Accepted:** 21 September 2023 **Published:** 25 January 2024

**Issue:** This article is part of the issue "Community Development and Preventative Care With Older People: New Values and Approaches" edited by Fiona Verity (Brunel University / Swansea University), Frances Barker (Solva Care), Mark Llewellyn (University of South Wales), Simon Read (Swansea University), and Jonathan Richards (University of South Wales), fully open access at https://doi.org/10.17645/si.i403

## Abstract

Prevention is becoming ever more central in UK care policy for older people, though precisely what this entails, and how it works most effectively in social care and support, remains ambiguous. Set against the "newness" of recent social care legislation in Wales, this article explores the perspectives of professionals on prevention and community development, particularly for older people. This draws on qualitative data collected from 11 Welsh local authorities, four NHS Wales health boards, and eight regional third-sector organisations, incorporating 64 interviews with directors, executives, and senior managers. Recent research has highlighted concerns over the slipperiness of prevention as a concept, resulting in multiple interpretations and activities operating under its banner. Consistent with this, our data suggested a kaleidoscopic picture of variously named community-based initiatives working to support the intricate web of connections that sustain older people, as well as provide practical or material help. Similarly, professionals highlighted varied agendas of community resilience, individual independence, and reducing the need for state-funded health and social care, as well as a range of viewpoints on the roles of the state, private sector, and the third sector. Analysis revealed fragments of familiar themes in community development; positive hopes for community initiatives, tensions between the mixed agendas of state-instigated activities, and the practical challenges arising from systems imbued with neo-liberal ideas. Realising the promise of prevention will require deft steering through these challenges.

## Keywords

ageing; community development; independence; older people; social care and support; social policy

## 1. Introduction

One of the four nations of the UK, Wales is a country of 3.1 million people (Office for National Statistics, 2022). As with other UK nations, and consistent with broader global trends, the proportion of this population aged over 60 years is increasing, being estimated to soon reach 30 percent (Older People's Commissioner for Wales, 2023). These demographic shifts have provoked urgent imperatives on how to meet current and future social needs for older people, particularly in a context where health and social care workforces and systems are under significant strain (Clifton, 2021; Welsh Government, 2023a). For Wales, these issues are further complicated by high levels of relative poverty and inequality, rooted in deindustrialisation and the decline of traditional heavy industries like mining and steelmaking (Best & Myers, 2019). The current UK cost of living crisis is also exacerbating the extent of these inequalities (Bevan Foundation, 2022), and the perceived strategic necessity of addressing the challenge, alongside Welsh labour government's policy values (Tarrant, 2022), have contributed to a renewed focus on prevention in social care policy and practice (Read et al., 2023; Welsh Assembly Government, 2011).

However, while recent UK-wide policy has emphasised prevention as one of its core tenets, research evidence from across the UK nations highlights significant variability in how this has been interpreted and enacted (Llewellyn et al., 2023; Marczak et al., 2019; Read et al., 2023; Tew et al., 2023). In England, for instance, Tew et al. (2023, p. 1) argue that inconsistencies in strategic implementation have been at least partially attributable to "the lack of any generally accepted conceptualisation as to what prevention might mean" in the context of social care. In Wales, Read et al. (2023) have established a slipperiness around the concept of prevention in social care policy, arguably contributing to the presence of "fused principles" around it. These principles encompass discourse over financial imperatives, cost-saving and budget reductions, together with values-based ideas such as encouraging independence, social justice, and a more general sense that prevention is "doing the right thing." The tensions emergent from the co-existence of different principles have implications for actors within local government seeking to further a prevention agenda in a context of devolved financial challenges (Ifan & Sion, 2019).

Devolution of powers from the central UK government has shaped public policy in Wales. The National Assembly for Wales was created in 1999 and renamed the Senedd in May 2020, after a series of interim legislative steps extended its taxation and borrowing powers. Devolved policy powers include health, education, housing, transport, and social services (Law Wales, 2021). Key to the approach adopted in devolved government has been avoiding considering any policy area in isolation from the others, for example, perceiving health, housing, and transport as interdependent domains of activity (Welsh Government, 2017, p. 13). Wales also has a strong history of community-led community development outside the state (Clarke et al., 2002). Working class solidarity and rural communities, together with the nonconformist religious movement, were major influences on community life and community development (Clarke et al., 2002) with mutualism and co-operatives having deep roots (Working Class Movement Library, 2023).

Since 1999 there have been various iterations of Welsh social policy to support community development, for example, initiatives such as Communities First (2001–2008) with its focus on poverty reduction (National Assembly for Wales, 2007). Successive Acts in Wales have prioritised well-being, co-production, and prevention as focal points of the reform of existing practice; two recent examples are the Social Services and Well-Being (Wales) Act 2014 (SSWBA; Welsh Government, 2014) and the Well-Being of Future Generations

(Wales) Act 2015 (Welsh Government, 2015). The SSWBA has an explicit focus on preventative social care, inclusive of community development, for example, support for place-based community programmes and community-owned initiatives and enterprises (Welsh Government, 2014). This emphasis is evident in other government strategies such as Age Friendly Wales: Our Strategy for an Ageing Wales, marked by language of empowerment and responsibility, with a focus on "independence, participation, care, self-fulfilment and dignity of older people," self-responsibility, and support "if needed" (Welsh Government, 2021, p. 2). Many of these concepts and terms originate from the 1991 UN Principles for Older People, now over 30 years old, demonstrating the longevity of this discourse around ageing in global and local policy (Office of the High Commissioner for Human Rights, 1991).

Much like the idea of "fused principles" and contested narratives around prevention outlined by Read et al. (2023) in relation to Welsh local authority practice, themes of contestation and obfuscation mark out community development more broadly, with tensions in values, agendas of state-instigated activities and local community actors, and "whose interests are served" (Mayo, 2008; Mowbray & Bryson, 1981; Pearce & Lohman, 2022; Shaw & Martin, 2000). Austin et al. write (2005, p. 404) that there is a need to "distinguish between community-based service delivery and community development"; they are different in genesis, processes, participant agency, and freedom to collectively imagine and act for change outside of prescribed boundaries. Moreover, there is a solid critique that policy language of "responsibility" and "community solutions" can move attention from structural level change as a priority preventative agenda (Austin et al., 2005; Ward, 2023).

Against this backdrop, this article explores professional perspectives on implementing the current Welsh government policy agenda on prevention and community development, as it relates to older people. In doing so, the complexity of these local arrangements, particularly in a context of financial challenge for state agencies, demonstrates a preference towards community-based care provision for this group. As outlined by the likes of Cockburn (1977), community working in the "local state" context has the potential to facilitate the growth of neo-liberal approaches in care and support, driven by notions of corporate management and alleviation of state responsibility (e.g., Mayo, 2008; Shaw & Martin, 2000; Ward, 2023). The extent that this is demonstrable in the Welsh context will be considered, amidst ongoing discussions of where preventative services are perceived best to sit, and how this is facilitated and evaluated at a local level.

## 2. Methods

Determining Best Preventative Social Care Practice (DBPSCP), the research study from which this article is drawn, is a Health and Care Research Wales-funded project exploring how preventative social care is understood and enacted across Wales. The SSWBA legislated for Wales to establish seven regional partnership boards (RPB), with these being the mechanisms by which health and social care integration would be managed across the country. As such the seven distinct regions incorporated statutory bodies from both health and social care: the 22 Welsh local authorities, the seven Welsh health boards, and the 22 community voluntary councils, with other third-sector agencies being involved with the RPBs in different regions. Each regional footprint generally consists of between one and six local authorities, one and six community voluntary councils, and one health board. In terms of policy implementation, these also sit in complex relation to other agencies, such as the RPBs in terms of health and social care, and public service boards (PSB) across other public policy areas, with statutory responsibilities shared and split between them.

For instance, each PSB is required to publish an annual local well-being plan specific to its locality (Welsh Government, 2023b).

The phases of research reported here incorporate four of the seven Welsh regions, with these, in turn, incorporating 11 Welsh local authorities, four NHS health boards, and eight community voluntary councils. The broader DBPSCP study has deployed additional phases of research establishing how service users and carers experience preventative services within their regions and local communities. Data reported here, however, are restricted to professional perspectives, stemming from an inductive, grounded theory exploration of how prevention was considered across the different regions, noting any variability or overlaps in definition and application, and how community development factored into this.

## 3. Qualitative Interviews

Data collection was conducted between May 2022 and January 2023 and consisted of semi-structured interviews performed and recorded over Microsoft Teams by the lead author. Interviews were carried out across all four Welsh regions (Localities A–D) and engaged with professionals working within that regional footprint. Regions were purposively sampled to reflect a range of sizes and organisations involved, as well as to incorporate both rural and urban settings. Participants within each region were also purposively sampled based on how prevention was interpreted at a regional and local level, with the key criteria being their involvement with strategizing or enacting preventative services. Participants were approached using previous contacts in RPBs as gatekeepers to establish contact over email, with information sheets outlining the DBPSCP study provided once this was brokered. Interviewees were split into two broad cohorts: those involved with RPBs and strategizing towards prevention at a regional level (cohort i) and those working at a local, managerial level within a health board, local authority, or third-sector organisation (cohort ii). Practically, the delineation of participants into these two categories means that there are considerable overlaps and variations between them in the types of roles performed. This is largely due to local variations in how systems and roles were organised. Generally, participants involved with RPBs (cohort i) were directors of social services, NHS executives, and senior representatives of community voluntary councils or other third-sector organisations. Those working at a local level (cohort ii) largely incorporated senior managers in health or social care, as well as senior professionals within community voluntary councils and other third-sector organisations. In total, 64 interviews were carried out across the four localities, as outlined in Table 1.

**Table 1.** Sample Size Split by Four Welsh Localities.

| | Cohort i | Cohort ii | Total |
|---|---|---|---|
| Locality A | 3 | 10 | 13 |
| Locality B | 6 | 12 | 18 |
| Locality C | 3 | 9 | 12 |
| Locality D | 3 | 18 | 21 |
| Total | 15 | 49 | 64 |

Interview schedules for both cohorts were developed to enquire about how prevention is understood and organised within each region, the types of initiatives associated with prevention for older people, how well these were felt to be working, and any barriers to implementing the preventative agenda. These were intended to take a semi-structured approach, with broad questions and follow-up prompts in place, conducted in a conversational style. The length of the interviews ranged from between 35 to 80 minutes, though the majority (56/64) were between 45 and 60 minutes.

### *3.1. Data Analysis*

Once completed, video recordings of interviews were converted to audio and transcribed. Transcripts were uploaded to QSR NVivo to assist with analysis. Analysis was performed in line with the inductive thematic approach of Braun and Clarke (2006) with a coding framework being developed over several iterations, and through ongoing group discussions within the research team. Though coding was predominantly undertaken by the lead author, dialogue between team members helped to validate coding interpretations, as well as highlight interdependencies between themes, and identify further amendments to the initial framework. Within this process, particular themes associated with the varying approaches to community development in each of the Welsh regions became more transparent, with this interlinking to how prevention was perceived locally, and how such approaches are funded and evaluated.

Additional validation activity was performed with the study steering group, designed to offer locally informed advice and guidance to the research team throughout the study's duration. The steering group was comprised of lived experience representatives in each of the researched Welsh regions recruited from local 50+ forums and was convened roughly once a quarter, though this fluctuated based on the demands of the study at particular times. The 50+ forums in Wales were established following recommendations from the Welsh Government in 2004. The intention behind them was to enable older people to have a representative voice in consultations with local authorities and other organisations (Caerphilly Over 50, 2023). The reported data was validated by a process of being presented to the steering group, feedback being gathered, and this ultimately re-informing the development of the framework. This process also offered the opportunity to open debate on alternative perspectives on how data were being interpreted.

## 4. Ethics

The research study was granted ethical approval by Camberwell—St Giles NHS Research Ethics Committee in February 2022 (REC ref no. 22/LO/0004). To ensure anonymity, participants have been identified by the part of Wales they work in (Locality A, Locality B, etc.).

## 5. Findings

In line with previous research (e.g., Read et al., 2023; Tew et al., 2023) an overarching dimension within many interviews was the multi-faceted way in which prevention as a concept was interpreted locally. There was a focus on supporting older people to remain independent and socially connected, hospital admission avoidance, and health and care integration with a focus on partnerships and multi-disciplinary teams, all set amidst the need to alleviate pressure on overburdened health and care systems. For older people particularly, one of the more consistently returned themes was the role local communities were felt to play within this. This included strategies for community development and local mechanisms and resources to support people to connect to statutory and other private or voluntary services. Relatedly, how interlocking services were organised and increasingly perceived as interrelated parts of a "whole system" was an identifiable theme. "Community" in this context most typically was viewed as "place-based community."

Our findings will first cover how community development for older people was conceived and understood by participants. This will explore the link between community development and prevention, as well as the range of ways this was discussed. Secondly, we will outline the different forms of community working perceived as being preventative by participants, with these including micro-enterprises, community connection, community asset-mapping, place shaping, and interpersonal interviewing. Finally, we will highlight how the role of the state was described alongside community development approaches, and how issues such as partnership working, and the economic context of local government influenced the approaches undertaken.

### *5.1. Community Development and Preventative Working: Concepts and Articulations*

Interviews enquired around how prevention was considered by participants across their various settings, and in what ways this was being enacted. A consistent thread within responses was the need for strengthened local communities, as well as debates on how this might be best nurtured, and the level of state involvement in this. Data collected were rich with descriptions of how community development formed part of the preventative agenda. Numerous interviewees specified that such approaches to community working were a core part of their strategies for social care and support:

> If a village is vibrant and has events on, we know notionally that produces more resilience in older people…so there's that tier of prevention as well, which is less about social services and more about healthy vibrant communities. (Locality D, P1002, local authority director)

> I suppose the strength of the voluntary sector is very much in the preventative fields and I suppose at one end of the spectrum it's about community development. (Locality B, P2007, third-sector manager)

> Because the aspiration from a preventative point of view is that we're trying to make sure that we're exploiting all opportunities within the community before we start looking at some of the more traditional means of meeting statutory needs. (Locality C, P2007, local authority manager)

These quotes confirm that part of the recent strategic focus on community development as a form of prevention aims to slow or reduce the flow of individuals into state-provided services. Participants expressed that, for older people specifically, the logic underlying this was often expressed through the connection between social isolation and poor health and well-being outcomes, with "vibrant communities" perceived to mitigate this.

How these communities were described by professionals was noted to incorporate a range of terms, demonstrating expectations of what communities could be, both as an end in themselves, and if they were to serve a preventative purpose. Ideas of health and vibrancy established above were complemented by notions of resilience, resourcefulness, connection, and cohesion:

> As we will tap into those resources and connect those resources to the people or those services' preventative agenda, people might actually be more aware of where they sit with regards to their health. (Locality A, P1002, health board senior manager)

> We don't seem to be that willing to engage in the conversation about managing demand and prevention is an inherent part of that. Prevention, self-care and prudent health care, and resilient communities. (Locality B, P1001, third-sector director)

Discourse around resilience and resourcefulness was particularly commonplace, as was the idea of connecting individuals to focal points of these resources and resilience within local communities. There was considerable variation between localities in how these characteristics of a community were felt to be most effectively coordinated with this often driven by the types of activities emphasised by health and social care planning bodies in each region.

### *5.2. Forms of Community-Based Prevention*

When discussing the role of community-based prevention, a range of diverse, though sometimes interrelated, initiatives were brought forward as examples. These incorporated a range of agencies, funding sources, and approaches. Though present across all regions, the role of voluntary, third, and private sector organisations was notably varied. A commonly reported initiative was the development of micro-enterprises, sometimes for care provision and often also for low-level support based within local communities. These were in place across three of the four localities, as well as referenced as aspirational plans in the other:

> We've been really successful around the development of micro-enterprises. I think the latest figures were...we've got over 100 individuals now who are providing over 300 hours of community support through micro-enterprises. (Locality B, P2013, local authority manager)

> We've got sort of micro-enterprises that are cropping up in the county now and that we're supporting to get developed. These are individuals...running their own little businesses, providing care. (Locality C, P2002, local authority manager)

The development of micro-enterprises as care providers was generally seen to offer citizens greater choice over which services they engage with. These initiatives were predominantly sole-trader small businesses offering care and support services, albeit networked into other similar sole-traders within their local communities. The work associated with this was largely performed by third-sector organisations. However, it was noted that in some areas the approaches associated with micro-enterprises differed:

> We used the Community Catalyst[s] model whereas some local authorities...have tweaked it a bit and in doing so I don't think they've done themselves any favours. (Locality B, P2013, local authority manager)

The precise nature of the "tweaks" to the Community Catalysts (2023) model inferred by this participant was unclear, though it was noticeable that localities had different forms of partnership working. For some, this work was commissioned, whereas in others it was taken in-house to local authorities via mainstreaming of the work into statutory budgets. This form of community-based prevention, regardless of its placement within the wider system, incorporated identification and assistance of potential micro-providers and then encouraged formal and informal support networks to share advice, knowledge, and best practices.

Though elements of prevention are undoubtedly evident in the work of micro-enterprises in and of themselves, they differed from many of the other initiatives discussed by virtue of their status as private sector sole traders based within local communities. Many other forms of "community working" outlined were incorporated into activities of third-sector organisations, or the state itself in some cases. One such example shared across each of the regions was the role of a community connector—individuals based in local communities with a broad knowledge of the events, activities, organisations, and initiatives operating within them. In spite of variations in origin, this term was often used interchangeably with titles such as social prescribers, local asset coordinators, or community navigators:

> The one exception that I would highlight is that…community connector, community navigator, social prescribing stuff. Now that has been a game changer. (Locality C, P1001, third-sector director)

> It very much includes social prescribing, it's about how you connect people into their communities. (Locality A, P1001, health board senior manager)

> In fact, in [omitted] we're often the first port of call and not a gap filler, so the community connector is a key element. (Locality D, P2006, third-sector manager)

For some participants, there was a distinction between social prescribing and community connection, with this hinged upon where the role was situated:

> We do have in [omitted] the social prescribers….I don't think they're placed in the right place at all because…in [omitted] they're placed within GP [general practitioners] surgeries. (Locality D, P2003, third-sector manager)

> When we talk about social prescribing, it's very much the medical model…it doesn't recognise that sometimes…access to good social engagement and involvement…is worthy in and of itself. (Locality B, P1003, local authority manager)

While the role of community connection or social prescribing was often seen as synonymous, there was a perception from some that the latter was more associated with medical systems. In these cases, the role was generally set within GP surgeries or hospital-based memory clinics. Though reported as a difference by some, the broad overlaps were demonstrable through community connectors also being placed in GP settings in certain localities:

> GPs were telling us that they…get a lot of people come through the door, that there may not be an actual medical issue or there may be a social issue…and how we can help support them do that. (Locality C, P2006, third-sector manager)

Other participants suggested that, rather than where the role was situated, another distinction was the activities being performed in and of themselves. This could include connecting individuals to pre-existing community events or activities, as well as other elements like understanding specific localities, developing the presence and capacity of community resources, and working co-productively to identify community-based activities that might benefit individuals:

> I lead on the asset-based social prescribing project…and that employs what we call local asset coordinators to link the most vulnerable people in communities back to community activity. I also lead on a place shaping asset-based programme which is around identifying those assets in the communities that can be used to link those people to. (Locality B, P2008, third-sector manager)

Here, the participant outlined two distinct asset-based projects with these incorporating the community connection or linking work, alongside aspects of “place shaping” and local community development. This distinction is further outlined in the two quotes below:

> She’s set up a load of groups, there’s like dementia friendly cinemas, there’s dementia friendly choirs, you know, cafes, you know, and she basically…sort of helps to develop those groups but then puts people in touch with them. (Locality D, P2002, local authority manager)

> When we look at things like local area coordination….I can’t see it’s worked much more effectively than where you’ve got, like you have here in [omitted]…community connectors who are almost like third-sector brokers. They were doing far less of the community development stuff and doing far more of the working with people to find out how they could access what’s already there. (Locality B, P1006, local authority director)

In the extract from Locality D, the work of a dementia community connector is described both in terms of “putting people in touch” with local groups and activities, as well as “helping to develop” community assets. Similarly, while not perceived as favourably, the participant from Locality B also highlights the difference between “community development” and helping to link people to “what’s already there.” The other dimension of this form of working is related to the mapping of local communities:

> With our community coordinator, we’ve mapped each locality to see who and how each third sector, private sector, anyone that’s within that locality, could support people that are requiring our services. (Locality A, P2006, local authority manager)

> They just went out and basically recruited about eight dementia advisors in their area without doing a mapping exercise…and then once they had them in place they found out that there was a duplication of work. (Locality B, P2006, third-sector manager)

> So it [community connectors] encompasses it all, it’s not just a standalone project, it pulls in other third-sector organisation, it tries to coordinate some of that support. (Locality C, P2006, third-sector manager)

Evident in the data are debates around the various types of community working required to pro-actively and effectively develop resilience and resourcefulness, with these varying in terms of who was best to perform such roles, and where responsibilities for the work lie. At a more interpersonal level, another core dimension of community-based prevention was felt to be embedded in the interactions between practitioners, people who use services, and local community members. Several of the professionals interviewed suggested that strengths-based and asset-based approaches were key to effective linking within communities. Generally, as outlined in the following extracts, such approaches were perceived as a prerequisite to successfully connecting individuals to community-based activities that would most benefit them:

> We are much more focused on what the individual outcome is….You know, what that person really wants to happen, what matters most to them, and in so doing improving the well-being of that individual. (Locality C, P1002, health board director)

> They identify what matters to that individual, what their goals are, any barriers…that are present to prevent them from reaching their goals, and then what strengths they have and how we can…co-produce some solutions for them. (Locality A, P2006, local authority manager)

Rooted in the language of the SSWBA, the importance of "what matters" conversations was returned to frequently. Each of the localities provided instances of such conversations being performed by social prescribers, community resource teams, or community connectors:

> The community connectors, for example, they do training in making every contact count and motivational interviewing and being able to have conversations with people who want to make a change but don't necessarily know where to start. (Locality D, P2006, third-sector manager)

There was a uniformity of response around adopting asset-based or strengths-based approaches, regardless of the organisation conducting the work. Within this, the aim is to identify individual assets and strengths that may enable people to better engage with the communities around them, as well as seek to co-produce potential forms that this engagement might take. The extent to which differences in how the various systems were organised to enact these approaches play out, and how these are experienced by service users, is outside the scope of this article, though it is worthy of further investigation.

### *5.3. Statutory and Community Service Provision: Contextual Challenges and "Whole System" Solutions*

There have been ongoing debates around how community development functions alongside local state agencies, as well as whose purposes are served, when linked to ideas of prevention. Within the collected data, discussions around how community development work was delineated between state provision and third-sector or alternative agencies were notable throughout the localities. In this section, we shall first highlight aspects of the local government context that have led to community-based work often being performed by non-state partners, before considering the extent to which this was perceived as a "whole system" approach by participants.

#### 5.3.1. Contextual Challenges

Without a doubt, one of the clearest challenges associated with community development and prevention for local actors was the current and impending financial situation of the local government. For many participants, the fiscal environment surrounding statutory bodies was a key contributory factor in looking to establish other non-state agencies within the preventative agenda:

> We’re working in a fiscally massively constrained environment and therefore who’s got what budget for what becomes a big issue and a driving force. (Locality D, P2011, health board manager)

For some participants, the financial pressures within their organisations meant that core funding for preventative services was often de-prioritised:

> The problem with prevention is getting it funded because our finance colleagues…they’re not very keen on investing in prevention because they can’t see the result very clearly. (Locality A, P1003, local authority director)

> I’ve got to mention, at the moment, with budgets, it’s really challenging. It’s going to be increasingly challenging over the next two years. (Locality C, P1003, local authority director)

This, coupled with what was perceived as a historic disinvestment in community development work, has meant that many such services have been dependent on short-term government funding:

> We have disinvested, within Wales, in community development and…that is a problem. (Locality B, P1003, local authority manager)

> I think we haven’t embedded where we should have done because of funding pressures, and therefore we’ve become reliant. (Locality D, P2013, local authority manager)

Financial issues were reported across all localities, and it was common to hear of community work being sustained through short-term funding mechanisms. In many of the localities, this funding was diverted to third-sector organisations. In others, though, third-sector partnerships were run on a commission-only basis. Regardless, an inherent dimension to much of the data was the belief that the financial issues of the local state could be mitigated by adopting a “whole system” approach to social care, with this extending beyond traditional state organisations in delivery.

#### 5.3.2. “Whole System” Solutions

Perspectives on how the delineation of the social and health care system between multiple agencies was working were varied, with this seemingly informed by the nature and quality of collaboration between state and other partners:

> We couldn’t do it on our own, we do need the third sector. But what we found with the third sector is they’re quite often subjected to yearly funding….What we need to do is ensure we can provide a continuity of service. (Locality A, P2009, local authority manager)

> The way that local authority relationships with the third sector have been historically is that we were effectively the “cash cow” and we were being asked to provide them with money, for them to deliver a service, so that would be inherently cheaper…and actually it isn’t necessarily cheaper. (Locality B, P1003, local authority manager)

While these participants allude to poor local authority outcomes, both financial and otherwise, when re-allocating funds to the third sector, others saw this form of working as an imperative given the economic context. When this collaboration between the sectors was felt to be working well, it was seen as a key part of the preventative strategy:

> The work we do with…the third sector around our community connection. We've now, we had moved statutory funding into their, their organisation, which was a direct replacement to build that up. (Locality D, P1003, local authority director)

Indeed, for some participants, ideas of partnership working were central to the "whole system" approach encouraged in recent Welsh legislation. Though this was sometimes restricted to statutory health and care systems, many participants saw the need for collaboration with alternative providers to develop communities:

> It's a whole system thing, isn't it? And I guess what I'm suggesting is we go even further, and we start with that community resilience and then we look at low-level services and early intervention. It's a whole system, but it starts much earlier. (Locality D, P2014, local authority manager)

> We can't deliver our, our services, without linking with third sector and the breadth of the third sector is phenomenal…so, when we're talking about delivery, we've got to…understand that really broad delivery. (Locality B, P1003, local authority manager)

Data highlighted ongoing debate around the role of the state in developing communities and how best to utilise scarce resources within a "whole system." Allusions to "top-down" or "bottom-up" approaches were implicit in descriptions of how care and support were organised within many local authorities. For instance, the development of micro-enterprises and "good neighbour" schemes were seen as hugely positive in many of the studied regions, though several participants mentioned concerns over local authority risks and liabilities:

> There are huge risks with it because they're unregulated, they're not monitored…so there are issues and I'm sure it's a complete pain in the neck for the Council to monitor all of these…micro-enterprises, but if I was going to design a domiciliary care sector today I think I would encourage that. (Locality A, P2005, local authority manager)

> We have tried, on a lower level, to get a good neighbours-type scheme up and running, which I think would be really good for prevention but the minute you start talking about DBS checks, you start talking about safeguarding…everybody runs away. (Locality C, P2006, third-sector manager)

Though the respondent from Locality A above highlights issues with regulation and local authority liabilities with respect to care provision, the use of micro-enterprises is still regarded positively. Interestingly, though, within that locality, there was greater evidence of a "top-down" approach to community working at play in one of the constituent local authorities. For instance, whereas other counties within each region would deploy third-sector organisations for community connection activities, participants from this local authority demonstrated a different approach:

> Hence why we decided to create…a community connector role for our well-being social service…loads of other organisations will use the third sector for that. And we've found that's worked better for us because our well-being service has the full catalogue of services available in the local authority…but also what we can do from our funding pool is we can commission third sector to work with us. (Locality A, P2009, local authority manager)

The logic associated with these variations in approach incorporated a range of themes. For some participants, the benefits of the third sector were in their capacity to deploy bottom-up, locality-based community work. This relied on their knowledge of communities, their ability to source alternative funding from private and other sectors, and the use of asset-based approaches to community and individual working. Another benefit mentioned by several participants was that third sector or voluntary organisations were sometimes perceived more favourably by a locality's citizens, particularly those that may be harder to reach:

> I suppose, for some, a distrust of statutory services, which creates that, almost, last-minute, "I'm not going to ask social services for help until I'm absolutely on my knees and completely desperate," at which point, there is very little we can do to re-able or support the individual. (Locality B, P1002, local authority director)

For some participants, the perceived desire of some citizens to remain distant from statutory services was justification for offering a range of initiatives rooted in community or other sectors. The interviewee below highlighted how micro-enterprises also served such groups:

> They're in the market of people who simply want to approach someone else to provide a service and don't want to come anywhere near social services. And those customers exist in every population across the country. (Locality D, P1003, local authority director)

Across all localities there were identifiable overlaps in the types of initiative discussed in terms of prevention and community development, as well as in the styles of approach adopted to enact them. That said, the extracts outlined above also demonstrate some variation in how the role of the state is perceived to operate most effectively.

## 6. Discussion and Conclusion

The findings outlined above explore how professionals working to support older people in four regions across Wales have embraced prevention, inclusive of community-based initiatives. Professionals interviewed demonstrated significant effort in this regard, with the development of initiatives that spanned new micro-enterprise models of care, community development initiatives, and supports for community networks each being referenced. The latter include community connection models, social prescribing, and community catalysts. Our study data suggested that many of these initiatives were actively seeking to place traditionally state-associated forms of work into local community organisations and create new markets and models of community care provision. The professionals working in this sphere also clearly saw these forms of community-based working as a potential force for good and community building, offering alternative modes of provision and thereby greater service and support access, choice, and control for older people. Consistent with previous instances of preventative policy, one core recent focus has been on developing resilient and healthy communities. The backdrop is a significant crisis in the provision of social care, which is propelling the reach for new forms of care provision.

Proponents of the initiatives also suggested that their presence in local place-based communities, and the support provided by local government through rerouted funding to the third sector, could help to strengthen and empower localities and support "vibrant" communities and engagement with older people. Some participants felt this to be driven by long-standing relationships between statutory services and civil society more broadly, with certain pockets of the population perceived to distrust state-delivered services and preferring to engage with community-based individuals and organisations. Likewise, how community development and community-based initiatives were described more broadly by participants highlighted a strong association between prevention and the theme of a "reduced flow" of older people into state-based systems of health and social care. Prevention was cast in health and well-being terms and access to services, and from an institutional perspective, in respect to future demand management.

That there were mixed agendas for prevention is not inconsistent with ends evident in community development literature. Within this, arguments are made that a common nomenclature can potentially mask the political and ideological agendas of those using such language (Cockburn, 1977; Mayo, 2008; Thorpe, 1985; Ward, 2023). For example, there is a difference between a "community-based care service" and a "community development project" in terms of agency and empowerment, a point emphasised by Austin et al. (2005) in their work on community development with older people. Also, terminology such as social prescription gaining traction across Wales, and the placement of such workers within settings like GP surgeries or hospital-based clinics, meant that there were associations between this form of community linking work and medical rather than social models of care. As noted by Verity et al. (2021) and others, with preventative social care there is a need to understand and enact support, including community development work, beyond leaning on the definitions associated with clinical approaches to prevention, which can be at the expense of collective and structural considerations. These discourses may influence the actions of local actors where demand management of an immediate crisis has the potential to override social justice and inclusion principles and the longer-term perspective the latter entails (Read et al., 2023).

Despite the promise of the "new" prevention agenda in Wales, recent evaluations of the implementation of the SSWBA have demonstrated that the experiences of service users, carers, and individuals within local communities have not been wholly positive and have tended to vary significantly (Cooke et al., 2019; Llewellyn et al., 2023). System-wide issues of inadequate resourcing and staffing, as well as meaning many of the desired changes for health and social care are seen as extremely difficult by professionals (Wales Council for Voluntary Action, 2023), have also negatively impacted experiences of social care by those engaging with it. This theme was only residual in the data reported here, though may be expected to re-emerge in the findings from the broader DBPSCP study where service user and carer interviews are undertaken. Moreover, the active collective agency of older people in community development, where initiatives are driven by older people themselves, is muted in this data. History has reinforced the need for an alert critical awareness in community development. Notwithstanding the current optimism evident in this study, we suggest that bringing to the fore the voices, hopes, experiences, and actions of diverse older people themselves, together with deft handling of the tensions and challenges in preventative work will be needed to realise a progressive ambition in the development of community-based initiatives in tight financial times.

This study is not without its limitations. For instance, the data reported here only incorporates the views of professionals working in statutory and third-sector organisations in Wales. The broader DBPSCP study engages with older people and their carers, ascertaining their perspectives and role in prevention, so closely entwined with ideas of community development. Beyond this, the sample of Welsh regions does not fully encompass the breadth of approaches being deployed across the country. Nevertheless, our findings offer some insights into how community development is considered and enacted by professionals working with older people in a range of different Welsh localities.

## Acknowledgments

The authors would like to acknowledge the health and social care professionals within Wales who gave up their time to take part in the study. Also, the input, assistance, and funding from Health and Care Research Wales has been invaluable.

## Funding

The funding for the DBPSCP study was provided by Health and Care Research Wales, project reference SCF-20–1797.

## Conflict of Interests

In this article, editorial decisions were undertaken by Ulf R. Hedetoft (University of Copenhagen, Denmark). The authors declare no conflicts of interest.

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ISSN: 2183-2803

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