Development of a transcultural social-ethical-care model for dependent populations in the Mediterranean Sea basin

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WP3 TEC-MED Project:

STATE OF THE ART – ANALYSIS AND CROSS-CULTURAL MODEL DEFINITION

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STATEMENT ABOUT THE PROGRAMME:

"The 2014-2020 ENI CBC Mediterranean Sea Basin Programme is a multilateral Cross-Border Cooperation (CBC) initiative funded by the European Neighbourhood Instrument (ENI). The Programme objective is to foster fair, equitable and sustainable economic, social and territorial development, which may advance cross-border integration and valorise participating countries' territories and values. The following 13 countries participate in the programme: Cyprus, Egypt, France, Greece, Israel, Italy, Jordan, Lebanon, Malta, Palestine, Portugal, Spain, and Tunisia. The Managing Authority (MA) is the Autonomous Region of Sardinia (Italy). Official Programme languages are Arabic, English and French. For more information, please visit: www.enicbcmed.eu".

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SUMMARY

The WP3 “State of the art” is aimed to develop the foundation of the TEC-MED Model. It is composed of **3 activities sequenced over time**. These activities are linked together, so that the result of the first activity will allow the development of the second and the third. A.3.1.1. consists in an integrative literature review in order to: 1) Analyze case studies about the most promising social care initiatives in Europe and the Mediterranean basin to elderly people with dependence and risk of social exclusion, and 2) to analyze the social care models in the participants countries. A state of the art is developed and a checklists and semi-structured interview guide, in different languages, to be use in the next activity. A.3.1.2. consists in the development of qualitative research based on semi-structured interviews and focus groups. With the results of these interviews and analyzing the background with the previous literature review a SWOT analysis to diagnosis the Social Care Practices in the participant countries is developed (Egypt, Greece, Lebanon, Spain and Tunisia). Finally, in A.3.1.3, first, a consultation online technical Delphi panel is developed with expert from the participants countries. With all the previous information, the TEC-MED model, and them validate with expert in an international online workshop. Thanks to a deep literature review and to the consultation with 207 stakeholders related with vulnerable elderly population at micro, macro y mesolevel, as well as final beneficiaries.

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WP3: STATE OF THE ART ANALYSIS AND CROSS-CULTURE MODEL DEFINITION

(A.3.1.1. ANALYSIS OF THE MOST PROMISING SOCIAL CARE INITIATIVES. DEC.2019)

1. INTRODUCTION

This activity is designed to screen and identify the existing social care models best practice in in the Mediterranean basin countries and the European Union, With its characteristics and trends in each participating country. This was achieved through an extensive literature review.

(Annex 1. Literature Review Matrix).

Objectives

General:

- To know what are the most promising social care initiatives for elderly, dependent in risk of social exclusion in European and the Mediterranean Basin countries

Specifics:

- To know the indicators used to determinate the status of dependence or exclusion risk in in European and the Mediterranean Basin countries
- To recognize the different profiles for elderly, dependent in risk of social exclusion in European and the Mediterranean Basin countries
- To know the characteristics of the social initiatives directed to the target population.
- To determinate, when possible, the outcomes/impact of the social care initiative.

2. METHODS

Extensive review of literature was completed through various search engines, such as Scopus, Web of Science, PubMed-Medline, ProQuest (PsycINFO, ERIC, Health & Medical Collection), Cochrane Library.
screening both peer reviewed works as well as **Gray literatura** Including white papers, (social) care models, academic papers (such as master and Ph.D. theses and dissertations), research and committee reports, government reports, conference papers, and ongoing research. The “gray” evidence will be reached through Open Grey, Google Scholar Database, ProQuest (ProQuest Dissertations & Theses Global A&I, PsycBOOKS, Sociological Abstracts Conference Proceedings and Dissertations) The search strategy was formulated and agreed upon by different partners to be

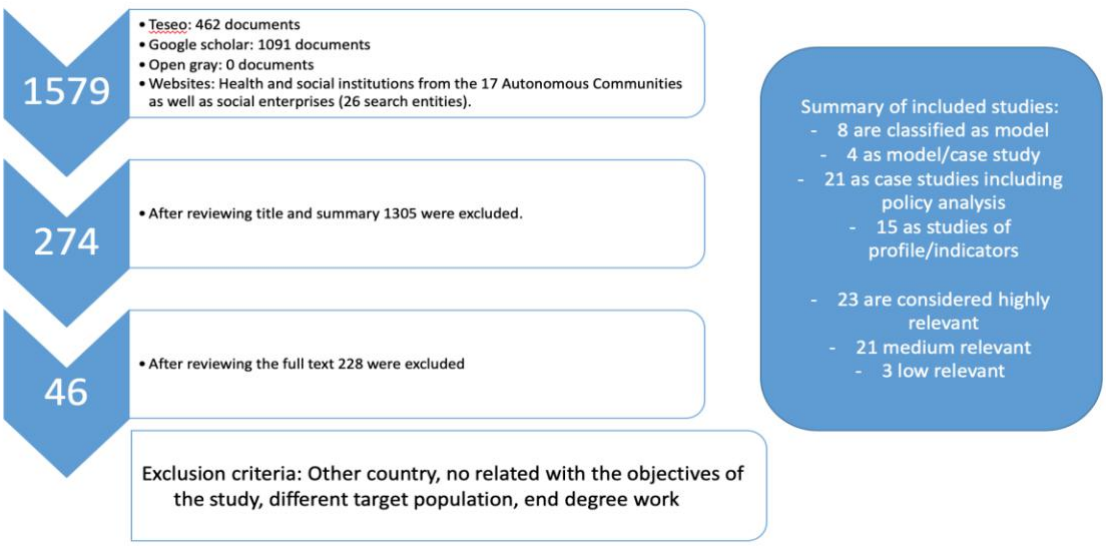
followed as stated in WP3 Guide .

1. MAIN FINDINGS

The following findings were reached based on the literature review and analysis of relevant research and practices in different countries that led to the findings listed below per participant country :

Spain:

Figure 1: Flow charts for refining data for Spain



The flowchart for refining data of Spain showing how literature review has been conducted and the findings of this search below:

"In Spain, the actual model of care for elderly populations follow the welfare social protection model, with a universal nature of Social Security. The Dependency Law (39/2006, of December 14), on the promotion of personal autonomy and care for people in dependency situations, is the official Spanish document that includes the current Care Model (Dependency Law, 2006). The Law defines dependency as the ""State of permanent character in which people who, for reasons derived from age, disease or disability, and those linked to the lack or loss of physical, mental, intellectual or sensory autonomy are found, they need the attention [...] of other supports for their personal autonomy" (Dependency Law, Article 2, 2006) The structure of the Law derives responsibility from the national level to the different Autonomous Communities, these being the ones that should Implement the Law and its derivative decrees (Asociaciones Estatales, 2019). This has influence in the level of development of the law that is not equal in the different Autonomous Communities (i.e., there is a rhythm of uneven progress in the territories of Andalusia, Cantabria, Catalonia or La Rioja, where the forecast for the full attention provided in the Dependency Law will be in 2024, when the rest of Spain is expected to achieve less of two years).

In general, three degrees of dependence have been established:

- Grade I. Moderate dependence: when the person needs help to perform several basic activities of daily life, at least once a day. In turn, it is distinguished in two groups: 1) Group 1.A. People with moderate disabilities for some Basic Daily Life Activity; and 2) Group 1.B. People with disabilities for some day Instrumental activities of Daily Life. In Spain there are 429.437 (32%) people inside Grade I.
- Grade II. Severe dependence: when the person needs help to perform several basic activities of daily life two or three times a day, but does not want the permanent support of a caregiver. In Spain there are 490.680 (37.6%) people inside Grade II.
- Grade III. Great dependence: when the person needs help to perform several basic activities of daily life several times a day and, due to his total loss of physical, mental, intellectual or sensory autonomy, he needs the indispensable and continuous support of another person. In Spain there are 384.195 (29.5%) people inside Grade III.

  The main principle is the promotion of personal autonomy, as well as the protection and attention to dependent people, through public and private services, the latter under institutional agreements. The system is universal but under copay of services depending on the resources of the dependent and the family. The main activities are: home services (home help, telecare, proximity services [food, laundry, technical aids]), specialized social care services (seniors centers, including day centers and institutionalization), economic help in some situations (for family caregiver, hiring a care assitant). The mecanisnm for the evaluation of the level of dependency is determined by each Autonomous Communities, but usually is carried out b health and social work professionals (health and social services).

Of the total number of dependent people, the system treats with some of the benefits or services indicated in the Law to 80.8% (1,054,275 people). The remaining 19.2% (250,037 people) are still waiting to receive the attention to which they are entitled (Asociaciones Estatales, 2019).

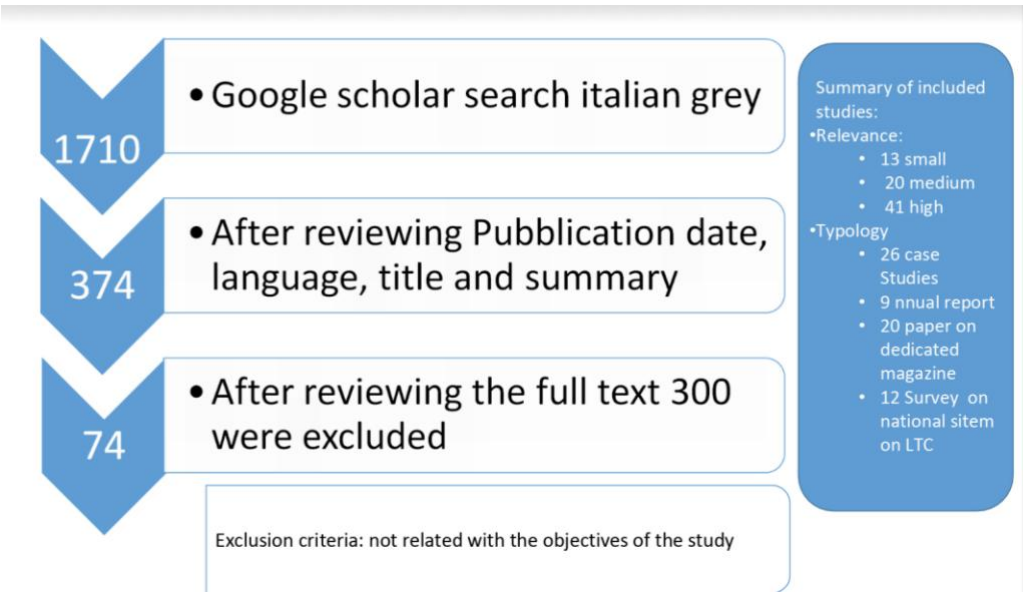
An example of this is the ""Care Strategy for the Elderly of the Community of Madrid 2017-21"" (Community of Madrid, 2017), where a model of care for the elderly is created. As summary, the age average exceeds 65 years (75%), being the gender variable significant compared with the average, where more than 65% are women, being even more decisive in ages over 80 years. The negative impact of gender that feminization of care may be having is still not evaluated to the extent that these are not the result of a free choice and that family caregivers have lost the support that Social Security contributions entailed.

Fernández (2019) state that the system of personal autonomy and care for dependency in Spain has suffered sharp cuts that have affected to the accesibility, availability, affordability and adaptability of services. Other example Dependency Attention Models from the private sphere are the case of the San Juan de Dios Hospital Order (Orden Hospitalaria de San Juan de Dios, 2019), which is based on the Social-Health Care Model proposed by the National Health System Analysis and Evaluation Commission (1991) and focuses on: 1) Chronic phase diseases; 2) Degenerative

diseases; 3) End-stage diseases; 4) Geriatric syndromes; 5) Functional disability; 6) Mental illness; 7) Intellectual disability; and 8) Drug dependence.

Italy :

Figure 2: Flow Chart refining data for Italy



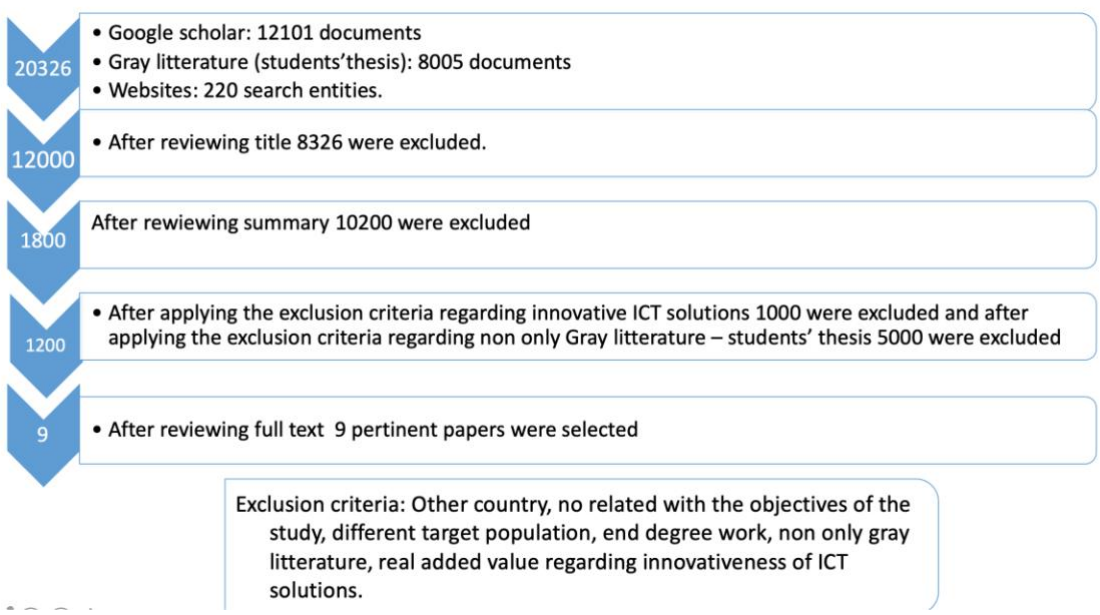
The flowchart for refining data of Italy showing how literature review has been conducted and the findings of this search below :

"The few comparative studies carried out at European level in the 1990s shows the image Italy, much less able than the others of the Center Northern Europe to provide services for the elderly population not self-sufficient: in the 1990s the elderly assisted in facilities residential in Italy were about 2%, against an average 6% in Central and Northern Europe, while those in the beneficiaries of home care were 1-2% against an average of 9% in other countries. In the face of this situation, the Italian social and health protection and social security system has maintained up to now on three types of intervention: monetary transfers, in particular the accompanying allowance; forms of home or residential social assistance; forms of home-care or social-health residential care. Specifically, Italy has a model of intervention more oriented towards monetary transfers rather than services on the territory, and a narrow coverage capacity at national level. In Italy, the number and percentage of elderly people involved through local services and also through the accompanying allowance, remains well below the needs of the elderly population with problems of self-sufficiency, and despite important territorial differences, social interventions in the domain of long-term care are generally limited. Despite a certain amount of growth, public home care services implemented by local authorities have never reached more than a small percentage of the elderly in some Northern regions. Moreover, these services guarantee only a limited number of hours of actual care per week in even the most developed contexts. Although the

home health care administered by local health authorities may show a higher percentage of the elderly covered, it is primarily aimed at providing either intensive short-term, post-acute care or specialised support, as shown by the limited number of hours of service delivered. Over all, home care services do not represent a substantial alternative to either institutionalisation or intensive informal care. Access to both residential and home care is not considered a social right with access limited by a variety of more or less formalised criteria that vary across municipalities, regions and sometimes even providers. The only general policy that focuses on elderly dependents is a national cash allowance: the Indennità di accompagnamento (companionship allowance). This measure was originally intended for disabled adults, not the elderly. It was meant to supplement the means-tested assistance that disabled adults receive and to be provided to those individuals who have been assessed as disabled or "totally unfit for work" and in need of continuous care, without regard to their incomes. This also brings to the fact that in Italy there is a more important family component. Italy has long been classified as having a typical familistic welfare/care model, which is sustained by uncompensated care for family members provided exclusively by women not in the labor force. However, since the 2000s, a relevant divergence from the typical familistic care model has been identified. In Italy, migrant domestic/care workers have increased drastically; this phenomenon has been called the "migrant-in-the-family model" and/or the "migrant-based care model.

Greece:

Figure 4 : Flowchart Refining data for Greece

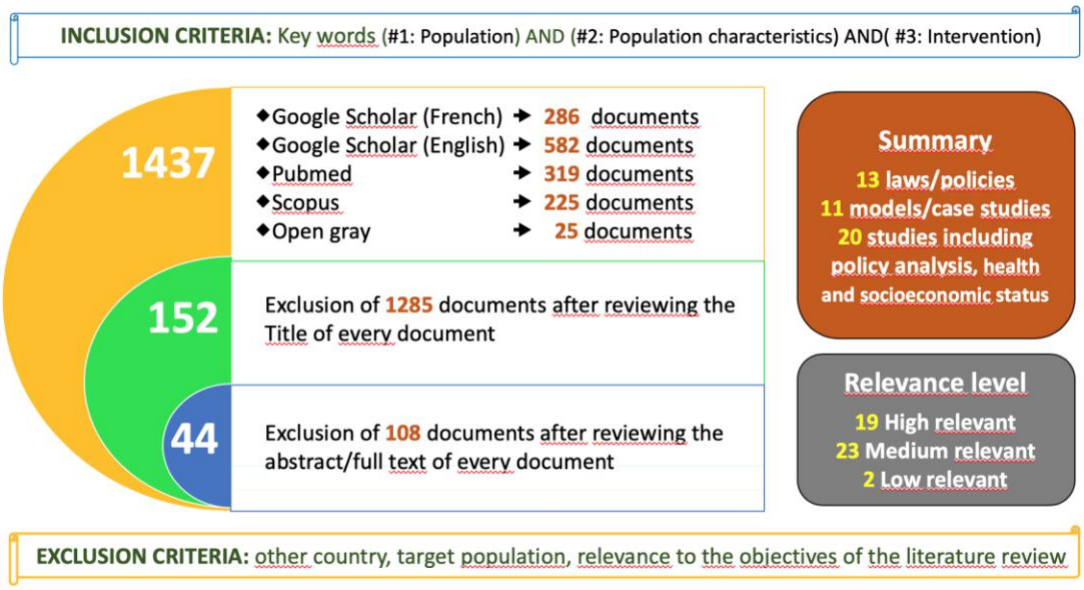


Social care services in Greece represent one of the oldest but also one of the most neglected areas of the Greek social protection system. Their development is closely

connected with the marginal role of social assistance within the framework of the Greek social security system. During the past decades, a number of socioeconomic developments, more or less common across Europe, have addressed significant challenges to the institutional and familial arrangements related to the provision of social care to the elderly. These developments have important implications for the so called “mixed economy of social care” that characterise the whole system of social care provision. Institutional care for the elderly is provided by the Elderly Care Units. They are either non-profit (established by the Church, NGOs and local authorities) or for-profit (market services). To provide long term care for elderly people who lack sufficient financial resources, the Ministry of Health and Social Solidarity signs subcontracts with non-profit Elderly Care Units; but for a very limited number of places. However, the percentage of elderly people using institutional social care services is low. The dominant trend is the provision of services in the community. Public sector instead of being the only significant provider should be considered as the regulator of the overall system. Local authorities, though, have developed social care services in a fragmented way; while the role of the third sector in the provision of social care has been described as residual. In parallel, however, available EU funds seem to enable the growth of the independent sector. As for market services, there is evidence suggesting the development of a market of care, but at the same time the work provided by female migrant carers has been leading to the creation of an informal care market. All in all, it seems that the emerging trends could alter the scope of the welfare mix components, reshape the boundaries and transform the character of service provision in social care services for the elderly.

Tunisia :

Figure 5: Flow charts refining data for Tunisia



The flowchart for refining data of Tunisia showing how literature review has been conducted and the findings of this search below :

In Tunisia, the model social care for elderly persons in dependency situations is based on a legal framework enacted since 1990s: Law 94/114 of October 1994 on the elderly protection; Decree 96/1016 of May 1996 and Decree 96/1766 of September 1996 on care principles to protect disabled elderly without family and/or financial support by public and private health establishments.

Several centres and services are now implemented and under the control of the ministry of women, family, children and Elderly affairs, the ministry of social affairs and the ministry of health. All social and health services are free of charge, or at a reduced rate for needy families. In addition, NGOs such as the Tunisian Association of Alzheimer and the Tunisian Association of Geriatric are carrying out activities and healthcare to assist disabled elderly and their families. These associations being with very limited human and material resources are unable to satisfy all needs. Their services remain limited geographically to the big cities (mainly in Tunis the capital city) but are absent in rural areas.

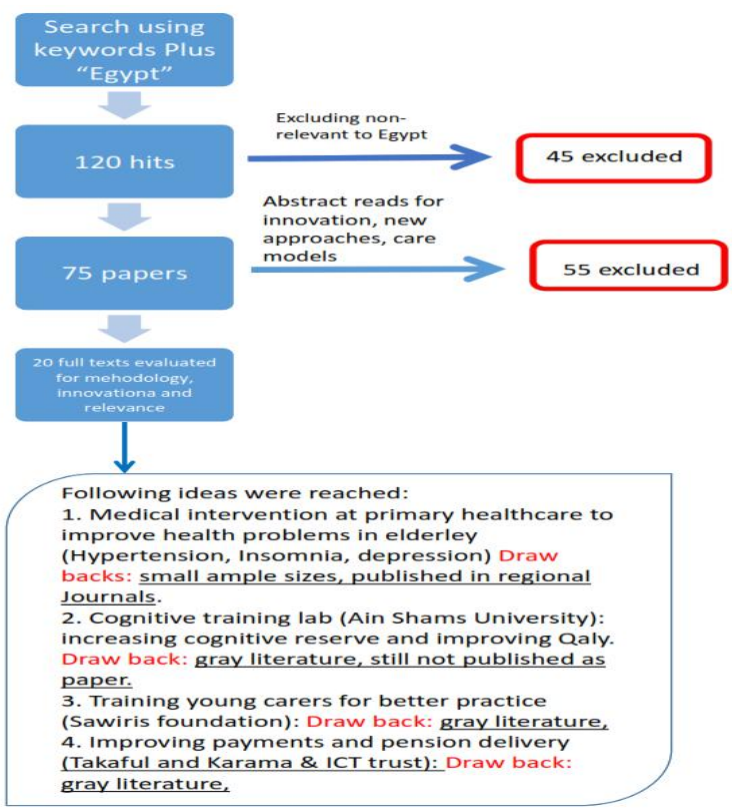
Recently, the government set up a new elderly care programme with a number of measures to help family members when they take care for aging parents requiring assistance. Health and social services were provided in their own home by a multidisciplinary team composed by trained and professional

personnel only free for families with financial difficulties. These caregivers can also train family members how they can provide the requisite care for their relatives in dependency if they want.

Other example of social-health care model from the government is “the paid family placement”: to deal with the high demand of poor and without support of elderly people and the lack benefits and services indicated in the Law of 1994 and its Decrees, the public authority set up this programme, which consists in placing the elderly person concerned in a foster home able to provide him with the psychological support he needs and in return for a monthly subsidy.

Egypt :

Figure 6: Flow chart refining data for Egypt

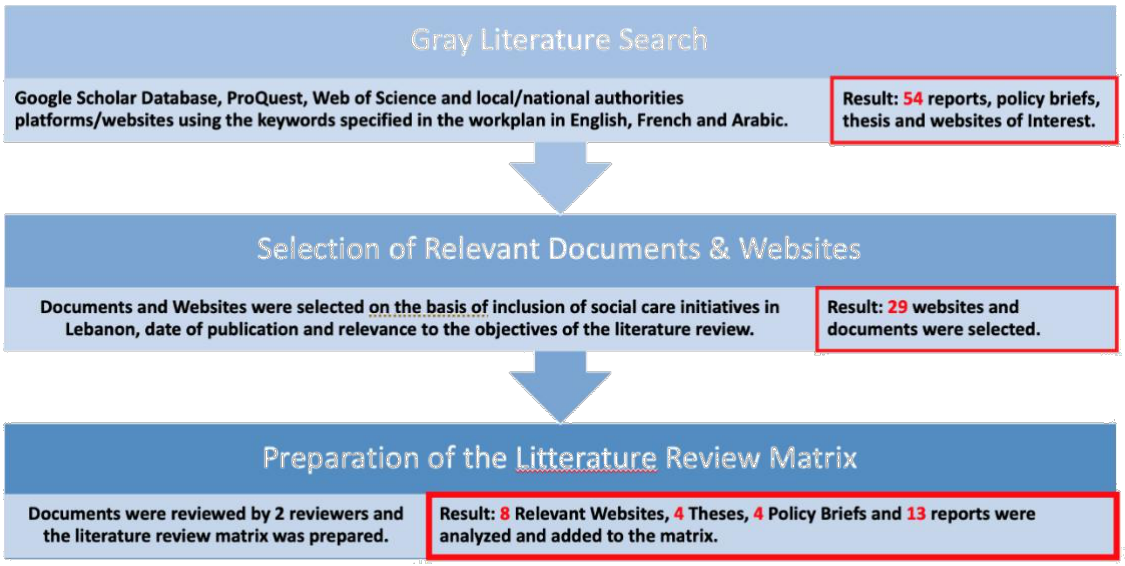


The flowchart for refining data of Egypt showing how literature review has been conducted and the findings of this search below :

"The elderly care model in Egypt is highly variable depending on provider and geograhic distribution. So, in Cairo, University hospitals started to appreciate the special care (Medical and Social) that should be offered to seniors. With Ain Shams University clinics as leading in geriatric medicine, they started to offer specialized and professional services. Theses services, however, are not sufficient to cover the whole area of Cairo, which necessitated furtehr collaboration with Ministries of Health and Social solidarity to establish network of specialized geriatric care centers. These new specialized geriatric centers are offering appropriate outpatient clinical support in addition to several social care forms. However, outside this newborn system, other healthcare providers do not have special care policies for elderly, leading to magementof their health problems as regular patients which carries several drawbacks based on the variances in aging related multimorbidities. On social level, the usual Egyptian social prototype, offered support through strong family ties, where different family generations used to stay in one big house. Since, Egypt is one of the countries with demographic transition, this social model of care is collapsing, necessitating new solutions e.g. nursing homes, seniors residents and professional care providers. These new services started to appear , however, still in a very early stage. Finally, economic care is offered through social solidarity ministry, in he form of different pension systems as well as improved delivery systems as Takaful and Karama Cash Transfer Program. In brief, Egypt care model for elderly has been - for long time- mainly provided by family members (social and economic support, aid in getting access to medical care etc. However, with the demographic transition in Egypt, this care model is shifting to more outsider provider e.g. governmental organizations or private foundations."

Lebanon:

Figure 7: Flow charts for refining data for Lebanon



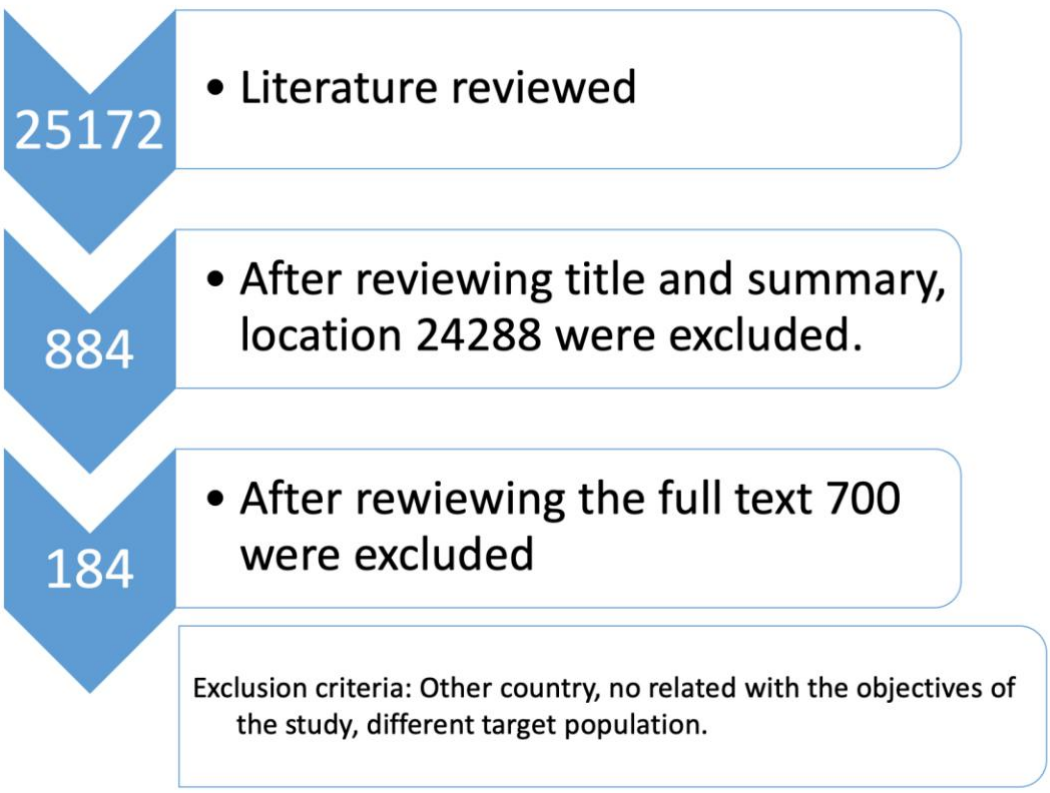
The flowchart for refining data of Lebanon showing how literature review has been conducted and the findings of this search below :

Lebanon will have the highest prevalence of older persons in the Arab region by 2030 (20%) (1) while still lacking a comprehensive model of care. Social security in Lebanon is largely dependent on the employment history with differences between public and private employees (2). The Ministry of Public Health offers primary healthcare services, a chronic medication program, support for patients in nursing homes, 100% hospital coverage for 64+ Lebanese with chronic and non-treatable diseases and "64+ Elderly Preventive Packages" for poor Lebanese under its "Emergency Primary Health Care Restoration Project towards Universal Health Coverage project" (3,4). In addition, Information Communication Technology is integrated in some public hospitals(5).

The Ministry of Social Affairs is working on a strategy for older age (6). It also offers different services: welfare services by contracted institutions and specialized development services (primary care, recreational activities, homeless support), health services through dispensaries and development services, daytime clubs, disability card services (offers privileges to disabled elderlies), the support program for poorest households with the Ministry of Public Health, national program of adult education, a nutrition project which provides hot meals for needy elderlies as well
as standards for long-term care (7). The Ministry of Tourism also offers free entrance to older persons to touristic sites. In addition, non-governmental entities have initiatives which support older persons such as academic institutions who offer trainings in the geriatric field (8), a University for Seniors (9) as well as research "Center for Studies on Aging". It is important to note that a lot of these activities are restricted to the poorest of the

poor and have limited funding where in some cases, some initiatives might get discontinued due to insufficient funding. Non-governmental organizations not only offer welfare services but also support older persons through palliative care services, Alzheimer's support (10), the Elderly Empowerment Project (pilot project in the Jbeil area to create a database of work , volunteering and leisure activities for the elderly) (11) and a draft law to protect the elderly from abuse and neglect (12).

Figure 8 Unified flow chart for all PPs



An International Search has been conducted as well to stand on the latest, the most innovative and the most impactful social care models. The analytical review below has been focusing on the EU counties not involved in the project . Data filtration method is shown in figure 8 , the literature review and figure 9 for the grey Literature review :

Figure 9 Flow charts for refining data (global literature review) :

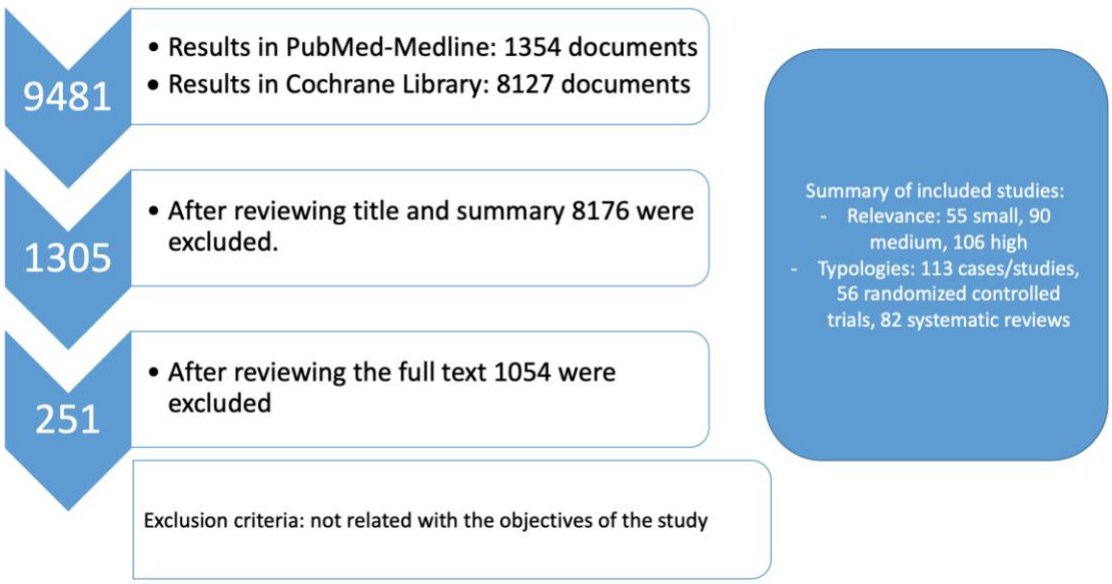
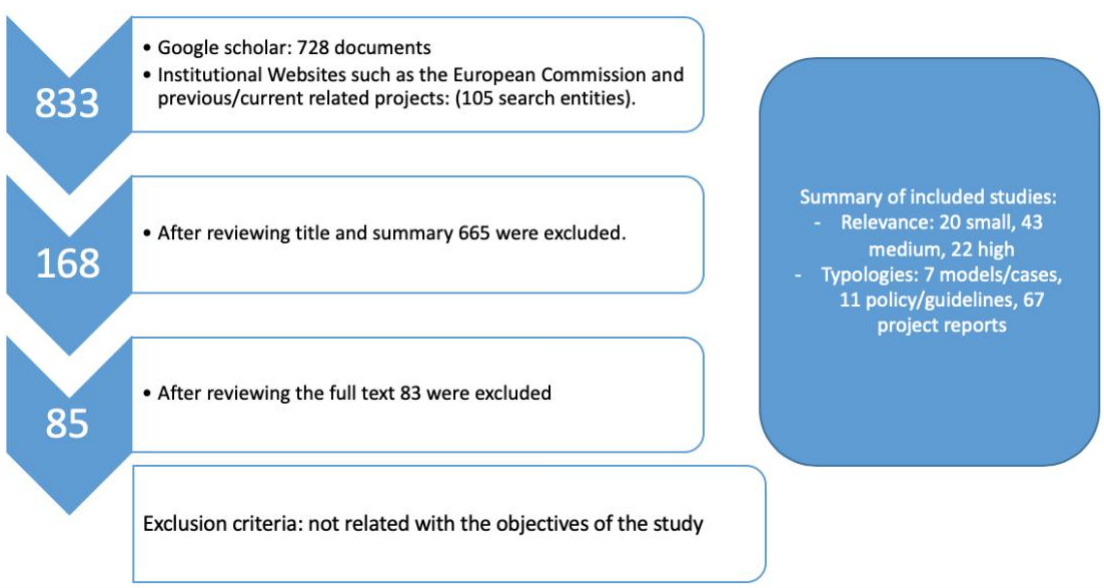


Figure 10: Flow charts for refining data (Global GRAY Literature review)



The main finding of the international literature review and the Case studies Concerning the academic literature concentrating on EU countries and the Mediterranean area, the vast majority of papers encountered represent case studies and randomized controlled trials related to integrated care and frailty. These studies are very important, as they will be used to extract useful indicators and description

of useful technologies for the TEC MED model. In this regard, great focus is given on personal motion technologies that might enable older adults and individuals with disability to live independently for longer period. Further, much of the studies focus on the measurement of Quality of Life Indicators, and other welfare indicators with a more social side. Further, some of the studies focus on the role of formal and informal careers, and their wellbeing. For what concerns the grey literature, Europe is quite divided between countries that share a tradition of universal, tax-financed eldercare. services, centered on public provision, and countries that have been more influenced by the global wave of marketisation in recent decades. The latter have carried out more market inspired

measures, such as competitive tendering and user choice models, and in some countries, there has been an increase of private, for-profit provision of care services. More specifically there are five main models: Nordic welfare state model (Denmark and Finland), Central European model (Germany), Liberal model (UK), Southern Europe (Greece, Italy and Portugal), Eastern Europe (Hungary, Lithuania and Poland). In Hungary long-term care for elderly seems to be of low priority compared to other central issues such as pensions. There is a strong expectation that the care will mainly be provided by members of the civil society, having a disproportionately negative impact on the women's lives because they are usually doing the informal care. Lithuania has a strong growth in the number of dependent elderly, which implies a strong pressure on the long-term care system. There is an expectation that the elderly stay in their own homes as long as possible. There is also some institutional support for the very frail elderly. Welfare technology is not very used. In Poland there is a blurred boundary between health and long-term care, as members of civil society and migrant workers are used in the provision of long-term care. In this regard, the official long-term care for elders is limited and state involvement is fragmented, also leading to the fact that implementation of welfare technology is limited. Portugal has had a rapid development of long-term care social in Portugal, including higher coverage in formal care and a mixed system, in which the nonprofit sector is a strong actor in the provision of long-term care. This system integrates health and care with the role of the family, and there is also a combination of delivery and financing from various actors. In Italy there is a catching up towards continental welfare states' levels of provision. Despite the fact that there is an

individual cash allowance, there is also an increased focus on market provision and migrants delivering care. Therefore, more than a marketization, we assist to an adaptation of an informal based-family model. In Greece the family plays the central role. The attempt to introduce a decentralized system of formal long-term care for elders in the 2000s was interrupted by the fiscal crisis. Inequality in access is high, as well as in in level of care dependent across geographic locations. In the UK there have been major cuts in public spending that have increasingly impacted funding for social care, with impacts more strongly felt in England. More and more care responsibilities are left to families, and people who need care (and their families) are under increased pressure to pay for care from their own private resources. There are also a lot of geographic inequalities. Germany saw a broadening of the scope of long-term care, but residential care is expensive, implying inequality in access to care for the elderly. At the same time, there is a stronger focus in homebased care that the elderly should stay in their own homes longer. Finland, saw a decrease of long term care for elderly after the crisis, and saw also a lot of support from the informal sector and people are encouraged to live in their own homes as long as possible. Denmark shows an increased focus on the elderly living as long as possible in their own homes. Another issue is a tendency towards marketization of care. Civil society still has a central role, but the use of rehabilitation, and welfare technology are core elements of the development.

Regarding the south Mediterranean, No enough information has been located on countries not participating in the action such as Morocco and Algeria.

CONCLUSIONS

This activity , revealed various practices, challenges and problems in care of vulnerable populations specially elderly. Analysis of different literature produced in various regions revealed diversity in care models, identified some promising activities that can be implemented widely and identified the need of more standardization of procedures, communications among different countries and dialogue between various activist in the area of care (social, medical and economic) of elderly to coordinate and appreciate differences between regions (culturally, economically and technically).

Review of literature revealed discrepancy regarding the outputs and research products between different regions e.g majority of works has been done in USA and Europe compared to the small number of publications produced from Middle East region

27 EU projects are either on going or to be started , it is very important to contact and develop synergies with such initiatives and align similar activities with our scope of interest .

5 COUNTRY REPORTS
(EGYPT, GREECE, LEBANON, SPAIN, TUNISIA)
DIAGNOSTIC OF SOCIAL CARE PRACTICES AND SWOT ANALYSIS

Introduction

As Mediterranean countries are showing common trends and needs of social care to elderly dependent populations, and in an effort to respond to the needs of the countries involved in the project, a country assessment of the social practices of each country was initiated.

This report is the main outcome of Activity A.3.1.2. Analysis of Current Social Care Practices in the current 5 participating countries: Spain, Greece, Lebanon, Tunis & Egypt. It is expected that the report is completed in the near future by a report in the same activity by Italy, which is under a process of changed partnership that affected the results of this report.

The aim of this activity was to understand the characteristics of the social care initiatives available in each of the countries and trends in social care practices for dependent, elderly with chronic illness or those who lack of family support in an effort to identify common grounds as well as gaps and challenges.

The report gathers 5 separate country reports regarding the social care practices in each of the countries involved in the project (3.1.2.a) based on a thorough literature review and structured interviews with key stakeholders in addition to the SWOT analysis of the social-care characteristics in relation to the target population, the key stakeholders, the current delivery services and their trends for the target population (3.1.2.b).

Each of the countries involved has shared with PP7 (the activity leader) and the other project partners the characteristics of the social care initiatives available in their respective countries, the characteristics and trends in social care practices for dependent, elderly with chronic illness or lack of family support as well as the strengths, weaknesses, opportunities and threats of the current model of care and the suggested actions.

The work package leader (Egypt) and lead beneficiary (Spain) reviewed the report to create this final version.

methodology

In order to achieve the aim of the *A.3.1.2. Analysis of the current social care practices in the six countries involved in the project*, the two subactivities were carried out. The methodology of each of them is described below.

A. 3.1.2.a. Social care practices in each of the countries. Semi-structured interviews

Each country was in charge of performing at least 3 semi-structured interviews with key stakeholders on the social care process in each country based on a pre-defined checklist and template approved by the lead beneficiary. (Annex 1 &2)
Each country translated the semi-structured interview guide to the local language and adapted the questions to the local context.

Profiles for interviews were shared among the partners and included the following profiles:

- Macro management: Leadership position in public administration which provides social-care services (may include policy makers and other stakeholders).
- Meso-management: Leadership position of social-enterprise providing social-care services, leadership position of NGO providing social-care services, leading academic figure studying or working in social-care services.
- Micro management: Social professional attending dependent, elderly population with risk of social exclusion (at a social-enterprise, NGO, etc.).
- Representative of the target population.

It is worth noting that all partners have worked on the inclusion of women and men in the interviews in an equitable manner as described in the following table. The 25 interviews which were carried included 13 Males and 15 Females.
The table below summarizes the number of interviews carried out by each partner:

Country	Total Number of Interviews	Macro Management Profile	Meso Management Profile	Micro Management	Representative from the Target Population
Egypt	3	1 (1 Male)	1 (1 Female)	1 (1 Male)	0
Greece	5	1 (1Female)	2 (2 Males)	1 (1 Male)	1 (1 Male)
Lebanon	6	1 (3 Females)	3 (3 Females; 1 Male)	2 (2 Females)	0
Spain	6	1 (1 Male)	3 (2 Males; 1 Female)	1 (1 Male)	1 (Male)
Tunisia	5	1 (1 Female)	1 (1 Female)	2 (1 Male; 1 Female)	1 (1 Female)
Total	25	5	9	9	2

The interview guide (Annex 2) was developed based on a checklist (Annex 1) which was developed following a thorough literature review in all countries.
Instructions were given for conducting, transcribing, and analyzing interviews. Partners were asked to share the transcription of each interview in the languages they were carried out in and a
summary in English of all of the conducted interviews.

A. 3.1.2.b Diagnostic of social-care practices in each country & 3.1.2.c SWOT Analysis.

Each country, based on the findings from the literature review previously undertaken in Activity **A.3.1.1. Analysis of the most promising social care initiatives** regarding social care practices and the summary of the current services available in the country and the findings of the semi-structured interviews, shared the characteristics and trends of the social care practices in their respective countries.

Finally, each country, based on the previous literature review and the results from the interviews they carried, conducted a SWOT analysis for the social care in their country where they identified the strengths, weaknesses, opportunities and threats for social care in their respective countries.

PP7 gathered all the information shared by the partners in this report which includes 5 separate country reports for each of the project partners, then reviewed by the WP Leader PP8 before LB Conducting the final revision.

Summary OF MAIN RESULTS:

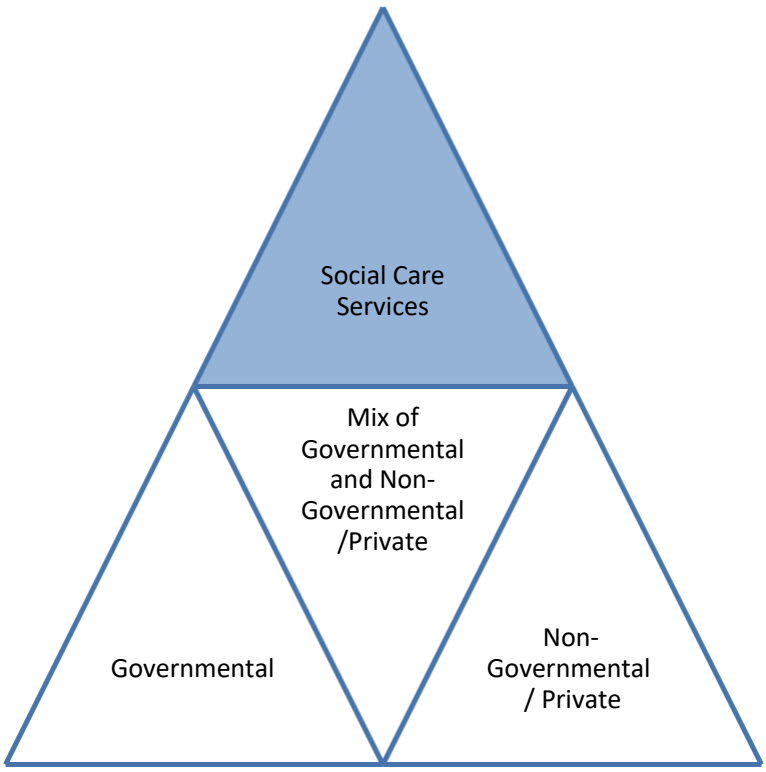
It is worth noting that the countries analysed in this report share common grounds in relation to social needs and care of older person but differences can also be noted in the governmental and public response to these needs.

A gap analysis is planned to follow this effort in order to identify main areas of concern to better respond to the needs through the TEC-MED initiative and ensure the trans-cultural component of the model while considering the ethical and gender aspects.

Characters of current social care services available in the 5 countries involved in the project

The scene is variable among the different countries in the project, despite diversity, the following features can be summarized from the study. The services in Egypt, Tunisia and Greece are strongly dependent on government, with much more liberation in the case of Spain, where private sector is playing a role and in Lebanon where they are dependent on governmental as well as non-governmental entities. The concepts of social care in all countries emphasize the importance of autonomy and independence of vulnerable populations. The defect, is still in the ability to practice these principles in real life situation tackling the problems of seniors in these different countries while ensuring an ethical, dignified and gender sensitive response.

Figure 1. Social Care Services Provision in the Studied Countries



Trends and practices in different countries of the study

The diversity in systems in the five countries has been reflected on the initiatives started in each of them trying to propose better solutions for social care services. In Egypt a promising initiative is the start of longitudinal survey of aging population on nationwide basis (AL-SEHA) with a follow up of 10 years that will allow decision makers to appreciate needs and problems of vulnerable population sector.

Based on the long history of social care system, Greece has developed two interesting initiatives including ACTIVAGE, FRAILSAFE. The two initiatives tackle the needs for more actively engaging and safe aging. In Lebanon, on the other hand, there are several improvement steps of the current practice, eg the national strategy of older age, which could increase understanding of aging needs and direct future plans and regulations.

Spain, with a well-developed social security system offered exemplar trends for proceeding with better quality of aging life through increased activity, engagement and autonomy of elderly population through several steps/initiatives e.g. Model of intervention Decent and Positive Aging (EDP). Trends in Tunisia tend to be more focused on healthcare services e.g more geriatrics trained physicians and improving e-medicine solutions.

Strengths:

Based on various conditions, strengths of the 5 countries models include:

Trend to a long-term social care system, Governmental commitment to provide services, Trends toward active engagement of elderly in community, more active aging pattern, Increased attention paid to healthcare system and unique aging related morbidities.

Weaknesses:

Centralization of services in most of the countries with government as the sole provider of service. This could lead to overwhelming and crashing of system in certain conditions, less engaging private sector and NGOs, and economic burden that could limit the quality of service. Lack of financial resources and infrastructure directed to elderly care is also noted in several countries as several are going through socioeconomic crisis. On the other hand, the models of private sector engagement (e.g. Spain), needs to be improved through continuous monitoring by the government to assure equitable and independent access to required care

Other weaknesses were also noted in relation to shortage in human resources and specialization of human resources in elderly care, lack of specialized services in specific conditions related to older adults, and limited ICT services for elderly care in some countries. Legal and policy issues were also noted in relation to older adults care along with sociocultural issues pertinent to each country.

Opportunities:

Possible collaboration and funding for improvement of services, Identification of best practices (active aging initiatives, engaging of elderly into community) could be translated from different countries to other partners.

Threats

Any incident that overwhelm country resources could endanger the system e.g. COVID-19 pandemic overwhelming health system in the partner countries.

In addition, changes in population demography, increased aging population could exceedallocated resources.

Actions:

Most notable, through SWOT matching, would be to seize the opportunities using current strengths e.g. using the available networks and infrastructure to facilitate exchange of experiences and collaborate between partner countries, translating successful experiences from one country eg ACTIVAGE, FRAILSAFE, EDG and AL-SEHA into other countries.

In addition to:

- Expanding the networks to include other countries
- Involving more stakeholders, new players to the arena of elderly care
- Informing decision makers to push for improving/issuing regulations that facilitate health, active aging engagement.

Finally, partner countries have shared some important features and characteristics that could be characteristics of the new model of care and ICT platform and include:

- The importance of the ease of use of the platform environment
- The importance of networking with all stakeholders (governmental, non-governmental, medical, academic, social, media, etc…) and focus on social networking and social integration of older persons within the new model and platform
- Registration process for the dependent older persons in the platform including medical history, clinical record, specific indicators (daily or other), social status, financial status and family status
- Integration of technological solutions within the new model and platform (telecare, telemedicine, monitoring, decision-making platforms for individualized social care, information systems/health history)
- Availability of trainings and training modules/materials within the new model and platform to empower caregivers, family members and older persons
- Support of homecare and home caregivers integrated within the new care model
- Availability of services, economic empowerment opportunities and social activities related to older persons on the platform for proper referral
- The importance of building a monitoring and evaluation system for the new model of care

egypt

Summary of the interviews

Partners from Egypt carried 3 interviews with interviewees from:

- The macro management profile (Governmental Interview with Former minister of Health and population)
- The meso management profile (Manager of a Social Development Centers, Academics, Public university, Geriatric Hospital)
- The micro-management profile (Social Caregiver, head of geriatric section for social services)

The most important conclusion of the interviews were the following:

The proportion of the number of elderly people in Egypt is increasing significantly, currently they number about 7 million, over sixty years. By 2050, it will reach nearly 24 million, including over 85 years of age. Despite the increase in the number of elderly people, it increases the percentage of diseases among the elderly, and this creates pressure on society, whether in social, health or pension terms. The problems facing older women are more women than men, and the ratio reaches every 100 women, compared to 83 men and 70 women who are married. They are housewives who have no pension but her husband's pension, and there is no one to serve her and she lives alone. This is also social pressure. In addition to immigration, especially in the regions, it causes greater social pressure. In addition to not providing the elderly in the event of leaving the pension, as there are no specific areas to work with, which leads to depression of the elderly.

These elderly people have many social problems and they affect the health aspects, and they are linked to the fact that the family in which they live does not have the culture to deal with the elderly in the old age and its problems and needs, in addition to that the elderly have problems obtaining various treatments as a result of the lack of patience in the elderly and the fact that they did not have the ability to buy medicines. Another type of elderly people: they have memory problems, and there are ways that people trained in how to deal with the elderly in such circumstances and what are the correct ways of living through which the elderly can be contained and attracted and how to communicate with him properly.

Basic needs of the elderly, including his feeling that he is still alive, that he has a role in life, and that there is still a need for the elderly, and family members realize that he can still choose his things and make a decision and not be marginalized, and must interact with the elderly and dialogue with him, and find places that match his needs in society even he feels that he still has a presence, he must be active and that he can pass on his experiences to the youth, in addition to the elderly needing safety and having the ability to provide his own medicine, have a suitable income for him, be in a residence suitable for him and appropriate to his circumstances .

Challenges and obstacles: no unified efforts for all the stakeholders, lack of specialists, shortage in training for specialists and care givers, lack of a team work culture, qualified institutions that correspond to the large number of elderly people and lack of a future plan for the elderly when they becomes a pension, lack of supervision on elderly houses specially

from ministry of social solidarity, plus lack of detailed database of elderly in Egypt with their files (medical, social), social and health services: there is a single legal framework, which is that when a person leaves the pension and has insurance he takes only his own pension. There is no law to protect the elderly from his family whether he wants to deplete him /her for money or house. As for those who do not work, he/she does not have a pension, so they resort to a project of solidarity and that needs many procedures in order to obtain a pension, so they remains a long period without money. In addition, there are those who work without having insurance at work, such as those working in the private sector or self-employed, who do not find a pension of their own in addition to their children who do not spend on them as each of them has his own obligations.

Results and implications of evaluating the current social model.

1. Establishing awareness and information programs for families and how to deal with the elderly people who suffer from health problems and how to deal with them,
2. Create a Database with exact data about the status of the dependents in Egypt.
3. Providing a system that provides pension access to the elderly at home
4. Providing pensions for those who do not have suitable pensions that meet their needs.
5. There should be activities for the elderly and clear locations announced for these activities
6. Create job opportunities for the elderly
7. Good supervision of the elderly.
8. Combine the orphanage houses with the elderly and give a role for the elderly with orphaned children.

Factors for Success and Lessons Learned

1. Support for non-profit organizations such as civil society institutions that provide services for the elderly represented by moral support is not only financial support
2. The presence of youth volunteers to participate with these institutions even if it was a small fee and therefore to improve the services provided for the dependents and to increase the impact.

Platform requirements

1. The registration process for the dependent must contain medical history, social status and family status
2. Availability of all service providers, whether governmental, non-governmental all over the country.
3. Knowing the dependent social and financial conditions
4. Online Training courses for care givers and Family members

Current social care services available in Egypt

In Egypt, most of social care services are provided centrally through the government (Social Solidarity Ministry), offering pensions, economic support (Takaful and Karama).
The program helps to deliver monetary support to the target populations (eg. aging) through a household delivery system that maintains the dignity of elderly, meanwhile assure their requirements fulfilled, hence, the name Takaful and Karama which means in Arabic help and dignity. The private and NGOs sector is still very immature. Limited contributions are initiated through non-governmental bodies which lay a heavy load on government. The credibility and long term dependence on governmental routes of social support, led to difficult implementation of solutions through alternative providers. Transparent and solid measures are needed to engage private sector into the scene. Health insurance system is defective and cannot cover the whole region or reach to target group efficiently. Overall, the healthcare system is overwhelmed by the huge increase in population, the lack of effective skeleton of service providers and the lack of functional medicare system, this is reflected on aging sector as the most vulnerable part of the community, coupled to the difficult access to efficient primary healthcare providers in several rural areas.
Health insurance system is defective and cannot cover the whole region or reach to target group efficiently.

General characteristics of the social care services and practices

The services -so far-are centralized, offered mainly through the government. Economic support is the main aspect of services to provide economic independence of target group. The lack of active engagement of private sectors is limiting the wide coverage or outreach to target groups. In addition, other aspects (Social, healthcare) are not appropriately delivered.
There is huge gap between the needs and available resources to offer decent social care model for vulnerable population. The distribution of responsibilities among various stakeholders is needed to overcome the complete dependence on governmental support.

The care givers are still limited to families and relatives, no professional personnels or training is offered to prospective care givers for elderly, which limits the potentials to reach different areas and sectors. Although, recently, in Ain Shams Geriatrics center, training sessions started to take place which should be generalized in the next years.

One positive aspect is the healthcare implementation. Although, healthcare system is still not performing satisfactory, however, there is growing interest in understanding needs of elderlies, specialty of Geriatrics is growing and implemented in different schools of Medicine. Arabic version of different assessment tests has been validated and customized to Egyptian culture and language.

Trends in social care services and practices

There are starting improvements in geriatric healthcare in local areas (Ain shams). Slow engagement activities of private sector and NGOs. Partnership between local and international organization to understand the situation of Egyptian elderly (e.g. A Longitudinal Study of Egyptian Healthy Aging [AL-SEHA] as an initiative to implement longitudinal aging survey in Egypt in partnership with SHARE [EU], HRS [USA] and GBHI.

AL-SEHA; an initiative aiming to follow up the socioeconomic, demographic and health determinants of aging in Egypt over 10 years' period. The study is harmonized to other HRS similar studies worldwide with the aim of providing data to understand the factors contributing to aging and identify challenges needed to be tackled in the coming years to accommodate the change in population pyramid in Egypt with more elderly portion of community. The study is led by Dr. Mohamed Salama, I-GHHE, AUC Egypt.

The Middle East and North Africa Research on Ageing Healthy (MENARAH) Network was established in 2020 to raise awareness and mobilise research related to population ageing in the region. The network consists of academics, international and national organisations and agencies interested in the wellbeing and quality of life of older people and their informal careers. The MENARAH network activities aims to build capacity and mobilise research to advance policy and practice response to population ageing and its associated needs.

The establishment of the MENARAH network is timely as it coincided with several regional and international activities related to ageing population. For example, the development and launch of the Arab States strategy on ageing and the launch of the WHO decade of health ageing in the run up to the UN SDGs 2030. Similarly, the United Nations are currently conducting in-depth work to reconsider traditional measures of population ageing and are developing new methodologies that are more sensitive to the experience of different nations that are subject various contextual socio-economic, epidemiological and health (in)equalities and other factors. The MENARAH network aims to pave the way for countries within the region to contribute to these regional and international developments.

Aims and objectives:

1. Raise awareness of ageing population and associated challenges and opportunities in the region
2. Engage in a constructive dialogue with key stakeholders in the region from researchers to non-governmental organisations and policymakers
3. Enhance opportunities for learning from the experience of other countries across the globe
4. Identify a set of research priorities aimed at enhancing the regions' preparedness to enable healthy ageing across various levels and sectors within the society

5. Mobilise research and policy responses addressing the wellbeing and quality of life of older people's and their informal careers in the region

SWOT Analysis - Egypt

STRENGTHS	**WEAKNESSES**
Solid pension system developed governmentally. The pension system covered all areas of Egypt and the efficiency and outreach is much improved with ability to reach all target beneficiaries in all areas Developed geriatric centers in cairo Successful implementation of household monetary support system (takaful) Success of the pilot health insurance system in port said Establishing new centers that can inform decision makers e.g src, ighhe (cairo) and ghi (alexandria)	Less engagement of private sector. Health insurance system is not developed yet. it does not cover all areas, only pilotted in one city, so not efficiently reaching the target groups Centralized geriatric care centers (mostly in cairo) Lengthy process of partnership with international stake holders, could defer potential international partners Limited dialogue between target groups and decision makers. So, target groups can not reach or deliver their needs to the government efficiently Lack of target group representatives or alliance groups
OPPORTUNITIES	**THREATS**
Increased opportunities for partnership with international bodies e.g. GBHI, SHARE, HRS Increased opportunities for regional collaboration (for example, the east mediterranean longitudinal aging study [EMAGE] involving Egypt, Lebanon, Jordan, Greece and Cyprus) More possible funding opportunities for support and capacity building (Egyptian government (eg), European Union (EU), national institute of aging (NIA), alzheimer's association (AA)	The change in demography (population pyramid) with more aging population expected in coming decade, with less prepared social and healthcare system Other areas start to gain interest, threating to shift focus of funding e.g. Latin America. More competitive profile for others e.g. Successful implementation of HAALSI in south Africa would recruit available funding to support ongoing success there (based on the fact that funding possibilities is limited, on competitive basis, the emergence of strong compititive groups on teh same area could be a threat of cutting down future funding and directing them to othe places of the world).

References:

https://www.gbhi.org/news-1/2020/2/25/towards-a-longitudinal-study-of-egyptian-healthy-ageing

https://www.worldbank.org/en/news/feature/2018/11/15/the-story-of-takaful-and-karama-cash-transfer-program

Greece

Summary of the interviews

Partners from Greece carried 5 interviews with interviewees from:

- The macro management profile (Deputy Head of Western Greece Region)
- The meso management profile (Deputy Head of a Social Service at Patras University Hospital)
- The micro management profile (General Director-Public Benefit Association and Care of Elderly and people with Disabilities-¨Frondizo¨) and
- Representative from the population (elderly person with chronic illnesses and family member that is a person with disabilities (Member of the Pan-Hellenic Federation of Parents and Guardians of Persons with Disabilities (POSGAMEA))

The most important conclusions of the interviews were the following:

1. Model of social care: There is no community care model and social care model for the elderly. The lack of social care policy in both local and national level is obvious. Thus needs of the local populations are not met. In addition, during the economic crisis the elderly population became one of the new vulnerable groups due to the lack or unequal access to healthcare and social services. The Services provided by the State in relation to the social care of the elderly in Greece (K.A.P.I., day care services, help at home and home assistance programs) are insufficient to meet the needs and thus the population at risk of social exclusion has been constantly increasing during the last years.
2. The elderly face many problems (economic, social, psychological etc) and need immediate care and specialized attention because of their old age. These needs have to be recognized and intervene to help these people cope with the developmental tests of aging. The Main Challenges related to elderly in Greece are:

    - Poor and degraded quality of life
    - Lack of quality and of access to health care services
    - Limited access to health and social information
    - Non-compliance with the therapeutic guideline
    - Passive modality of life associated with the multidrug effect
    - Accessibility problems for the disabled ageing population
    - Societal marginalization (basic care pillar)
    - High cost of care
    - Complete lack of interconnection between social and health care
    - Lack of training of formal and informal caregivers
    - Health illiteracy
    - Technological illiteracy
    - Lack of ICT tools and services specialized in seniors' care
    - Lack of health prevention policy
    - Lack of specialized and experienced formal and informal caregivers

3. Consequently, it is crucial to recognize and to develop best practices
    - School of healthy aging
    - University of the third age
    - Erasmus for seniors
    - Telephone-alarm programs
    - Smart homes for seniors
    - Help at home services going beyond patient support, family education
    - Training and familiarization with technological solution (in reality, the elderly do not need caregivers to use them)

4. There are not enough technological solutions widely adopted in Greece, beyond those used for specific diseases such as: Alzheimers' Patient Positioning Systems and other similar technologies. In the coming years, it will be necessary to adopt more technological solutions such as smart homes, systems to prevent or detect falls, various mobile applications, social alert and social welfare platforms and all the above mentioned.

5. Models and characteristics to be included as ideas for a new electronic platform for the social care of patients: easy to use platform environment, monitoring of daily indicators, self-care, clinical records, coaching and training, empowerment (formal/informal caregivers, patient).

Current social care services available in Greece

Social care services in Greece represent one of the oldest but also one of the most neglected areas of the Greek social protection system. Their development is closely connected with the marginal role of social assistance within the framework of the Greek social security system. Thus the creation of a unified network of personal social services offering provision in line with the principle of universalism has not rendered possible.

In the framework of the Greek social protection system, the term social care was introduced by Law 2646/1998 on the "Development of the National Social Care System". Social care is defined as the "protection provided to individuals or groups of people via prevention or rehabilitation programs and aims at creating equal opportunities for individuals to participate in the economic and social life and at ensuring a decent standard of living. The support of the family is a fundamental objective of the above mentioned programs". The number of elderly people living in institutions providing social care is extremely low. Consequently, care for the elderly is characterized as a "family affair" (Ministry of Health and Welfare, 1999). Nowadays, community care for the elderly is provided through KAPIs, the program "Help at Home" and through the Day Care Centers for the Elderly (KIFIs).
The health care system is not connected to the social care system which impacts the quality of life of the elderly. Intermediate structures are missing or are in an embryonic development in Greece (e.g. day centers for Alzheimer patients, support to the caregivers of the elderly, residential or respite settings). There is a shortage of places and an uneven distribution within the country (Sissouras et al., 2004; Papaliou and Fagadaki, 2005).

General characteristics of the social care services and practices

According to the ESPN Thematic Report on Challenges in long term care (Greece 2018) " State support for non-self-sufficient elderly people and disabled people (children and adults) in Greece includes disability and welfare benefits, limited direct provision of institutional care, coverage of some care needs through public social insurance and a range of community-based services. The services provided are of limited coverage, and their supply falls well short of demand; they are inadequate to meet the ever-rising needs in this area".
Long-term care for frail, incapacitated elderly people (mostly indigent or living alone) is also provided by approximately 240 care homes (residential and nursing care facilities) that are run by private (for-profit and non-profit) organizations (Eurofound, 2017b) and are mainly located in urban areas. Estimates suggest that non-profit and for-profit residential care homes for the elderly have a total capacity of about 12,000 beds (Eurofound, 2017b), though the president of the Greek Care Homes Association (PEMFI) puts the figure at about 15,000. Almost half of the care homes are situated in the Greater Athens Area, and the vast majority are run by private (for-profit) enterprises; the remainder are managed by the Church, charitable organizations and local authorities.

Public care facilities and services for dementia and Alzheimer's disease – which affect an increasing number of people in Greece – have, until very recently, been rather negligible; specialized care was mainly provided by a small number of non-governmental organizations (NGOs). To address this gap, in 2014 the government established the National Observatory for Alzheimer's and Dementia, and in 2016 adopted the National Action Plan, which includes the creation of special care units (day-care centers, etc.) and the provision of support for carers (Minister of Health, 2016). In this context, in September 2017, the government announced the establishment of seven day-care centers, six memory and cognitive disorders clinics and five palliative care hospices for the terminally ill (Greek Association of Alzheimer's Disease and Related Disorders, 2017). The plan also aims to facilitate the linkage of these services with all the other social care. However, in reality these new structures are not fully developed in 2020.

As regards the day-care services for the elderly in the community, these are provided through the 68 day-care centers for the elderly (KIFI)11 currently in operation (EETAA, 2017). At present, there are 860 'Help at Home' schemes in operation, run by 282 agencies (municipalities, municipal enterprises, non-profit organizations, etc.) and providing services to about 71,563 beneficiaries (EETAA, 2017).

Trends in social care services and practices

The new social care model in Greece should focus on mental diseases (especially to depression), chronic diseases, geriatric syndromes and substance dependence.

Important topics to be addressed are: a. the development of primary care, b. training of informal carers and their general support, c. the development of intermediate structures, d. wellbeing activities for ageing population, e. integrated care pathways for older people with the presence of a case manager.

We would like to present some international/national trends in social care service for the elderly which have the common characteristic to involve partners from the region of the Western Greece. However, these constitute only segmented-fragmented case studies and not actual trends in the social system of care.

ACTIVAGE is a European Multi Centric Large Scale Pilot on Smart Living Environments. FFN (Fragility Fracture Network – which is a local NGO very active in the field of active ageing and very powerful in the scientific community for frail older populations) is one of the partners in Greece. The main objective of ACTIVAGE is to build the first European IoT ecosystem across 9 Deployment Sites (DS) in seven European countries, reusing and scaling up underlying open and proprietary IoT platforms, technologies and standards, and integrating new interfaces needed to provide interoperability across these heterogeneous platforms, that will enable the deployment and operation at large scale of Active & Healthy Ageing IoT based solutions and services, supporting and extending the independent living of older adults in their living environments, and responding to real needs of caregivers, service providers and public authorities.

ACTIVAGE ultimate goal is to create the evidence and to be the reference driver of this virtuous circle of the Active and Healthy Ageing market growth that will increase the demand by payers, providers and users, and will intensify the offer of solutions by the industry, SMEs and financial services.

O1. To deliver the ACTIVAGE IoT Ecosystem Suite (AIOTES), a set of techniques, tools and methodologies **for interoperability at different layers between heterogeneous existing IoT Platforms** and an Open Framework for providing **Semantic Interoperability of IoT Platforms for AHA**, addressing trustworthiness, privacy, data protection and security.

O2. To set up a European Multi Centric Large Scale Pilot distributed across nine interconnected Deployment Sites of seven European countries constituting the whole operational and evaluation space, in order **to build local IoT ecosystems on top of legacy open or proprietary IoT platforms**, encompassing all stakeholders in the AHA value chain and highlighting seamless services connectivity support while users are moving in their living environments.

O3. To set a common Reference Evaluation Framework implementing the GLOCAL approach able to complement Global and LOCAL reference features and requirements. The evaluation framework will allow the assessment of interoperable

IoT-enabled Active & Healthy Ageing solutions enhancing and scaling up current existing services on every Deployment Site, **for the promotion of independent living, the mitigation of frailty, preservation of quality of life and autonomy of older adults in smart living environments.** The objective is to create significant evidence and value of the benefit produced on all these aspects, **for the sustainability of the H&SCS, and for validating new business, financial and organizational models for care delivery**, both in a local/national and European scope.

O4. To provide a co-creation framework that enables the **identification, measurement, understanding and prediction of the demands and needs of IoT ecosystem on AHA users**: older adults, caregivers, health and social care professionals and providers, assessing their needs, preferences and perceptions regarding user acceptance, trust, confidentiality, privacy, data protection and safety. The goal of this objective is to raise and identify some unknown key success factors related also to deployment and scaling up activities.

O5. To set up and operationalize a communication and dissemination program that allows **worldwide outreach of project activities and achievements**, to make ACTIVAGE a global reference framework of evidence-based values of IoT for AHA.

The mobility scenario ACTIVAGE in Greece for smart homes for the elderly constitutes a great example of good practice. It focuses on

a. Daily activity monitoring at home for informal carers support and for formal carers follow up,

b. Integrated care for older adults under chronic conditions

c. Monitoring assisted persons outside home and controlling risky situations

d. Support for transportation and mobility

For further information please visit: http://www.activageproject.eu/docs/open-call/ds_posters/5.DS%20GREECE/DS_GR_02.pdf

FRAILSAFE

The leader of the extremely interesting project frailsafe, is the University of Patras. FrailSafe aims to better understand frailty and its relation to co-morbidities; to identify quantitative and qualitative measures of frailty through advanced data mining approaches on multiparametric data and use them to predict short and long-term outcome and risk of frailty; to develop real life sensing (physical, cognitive, psychological, social) and intervention (guidelines, real-time feedback, Augmented Reality serious games) platform offering physiological reserve and external

challenges; to provide a digital patient model of frailty sensitive to several dynamic parameters, including physiological, behavioral and contextual; this model being the key for developing and testing pharmaceutical and non-pharmaceutical interventions; to create "prevent-frailty" evidence-based recommendations for the elderly; to strengthen the motor, cognitive, and other "anti-frailty" activities through the delivery of personalized treatment programs, monitoring alerts, guidance and education; and to achieve all with a safe, unobtrusive and acceptable system for the ageing population while reducing the cost of health care systems.

EU FrailSafe offers an integrated assessment system, using cutting-edge technology. The solution estimates people's frailty level and locates a person's weakness in order to provide personalized suggestions. It also provides a health monitoring tool and has the potential to generate real-time notifications in case of adverse events. The solution complements traditional clinical assessments in identifying those at higher risk of developing adverse health events, and thus facilitating comprehensive integrated care plans for older people.

It is important to note that the role of social care in the frailsafe solutions is crucial. Thus, specific job description and decision making tools have been prepared in order to better serve the needs of the elderly population.

For further information please visit https://www.frailsafe-project.eu/solution/frailsafe-solution

SWOT Analysis - Greece

The social care in Greece is based strongly on the "Help at home" program which is a successful social support program, valued very positively by the local communities. The KAPI institutions are popular organisms in Greece offering day care activities for the elderly and their effectiveness is guaranteed. Residential organizations cannot cover the needs of local populations. Funding and therefore the viability of such social structures for the elderly population are not certain. However, social care model in Greece is characterized by the lack of technological infrastructure and to the inadequate training and further education for the program's personnel. There are no geriatric courses or specialty in medicine in the Greek faculties which impacts all the system of gerontology or geriatric care.

STRENGTHS	weaknessses
High-quality services provided by the "help at home" services but only in order to facilitate the assurance of a dignified and healthy living in their own home. At the same time, the beneficiaries' families are alleviated and disengaged by an important load of care. **Decreased institutionalization rates due to the economic crisis.** Families prefer caring their relatives in order to keep social and economic benefits of the elderly population. **Wide social acceptance for the "help at home" and KAPI services.** These services enjoy a wide social acceptance throughout the country. **Strong self-regulation mechanisms** a as a response to the lack of harmonized regulation and legislation on behalf of the state.	**Increased utilization of hospital services**. In many cases, the elderly in need of primary health care services end up to hospital services. In their vast majority, elderly users of hospital services are unsatisfied. **Lack of evaluation of existing social services:** while in most European countries impact evaluation is a widespread process, in Greece with regards to social programs and services the evaluation is quasi inexistent. **Lack of trust and limited information/access to public services:** government and institutional websites are unfriendly-user and health and social illiteracy rates are very high especially those of the ageing population. **Lack of high specialized trained personnel:** there is a lack of geriatric specialty in Greece. There is only a generalist approach regarding special pathologies. This means that there are not qualified medical doctors regarding the whole spectrum of care for the elderly (this could range from

	stroke to Parkinson's disease, falls and fracture prevention, diabetes or cardiovascular disease). **Personnel shortages.** In many structures there is an urgent need for specialized and well trained personnel in social care. Stress and staff burnout are, consequently, frequent phenomena. **Lack of diversified services:** services for the elderly in the public sector are very fragmented and lack of intermediate structures such as Parkinson centers and day care centers for Alzheimer patients. Intersectoral coordination is inexistent between private and public sector as well. **Limited ICT services for elderly care:** the technology barrier is very important. An older person in Greece does not dispose administrative, social and health registry.
opportunities	**THREATS**
Political willingness to change the structure and culture of social care system: local and national politics have declared their willingness to facilitate connection between social and health sector, to increase citizen participation and to reduce social inequalities especially in the western Greece region. **Trend in a more transversal and holistic care for the elderly:** early prevention and community care models are actually in discussion in the Greek society. There is a trend in	**Unstable regulatory regime.** The last 10 years of economic crisis, have impacted the care for the elderly. The legislative regime is unclear and there may be changes that threaten the viability of local structures and create disruption in several regions. The recent financial crisis has serious effects on overall social costs and threatens the sustainability of social structures. Thus, the system is unable to service the increased number of elderly population in need. **Increased social and healthcare inequalities and inequities:** during

primary care centers with the support of the EU. **Solid cultural and social values:** protagonists in this value chain are family caregivers and civil society organizations. Greek society is based on family caregiving and it is one of the top ranked countries in the EU regarding the deinstitutionalization of care for the elderly and the disabled people. The intergenerational support is very important and social representations about ageing population are generally positive.	the economic crisis, the inequalities and inequities of some vulnerable groups have been increased. Thus, the elderly appear as one of the new vulnerable groups because of the limited access to health services. The portion of ageing population at risk of poverty regarding the overall Greek population, has been considerably increased. **Fragmentation of Greek society:** the economic crisis had impact the structure of the Greek society. Thus, a fragmentation of economy and of ideas has been created. Consequently, a part of Greek population striken by high unemployment and financial problems, have a mitigating image about the elderly (who are not working and could be an obstacle to the whole economy). **Professional training and high quality of nursing care and specialized management:** there are some newly recognized training courses for nurses, managers of gerontology organizations. **Telecare of elderly population:** Integrated telemedicine for fall prevention of the elderly, for better recognition of social and mental impairment for targeted ageing patients are some opportunities existing in Greece.

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Lebanon

Summary of the interviews

Partners from Lebanon carried 6 interviews with interviewees from:

- The macro management profile (Governmental Interview with 3 representatives from the Ministry of Social Affairs)
- The meso management profile (Manager of a Social Development Centers, 2 Academics, Nursing Home Manager)
- The micro management profile (NGO coordinator and a nurse working with the geriatric population)

The most important conclusions of the interviews were the following:

Lebanon is still lacking a comprehensive model of care for older persons. The available social-care services in Lebanon include:

1. **Social security** but it is largely dependent on the employment history with differences between public and private employees so a lot of older persons do not have social security after retirement.
2. **Retirement plans** which are lacking and are reserved only for public employees or some private employees (uneven and not equitable). Most older persons do not have income after retirement age.
3. **Healthcare services** offered by the Ministry of Public Health such as: primary healthcare services, coverage of uninsured older persons who need to be in a nursing home, a chronic medication program, 100% hospital coverage for 64+ Lebanese with chronic and non-treatable diseases and "64+ Elderly Preventive Packages" for poor Lebanese under its "Emergency Primary Health Care Restoration Project towards Universal Health Coverage project".
4. **Social and health services** offered by the Ministry of Social Affairs which offers: coverage of older persons who need to be in a nursing home for social reasons, welfare services by contracted institutions and specialized development services (primary care, recreational activities, homeless support), health services through dispensaries and development services, daytime clubs, disability card services (offers privileges to disabled elderlies), the support program for poorest households with the Ministry of Public Health, national program of adult education, a nutrition project which provides hot meals for needy elderlies as well as standards for long-term care, Social Development Centers which offer social services for older persons.
5. **Services offered by non-governmental organizations** such as:
    - Nursing homes,
    - Social welfare services,
    - Care for homeless elderlies,
    - Free restaurants and food supplies, ○ Daycare centers and clubs,
    - Social activities and trips,

- Palliative care,
- Care for specific conditions such as Alzheimer's disease,
- Empowerment projects,
- Advocacy and awareness services.

6. **Academic services** such as the University for Seniors, special workshops and trainings in Social Development Centers as well as programs and training in geriatrics.
7. **Governmental entities such as:** A directorate at the Ministry of Social Affairs which oversees social care on contractual basis with organizations (older persons are accepted in care organizations based on social needs and not financial or medical needs.) A directorate at the Ministry of Social Affairs care for the rights of the disabled and for non-governmental organizations. A higher council for elderly affairs at the Ministry of Social Affairs which acts as a strategic entity and applies recommendations from international congresses. The services offered by the Ministry of Social Affairs are complementary with those offered by the Ministry of Public health, but they might not be enough in quantity and coverage.

Challenges related to older care in Lebanon include: majorly the need for Comprehensive Retirement Plan (social and medical) and Financial Independence, the changing family dynamics and migration, the current financial crisis in Lebanon, homeless older persons, the current Lebanese law and guardianship system which deprives older persons from their rights to voice their needs, unavailability of platforms that has data on older persons, social culture of older persons who refuse to participate in social activities and families who do not support their social engagement, lack of human and financial resources, mental health problems, unequal services in different regions, lack of infrastructure to support the elderly, high cost of private nursing homes, lack of training of home caregivers, among others.

New ideas for the platform were also identified as important areas to include in the new model such as: training of professionals and home caregivers, community education and awareness , inclusion of clinical records (electronic medical records), integration of technological solutions (GPS, telecare…), fall prevention using technological services, inclusion of social activities and available services, inclusion of indicators for effectiveness and satisfaction, change the system of elderly homes, to have a bank where a person can volunteer hours of services to older person and then once he/she needs someone to care for them they can use these hours, social networking and guidance for older persons, focus on the older persons' interest in technology as many are currently using smartphones and tablets as well as social media, networking among municipalities, academia and NGOs, economic empowerment of older persons through projects that allow them to work within their communities or develop small businesses and investments , modules for caregiving (nutrition, physiotherapy, mental health, …), etc… In addition, interviewees stressed on the importance of contextualizing the model to the needs of the country.

Current social care services available in Lebanon

The available social-care services in Lebanon include:

1. **Social security** but it is largely dependent on the employment history with differences between public and private employees so a lot of older persons do not have social security after retirement.
   The National Social Security Fund (NSSF) which is a contributory fund that gathers the contributions of employers, employees, and the government and, in turn, provides: The End of Service Indemnity; Health and Maternity Insurance; and the Family and Education Allowances. The contribution to the fund is 23.5% of the wage, with 21.5% by the employer and 2% by the employee. Because the contribution is high for the employers, more than 40% of employees are not registered with the NSSF and NSSF does not cover informal labor or self-employed.
2. **Retirement plans** which are lacking and are reserved only for public employees or some private employees (uneven and not equitable). Most older persons do not have income after retirement age. The below are the different schemes currently in place for pension plans:
   - The Existing System for the Private Sector is the End of Service Indemnity System (ESI) which is a lump-sum cash benefit, received upon retirement.
   - The Civil Service and Military Pension Schemes-public sector pension (Individuals can either choose a lump-sum pension or a permanent pension paid in monthly instalments and which is more generous than that of the private sector).
   - Lebanese Universities (have special schemes for end of service systems)
   - Syndicate Schemes (engineers and lawyers for example have special schemes related to syndicates and can have a retirement salary)
   - The Army, Internal Security Forces and Public Security Cooperatives
   - Private school's solidarity and pension funds (available for teachers and have a specific scheme) (Rached, 2012)

3. **Healthcare services** offered by the Ministry of Public Health (MOPH) such as:
   - Primary healthcare services: older adults have access to primary health care services including doctor consultations, laboratory tests and diagnostic imaging at a reduced cost at any of the MOPH's 210 Primary Health Care centers (PHCs) in the National Primary Healthcare Network.
   - Coverage of uninsured older persons who need to be in a nursing home: Nursing homes in Lebanon are privately owned for profit or non-profit institutions. The institutions are distributed across all 6 governorates and house around 1.3% of the total elderly population in the country. For poor and dependent patients, the MOPH covers a fixed rate per month of the nursing home fee but only for 71.4% of these institutions.

- A chronic medication program: the program, financed by the MOPH and managed by the YMCA, was launched by the MOPH in the early 1990s to assist low income households in accessing chronic medications. The medications are distributed across 440 dispensaries, PHCs and other outlets. The total budget of the program is 10 billion LP including 3.9 billion/ year paid by the MOPH for drug procurement. While the program targets populations of all age groups, numbers show that 60% of the beneficiaries are elderly.

- 100% hospital coverage for 64+ Lebanese with chronic and non-treatable diseases: The MOPH launched in 2016 a project aiming at comprehensive (100%) hospitalization coverage for all Lebanese elderly over the age of 64 to cover three main elderly needs: chronic diseases, cancer and non-treatable diseases, and Alzheimer's, Parkinson and osteoporosis. Physical therapy, nursing care at home, psychological support services and other diagnostic services are also covered under this initiative.

- "64+ Elderly Preventive Packages" for poor Lebanese under its "Emergency Primary Health Care Restoration Project towards Universal Health Coverage project": The MOPH also provides essential health care packages for free to 150,000 Lebanese with limited income under its Emergency Primary Health Care Restoration Project towards Universal Health Coverage project. Among these packages is the elderly 64+ package which includes immunization, laboratory tests, consultations, radiology, etc…
(Hamadeh, 2018)

4. **Social and health services** offered by the Ministry of Social Affairs which offers:
   - Coverage of older persons who need to be in a nursing home for social reasons,
   - Welfare services by contracted institutions and specialized development services (primary care, recreational activities, homeless support),
   - Health services through dispensaries and development services,
   - Daytime clubs,
   - Disability card services (offers privileges to disabled elderlies),
   - The support program for poorest households with the ministry of public health,
   - National program of adult education,
   - A nutrition project which provides hot meals for needy elderlies as well as standards for long-term care,
   - Social development centers which offer social services for older persons.

(Ministry of Social Affairs, 2016)

5. **Services offered by non-governmental organizations** such as:

- Social welfare services (ex: Caritas Lebanon) ○
  Care for homeless elderlies (ex: Mission de Vie)
- Free restaurants and food supplies (ex: Beit el Baraka, Restos du Coeur, Food Blessed…)
- Daycare centers and clubs (ex: Minerva - The Alzheimer's Association Lebanon)
- Social activities and trips (from religious organizations)
- Palliative care (ex: Sanad, Balsam)
- Care for specific conditions such as Alzheimer's disease (The Alzheimer's Association Lebanon which offers weekly support group meetings for caregivers, monthly conferences and a daycare center)
- Empowerment projects (ex: The Elderly Empowerment project by IDRAAC which offers older persons residing in Byblos work, volunteering or leisure activities to engage them socially and empower them economically)
- Advocacy and awareness services (ex: The draft law by IDRAAC which protects the elderly of Lebanon from discrimination and neglect following a comprehensive legal review of the laws related to the elderly in Lebanon.
  The proposed law allows the elderly or people with symptoms which are caused by aging to have precautionary measures before their health deteriorated. The new law allows a person to identify a person of trust while he/she still has full mental capacity to be able to take predefined decisions on behalf of the older person in case he/she loses his/her mental capacity.)

6. **Academic services** such as the University for Seniors, special workshops and trainings in Social Development Centers as well as programs and training in geriatrics.

General characteristics of the social care services and practices

It is important to note that the lack of a retirement plan and comprehensive social and health coverage for older adults is the main concern in Lebanon in term of social care services and practices. A lot of efforts were done to set an equitable retirement plan but still, this plan did not see the light.

The majority (around 98%) of older persons in Lebanon live in their homes and not in institutions. (Sibai, 2009)

In addition, services offered in the current social care model are characterized by the following:

1. Unequal distribution in different regions of Lebanon (more in urban communities)
2. Catering for the poorest and underprivileged populations in general

3. High out-of pocket spending of older persons on health and social services
4. Lack of data collection and reporting about the use of the services
5. Lack of awareness of the general population on the available services
6. Insufficient or unsustainable funding of services
7. Issues with infrastructure of the social care system
8. Lack of collaboration and networking among different partners
9. Issues due to the current financial and political situation in Lebanon which reflect on the services offered to older persons
10. Lack of human resources specialized in dealing with older persons in Lebanon
11. Issues due to changes in family structure in Lebanon due to migration of children (who are sometimes caregivers of older persons) and which is leading to increased institutionalization
12. Lack of social and leisure activities
13. A social culture which sometimes does not support engagement of older persons in social activities leading to social isolation
14. High cost of private institutions for older age and homecare companies
15. Short-term planning efforts

All these characteristics are main challenges in the provision of social care services to older persons.

On another note, there are different characteristics which give the current social model of care its strengths in Lebanon such as:

1. Social and cultural norms within the Lebanese society and family cohesion which helps in supporting dependent older adults.
2. The strategic vision for older age led by the Ministry of Social Affairs who has a higher council for elderly affairs and who is working on a national strategy which will be an important milestone in the development of action plans related to old age in Lebanon.
3. The complementarity of services and close collaboration between the Ministry of Social Affairs and the Ministry of Public Health in services provision especially for the poorest and which aids in filling the gap in services such as (Primary healthcare centers, Social development centers, Medication Programs, etc…).
   Some examples of services also include:
   - The Disability card by the Ministry of Social Affairs which offers disabled older adult in-kind benefits and social advantages.
   - Poorest households card which the households classified as poorest obtain from this program a card by which the household benefit from a series of social services among which: health insurance in the hospitals contracted with the program and a temporary nutrition card service in collaboration with the World Food Program (WFP).
   - Standards of care for nursing homes: this is an initiative by the Ministry of Social Affairs to advance the infrastructure of Nursing home and work on accreditation standards in the near future to assure better services.

4. The important work of NGOs offering services to fill the gaps currently available in the model.

Trends in social care services and practices

Despite the challenges faced in social care practices in Lebanon, there is a lot of efforts currently being done to overcome these challenges. Below are the main trend of social-care services available at the moment:

1. The National Strategy for older age: which is being prepared by the Ministry of Social Affairs to develop related actions on a national level.
2. Nursing Home Standards initiative: Standards were put for institutions to abide by in an effort to start an accreditation process for institutions caring for older persons.
3. Work on a comprehensive retirement plan: however, it is still not in place due to economic and social challenges.
4. Social security after retirement: which is now available for persons who have been under the National Social Security Fund for more than 20 years prior to retirement.
5. Comprehensive health coverage: this is being addressed on a national level as part of ministerial strategies but is still not in place for the total population due to lack of resources.
6. Home caregiving and family support: which is a very important element in the Lebanese culture while family cohesion is a supporting element for older persons in Lebanon.
7. Interest in social initiatives related to older age: through clubs, social engagement, leisure activities to decrease social isolation. In addition, more focus is being put on the mental health of older persons.
8. Advocacy, legal and policy efforts: which are being done to improve the status of older persons in Lebanon and preserve their rights

SWOT Analysis - Lebanon

Strengths	Weaknesses
National & Governmental Efforts (by the Ministry of Social Affairs, Ministry of Public Health and Ministry of Labor) Work on national strategy for older age Work on age friendly cities plan Social Services from the Ministry of Social Affairs (Social Development Centers, Disability Card, Poorest Households Card, Social Services ….) Healthcare Services from the Ministry of Public Health (primary healthcare, healthcare coverage of the uninsured, medication programs, etc…) Standards of care for nursing homes Accreditation standards of hospitals Retirement plans of the public employees **NGOs and Academic Insitutions Services:** Nursing homes Social welfare services Free restaurants and food supplies Daycare centers and clubs Social activities and trips Palliative care Care for specific conditions such as Alzheimer's disease Empowerment projects Advocacy and awareness services University for Seniors Work on laws and policies **Cultural and Social Norms:** Religious norms and socio-cultural morals Family support Social cohesion Social groups to support older persons at home **Low institutionalization rates**	**Financial:** Lack of resources dedicated to old age Financial dependence of older persons **Legal and Policy Issues:** Lack of equitable comprehensive retirement plan (social and medical) The current Lebanese law and guardianship system which deprives older persons from their rights to voice their needs (this law stipulates that if a person of older age has decreased mental capacity, the court can assign a legal guardian who will take decisions on behalf of the older person; this mechanism puts the older person's at risk of abuse from the legal guardians in many cases). **Infrastructure and Support Services:** Uneven distribution of services in different regions High cost of private nursing homes Lack of awareness on available services for old age from the community Lack of infrastructure and supporting environment to support old age Lack of support of homeless older persons Lack of work on prevention initiatives for health conditions Lack of data and reporting about older age indicators and services in Lebanon **Human Resources:** Lack of Lebanese workers working with older persons Lack of training of caregivers (formal and informal) Lack of specialized professionals in geriatrics **Social Issues:** Local culture related to old age (from older persons and caregivers) Social isolation of older persons after retirement Increased risk of institutionalization

Opportunities	Threats
Training & Capacity Development: Training of family caregivers Capacity building of older persons Community education and awareness about old age Training of professionals (through the online platform to build their capacity on older persons' needs) **Social Networking:** Social networking between older persons through social groups and committees Networking between stakeholders **Technology:** Interest of older persons in social media Platform for data collection about old age Use of technological tools for monitoring of older person's statuses **Development of Services:** Development of homecare services Variability in offerings of elderly centers (day programs, clubs, …) Guidance of elderly on available services after retirement (in the form of a center) **Financial empowerment of older persons:** Work Opportunities Investment Opportunities	**Financial Situation:** Current financial and political crisis in Lebanon Decreased funding from governmental institutions to old age matters Unmaintainable funding from donors and granting agencies **Family and Population Structure:** Changing family dynamics and migration **Adaptability of International norms and standards to the local Lebanese context**

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spain

Summary of the interviews

Partners from Spain carried 6 interviews with interviewees from:

- the macro management profile (directorate of social services and social inclusion of the government of Andalucía, agency of social services and dependence of Andalusia)
- The meso management profile (representative of the council of elders of the Seville city council, director of the plan for personal autonomy and prevention of dependence, managerial position of a non-profit socio-sanitary institution) and
- The micro management profile (professional nurse of residential care).
- Final beneficiary representative (member of the municipal council for the elderly).

Although the interviews have offered broad and complex reflections, the following paragraphs offer a synthesis of the most significant and representative dimensions of the interviewees' speeches.

1. Globalization: highlight that phenomena such as globalization and globalization (held & mc grew, 2001) have caused significant changes in the social structure and demographic dimension of our territories. We are in fact facing a substantial growth of cities and the same time, most aged and older high presence in core rural emptied with an increased risk of vulnerability linked to chronicity, pluripatología, dependency.

2. Evolution in the concept of aging: the analysis of the interviews shows the need to referes to older people not as a homogeneous group but rather that includes diversity, for example, age, culture and socio-economic status.

3. Barriers: on the other hand, there are numerous barriers to achieving quality development throughout all stages of life: physical (eg access to housing); economic (eg lack of resources and insufficient benefits; housing problem); legislative (eg lack of compliance with the dependency law, pension system that does not support needs, territorial inequality), political-administrative (inequality of services due to privatization, an unprepared administration and due to the diversity of models of care, lack of socio-sanitary coordination, lack of continuity of care and in the progressive transition of the elderly; need to enhance home care so that the client does not leave his usual context; precarious labor system); social (the double vulnerability of being elderly and at risk of socio-economic exclusion; loneliness, long-term care, lack of specialized personnel, focus on family vs. Professional care); formative and cultural (stigmatization and self-stigmatization of socio- health professionals , feminization of care work) .

All these questions make necessary adaptation is public policy and rethinking the models of care towards alternative prosocial, of social cohesion and empowerment of the population. Policy respond to the need for inclusion of diversity in all its possible significant - extensions and regeneration of the social environment.

At the same time, the need to dignify the aging culture and its representation is detected to raise awareness of the need to include the elderly as an integral and active part of the population, focusing on the elderly not only as a vulnerable element but as an active protagonist of community development, with intergenerational action. The autonomy of the individual must be maintained as an achievable right at all stages of life and with quality of life.

In this sense, the need to educate in values –such as listening and respect- and promote decent, ethical quality care, attending to basic needs, preventive vision, decision-making and resource management; based on social capital and the creation of networks -trust, relationship, coordination- recovering the strength of historical-cultural wealth such as the experience of care, of women, of the elderly -the accumulation of social capital- and also the culture of territory (eg dance, shared traditions, gastronomy). In the same way, the need to include innovative measures and to promote cooperation and coordination between different agents at different territorial and sector levels, multidisciplinarity (eg. Local administration and companies) for optimization of resources, effectiveness of services are highlighted, to provide a response at the urban and neighborhood levels (neighborhood radars, local senior card).

Resources: the role of civil society is highlighted, with a special attention to the many positive experiences that can be used as a model and as a starting point to promote autonomy and the development of the dignified well-being of older people -also through european models- such as friendly cities and/or cohousing. The use of technology (telecare, telemedicine, monitoring, decision-making platforms for individualized social care, information systems / health history, the media as information channels for the elderly population)

It is essential to bear in mind the peculiarity of the Mediterranean well-being model and the transversal values in its territories.

Current social care services available in Spain

Social care can be defined as the fourth pillar of well-being along with education, health, and pensions (Moreno, 2012). In Spain, the current model of care is governed by the dependency law (2006). As dependency care benefits, article 14 contemplates economic benefits and services, although the latter will be a priority and will be provided through the public offering of the social services network by the respective autonomous communities (ccaa) through centers and public services or duly accredited private companies.

The structure of the law derives the national responsibility of the different autonomous communities that are responsible for implementing the law and its derived decrees, with different levels of development in the different territories. Resources and assistance provided depend on the level of dependency, which is set to three degrees and is evaluated as determined by each community a utónoma, but usually jointly between health professionals and services social. The services provided and available resources are different according to the ccaa, which causes inequalities in care. Services prevail in the concerted and/or private sphere, and with a clear fragmentation and disconnection between the social system and the health system (for example, they do not share digital platforms).
The current dependency law does not guarantee sufficient care needs and does not define a successful service delivery model. The dependency law has created a pool of dependents with recognized rights who do not receive benefits (dependency limbo), which is related to the economic crisis, budget cuts and policies.

Of the total number of people classified as dependents, in 2019 it is estimated that 80.8% (1,054,275) (state associations, 2019) have benefited from this system. Law 39/2006, of December 14, on the promotion of personal autonomy and care for people in dependence (BOE no. 299, of December 15, 2006), as amended by royal decree-law 20/2012, of 13 July, on measures to guarantee budgetary stability and the promotion of competitiveness (BOE nº 168, of July 14, 2012), regulates the basic conditions for the promotion of personal autonomy and the care of people in situations of dependency through the creation of the system of autonomy and care for dependency (SAAD)

General characteristics of the social care services and practices

We defined a “dependent person” as someone who suffers loss of physical, mental, intellectual or sensory autonomy that prevents them from living or developing basic activities of daily life. The guiding principles of social care services are the promotion of personal autonomy, protection and care of dependents through public and private services (through co-payment systems based on the resources of the dependent person and the family). Article 16 of the law establishes that the network of saad centers will be made up of: • public centers of the ccaa and local entities. • state reference centers for the promotion of personal autonomy and care for situations of dependency. • duly accredited private centers. In accordance with the provisions of article 3 of the order of the ministry for equality and social welfare of august 3, 2007, the network of centers and services of the system for autonomy and care for dependency in the autonomous community of Andalusia it will be made up of the following types: a) public centers and services owned by the administration of the regional government and its dependent bodies and entities. B) centers and public services owned by the local c) private third-party centers and services defined in article 2.8 of law 38/2006, of December 14. D) private centers and services arranged by private initiative for profit.

The determinants of the demand for long-term care are determined by different variables: 1. Demographic aging (aging of the aging) 2. Health status 3. Social and institutional factors (household structure, characteristics of adult population and the current care model, the massive incorporation of women from the world of work; reduction in the average size of households) (Lipszyc, sail & Xavier, 2012). By

not responding to these contributions, the weight of family care that affects not only the latter but also the economy and equity, especially gender, is delegated (committee for social protection and European commission, 2014: 6) 4. Technology (new solutions that facilitate autonomy) eg. Robotics applied to gerontology or advances in communication and remote control. The white paper on care for people in situations of dependency in Spain (rodríguez-castedo [dir.], 2004: 80), records a serious situation in the need to reform the care system oriented towards the integration and coordination of resources (especially medical and social care), person-centered care and legal frameworks and sustainability. Demand not covered by the formal care system is covered through family or non-professional networks in the immigrant community and without hiring. In the same way, there are few health professionals qualified due to lack of a system of quality training for professionals of the social services, so those who are engaged in this work are forced to self-train as a self-educated and work in a precarious situation and they are victims of stigmatization. The Spanish welfare model registers the same characteristics as the Mediterranean model (with the main public pillars integrated with private and cooperative pillars), characterized by a high level of familiarization of care, feminized and not professional. The variability in care models not only by autonomous community but also at the city level produces territorial inequality in services.

Trends in social care services and practices

Although there is an increase in the number of people served, there are several difficulties due to cuts and economic crises, such as accessibility, availability and affordability, adaptability.

There are different models in innovative care services that will be described in the next section, such as:

Decision-making model for designation of social services for seniors.

1. Person-centered care

2 . Tendency to swing the attention on the primary care and integrating socio-health care

3 . Care family vs professional care

4 . Defamiliarization of care

5 . Model intervention or n aging worthy and positive (edp)

6. Decision-making model

7 . Strategies for managing dependency and complex chronic diseases

8 . Trends in the services attention or residential n.

1. Person-centered care

Person-centered care is a model of care that seeks and prioritizes the quality of life of the elderly who need care. It proposes an attention based on professionalism and technical knowledge, but putting the user of the services at the center of care planning. Starting from their needs, but above all, guaranteeing their rights and respecting their preferences and wishes in care and in daily life (Martínez Rodríguez, 2015).

It promotes person-centered care (Brooker, 2004) rather than focusing on services that have greater rigidity. This trend has begun to develop in Asturias, Castilla y Leon, Basque country, Catalonia, Madrid with positive results (Martinez, 2016) basad you on the completeness and integration of resources (eg. Fundación Matia-proyecto etxean ondo; Fundación Pilares para la autonomía personal, Madrid) (Rodríguez, 2010; Díaz- Veiga et al, 2014).

An example of this trend is the proposal **of Acciones Sociales y de Salud para Asturias (social action and health for Asturias)**, a health strategy and care to people with chronic diseases. In this sense, it is proposed to develop a project that improves the quality of life, avoiding the isolation and inequalities of people with chronic, terminal, dependency and social needs, integrating current social and health systems.

The Asturias Health Ministry (2007) proposes the design of a socio-health intervention model that should have as its main objective the elaboration of a strategy to give a political response to the problem of the different groups of dependent people, based on strengthening of the coordination and collaboration of all the actors involved in the processes. At the same time, the policies that delay the creation of the foundation of the number of dependents, promote healthy aging, prevent accidents, the risk of diseases than in training people and the subsequent rehabilitation of any disease. The objectives of the regional strategic plan of Asturias of the ministry of health of 2018-2021 are:

1. Promote primary care as the core of the public health system, which guarantees continuity of care throughout life and acts as a coordinator of cases. 2.guarantee a stable structure and endowment of material and human resources that meets the criteria of functionality and comprehensive health and social needs. 3. Adapt the competencies and functions of the professional teams to the strategic reorientation. 4.increase resolution capacity and innovation with the use of new technologies and information systems. 5. Evaluate and reduce the unwarranted variability of clinical practice. 6. Orient this level of care towards the development of activities related to the promotion and prevention of individual and population health, and make it a link between the health system and the community. 7. Extend and spread good practices.8. Move towards excellence in care. 9. Stimulate that

primary care is a space for knowledge management and a tool for professional development. 10. Promote research.

11. Promote transparency actions in the evolution of the budget, advancing in an economic allocation in accordance with the new responsibilities it assumes.

The dependent care model developed by the San Juan de Dios hospital order exercises comprehensive care that addresses the health, social, spiritual and family needs of the person in need. Its main objectives are:

- provide a benefit that simultaneously covers the social and health needs of people with chronic diseases and disabilities that lead to dependency, planned in the medium and long term.

- provide accessibility, appropriate to their clinical and social situation, and their continuity of care. This is achieved by establishing the necessary measures for this purpose with the rest of the hospital's primary care and social services. The care model proposed by the order is based on the social and health care model proposed by the analysis and evaluation commission of the Spanish National Health System (1991), which includes: 1) chronic phase diseases; 2) degenerative diseases; 3) terminal stage diseases; 4) geriatric syndromes; 5) functional disability; 6) mental illness; 7) intellectual disability; 8) drug dependency; 9) physical needs; and 10) needs of caregivers.

The proposed model places at the center, as its core, respect for the dignity of the person, considering this value as universal. From this point of view, the person has value in himself and not based on circumstances or internal or external elements. Therefore, the San Juan De Dios model must be oriented at all times to preserve the dignity of the person served who, as a result of their disability, illness or exclusion, partially or totally lose their autonomy, that is, their ability to make decisions, an essential element in the configuration of dignity.

Other examples of services related to person-centered care are: attention to physical activity, nutrition, memory. Attention to the intention of specific problems such as Alzheimer's; attention to the "old frail", psycho-emotional intervention program (Bengoa y Nuño, 2008).

The **active aging** approach becomes a promoter of subjective well-being of the satisfactory longevity process: a challenge in the education of older adults. Development of a personological program characterized by being: intentional, motivational, objective, systemic, individualized, reflective and experiential.

To promote the subjective well-being of older people in the process of satisfactory longevity, an educational program with a personal, participatory, creative and empowering approach to human development is required. An educational program

with a person logical approach is proposed to promote subjective well-being in the process of satisfactory longevity in the elderly belonging to the university chair of the **casa de los abuelos** in the municipality of Amancio. Theoretical, empirical and statistical methods were used to obtain, process and analyze the information, allowing the initial diagnosis to be made and the proposal to be designed based on the experiences, needs and motivations of this age group. Disability prediction, economic and material security, social and family protection, participation and social recognition and well-being in different areas of life. Community work is the basis of care for the elderly, prevention or care for the most fragile groups can find a community response. The family is essential to meet the challenge, but must receive the necessary help to do so.

Experience in intervention with elderly people in situations of dependency at the M**atia Foundation.** Among the main objectives arising from this model is to offer, through a team of competent professionals, organized interdisciplinary, professional care, complementary to the family and social relationship, of high quality, as well as very professional, very close, personalized and human, incorporating volunteering. And considering the family as the central axis of the intervention with the user and resident. Residential care model: the objectives are the execution, following the strategic planning of the activities carried out in the centers of gerontological and residential units to achieve the best quality of life for the elderly people served and their families. In the integrated document, the introduction of new, more advanced and psychosocial care within this service model, we highlight the following key themes: the influence of the environment on quality of life and the holistic nature of the intervention.

2. Tendency to swing the attention on the primary care and integrating socio-health care

Primary health care can be defined as: "essential care, based on practical, scientifically sound and socially acceptable methods and technologies, made available to all individuals and families in the community through their full participation, and at a cost that the community and the country can support, in each and every one of the stages of its development, with a spirit of self-responsibility and self-determination (Martín Zurro, 1994) .

There is a tendency to focus attention on PHC (eg Asturias Health Department), in the different autonomous communities, reflected in these guidelines (IIS, 2010):

1. Integration of the care, conceiving the attention on the primary health as the center of the system, strengthening primary care teams and creating simplified circuits coordination between different levels of health and social care (IIS, 2010) .

2. Conception of specialized care as support for primary care not only in the hospital environment or through the bed resource, but as an advisor and collaborator for the

resolution of the needs of the citizens of their health area (Bamberg Foundation, 2018).

3. Equity in health services: absence of differences in access to services for equal health needs (horizontal equity) and increase in access or other resources for defined groups of population in the social, demographic or geographic aspect, with higher health needs (vertical equity) (WHO, 2000)

4. Strengthen palliative care throughout the public health network (Consejería de Salud, 2007)

5. Multidimensional and multidisciplinary evaluation of citizens who need their services through the creation of evaluation and social support teams (Ministry of Health and Consumption, 2007).

6. Adaptation of the structures and professionals to the current needs of the system, taking advantage of all available and underused resources, through training and structural adaptation of the centers.

3. Family care vs. Professional care

In Spain, formal care received at home is complementary to informal care, while formal care outside the home has a substitute nature (Oliva Moreno et al., 2019). The greater response to the need for care by dependent people is covered in a relevant way by informal care through families, and almost always more specifically in women (Rodríguez-Cabrero, 2011).

Informal care makes us reflect on the weight of the role of women, culturally linked to family care. Informal care almost semper falls on women in the family or is delegated to other women in the family or through informal work, often done by immigrant women, in an administrative position irregular and low wages (Robledo, 2003). In this sense, the rethinking of care shows how public policies reinforce the patriarchal elements, which gives rise to questioning the sexual division of labor and the gender inequalities established in the management of care.

Other current trends are related to:

- new schemes of home hospitalization in elderly patients with complex conditions associated with acute health processes.

- nurse specialists in case management for patients with multiple pathologies.

- models based on housing development from the perspective of promoting autonomy and adapting to the elderly population.

- social network programs, mutual aid groups and intergenerational support.

4. Defamiliarization of care

Similarly, defamilization is important because it implies the concept of well-being not as a family collective, but as the well-being of each of its members and is reflected in the social policy effort, the service of dependent services and the effort of conciliation. Responsibility for well-being leaves the home to the state, which becomes a dynamic and promoter of the structure of opportunities aimed at reconciling work and family (Eping-Andersen, 2000; Rodríguez and Navarro, 2008).

The Mediterranean welfare model is characterized by the dichotomy between strong and weak subjects; very generous performance for the central categories of the labor market (public employees and workers employed by large companies) and modest for the weak and peripheral (workers, temporary workers, seasonal workers, self-employed, employees of small companies, etc.), in a dynamic of insider-outsider; delay in creating a safety net base against the risk of poverty; delay in the evolution of the universal meaning (national health services); family role; labor markets characterized by deep sectoral and territorial divisions, and a shadow economy; welfar mix; particularism in clientelism and financing with tax evasion:

“in southern europe, households are assumed to be primarily responsible for the well-being of their members, and therefore family policy is second. That is why the citizens of these countries give the family a high priority on their scale of values ” (Flaquer, 2002, p.202).

5. **Dignified and positive aging model**

The intervention model aging worthy and positive implements the logic of process management intervention from a broad perspective, in which the main objective is the promotion of aging worth positive of the largest users of services, which is defined and delimited by a series of general principles. Criteria that guide the practices and attitudes that professionals develop in the intervention. The principles and criteria constitute the ethical framework and the values that give shape and foundation to the model, and are based on universal values that promote the dignity of the elderly and active aging. The EDP model considers five basic principles as fundamental: bioethics, active participation, collaborative intelligence, well-being and administration. The key to the intervention model is the interrelation between theory (concept) and practice in intervention (praxis); variables that this model considers an interrelational key.this is the attribute of the model, as well as progressivity (possibility of change depending on the interrelationships). The model includes different criteria associated with each of the principles. The criteria are more specific guidelines for action that are framed in each of the previous principles and that provide a closer framework, being a bridge in professional performance "(Rodríguez-González, a, 2016).

This model proposed by the **Ageing_Lab Foundation Jaen Spain** to embroider the aging of the population facing the need to rethink the intervention against this

challenge based on principles, criteria and a key objective: the promotion of positive aging. The edp intervention model applies the logic of process management to intervention from a broad perspective, in which the main objective is the promotion of worthy and positive aging of the older users of the services, which is defined and delimited by a a series the principles constitute the ethical framework and values that shape and base the model, and are based on universal values that promote the dignity of older people and active and positive aging. The edp model considers five basic principles as fundamental: bioethics, active participation, collaborative intelligence, well-being and administration.

6 . Decision making model

Iglesias, et al, (2018) proposes a decision-making model for the designation of social services to the elderly population, which focuses on two types of variables: two external variables (social support and housing) and three internal variables (basic functional capacity, instrumental functional capacity and cognitive state). For each predictor, define the following levels:

- social support: 1) precarious (network size equal to zero or frequently instrumental support less than once a month); 2) insufficient (frequency of instrumental support between one and two times a month); and 3) adequate (frequency of weekly or higher social support). To evaluate this support, it proposes the use of the Díaz Veiga resource scale.

- housing: adequate or inadequate, depending on the score obtained in the evaluation scale designated ad hoc for the development of the model, which includes habitability conditions, services and architectural barriers.

- functional capacity: Barthel and Lawton and Brody index.

- cognitive state: brief portable mental state questionnaire (SPMSQ).

Given these variables and levels, a hierarchy can be established that includes 16 classifiable conditions.

7 . Dependency management strategies, such as complex chronic diseases

Different alternative models are presented hospitalization, facilitating home care of complex chronic patients (for hospitalization or home, model substitute income, high-facilitator model, case management and complex chronicity, evercare).

Discharge facilitator model

The development of new models of alternative care to conventional hospitalization, such as home hospitalization, arises from the current demographic and health situation. In researching comprehensive home hospitalization schemes, geriatric

medicine has an opportunity, given its experience in interdisciplinary work and in carrying out complex interventions (Sánchez-Martín, 2014).

Promoting action for the comprehensive care of the elderly (pace): the patient's profile is a more multi-medicated, multipathological, but still retains the ability to remain at home. The program provides case management through day centers and multidisciplinary teams, which consist of nurses, doctors, social workers, nutritionists, and professionals.

Evercare: it is based on the use of advanced practice nurses as case managers, who seek the integration of social and health services to meet the individual needs of chronic patients and the main objective is to maintain health, avoid income, anticipate changes and facilitate the transition between levels

Geriatric population: some approaches of the case management service have focused on the geriatric population as such, although again we find the problem that the majority of this population presents complexities associated with many processes. In frail older people, case management has shown a decrease in the use of services and associated costs.

For the development of new case management services or the refinement of existing ones, an additional step must be taken in the investigation, using, on the one hand, methodological frameworks that guarantee the adequate design of complex interventions (such as that of British medical research on the other hand, incorporating the vision of patients and caregivers. Patients can make an essential contribution by providing information on what aspects are essential to understanding new mechanisms on how to reduce complexity or strengthen patient participation in their healthcare.

Substitute income model

Objective: avoid acute hospitalization

-derivations mainly from the emergency department.

-center in patients with acute chronic disease

-intervention limited in time (days)

-main health component (under rehabilitation component)

-different medical specialties involved according to the profile of the patient (internists / infectologists, pulmonologists, geriatricians or surgeons)

Case management and advanced practice nurses for the management of complex chronic diseases

Some approaches of the case management service have focused on the geriatric population as such, although we again find the problem that the majority of this population presents complexities associated with many processes (Sevilla-Guerra & Zabalegui, 2019). In frail older people, case management has shown a decrease in the use of services and associated costs.

The management of complex chronic diseases and cases facilitates the promotion of the action for the comprehensive care of the elderly (pace): the profile of the patient is one of the main medications, polypathological, but still retains the ability to stay at home. The program provides case management through day centers and multidisciplinary teams, which consist of nurses, doctors, social workers, nutritionists, and occupational therapists.

8. Alternatives to residential care services

Residential care services are highly institutionalized and do not respond to the diversity of demand. There are experiences that are closer to the home model, such as housing units that have common spaces such as a kitchen, living room and individual rooms for residents, without exceeding an approximate number of 15 people with stable professionals who can generate empathy with users due to have a deeper knowledge of life stories (etxean ondo, at home or at home, well Sancho Martínez Rodríguez et al. (2015)) related to the independence and well-being of residents, satisfaction of families and that of workers. In fact, the hours of home help currently offered to dependents are very few and, as mentioned, imply the existence of a " family caregiver" in the home

On t lso lodging experience with common services (gym, physiotherapy, activity rooms, etc.) And medical and welfare services (Guipúzcoa supervised apartments and homes for the elderly with services managed by the city of Barcelona). They can be officially protected homes adapted for the elderly and that provide services and are equipped with community spaces, where users pay a fee related to their income.

It is essential that residential care allows the integration of both the elderly in the city and the other part of the population with this group.

There are also other integrative and successful services of the services to facilitate autonomy and increase the quality of life of dependent elderly people, favoring their permanence in their environment that home help services should increase and coordinate:

- food delivery service: healthy and adapted diet present in different municipalities of Spain and sometimes by the city council or the autonomous communities (Menjar home in the Valencian Generalitat)

- laundry service at home

The psychosocial intervention model is based on the interdisciplinary and complementary nature between the different disciplines involved, complementing the contributions that behavioral gerontology offers for environmental design, care, treatments, etc. With a population that has a high prevalence of situations of dependency, neurological and psychiatric pathology, sensory deficits, etc. The results of this model include:

1. Psychosocial intervention programs with very high participation.

2. Improvement of direct customer satisfaction.

3. Integration of the psychosocial and socio-health care model and the management and development model of an organizational culture aimed at people and their families.

4. Progressive adaptation of the organization to an increasing level of dependency and of an important psycho-psychiatric nature.

5. Important advances in the training of people and in the development of a skills management model.

The Matía Foundation also proposes an organizational model based on the development of the psychosocial and socio-health model, specialization and personalization in care, the generation of new specialized resources, the development of three fundamental areas of intervention such as the socio-health area, the psychosocial area and the area of socio-community integration and participation.

SWOT Analysis – Spain

STRENGTHS	OPPORTUNITIES
Ethical paradigms of work and values Tendency to decent conditions for professionals Paradigm of Active Aging and Cognitive Development - **Legislation** Universal/Dependency Law **Financing and coordination of economic resources.** Presence of public financing Collaboration with companies Regulated profesionals of residential and home care. Trends in global and intersectoral actions **Organizational characteristics** Existence of public organism Tendency to collaboration of social services and health. Tendency to continuity of care Systematic assessment of the elderly. Cuality of life as a resulting on health Prevention from all areas by multidisciplinary team and therapeutic and diagnostic intensification **Existing services** Home and institutional care Home and residential services, proximal services The assistance and technological support **Training** Financial support for training Qualified personnel training Historical welfare Baggage Previous programs that have shown effectiveness **Awareness of society and positive experiences** International Day of the Elderly School and coexistence education White Paper on Active Aging	**Legislation** Support from the EU and international organizations, coordinating countries. Political creation and joint legislation (social protection laws, universal assistance tax programs) Improving non-policy dependent legislation (shielding) **Change in the organization of care** Development of new models that address vulnerability taking into account current trends proposed by different agencies Care from the paradigm of active aging. Models care incipient (infrastructure, physical activity, focusing on the individual and the community) Tendency to have Primary Health Care as a socio-health care center Adaptation of social structures to dependency. Prevention from an early approach to aging **Quality of professional work** Training and professional development; Work organization, redesign, adaptation and ergonomics; Flexibility, part-time work and reduced hours; Motivation **Professional training and qualification, quality of care** Recognition of training (university) and research Nurses and other advanced practice and case management professionals Health specialties (eg Geriatrics) Improve visibility and professional recognition. Systematic and good practice guides. **Strategies** Coordinate and know the collaboration between social entities and all resources Technical team by neighborhoods. Family support

	The institution comes to occupy the role of the family. Unify efforts Transparency in economic management. Promote community participation. Agreements with local trade. Attention to psychological, social and emotional processes. Technology: municipal website (neighborhoods/problems / relationships) Friendly cities for the elderly: architectural and technological investment. Free and social activities vs. slave grandparents. (Aging laboratory) **Economy** Youth employment New job training New economic model **Cultural and social values** Leading role of civil society. Participation as a right and a duty Female wealth in social capital (network and relationships) Generate social capital: trust; Listens; Consult and know the reality Network support and intergenerational help Intergenerational values Coexistence and solidarity (maintenance of social relations) Visibility of the elderly population. The old man like wealth Tendency to create social awareness Diversity not homogeneity of the elderly population **Technology** Insert holistic prevention in platforms (active aging) Use of RRSS Create a unique comparative story Integrated information platform to evaluate the care of nurses. Telecare as an opportunity to improve care Telemedicine, smart home Home automation (adaptation to housing). Radio / television programs
WEAKNESSES **Legislation**	**THREATS** **Organization care**

Limbo dependency produced by the Dependency Low (80% of the demand is met) and difference between CCAA regulations governing residences (lack of control and qualified workers)	Lack of accessibility, availability, affordability, adaptation.
Financing	Inequality and vulnerability (variability in care models not only by autonomous communities but by residences that produce inequality)
Discontinued financing/not all covered	Difficulty of care for patients at risk of poverty.
Financing of resources sensitive to economic trends	Focus diseases and treatments
Difficulty of access to housing	Focus on family and society vs. the institution
Physical, bureaucratic and technological barriers	Paternalistic system
Copay	Dehumanized treatment
Organizational characteristics	**Financing and legislation**
Political discontinuity and dependence on it	The state pact is missing
Difficulties in intersectoral coordination	Lack of stability in policies subject to changes in political governance
Lack of a unified model between institutions	Decrease in socio-health resources
Microfragmentation within the same services Bureaucratic Barrier	Private financing risk of social exclusion
Physical barrier (eg, homes not adapted)	Copay
Technological barrier (lack of unique socio-sanitary history)	Lack of resources and low socioeconomic income
Lack of administrative preparation to adapt to social transformations	**Professional work**
System of services segmented by Autonomous Communities, diversification of services related to different economic resources	Misuse of communication as a form of exclusion.
Sociocultural problem	Care work covered by an informal network of family members or immigrant community (with low wages and lack of employment and labor rights)
High percentage of population at risk of poverty and social exclusion, due to economic, political and social vulnerabilities	**Transformations**
Stigmatization and self-stigmatization of staff.	Economic crisis
Lack of gender perspective and cultural diversity, vulnerabilities (poverty, loneliness)	Social differentiation that translates into a high diversification of the contributions of the service Aging
Lack of shared values	
Divers multicultural idad	Emotional health factors (loneliness, depression)
Feminized work	Social and institutional actors: the structure of households, the characteristics of the adult population and the current care model, the massive incorporation of women from the world of work; reduction in average household size
Lack of visibility of the elderly population and differences between the different age ranges in it (65-86)	
Mediterranean wellness model (focused on the private and the family)	

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Tunisia

Summary of the interviews

Partners from Tunisia (PP5) carried 5 interviews with interviewees from:

- The **macro management** profile (Elderly person protection Director - Ministry of Women, Family, Children and Elderly affairs. http://www.femmes.gov.tn/fr/acceuil/.
- The **meso management** profile (General Inspector, Deputy Director and President of the National Committee for Specific pharmaceuticals, Tunisian, National health insurance fund. http://www.cnam.nat.tn/
- The **micro management** (Professor of University, President of the Tunisian Association Alzheimer. http://jamaity.org/association/association-alzheimer-tunisie/ AND Medical Doctor, PhD Epidemiologist and Gerontologist, President of the Tunisian Association for Research and Study in Geriatrics and Gerontology.
- The **micro management**: Representative from the final beneficiaries: Mr AL, Age: 85 years old, Patient with significant comorbidities including diabetes, arthritis, CVD. At risk of financial exclusion.

The most important conclusions of the interviews were the following:

Extent of the phenomenon

Seniors now occupy an ever-increasing place in Tunisian society and, according to projections by the National Institute of Statistics, around 2030, people aged 60 and over should represent one fifth of the total population in Tunisia. According to a study conducted on 2003, the loss of autonomy concerns nearly 10% of the Tunisian population aged 65 and over living at home (1). This poses a serious public health problem, in a context of limited financial and human resources.

Needs of the elderly people dependent and/or at risk of social exclusion

The changing age structure of the Tunisian population also gives rise to many fears about the state of health, social protection or spending on health. The health and social well-being of the elderly will also gain in importance not only because of the increase in the number of Tunisians aged 65 and over but also and above all because of the fact that the new generations of our seniors are more educated, more privileged and more consumers of care and medico-social goods of all kinds. The consequences are enormous for health care and social assistance systems.

Legal background and characteristics of the current social care model

In Tunisia, the social care model for elderly persons in dependency situations is based on a legal framework enacted since 1990s: Law 94/114 of October 1994 on the elderly protection (1); Decree 96/1016 of May 1996 (2) and Decree 96/1766 of September 1996 (3) on care principles to protect disabled elderly without family and/or financial support by public and private health establishments.

Several care services are now implemented under the management control of the ministry of women, family, children and Elderly affairs, the ministry of social affairs and the ministry of health. All social and health services are free of charge, or at a reduced rate for needy families. In addition, NGOs such as the Tunisian Association of Alzheimer and the Tunisian Association of Geriatric are carrying out activities and healthcare to assist disabled elderly and their families. These associations being with very limited human and material resources are unable to satisfy all needs. Their services remain limited geographically to the big cities (mainly in Tunis the capital city) but are absent in rural areas.

Challenges, weaknesses, strengths and lessons learned

- ***Strengths***. If the social model continues despite the countless difficulties, it is because it has many successful key elements. The most important successful key elements of the social model for elderly are a solid national solidarity, family solidarity, a well-developed associative network, political willingness to restore social justice and a solid legal foundation.
- ***Challenges***. The continuous increase in life expectancy represents real progress for our country but also a real challenge for the national community. It is, in fact, known that the cost charged to dependent elderly people translates into a very significant financial cost which very often rests solely on families. The challenge then implies that the national solidarity effort really helps to cope with age-related difficulties.
- ***Weaknesses***. There is no national care program and a lack of social security no for people with some incapacitating diseases in elderly persons, e.g. people with Alzheimer's disease and related dementias Alzheimer. Their families are facing a lot of problems (social and financial). They are helped for some needs by the Association Alzheimer Tunisia. Primary Health care professionals did not have the needed competencies for screening this disease.

Ideal model of social-ethical-transcultural care

New and ideal model of elderly' social and health care will include a number of measures:

- help (financial needs) family members when they take care for aging parents requiring assistance;
- provide health and social services to elderly in their own home by a multidisciplinary team composed by trained and professional personnel only free for families with financial difficulties;
- assist (by capacity building) family members how they can provide the requisite care for their relatives in dependency if they want.
- set up a common logistical platform shared by all the institutions related to elderly social care and targeting to implement and manage the ideal social model (clinical record, self-care, coaching and training, empowerment (patient, agent, family);

- implement a monitoring and evaluation system to assess the impact the new implemented model.

Current social care services available in Tunisia

Tunisian social policy targets, as a priority, certain categories of vulnerable populations including people with specific needs (elderly, disabled people). Anxious to ensure good governance of social assistance intended for these vulnerable categories, the Tunisian government has adopted a social model which aims to federate social initiatives and actions. This is the Amen Social program which was launched on January 25, 2019 (5).
This program is part of the social security reform for the poor and low-income social strata. It was designed to fight precariousness, poverty and social exclusion. Founded on the principles of solidarity, equal opportunity and social justice, it works to reduce inequalities and promote self-sufficiency and social integration.
To do this, this program revolves around 4 major interventions:
-Improving living conditions by guaranteeing the right to a minimum monthly income as well as social assistance on the occasion of the start of the school year and various religious holidays;
-Improvement of social coverage by facilitating access to basic services, in particular with regard to health care (free and low-cost treatment and stay in public health facilities);
-Strengthening economic empowerment by guaranteeing priority access to vocational training and employment;
-Improving the living environment by facilitating the right to social housing.
This program currently covers 905,000 poor or low-income families, which represent 24.5% of the total Tunisian population. They are divided into two groups:
-The first group is made up of 285,000 poor families who already benefit from the benefits of the national program of assistance to needy families which was set up in 1986. These families also benefit from health cards giving free access to care in public health facilities (free medical aid).
-The second group includes the 625,000 other families who only benefit from discounted care cards.
It is important to note that this program does not include specific measures for the elderly, but it primarily targets families with elderly and disabled people.
Finally, it should be noted that the supervision of the progress of this program is provided by 1,500 legal social workers who oversee its smooth running in the field. As of May 2, 2019, this ambitious social model was complemented by an equally ambitious program called "ينيمحأ Ahmini" (protect me). It is a social and health coverage program dedicated to rural women working in the agricultural sector (6). The launch of such a program presented itself as a social priority since 90% of the women concerned had no social security coverage and worked in extremely difficult conditions. Ultimately, this program aims to cover no less than 500,000 women.

Social security mechanisms and tools

In Tunisia, there are two large social security funds:
-The National Social Security Fund (CNSS) covers employees in the semi-state and private sectors;

-The National Pension and Social Security Fund (CNRPS) is dedicated to state employees (civil servants, employees of local authorities, employees of public enterprises).
Seniors who have worked and contributed to one or the other of these funds receive a retirement pension. As for those who have never worked and those who have held self-employed jobs (agricultural workers in particular), they benefit for the most deprived of them from state aid according to the provisions of the Amen Social program mentioned above.
With regard to the social security sickness branch, it is represented by the National Health Insurance Fund (CNAM) which insures elderly people affiliated to one of the two social security funds indicated above. Poor or low-income elderly people benefit from free or reduced-cost medical care, which is one of the main components of the Amen Social program.
Elderly people with a disability card also benefit from a certain number of privileges, depending on the specifics of their disability, the requirements for care and their socio-economic conditions.

The legal and political framework (7)

The socio-health care of the elderly Tunisian population is organized around a real legal and regulatory arsenal which is essentially structured around the following main texts:
-Law n ° 94-114 of October 31, 1994, relating to the protection of the elderly which affirms, among other things, the responsibility of the family in the protection of the elderly and the satisfaction of their needs (article 2). This law also provides that the public authorities take the necessary measures to facilitate access to healthcare, housing, public transport, administrative services and integration into social life.
- Decree n ° 96-1016 of May 27, 1996, fixing the conditions and the methods of assumption of responsibility by the families of the elderly without support. -Decree No. 96-1017 of May 27, 1996, establishing the conditions of accommodation in institutions for the protection of the elderly.
-Decree No. 96-1767 of September 30, 1996, fixing the conditions and the amount of the contribution of the elderly person or his family to the costs of social and health services provided at home.
-Order of the Minister of Social Affairs of September 30, 1997, fixing the amount of material assistance allocated to the needy elderly and the conditions for granting this assistance.
-Order of the Minister of Social Affairs of September 30, 1997, fixing the amount of material aid granted to the foster family of a needy elderly person and the conditions for granting this aid.
As for the texts organizing the health care of elderly patients which have been published by the Ministry of Health, their common denominator is the improvement and strengthening, without any concession, of the quality of reception, orientation , accommodation conditions and diagnostic, therapeutic and preventive care for the elderly in public health facilities. They are four in number and appear, chronologically, as follows:
- Circular n ° 38/91 of May 4, 1991 relating to the strengthening of health care for the elderly in hospitals and public health facilities;

- Circular n ° 92/92 of October 27, 1992 relating to the reception and care of the elderly in health establishments;
- Circular n ° 52/08 of June 14, 2008 relating to the reception and care of the elderly in public health facilities;
- Circular n ° 89/08 of September 30, 2008 relating to the care of resistance fighters in public health structures.

Most relevant political initiatives

Several initiatives have been undertaken in favor of the elderly, both from a health and social point of view. Among the most relevant social measures, the following 6 should be mentioned:

-Allocate a solidarity allowance to the needy elderly (a monthly financial aid which enables them to provide for their basic needs and therefore avoid social exclusion and marginalization.

-According financial and in-kind assistance to families in precarious situations who have to depend on a heavily dependent elderly person.

-Encourage the accommodation of elderly people without family support in foster care. This measure was instituted by Law No. 94-114 of October 31, 1994, relating to the protection of the elderly. The aim of such placement is to promote their social integration and to prevent their institutionalization. It is, however, subject to several conditions, among which is obviously the free and informed consent of the person concerned. It should not be a carrier of motor or cognitive impairments. It is important to note that host families are entitled to regular financial compensation. They can also benefit from various material and social assistance.

-Promote education and literacy for seniors as a lever for integration and the fight against social exclusion. This action is done through the National Program of Education for Adults (PNEA) which advocates the right to education for all, throughout life "This program aims to help the elderly to improve their quality of life (6).

-Work to keep the elderly in activity by promoting their involvement in volunteering. It is within this framework that a national database has been created to identify people who are eager to maintain social and economic utility. The aim of such an action is to promote the independence and social integration of the elderly for as long as possible.

-Creation of reception centers (12 in total) to house elderly people who are homeless, destitute and without family support.

As for health care, it revolves around the following main measures:

- Establishment of priority for elderly patients in public health facilities, at all stages: reception, registration, referral to appropriate services and care, additional analyzes and examinations, conditions of stay and accommodation.

-Free care for the poor elderly treated in public health facilities, thanks to a free or very reduced rate plan.

-The implementation of a specific program to promote the health of the elderly. Created for over 20 years, this program has come at the right time to allocate an appropriate and sustainable institutional framework for the protection of the health of this sensitive segment of the population. It covers a vast field of action which goes from the continuous training of the different categories of health professionals in the field of medical care or geriatric nurses to the information and education of the

elderly and their families. Although it is essentially based on a series of preventive measures such as the annual flu vaccination, the national health program for the elderly also includes curative measures such as the surgical management of sick patients with cataract.
-The creation of Geriatrics units and consultations specializing in geriatric care within public hospital structures; Geriatrics hospital units are called upon to play a leading role in the theoretical and practical training in Geriatrics of the various categories of health professionals. In this perspective, they could constitute a reference field for future graduates of the geriatric sector .

General characteristics of the social care services and practices

The Tunisian revolution has fundamentally changed the social chessboard. In particular, it has brought about a total upheaval in social policy priorities. Since then, the successive governments have set themselves the priorities of fighting youth unemployment and reducing social inequalities, especially in the underprivileged regions. These two priority actions have become the lever of the fight against regional inequalities which is also set up as a social emergency. As for the defense of the rights of the elderly, whether independent or dependent, has since been thrown into oblivion and people who work for the cause of this population are becoming more and more discreet. This observation is mainly linked to the drastic reduction in the aid and resources made available to them, as well as to the disappearance of the public authorities' enthusiasm for this cause which is no longer one of their priorities as evidenced by the outright suppression of the State Secretariat for the Elderly.

Significant fact to note, the Tunisian system of care for the elderly does not present any notable differences either from a regional or professional point of view. Indeed, the actors of the public service of social aid and health care, NGOs and associations for the protection of the elderly operate in an identical manner in all regions. In addition, the State provides them with identical human, financial and logistical resources. The few differences are in the private sector. Indeed, it is in major cities (Tunis, Nabeul, Monastir, Sousse and Sfax) that private promoters focus their investments in the accommodation (temporary or permanent) and day care sectors. Likewise, there are very few geriatric practices in disadvantaged regions in comparison with the big cities on the eastern coast.

Social and health integration model

In the Tunisian model of care for the elderly, the integration of social and health dimensions is recommended in the framework law which organizes this care (law n ° 94-114 of October 31, 1994). In this model these two dimensions are inseparable. In the field, this integration is illustrated by the home intervention of associations for the protection of the elderly. They play an essential role in the national social promotion strategy aimed at improving the quality of life of categories of population with specific needs in terms of health care and social assistance. This role is at the heart of the care, assistance and home support system for poor elderly people without family and financial support.
Through its mobile medico-social support teams, the associative fabric takes over from the institutional system of assistance and care at home for the elderly. Given

the nature and scope of this mission, it is now positioned as a major and essential player in the personal services and home help sector.
Associations for the protection and assistance of disadvantaged elderly people thus occupy a special place in the home care system for elderly people, which remains an absolute national priority. It is about offering them the possibility of continuing to live in their usual living environment (family, social and emotional environment), and this, in order to strengthen their autonomy and allow them to age with dignity. Home help and care for the elderly are interventions whose benefits are well established. These benefits can be individual (avoid uprooting and institutionalization, avoid or shorten hospitalization, etc.) or collective (all studies have shown that home care is much less costly than institutionalization or hospitalization. ...). In addition to its major role in the medico-social protection of the most underprivileged elderly, the associative fabric offers this sensitive segment of the population other services such as support in administrative procedures, legal assistance as well as listening, orientation and counseling activities.

Structure of the model and main key players
In Tunisia, the socio-health care system for the elderly, whether independent or dependent, is based on a legal basis, the foundation of which is Law No. 94-114 of October 31, 1994 relating to the protection of persons elderly (JORT n ° 87 of November 4, 1994, pp. 1765-1766). This law constitutes the pivot of the respect of the fundamental rights of the elderly in our country. It also represents the common denominator of achievements and achievements made in their favor in the health and social fields. This system is organized around the following 5 essential pillars:
- Give priority, as much as possible, to keeping elderly people at home so that they can continue to live in their usual family and social environment;
-Reduce social inequalities and guarantee poor elderly people a minimum income so that they are not excluded from society;
-Facilitate access to health care and social assistance in the event of illness or disability;
- Play national solidarity to guarantee our seniors a dignified and decent life;
-Promote volunteering and encourage the active participation of seniors in the various activities (social, economic and educational) of development.
The proper functioning of this system is based on a multi-sectoral collaborative practice of health care and social services workers. Indeed, the different partners involved in the socio-health care of the elderly are distributed as follows: i) Public sector stakeholders:
-The General Directorate of Social Promotion reporting to the Ministry of Social Affairs;
-The Directorate of the Elderly under the Ministry of Women, the Family, Children and the Elderly;
-The Directorate of Basic Health Care (DSSB) under the Ministry of Health.
The first two structure operate in the social field. As for the DSSB, it takes care of the health component of the model through the national health program for people it has developed within it.
ii) The Tunisian Union of Social Solidarity (UTSS) which is an NGO working in the field of mutual aid and social assistance for the benefit of the poorest sections of the population. It supervises the centers for the protection of the elderly.
iii) Associations specializing in the protection of the elderly

There are 25 associations for the protection of the elderly: an association at the level of the chief town of each governorate (except in Medenine where there is one more in Ben Guerdane). As indicated above, these associations only take care of poor and unsupported elderly people.
Most of these associations have multi-purpose mobile teams made up of doctors, nurses and social workers. They are placed under dual supervision: that of the Ministry of Women and the Family and that of the Tunisian Union of Social Solidarity (UTSS). This is placed under the supervision of the Ministry of Social Affairs. Among these mobile teams, it is worth mentioning the "SOS ELDERLY PERSONS" Unit which has been set up by the Manouba Association for the Protection of the Elderly. This Unit has made a free emergency telephone number available to the elderly to facilitate the reporting of emergency situations. It is also important to note that among these associations, 11 of them offer accommodation possibilities. As of today, there are 12 elderly protection centers that house nearly 800 elderly people who meet very strict selection criteria, particularly social ones. The Manouba protection center for the elderly is the best known of them. It alone houses nearly 120 people. The most recent is that of Gammarth which houses around 80 people. iv) Other Associations
Although they are not specialized in the protection of the elderly, some associations offer equally important services in favor of this elderly population. Among these, mention should be made of the following associations that are specialized in personal services:
-Tunisian Association for Family Support;
-Association of Assistance to the Great Disabled at Home (AAGHD);
- Self-Development Support Association “ASAD”;
-Tunisian Union for Aid to Mentally Insufficient (UTAIM); -
General Association of Insufficient Motors (AGIM); -
Association to support multi-handicapped people;
v) Private sector operators. From a social point of view, the contribution of the private sector in the care of the elderly remains insufficient both qualitatively and quantitatively. Indeed, we still do not have real nursing homes. The few residences available are small and their services are almost limited to simple accommodation. Likewise, the structures specializing in the temporary reception of the elderly are very few and not necessarily well structured. Finally, it should be noted that the Tunisian private sector is currently experiencing the proliferation, in an anarchic and uncontrolled manner, of companies which offer, among other things, support and home help services (home help, home help life...).

Trends in social care services and practices

Given the fact that any social reform must take place in the socio-economic context of the country, the development and future action of the Tunisian social protection model must revolve around the following essential priorities and objectives:
i) Reduce the poverty rate on a continuous and sustained basis. The government expects a reduction of almost 50% of this rate which, according to its forecasts, should stabilize around 7% by 2030 against 15% today.

ii) Reducing the risks of sliding towards poverty and precariousness. This presupposes the implementation of suitable tools in order to effectively combat all forms of vulnerability
iii) Make every effort to reduce the unemployment rate, which currently stands at 15.1%. Particular attention must be paid, however, to unemployment among young higher education graduates, which is almost twice the national average, almost 29%.
iv) Ensure that everyone can live in good health. To do this, it is the responsibility of the state to facilitate access to quality care for all. This necessarily involves strengthening the social coverage of the poorest sections of the population.
v) Promote the living conditions of the most disadvantaged social categories. To achieve this, it will be necessary to further strengthen their right to a guaranteed minimum income for integration as well as their ability to access education, vocational training and social housing.
vi) In order to be able to apply all the measures listed above, the Tunisian State is called to significantly increase direct social transfers to poor or low-income families. The optimization of these transfers has the effect of improving the efficiency of the national program of assistance to needy families which is now part of the Amen Social program.
vii) In addition to optimizing social transfers, we must necessarily work to improve the governance of the social model. It is for this reason that the Government is in the process of setting up a database gathering all the families and people eligible for benefits from the social model.
viii) All of the above trends have long-term consequences of strengthening inclusion mechanisms and empowerment. These mechanisms will undoubtedly reduce social inequalities and the risks of exclusion. In the long term, the values of social justice and equal opportunity will be strengthened.

Within Tunisian society, family careers and caregivers play a central role in the support and care of elderly people living at home. Their involvement and their share of responsibility take on much greater importance when an elderly person loses their independence. It should also be remembered that in the Tunisian social tradition, daughters and daughter-in-law are the main providers of help for the elderly, especially when illness or disability arise. Given our ancestral customs drawn from our Arab-Muslim culture, the family remains the essential pillar of the physical, emotional and financial security of dependent elderly people living at home.
In addition to natural caregivers, a multitude of other professionals specializing in gerontological care are involved in the care of dependent elderly people at home:
- The multidisciplinary teams of associations for the protection of the elderly, which are often made up of complementary professions: health professionals (doctor, nurse or nursing assistant), social workers (social worker, etc.);
-Geriatric doctors who are trained in the Faculties of Medicine within the framework of qualifying postgraduate training in Geriatrics sanctioned by a specialized Masters diploma;
-The social workers who play a key role in the daily support of elderly people at home;
-Medical assistants, including physiotherapists and occupational therapists also work at home on medical indication;

- Caregivers and caregivers who are offered to families by service companies working in the home care sector for dependent elderly people;
-Family doctors who constitute a new profession are called to play in the near future to play a leading role in the care and assistance system for elderly people living at home.

In Tunisia, primary care professionals in the public sector do not work at home. Their role is confined to primary care structures where they apply, among other things, the various preventive and curative measures included in the national health program for the elderly (treatment of age-related chronic diseases, treatment surgery for poor patients with cataracts, education and information for the elderly and their families, vaccination, etc.) overseen by the Directorate of primary Health Care.

As mentioned above, Tunisia currently has two types of social transfers, namely the aid program for needy families and free medical aid. In 2020, the budget allocated to social transfers amounted to 2,870 MD, or 6.1% of the state budget (47,227 MD). The share of aid to needy families is estimated at 786 MD or 27.4% (1.7% of the overall state budget). In granting social assistance, the state gives priority to families with the elderly, the disabled and children.

In order to strengthen home care for the elderly, the Tunisian government has set up a support system which encourages families to take in elderly people without family support. These host families receive a monthly allowance of 200 Tunisian dinars.

The Tunisian model of medico-social care for the elderly living at home is essentially based on the mobile teams available to associations for the protection of the elderly, which are established at regional and local level. These mobile teams integrate medical and social dimensions perfectly. They provide medical assistance (medical follow-up, transfer to public health facilities for specialized consultations and medical examinations, supply of medication, psychological support, etc.) and social assistance (permanent or occasional financial assistance, in-kind assistance, assistance in improving 'habitat…).

These associations also take care of the cultural aspect by organizing cultural and leisure activities for the benefit of the elderly who are under their protection.

At the institutional level, the centers for the protection of the elderly mentioned above provide comprehensive care for elderly people without resources and without family support, offering them multiple medico-social services (health care, permanent accommodation, activities cultural and leisure activities)

Reform of the social security system

Tunisia currently has a national program for the development of digital health (e-health) based on the digitization of hospital and health information systems. Among the initiatives taken in this context, there is the deployment of the Electronic Medical Record (DMI) which has the essential objective of improving the quality of patient care. This program also aims to set up telemedicine devices to promote the long-term care of dependent people or people with reduced mobility (teleconsultation, tele-monitoring, etc.).

On the social front, the Tunisian government decided in December 2019 to set up a national social protection platform. The objective sought here is the establishment of comprehensive social security coverage. This strategy aims to establish a certain number of benefits and social rights for the most vulnerable categories of the population, including the elderly. On the other hand, the online social platform offers

a great deal of information of great importance aimed at facilitating access to social services such as eligibility for social assistance and the methods of benefiting from it.

SWOT Analysis - Tunisia

STRENGTHS	weaknesses
Solid national solidarity (national solidarity is a governmental and non governmental approach, and a sociocultural and religious norm in Tunisia) National program for elderly health promotion Services and programs offered by the ministry of social affairs Health services offered by the ministry of health Multiple NGOs offering services Existences of disability card offered by the ministry of social affairs Private residence centers Foster families for elderly (approach encouraged & implemented by the Minister of Social Affairs) Socio-cultural & religious protective factors = family support & social cohesion Building capacities for geriatric Work on laws and policies Retirement plans of the public, and private (who have joined the social security system) employees Adhesion of Tunisia to achieve the goal of universal health coverage (The 2030 Agenda for SDGs targets to leave no one behind, equity according to gender and age, and so it explicitly encourages the integration of aging into our development policies and programs) (https://www.undp.org/content/undp/fr/home/blog/2016/9/30/leaving-no-one-behind-means-confronting-ageism-in-development-/). The state guarantees prevention and health care to all citizens and provides the means necessary to guarantee the safety and quality of health services (article 38 of the 2014 constitution)	Socioeconomic inequities Socioeconomic crisis => lack of resources (human, financial & equipments) Lack of elderly financial contribution to social security cover during years of activity (Many of those who worked in the private sector (formal and informal) had not been registered in the social security system) lack of training of caregivers Local culture related to old age (from older persons and caregivers) Social isolation of older persons after retirement High cost of private nursing homes Lack of awareness on available services for old age from the community A lack of coordination between the different actors of the social model Lack of specialized professionals in geriatrics

Actual reform of social coverage system (modernization of the social coverage system (through the e-health Tunisian strategy: mainly the project of "Vital card" (electronic treatment cards) and reform (new procedures of social care for vulnerable categories) aiming to reduce social care coverage inequity)	
opportunities	**THREATS**
Reform program of SA ministry (modernization of the social coverage system (through the e-health Tunisian strategy: mainly the project of "Vital card" (electronic treatment cards) and reform (new procedures of social care for vulnerable categories) aiming to reduce social care coverage inequity) Interest of civil society to help elderlies and their families Development of home care services Social networking between older persons through social groups and committees Capacity building of older persons Financial empowerment of older persons Training of social and health professionals Interest of older persons in social media Creation of a platform for heath data collection (between cnam & facilities) Networking between stakeholders Use of technological tools for monitoring of health status Project of data center allowing to use / share of computerized medical record in health facilitiesimproving health services A solid legal foundation (several laws governing the social security system including the lederly population)	Demographic and epidemiological transitions (increased number of elderlies and chronic diseases: The aging of the population and the prevalence increase of chronic diseases which are covered free of charge for insured persons of all ages) Current financial and political crisis in tunisia Health professionals migration Decreased quality of public health services Purchase power reduction Instability of financial resources caused by the volatility of state resources Inadequate governance A lack of coordination between the different actors of the social model (for example : regarding some aspects, there are disagreement between National Health Insurance Fund and Ministry of health (CNAM), between some NGOs and Ministry of health, between private sector and CNAM)

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conclusion

These 5 country reports provide an overview of the current status of social care for elderly populations in each of the studied countries.

The differences in the social care systems in each of the countries on the political, legal, cultural and economic levels are quite clear from the results of the structured interviews and the analysis of social care practices and trends. While some countries have an established system of social care embedded within their legal and political frameworks, some other countries still lack a comprehensive system and a complete pension and retirement plan for older age. Despite the differences, we can identify important key stakeholders in the countries studied: governmental (Ministry of Social Affairs, Ministry of Public Health, Policymakers), non-governmental institutions, local community groups (in municipalities and councils), as well as private sectors offering elderly services and healthcare. In addition, we note similar weaknesses in the areas of staff shortage in geriatric care, financing, equity and distribution of services. The global changes in family structures, economic situations of countries, political instability, globalization effects and culture of aging seem to be important threats in most studied countries.

There seems to be a lot of interest in integration of information and communication technology in the social care of the elderly, homecare, family role and training and this has been shared by the partners in their analysis as a possible opportunity for better care. This provides an important advantage for the pilot TEC-MED model which will be developed in the coming months. Political interest is surely an important key to be able to expand and invest in the care of older people in countries.

The gap analysis which will be performed secondary to the current reports will surely provide a clearer understanding of the needed changes and actions which will need to be carried in order to address the needs in each country and provide a transcultural solution.

Annexes

annex 1

Checklist for the interview

- **Extent of the phenomenon:** the population older than 65, life expectancy, dependency and chronicity, poverty, material deprivation and social exclusion;
- **Needs of the target group (dependent, elderly people in risk of social exclusion):** social security mechanisms and tools to approach the need of the target population;
- **Legal background and initiatives:** legislation setting up the social care services, evolution of such legislation, other relevant legislation in the country of reference; policy initiatives
- **Characteristics of the current model/s of social care:**
    - **Principles or values:** theoretical background, principles or dimensions of care that are included in the model, with special emphasis in social-ethical and transcultural aspects (including cultural values, approach to different cultural backgrounds), gender perspective, changes led by migration movement;
    - **Characteristics of the current models:** to what extent the current models have a socio-ethical, transcultural, and social perspective? What are the indicators of these characteristics?
    - **Structure and stakeholders:** Institutions (central state versus regional and local public administration [for instance municipalities], social care enterprise, NGOs…), and caregiver (formal vs informal) are involved/providing services and how is the structure and organization, integration of social and health care
    - **Role of formal and informal caregivers**: type of care model (family versus market), typology of informal caregivers (spouse or child), typology of formal caregivers (for instance civil servants or migrant), typology of primary care professionals. What are the defining elements of such roles?;
    - **Types of intervention**: monetary transfers, in particular the accompanying allowance, forms of home or residential social assistance, forms of home-care or social-health residential care;
    - **Technological solutions adopted**: social alarms, electronic assistive devices, telecare social alert platforms, environmental control systems, automated home environments and 'ubiquitous homes', mobile apps, electronic health records; social care platforms and how they are oriented.

    - **Budget considerations**: channels for financing the services, costs to healthcare provider; costs to participant, overall cost of intervention, cost benefit analysis of the interventions (considering for instance prevention of admission to institutional care, i.e. residential/nursing home);
    - **Quality of life and user satisfaction**: quality of life measures, health-related quality of life measures, healthcare professional workload, measures of service satisfaction, measures of device satisfaction, healthcare professionals' attitudes or satisfaction, social inclusion of target group;

- **Challenges, bottlenecks, strengths and lesson learned:** analysis of the current social model taking into account these elements.
- **Ideal model of social-ethical-transcultural care:** possibilities of improving the current social model in the country by implementing a new social care model, characteristics of the ideal model attending to the previous explored dimensions.
- **Implementation of the ideal model**: what would be necessary to implement the model in practice?
- **Ideal social care platform:** modules and characteristics that should include in a platform targeted to implement the ideal social model.

annex 2

WP3 Expert Interview Outline: "Country Social Care Model"

As you know, we are interested in understanding what are the social care models for elders in the pilot countries of the project. For that purpose, we are conducting interviews with experts in selected European countries. We have prepared a set of questions that we like to record for accuracy purposes. We will transcribe the recordings and build on them to develop a social care model for elders in in the country of reference.

Interviewer Name

Interviewed:

Name and surname

Current position and responsibilities

PART I. BACKGROUND QUESTIONS

1. **Can you please describe the institution in which you work and its main activities?**
2. **Please, can you describe your main responsibility as part of this institution?**
3. **Can you please describe your specialization and background?**

PART II. GENERAL QUESTIONS ON SOCIAL CARE FOR THE TARGET GROUP

1. **What is the extent of the phenomenon? What are the needs of the target group (elderly, dependent in risk of social exclusion)?**
2.
    A. **Elderly**
    B. **Dependence and chronicity**
    C. **Poverty, material deprivation and social exclusion**

PART III. SPECIFICS OF THE COUNTRY SOCIAL CARE MODEL

1. **In your country, which are the priority areas regarding social and health policy? it is considered attending dependent people a priority? And dependent in risk of social exclusion?**

2. **Which is the current model /s of social care? Who is the target population? Is there a social care for dependent, elderly people at risk of social exclusion?**

3. **How are the characteristics of the social care? Are the different models (similarities and differences)?**

    A. **Which are the principles or values: are contemplated social-ethical, transcultural (including cultural values, approach to different cultural backgrounds), gender perspective**

    B. **Which is the legal and policy framework? Which are the most relevant policy initiatives? Are there social security mechanisms and tools?**

How is the model structured? Which are the main stakeholders: institutions (public, social enterprise, NGOs) and professionals involved? Are there regional differences? Professionals? How are integrated the social and health dimensions? What is the role of the family, the state and the market? What is the role of formal and informal caregivers? informal caregivers (spouse or child), formal caregivers (for instance civil servants or migrant), primary care professionals? Other agents involved?

    C. **Types of actions are carried out: Monetary transfers, in particular the accompanying allowance? Forms of home or residential social assistance?**

Forms of home-care or social-health residential care? Other forms of care?

Which groups are the most involved and which are complementary?

Can you provide information on the budget considerations (funding of services, funding of care provider of target group, total cost)?

4. **What are the technological solutions widely adopted (e.g. social alarms, electronic assistive devices, telecare social alert platforms, environmental control systems, automated home environments and 'ubiquitous homes', mobile apps)?**

5. **Are there social care platforms aimed to support the social care (including support to population, professional, institutions), such us online platform, clinical record, apps to follow daily indicators, self-care, empowerment, training, management, etc.? How did you know about it? What are their characteristics? Where and how is implemented? Do you know how to use it? How did you reach that information?**

PART IV. OUTCOMES, IMPACTS AND EVALUATION OF THE CURRENT SOCIAL MODEL

1. **Has been measured the outcome and impact of the social care model? How? Which are the results?**
    A. **Quality of life measures**
    B. **Health-related quality of life measures**
    C. **Measures of satisfaction**
    D. **Social inclusion of target group**
    E. **Healthcare professionals' attitudes or satisfaction, workload**
    F. **Are there any validation/certification?**

PART V. CHALLENGES AND BOTTLENECKS

1. **What are the main trends concerning the social care model your country? What are the mail developments?**
2. **What are the challenges in implementing the model?**
3. **What are the main weak points and difficulties of the model?**

PART VI. SUCCESS FACTORS AND LESSONS LEARNED

1. **What are the main success factors and strong points of the model?**
2. **What are the lessons learned from your experience?**
3. **Can you suggest any best practices? What are your suggestions for improving the social care model in your country?**

PART VII. IDEAL SOCIAL CARE MODEL TRANSCULTURAL, SOCIAL-ETHICAL AND GENDER PERSPECTIVE

1. **In which extend it is important to implement a model with these characteristics?**
2. **Taking into account the previously questions, which characteristics should have the ideal social care model from a transnational perspective? How it could improve the self-care management and the empowerment?**
3. **How could be it promoted and implemented (coaching and training, output and impact evaluation (such as social and health outcome indicators or professional indicators), organizational and managerial procedures needed)?**

PART VIII. IDEAL PLATFORM TO IMPLEMENTED THE SOCIAL CARE MODEL

1. **Which modules and characteristics that should include a platform targeted to implement the ideal social model (clinical record, self-care, coaching and training, empowerment (patient, agent, family roles)?**

These are all the questions we/I had.

Is there anything I forgot to ask or you would like to add?

Thank you for answering our questions!

5 COUNTRY REPORTS
(EGYPT, GREECE, LEBANON, SPAIN, TUNISIA)
GAP ANALYSIS AND TEC-MED INTERVENTION FRAMEWORK DEFINITION

EGYPT

1. Introduction

Delphi method

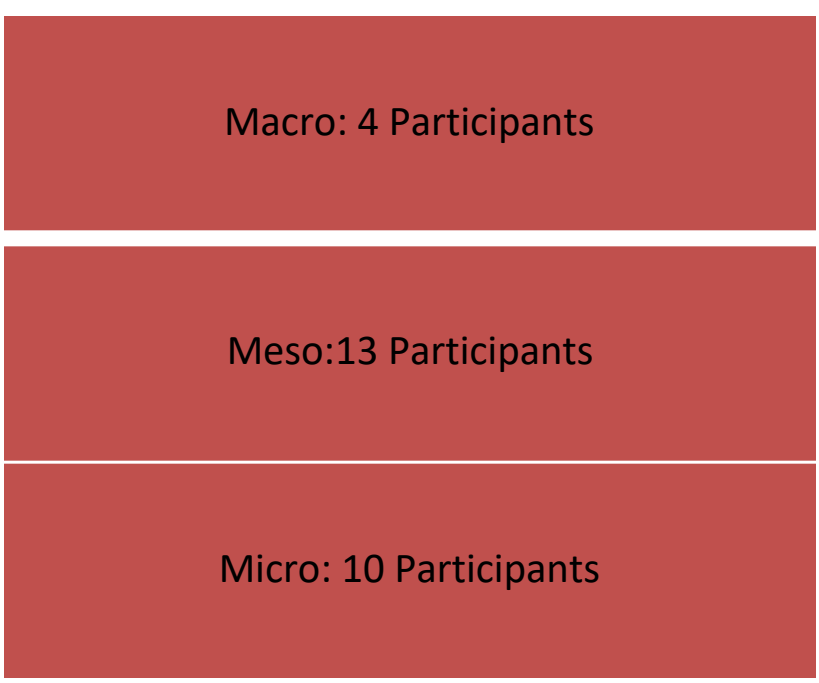
The **Delphi method** is a forecasting process framework based on the results of multiple rounds of questionnaires sent to a panel of experts. Several rounds of questionnaires are sent out to the group of experts, and the anonymous responses are aggregated and shared with the group after each round.

The process is usually repeated until a consensus is achieved, usually ending with three or four iterations.

35 key stakeholders were identified and contacted by emails to participate in the Delphi rounds

27 participants responded to the first Delphi round ,**21 participants** to the second rounds and **12 participants** to the final round.

2.Participant profiles



2. Participants:

Participants (13 females and 14 males) from different backgrounds:

- Non-Governmental
- Governmental
- Medical
- Psychological
- Private Organizations
- Academic
- Social

3. Results of Delphi Rounds

1st Round:

Participants were asked to answer the following questions:

- Please enumerate all topics you feel would be of a priority for the care of elder vulnerability population, kindly write down as many as you see fit.
- (Current State) Define which is the current situation to be analysed by answering the question Where are we?
- (Desired State) Set future goals, so we will answer the question Where do we want to go?
- (GAP) Locate the gap that separates us from our final objective. In this section we will answer the question How far are we from Our goal ?
- (Initiatives) Determine the action plans required to achieve our final objective, therefore, we will respond to How do we reach the stated objective ?

These questions facilitate the identification of priorities and the challenges in elderly care were used in the second round to reach consensus.

Priority areas have been identified in relation to the aforementioned aspects, related to social care for the elderly population:

- Non communicable diseases
- Nutritional problems
- Physical movement problems
- Stigma and cultural barriers to aging,
- displacement of older adults

- mental health (sleep disorders, depression, dementia and neurological disorders)
- caregiving burden on women,
- medication adherence
- Elder abuse

- Providing financial support for the elderly in need
- Expanding the scope of social care (caregiver education, caregiver stress relief resources, community resources)
- Changing the attitude towards nursing homes,
- Expanding rehabilitative services to the disabled.
- Expanding multidisciplinary home care
- Focusing on the concept of occupational therapy and home safety issue
- Elderly friendly environment to be expanded to elderly friendly cities
- Focused media awareness of chronic medical problems
- preventing strategies and optimization of treatment to prevent future disability,
- emphasizing role of healthy lifestyle and life course approach for disability prevention
- Employment of elderly based on the residual abilities in suitable jobs or volunteer activities
- Funding researchers targeting frailty, sarcopenia and risk factors for disability to find optimal preventive measures"
- Access to care & Health insurance,
- Safe transportation,
- equity of care options,
- high quality social support
- mode of payment,
- geriatric health curricula at medical and nursing schools
- community global awareness towards the increasing population geriatric populations.
- social wellbeing
- quality of life and support-
- universal health coverage
- Setting adequate infrastructure for socially including the elderly (ramps, elevators, etc.)
- Increasing the budget for pensions and providing compensation for elderly with no prior governmental service.
- Increasing number of facilities serving the elderly (clinics, daycares, elderly homes).

2nd Round

After having identified the relevant issues, it was necessary to build consensus on the priorities according to the participants' perspective, evaluating the items derived from the first round.

In this round we aimed to build consensus on Priorities collected from the first round. Experts were asked to rate them on a scale of 1 to 7.

Median scores and interquartile ranges (IQRs) were calculated for the participants' responses to each question. Responses where the median is ≤2 (high level of agreement that the topic is important) with a small IQR (≤1.5) were considered important topic of interest that have reached consensus.

The set of items that appeared refer to the priorities that emerged from the responses in the first round regarding the **CURRENT SITUATION** in relation to the social model of care for the elderly dependent population and / or at risk of social exclusion.

Regarding the priorities for the current state, the following subjects were identified as important by the participants:

- Elderly Abuse
- Providing financial support for the elderly in need
- Expanding the scope of social care (caregiver education, caregiver stress relief resources, community resources)
- Geriatric specialized healthcare and nursing home sector, assurance of continuum of equity care
- Emphasizing role of healthy life style (diet, exercice , smoking and drug abuse) and life course approach for disability prevention
- Employment of elderly based on the residual abilities in suitable jobs or volunteer activities
- Funding researchers targeting frailty, sarcopenia and risk factors for disability to find optimal preventive measures"
- Safe transportation,
- Equity of care options,
- geriatric health curricula at medical and nursing schools
- universal health coverage
- Setting adequate infrastructure for socially including the elderly (ramps, elevators, etc.)
- Private sector engagement
- Well trained heath and care workforce
- Situational analysis

- Socioeconomic characteristic (education, occupation,living situation, social network,income) and demographics(age, gender, geographic location. old age dependency ratio)
- Geriatric specialized health care sector, continuum and equity of care
- Improving laws and policies regarding the elderly care
- Aging related multimorbidity's
- Stigma of aging

Final topics to be analyzed:

1. Geriatric health curricula at medical and nursing school
2. Geriatric specialized health care
3. Aging related Multimorbidity
4. Emphasizing role of healthy lifestyle (Diet, exercise, smoking, drug abuse) and life course approach for disability prevention
5. well trained health and care workforce
6. Geriatric health curricula at medical and nursing schools
7. Improving Laws and policies regarding elderly care
8. Socioeconomic characteristics (Education, occupation, living situation, social network, income) and demographic (Age, gender, geographic location, old age dependency ratio)

<u>Final Round:</u>

For each topic, we assessed:

Priority range again: This time each item was ranked (1-8), but participants were asked to use each number only once, leaving those that they felt were not so important blank.

Then for each item we asked about:

1- Where are we (Current Situation)
2- Where should we go (Ideal Situation)
3- Identify the gaps between the 2 states and come up with steps to close those differences

Topics identified through the 1st and 2nd rounds were reassessed in the 3rd round to identify high priority areas based on expert perspectives as follows:

- Geriatric specialized health care

- Emphasizing role of healthy lifestyle (Diet, exercise, smoking, drug abuse) and life course approach for disability prevention
- Socioeconomic characteristic.
- Well trained health and care workforce

GAP Analysis for the above identified topics showed

1- <u>Current situation:</u>

Topic 1: few specialized doctors and centres for geriatric health, there are some specialized health care centres, like for Parkinson's or Alzheimer's and there are many general healthcare homes for geriatrics which are not specialized at all.

Topic 2: Healthy lifestyle is not embedded in society at all. The healthy lifestyle is not linked to disability, Elders rarely follow a good lifestyle, and many continue smoking even at an old age.

Topic 3: The current situation lacks information regarding socioeconomic and demographic characteristics.

Topic 4: Informal arrangements are the normal situation. Many families rely on uneducated (usually internally migrant) young female workers to provide care. Private agencies that have been organizing home care are increased in number. However, with no quality assurance measures nor standard training, the risk for older people is increased. There are some limited charitable efforts (mainly religious or international organizations)

2- <u>Where should we go?</u>

<u>Topic 1:</u> All general practitioners have basic knowledge of ageing related health issues and are able to refer to specialist physicians. Geriatric specialised health care is available at high standard and accessible to all regardless of income or socio-economic status.

<u>Topic 2:</u> Full understanding of healthy ageing among older people and their caregivers. More importantly availability of opportunities to make elders remain active both mentally and physically. Models from other countries, such in Turkey, with open gyms targeting older people and public acceptance could be replicated.

Topic 3: Equality across all socioeconomic strata in most of the health and care outcomes including quality of life and wellbeing. A national efficient information system is needed

Topic 4: Care agencies (both home and residential care) to be subjected to quality assurance measures. Care workers to be registered and subjected to background checks. Local authorities to be involved in the process. Better coordination between training institutions and employment agencies and care providers.

3- Identify the gaps between the 2 states and come up with steps to close those differences

The gaps between the 2 states and the steps to close those differences

- *Topic 1:* ***Considerable gap.*** *Changing laws, policies, and incentives towards geriatric specialized care. Introducing topics related to aging and providing respect and understanding towards the elderly within school curricula.*
- *Topic 2:* ***Considerable gaps in both the availability and accessibility.*** *Continuous education and raising public awareness in TV programs and internet advertising for the importance of healthy food, exercise and regular medical care to improve the quality of life. Availability of public places that are equipped to help the elderly.*
- *Topic3:* **The data could be hard to collect**. The steps can include cooperating with other organizations, requesting hospitals to collect such data is a must. These data also must be filled by all patients. Well-designed questionnaires could be helpful tools. A national efficient health information system is an utmost priority.
- *Topic 4:* **Significant gaps: Offering** more specialized curriculums in the universities and providing relevant job positions at different hospitals. None of these points are available in Egypt nor in a prominent way in the MENA region.

- **Conclusion:**

Some of the priorities:


Health
Social
Finanace
Legal
Education
Infrastructure
Training

GREECE

INTRODUCTION

Delphi Process / Profile of the participants

The Delphi method is a popular technique for forecasting and an aid in decision-making based on the opinions of experts, which has been in existence for over half a century. This work evaluates its methodology and reviews its validity in the present day, especially in the area of Social Sciences.

The main benefits relate to the gaining of expert opinions without the time and geographical restraints involved in alternative methods. The anonymity that is central to the Delphi method also has benefits for the researcher.

"Delphi Process"

- Two rounds of Online Questionnaires,
- Invited participants are still filling the questionnaires in (number of successful participants so far is 15 and 12, and 45 more are invited).
- The results of the process presented today will keep being adjusted according to the feedback from more replies coming in.

First round: Identification of main problems and priorities that need to be tackled.

Second round: Validation of the information and setting priorities on each problem identified on the first round.

"Profiles of Participants"

- Policy makers and regional government bodies.

(e.g. Regional Policy Office of Western Greece, 6th Regional Health Office)

- Local executive administration (municipality health offices).

- Representatives from Open Health Care centers and Institutions and local NGOs.

(e.g. Geriatric and Gerontology Association, University Hospital of Patras)

- Health Care and Therapy providers (public and private sector).

(e.g. Therapy clinics, Open Health Centers, old people's care homes.)

- Health and social care professionals working in the health and social sector.

(e.g. Medical doctors, social workers, psychologists)

PP4 - "Delphi Method - Results"

Main results for Greece: "Current State/Desired State/Gap analysis

The results of the -so far- collected questionnaires are indicative, as the replies are still less than the target number. More specifically, up to now we have gathered only 9 finalized questionnaires, out of 40 that have been sent out, and we expect more. The replies gathered so far are a specimen of the situation in Greece today, what the ideal goals should be and where the gap lies between the two.

The following is a detailed description and assessment of the replies we have gathered so far:

1)

As far as the question of prioritizing the care and needs of the vulnerable population of the elderly, the majority of the responses agrees that the basic needs should be met first (meaning that they are not), such as adequate medical care and care at home.

Secondly, most put emphasis on the need of the elderly for social integration, security in social environments and abolishment of the marginalisation that the elderly seem to be faced with.

Psychological support and acceptance, as well as familiarization with technology seem to be at next level of priority, always according to the majority of the given responses.

2)

The view of the current situation in Greece as far as the social care model is concerned is more or less the same for all the participants. The emphasis is put in the deep lack of adequate medical care and social benefits for this particular population group. The lack of government intervention is commonly accepted by the participants. There is a need for research, and new practices are essential.

3)

In regard to what the ideal situation in Greece could be the majority points as a first priority to the needed state/government input and policies that should be in place, in order to drive the collective effort towards the specific ideal direction. More specifically, the majority of the participants states that the goals should include:

- Adequate medical care
- Social integration, care outside institutions
- Adequate financial resources / program funding
- Improving the quality of life of the elderly
- Covering psycho-emotional needs

- Continuous assessment and recording of needs
- Adequately trained staff
- Increased state intervention
- Enhancement of tele-tools and technological familiarity

4)

As far as the gap between the current and the ideal situation is concerned for Greece, the majority appears to believe that it is a bit chaotic. Even though there have been increased attempts to raise awareness over the need for change in the last decades, the reality and the existing practices of a social care model for the elderly are deeply lacking, and are in need of state intervention and revamping. The inadequacy of the health care system, along with a bad organisation of the support bodies, in conjunction to the high level of bureaucracy, have weakened the elderly group and has made them even more vulnerable, marginalised and inactive. The needs that need to be covered are multifaceted and long-term, and in order to reduce the gap, a stable and targeted state intervention is required.

Taking into account the responses of the participants about the required strategies and action plans, as well as the initiatives that could promote change, we have made the following conclusions as to what is needed to be implemented:

- Deeper and more organised evaluation of needs
- Better cooperation of local policy and executing bodies
- Better training programs for staff
- Financing of targeted programs
- Psychological support teams
- State intervention and care
- Creation / strengthening of structures that will meet the needs of the elderly
- Development of tele-tools and familiarization with technology.

Summarizing the responses of the participants in the questionnaires, we distinguish three essential goals that need to be met:

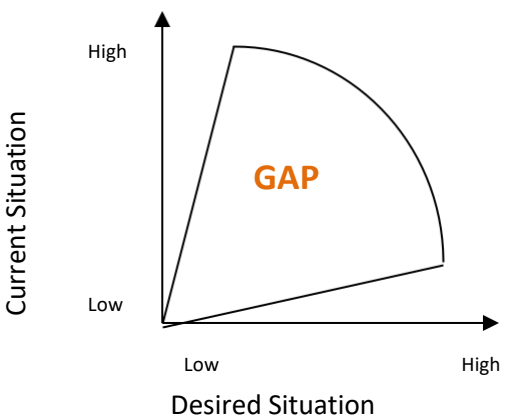
a) A well-rounded assessment of needs, so that

b) A future implementation of an organized and targeted intervention of the policy bodies is meaningful, towards a

c) Adequate social care model that supports the elderly sufficiently and in the long run, with a long-term goal of abolishing marginalization and promote the inclusion of the elderly in the society, always with respect to the uniqueness of the population that belongs in it.

As far as the gap analysis is concerned, the results indicate that the vast majority agrees that strict changes and interventions should take place.

Although there is obvious concurrence of views, this fact automatically reveals the deep lack of present social health services in Greece. So the basic gap is not among participant's opinions but between the current situation and the desired one.



Regarding the gap diagram we can realize that the presented distance between the current situation and the desired one is chaotic. Collective intervention, innovation and revision of social services already provided required. The depicted lack of adequate health and social care services dictates the need for immediate intervention with the main aim of eliminating - as far as possible - the social divergence of the elderly.

Being more specific, the template below analyzes separately the given aspects:

- Current State
- Desired State
- Gap (Knowledge/skill/practice – Methods used)
- Initiatives
- Timeline

We hoped that more replies could be included to our results from this research, so that they could come in as feedback to re-evaluate the above. Unfortunately, the amount of replies was not the expected so the final gap analysis may not be absolutely representative.

LEBANON

1. Introduction

The aim of the Delphi method was to collect opinions of key stakeholders in relation of elderly persons care and reach consensus among these experts.

We identified **29 key stakeholders** that we contacted by emails and phone to participate in the 2 survey rounds we organized.

16 participants responded to the first and second rounds and we followed up with them to fill the surveys.

2. Participant profiles

The participants' profiles were as follows:

Figure 1: Participants Profiles

Participants (10 females and 6 males) were from different backgrounds:

- Non-Governmental
- Governmental
- Medical
- Paramedical
- Private Organizations
- Academic
- Social

3. Results

For the first round, participants were asked to answer the following questions:

1- Please enumerate all topics you feel would be of a priority for the care of elderly vulnerable persons in Lebanon. Kindly write down as many as you see appropriate.
2- Actual State: What is the current situation of social care of elderly in Lebanon?
3- Desired State: How would you like the social care model for elderly in Lebanon to be (future goals)?

4- Gap: How far are we from the desired social care model?
5- Initiatives: What are the most appropriate initiatives and action plans required to reach the desired social care model and overcome the aforementioned gaps?

The open ended questions have helped in identifying a list of priorities which were used in the second round to reach consensus.

Some priorities were repeated among the different participants such as: financial security, pensions plans, social security, health related services, protection, capacity building, age-friendly initiatives, food security and emergency preparedness.

For the second round, the results of the first round were crucial for the development of a list of priorities and experts were asked to rate them on a scale of 1 to 7.

To assess the degree of consensus on the different priorities, the median score (Mdn), was calculated to indicate its importance and the interquartile range (IQR) was calculated to get an impression of the degree of consensus. IQRs with a value of ≤1, indicated a good consensus and a median of >6 was considered important.

Regarding the priorities for the current state, the items highlighted in blue were identified as important by the participants.

Priority	**Median**	**IQR**
Financial security	7.00	0.00
Health coverage and health services utilization	7.00	0.00
Emergency Preparedness	7.00	0.50
Food security and malnutrition	7.00	1.00
Listening to the needs of older adults	7.00	1.00
Protection of human rights of older adults (through laws and legislations)	7.00	1.00
Social security for old age	7.00	1.00
Support of nursing homes (comprehensive services including rehabilitative, preventive, and curative services.)	7.00	1.00
Capacity building of staff working in old age	7.00	1.50
Comprehensive and equitable retirement plans and pensions	7.00	1.50
Primary care development	6.50	1.00

Social inclusion activities and support	6.50	1.00
Empowerment of older people (social/activities, educational/trainings and financial/jobs)	6.50	1.00
Home-based and family-based support and care	6.50	1.00
Empowerment of older women in particular	6.00	1.00
Involvement of older adults in their plan of care/ participatory approach	6.00	1.00
Preventive care development	6.00	1.00
Housing support	6.00	2.00
Infrastructure and friendly facilities/cities/transportation for old age	6.00	2.00
Networking and collaboration between stakeholders dealing with older adults (private and public)	6.00	2.00
Old age research development	6.00	2.00
Stigma related to old age and cultural issues	6.00	2.00
Media & social media involvement in older age	5.50	1.00
Continuing education and capacity development in old age	5.50	1.50
Curriculum advancement for geriatric specialties	5.00	1.00

Table 1 : Priorities for the Current State in Lebanon

Regarding the priorities for the desired state, the items highlighted in blue were identified as important by the participants.

Priority	**Median**	**IQR**
Comprehensive health coverage and health services utilization	7.00	0.00
Listening to the needs of older adults	7.00	1.00
Legislations and laws for protection of human rights of older adults	7.00	1.00
Social security for old age	7.00	1.00
Comprehensive and equitable retirement plans and pensions	7.00	1.50
More empowerment of older people (social/activities, educational/trainings and financial/jobs)	6.50	1.00

Home-based and family-based support and care	6.50	1.00
Infrastructure and friendly facilities/cities/transportation for old age	6.00	2.00
Networking and collaboration between stakeholders dealing with older adults (private and public)	6.00	2.00

Table 2 : Priorities for the Desired State in Lebanon

When asked how far are we from the desired social care model, the median score was 2 (IQR=2) (where 1 is nowhere near and 7 is extremely close) indicating that there is an agreement among the participants that we are far from the desired state.

Results were as follows indicating gaps in Governmental Support and Resource Allocation, Infrastructure and City Planning (elderly friendly) and Comprehensive Old Age Care (Health, Financial,& Social).

Gap	**Median**	**IQR**
Education and Training of Professionals	4.00	1.50
Research, Data Collection and Development	3.00	2.00
Standardization and Quality Control of Services	3.00	3.00
Networking and Partnerships	3.00	3.50
Governmental Support and Resource Allocation	2.00	2.00
Infrastructure and City Planning (elderly friendly)	2.00	2.50
Comprehensive Old Age Care (Health, Financial,& Social)	2.00	2.50

Table 3 : Gaps in Lebanon

As for the initiatives, the highest priority was cited for the National Strategy for Old Age Care (including basis for old age care, financial & social support, retirement, pension plans and safety nets) (Median =7 and IQR=0) followed by several initiatives listed in blue in the following table.

Initiatives	**Median**	**IQR**
National Strategy for Old Age Care (including basis for old age care, financial & social support, retirement, pension plans and safety nets)	7.00	0.00
Emergency Plan for Old Age	7.00	1.00
Disease Management Programs for Conditions Related to Old Age (Alzheimer's, Dementia, Chronic Diseases, Terminal Illnesses requiring Palliative Care,...)	7.00	1.00
Governmental Support and Services	7.00	1.00
Laws and Regulations Related to Old Age	7.00	1.00
Centralized Unit for Old Age Affairs and Programs	6.50	1.00

Training and Capacity Development of Staff and Professionals working with Elderly	6.50	1.00
Advocacy with Policymakers and Legislators	6.50	1.50
Elderly Friendly Cities	6.50	1.50
Community Mobilization and Partnerships with Municipalities	6.00	1.00
Awareness programs: schools, media, community and professionals	6.00	2.00
Intergenerational Activities and Programs	6.00	2.00
Networking and partnership with local and international organizations in various sectors including education, health, social welfare, and development	6.00	2.00
Social and Financial Support Initiatives (work, volunteering opportunities, social activities)	6.00	2.00
Senior Citizens Programs and Benefits	6.00	2.50
Funding for Research and Development	5.50	2.00

Table 4 : Priorities for the Initiatives in Lebanon

4. Conclusion:

The 2 rounds reflected the priorities and consensus among stakeholders was reached as the needs and priorities of older adults in Lebanon can be summarized as follows:

- Comprehensive social care of older adults (health, financial, social, retirement, pension plans ….)
- Age-friendly infrastructure
- Emergency preparedness and planning
- Food security
- Listening to the needs of older adults
- Legal and policy issues related to old age
- Legislations and laws for protection of human rights of older adults
- Social security for old age
- Empowerment of older people (social/activities, educational/trainings and financial/jobs)
- Home-based and family-based support and care
- Networking and collaboration between stakeholders dealing with older adults (private and public)

Figure 2: Some of the priorities for Lebanon's older adults

SPAIN

INTRODUCTION OF GAP ANALYSIS

The Gap Analysis is part of the third activity of the WP3 “Development of a transcultural social-ethical-care model for dependent populations in the Mediterranean basin": A.3.1.3. Gap Analysis and TEC-MED Intervention Framework Definition, together with the A.3.1.1. Analysis of the most promising social care initiatives and the A.3.1.2 Analysis of the current social care practices in the six countries involved in the project.

Specifically, the aim of the activity A.3.1.3. is to conduct a GAP analysis and create the first draft of the TEC-MED Model in order to answer to this question: *How can all the findings under WP3 activities, in addition to technical consultation workshops be used to create the draft of the TEC-MED Model?*

Before starting to describe the development of this activity, it is necessary to specify that the work methodology had to be changed due to the new needs of COVID-19.

In fact, the GAP activity initially aimed at conducting different workshops for each country, has been replaced with a suitable methodology for online work, as described below. Aware of the loss of values of the activity due to the lack of confrontation and face-to-face co-creation of a workshop -where it is easier to create dynamics of debates and create community- we have tried to fill this gap with a rigorous and in-depth consultation and consensus building through the Delphi method, and guaranteeing the involvement of all the different levels and scope of stakeholders of this project.

The presentation of this Report becomes one of the milestones on which the innovative TEC-MED Model is developed. It aims to guide users, professionals and institutions and administrations in understanding the organization of the TEC-MED project, as well as in its scope. Experts in the field of aging, social care, ethics and transculturality have carried out a gap analysis and the definition of the intervention framework for the development of the TEC-MED Model. A total of fifty-six experts were invited to participate in three rounds of a Delphi panel, in order to establish

the priority aspects that must form the basis of the intervention framework for the development of the TEC-MED model.

Key stakeholders with the profile described before were invited to discuss the next aspects 1) Identify the gaps in the social-care system; and 2) Rank the gaps in order of priority.

METHODOLOGY

The Delphi method is a structured process that uses rounds of questionnaires to gather information, and rounds are continued until group consensus is reached. This widely used method allows for the inclusion of a large number of individuals across diverse geographic locations and, unlike a face-to-face meeting, avoids the situation where a specific expert may dominate the consensus process.

The aim was to address the **current situation** about the social care in Spain, the **desired state**, the **gaps**, and the best **initiatives** to achieve the final objectives (Figure 1).

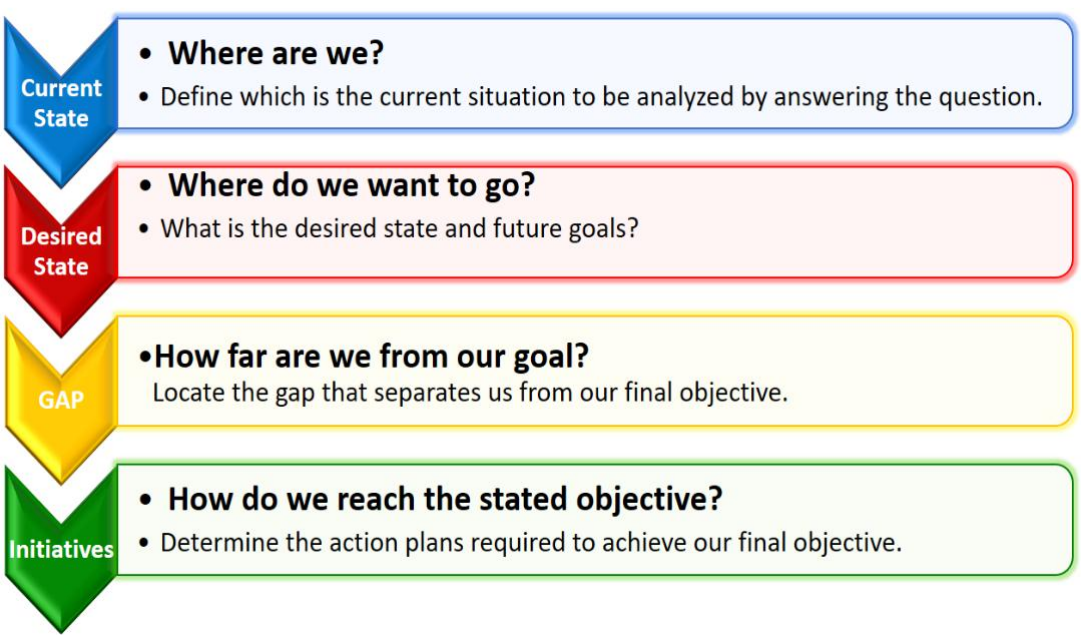


Figure 1. Objectives to achieve with the Delphi technique

Participants

The objective of involving at least 20 experts was exceeded, inviting 56 experts to participate. They were identified through partner organizations and networks and those who participated in the semi-structured interviews and planning committee were also selected. Several professional sectors (according to the Quadruple Helix Model), different expert profiles (sex, age, area of knowledge), as well as management levels (micro, meso and macro level) were taken into account. Potential participants were invited to take part by completing an online survey accessed via a URL link.

Procedure

Different stages were carried out between May and June 2002 (Figure 2)

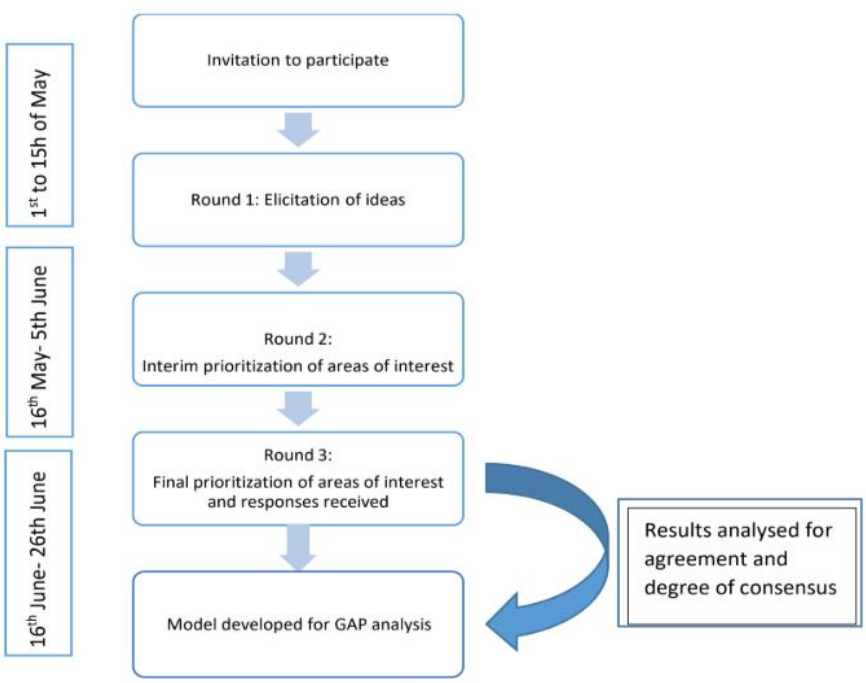


Figure 2. Flowchart for the process of Delphi method

Round 1: Elicitation of relevant topics

Participants were invited by email to answer a survey to confirm their participation. Invitation emails were sent to around 56 potential participants as the response rate was expected to be around 50-75%. Finally, **38 people answered** (67.8%). Participants were asked to identify priority areas about the care provided for aging population.

A qualitative analysis of the data resulted in the configuration of the items for the second round.

Round 2: Building consensus on priorities

Experts from the second round presented a list with all the priorities that were identified during the first round. **Thirty-two people** indicated the importance of each priority using a seven-point Likert scale ranging from 1 (not important at all) to 7 (extremely important). Except for the GAP dimensions that was assessed how near we are from the desire state (the difference between the current state and the desire state) ranking from 1 (not near at all) to 7 (extremely near).

Moreover, there was a blank space for each dimension (current state, desire state, GAP and initiatives), were experts were able to do suggestions, ask for clarifications or modifications, etc.

Later, the data will be analyzed by calculating the interquartile deviations (IQD). The IQD is a measure used to express the degree of consensus obtained, with a higher IQD referring to a smaller degree of consensus. When using a seven-point scale, IQDs with a value of ≤1.5 indicate good consensus.

Round 3: Reaching consensus on priorities

All experts that participated in the second round were invited to take part in the third and final round of the Delphi study. Finally, **26 people answered.** The questionnaire, including the feedback about median and IQD for each item from the second round, was sent to the participants to re-rate their answers from the prior round. Of all items, those that have an IQD ≤ 1.5 were taken out of the questionnaire.

Furthermore, the data were analyzed by calculating the median score (Mdn), to indicate the importance of every priority. A median score of ≥6 was considered important.

TEC-MED Social Care Model

The results obtained are the basis of the TEC-MED project proposal for the development of a new innovative social care model. The characteristics of the participants are described below, as well as the most revealing aspects for each of the topics and categories. In each round have participated respectively 38, 32 and 26 people.

Women represented more than 60% of experts in all rounds of analysis (64% in the first round, 62.5% in the second round, and 65% in the third round respectively) and 47% and 37.6% of these experts belong to a level of micro and meso management (Figure 3).

Field of expertise	First round (%)	Second round (%)	Third round (%)
Women	64	62.5	65
Macro management	18.4	15.6	11.5
Meso management	31.6	46.8	34.6
Micro management	50	37.6	53.9
Civil society	23.7	3.1	11.5
Business	21.4	15.6	19.3
Public administrations	7.9	53.1	57.7
Research and education	47	28.2	11.5

Figure 3. Participants Profile

The strategy of attracting experts / as possible to achieve business sectors, to public administrations, research centers and / or educational, and civil society (Figure 4).

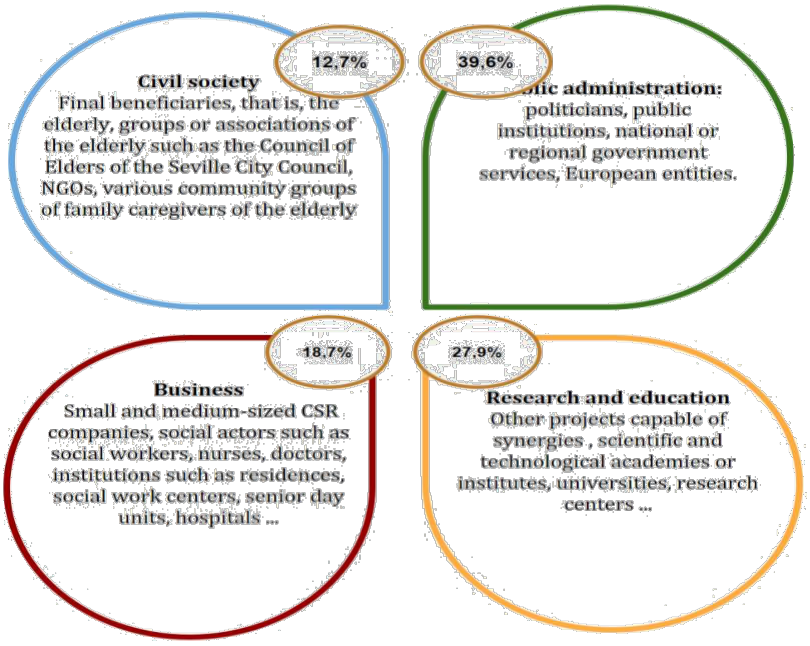


Figure 4. Quadruple Helix. Source: Carayannis and Campbell (2009)[1]

From the results obtained in Spain, the TEC-MED social care model focuses on those aspects that have been agreed by the experts, prioritized and considered achievable, taking into account the objectives of the project and the main expected outputs.

The qualitative analysis carried out after the first round, reflected the existence of four categories in which the experts' ideas could be classified: a) Governance; b) Model features; c) Professionals; and d) User and family.

Some examples of the items created from the results of the first round categorized based on these dimensions are shown in the following tables (Table 1 and 2).

[1] Carayannis, E., & Campbell, D.F.J. (2009). Mode 3'and Quadruple Helix: Toward a 21st century fractal innovation ecosystem. International Journal of Technology Management 46(3/4). doi: 10.1504/IJTM.2009.023374.

Table 1. Results from the second round according to experts

	Current state	Desired state	GAP	Initiatives
Governance	• Territorial differences • Universal coverage problems and guarantee of rights	• Lack of State agreement for attention • Accessibility • Integrated policies - long-term care promotion • Universal access and rights coverage • Territorial equity • User empowerment / participation • Public procurement	• Bureaucracy	• State agreement and regulations • Universal and integrated coverage • Territorial equity • Public financing • Person-centred long-term care • User participation • Raising awareness of social determinants and gender • Diagnostic studies • Social protection policies • Socio-educational interventions
Model features	• Home support is missing • Absence of medium-long stay centers • Poor evaluation • Lack of public-private coordination	• Person centred model (biopsychosocial needs) • Residential alternatives • Respect for rights and values • Promotion of autonomy • Gradual and flexible care adapted to gravity • Quality assessment • Interdisciplinary team • Make best practices visible • Prevention of abuse • Home care • Integration of key agents in programs • Attention for medium-long stay • Quality versus business profit	• Professionalization of services	• Person centred model (biopsychosocial needs) • Scientific basis • Home care and professionalization of these services • Reform home care services • Collaborative space design • Residential alternatives • Intermediate care resources • Waiting list coverage • Eliminate bureaucracy • Free-clamping centers • Primary health care – socialhealth care • Supply-demand adjustment • Portfolio-services protocols • Incorporation of ICTs • Coordination structures (socio-sanitary commissions) • Model evaluation • Homogenize initiatives • Ethical considerations • Care cooperative
Professionals	• Job insecurity • Professional stigma • Need of training	• Favorable working conditions, recognition • Adequate professional-user ratio • Socio-sanitary specialization and professionalization • Research		• Interdisciplinary teams • Specialization and training • Research • Improve working conditions • Adequate professional-user ratio • Management specialization • Professional accreditation
User and family	• Greater needs as life expectancy increases • Fragility • Social isolation	• Personalized attention • User / family participation • Promote autonomy • Caregiver care		• Empowerment • Inclusion in integrative activities • Self-care promotion

Table 2. Results from the third round according to experts

	Current state	Desired state	Initiatives
Governance		• State Pact for health care • User empowerment / participation • Integrated policies • Active aging and palliative / long-term care promotion • Universal access and rights coverage • Accessibility • Territorial equity	• State Pact for health care • Universal access and rights coverage • Integrated policies • Territorial equity • Active aging and palliative / long-term care promotion • Social awareness • State regulations on quality of services • Intergenerational solidarity • Social protection policies • Public financing
Model characteristics	• Lack of support to stay at home • Lack of medium-long stay centers • Public-private coordination	• Home care • Residential alternatives • Respecto for rights and values • Active aging • Gradual and flexible care adapted to severity • Socio-health integration • Prevention of abuse • Home care • Public and private coordination • Leadership of social agents and horizontal management • Companies audit regarding the quality of care • Model based on scientific evidence	• Integrated and person / family focused care • Residential alternatives • Demand coverage waiting list dependency • Prevention of abuse • Reduce bureaucracy • Flexibility of care according to needs and severity • Professionalized home services • Care quality assessment • Increase in residential places • Home care and local / community care • Primary health care: provision for social health care • Architecture of institutions similar to the user context
Professionals	• Job insecurity	• Improvement of working conditions • Specialization and professionalization • Social recognition • Adequate professional / user ratio	• Adequate professional / usurious ratio • Training • Research • Professional development
User and family	• Increased needs due to longer life expectancy • Social isolation	• Personalized attention • Promote autonomy • Family participation in decision-making • Caregiver care • Dependency as part of the life cycle	• User / family empowerment • Development of integrative activities • Self-care promotion

Tables 1 and 2 show the most relevant aspects according to the experts (IQD ≤ 1.5). In addition, those categorized as most priority (Mdn ≥6) have been highlighted in red. In both rounds certain items are repeated, so they are considered of great interest. Finally, it is possible to observe that the aspects that the experts would like to achieve are transformed into initiatives to be developed in this new model.

Finally, a summary of the proposals, aspects and initiatives collected throughout the GAP-Analysis is shown below (Figure 5).

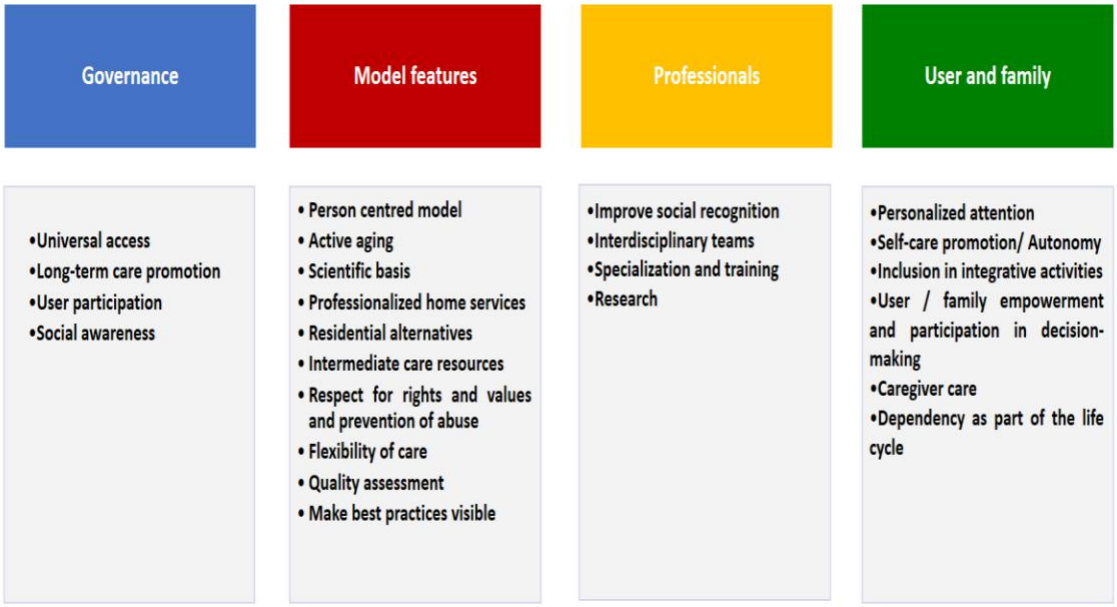


Figure 5. Summary of the categorization of the Social Care Practice according the responses of the experts

Governance: Experts currently point out that there is real territorial inequality and difficulty in guaranteeing the rights of the elderly, something that is not only a current demand, but something that they want to overcome in the future. Experts are also committed to greater participation of older people in political decision-making and design, as well as improving accessibility and policy integration. However, they show a clear bureaucratic difficulty. Reverting these situations are the main initiatives, as well

as raising awareness in society and public institutions about the dignified quality of life of the elderly.

Model features: The current care is focused on acute processes, without taking into account the needs of long stays for many older people as dependency increases. The evaluation of the care provided to the elderly is neither homogeneous nor of quality, and there is no real coordination between the public and private sectors. Distinctive characteristics of the TEC-MED Model will be the focus on the person as the center of care, the promotion of active aging, flexibility of care according to the evolution of the situation of dependency on the elderly, use of ITCs, and the development of guides and best practices based on scientific evidence. The development of this model will promote a quality control system of care, respect for the rights and dignity of the elderly, including the prevention of abuse. The model will be applicable in different residential settings, even supporting and reforming home care, and the professionalization of home care services will be promoted.

Professionals: Currently, health and social care professionals are subject to job insecurity in Spain, linked to the stigma of the profession. The look towards the professionals in the provision of social care implies a mobilization towards the social recognition of their work, specialization and continuous training, the attention provided by interdisciplinary teams, as well as support for research in areas of aging.

User and family: The real situation of the elderly stands out for loneliness, isolation, and fragility. The TEC-MED model will personalize social care for the users and / or their family, empowering them for decision-making and caring for the caregiver. The promotion of autonomy and self-care of the patient is a priority. Lastly, proposals for integrated activities will be developed for the inclusion of elderly dependents and / or at risk of social exclusion.

Conclusions

The results of the GAP-Analysis in Spain are intended to be combined with the information obtained in the rest of the WP3 activities. It will be necessary to attend to the results shown by the partners from other countries to direct the model towards the

most relevant, priority and common aspects, taking into account all the dimensions: governance, model characteristics, professionals, and user and family.

The gap analysis has been essential to confront the current state of the care system in Spain with the state in which our community would like it to be, in order to be able to propose a model that bridges these two realities.

Thanks to this analysis, the TECMED model proposal can take into account the strengths, obstacles and possible tools to solve this gap presents in the Spanish Social Care System.

The richness, complexity and depth of the Gap carried out has been guaranteed by the participation of experts at all levels of social care.

In this sense, Delphi has made it possible to focus on the key elements, agreed by experts -representative of our community- which should be present in the TECMED Model proposal.

In fact, this activity -together with the other activities of the WP3- allows creating the guidelines for the creation of the TECMED Model.

In this sense, there is a general consensus on the need for social care that has universal access and equity in services through the promotion of long-term health -with the participation and awareness of the entire community- offering a model of comprehensive care centered on the person. The person at the center of this model must be empowered by participating and making decisions in all processes, take care of them as much as possible at home, and when not, in an environment that is similar to it. At the same time, it is essential to protect and value the work of the caregiver and the family, guaranteeing specialization and professionalism.

Some initiatives evidenced after analyzing the results have been considered more complex to be initially tackled in the TEC-MED project. However, they have been considered so important that a new project has been proposed to capitalize on the primary results. This includes the ideas of the experts that require a more global approach, and that mainly involves administrations. Based on the gap analysis activity, lines of action with a strong governance nature and transfer of results in other countries, will be the result of the objectives set for this Project.

References

Jander, A., Crutzen, R., Mercken, L. *et al.* Web-based interventions to decrease alcohol use in adolescents: a Delphi study about increasing effectiveness and reducing drop-out. *BMC Public Health* 15, 340 (2015)

TUNISIA

1. Delphi method

The Delphi method is originally defined as a method for “eliciting and refining group judgments” [1]. The more used employment of the Delphi method is for "facilitating structured group communication in order to gather a consensus of expert opinions in the face of complex problems, expensive endeavors, and uncertain outcomes" [2]. Generally, three structured rounds are enough [3].

We used Delphi method to collect opinions of key stakeholders in relation of elderly persons care and gathered the consensus about the best measures in Tunisian context.

2. Application of Delphi method in Tunisia

We identified **31 key stakeholders** in relation with the topic of TEC-MED projects, the social and health care of elderly people.

From the **31 stakeholders**, five (05) were **designed directly by their ministers**: the representatives of the ministry of health, the Ministry of Women, Family, Children and Elderly affairs, the Ministry of social affairs, Ministry of religious affairs, the Ministry of High Education and Research (*table 1*).

The identified stakeholders were invited by e-mails, phone and mailing to participate in Delphi survey. *Figures 2, 3 and 4* showed the responses rates.

We started the first round on 17th May 2020. Until 15th June 2020, only 24 (from 31) stakeholders filled the questionnaire on line, i.e., a response rate = 77.4%.

We started the second round on 18th June 2020. Until 29th June, only 18 (from 24 invited by mails) stakeholders filled the questionnaire on line, i.e., a response rate = 75%.

We started the third round on 30th June 2020. On the 15th July all contacted stakeholders (18 from 18) filled the questionnaire on line, i.e., a response rate = 100%.

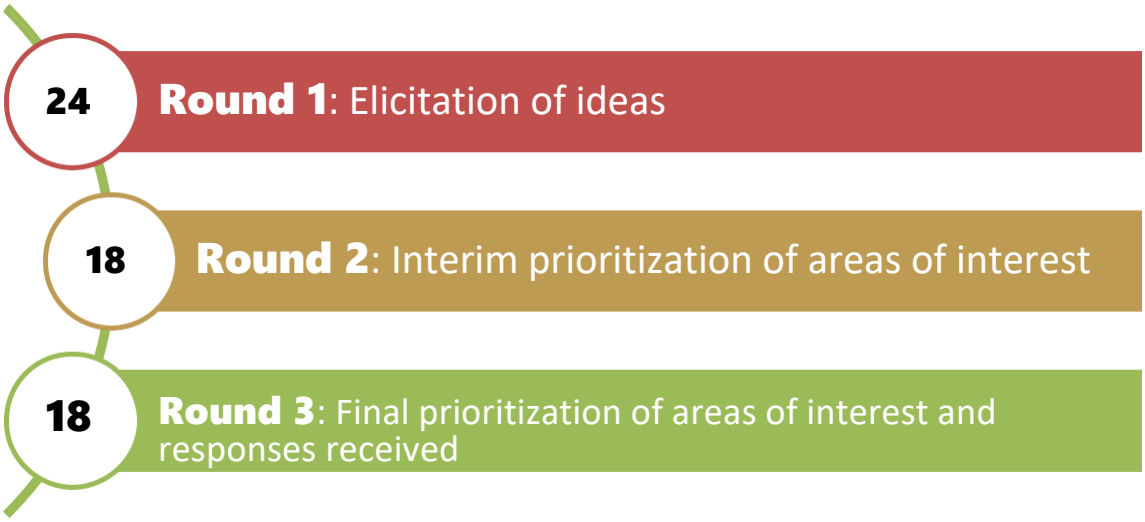


Figure 1: Conceptual framework of Delphi method

Table 1: List of Tunisian stakeholders and number of respondents in every round

Government/Organisation	Last name	Title and Function	Round		
			1	2	3
MACRO Management level					
Ministry of Health	OUENICHE Saida	Deputy Director of care qualities - General Directorate of Health	■	■	■
Ministry of Women, Family, Children and Elderly affairs	MATTOUSSI Khaled	Sociologist	■	■	■
Ministry of Social Affairs	BEN BRAHIM Raja	General Directorate of Social Promotion	■	■	■
Ministry of religious affairs	DRIDI Sonia	Director of religious awareness	■	■	■
Ministry of High Education and Research, Faculty of Medicine of Tunis	BEN HASSINE Lamia	Professor of Medicine, Head of Family Medecine Department			
Directorate of Primary health care	GUEZMIR Kais	Doctor, Responsible of National Programme of elderly health	■	■	■
National Institute of Nutrition and Food Technology	KAMMOUN Ines	Professor of Medicine, Head of Endocrinology Department	■	■	■
National Institute of Health	BEN MANSOUR Nadia	Associate Professor in Preventive Medicine	■	■	■
Directorate of Elderly person protection	BEN CHEIKH Imen	Doctor, Director	■		
National health insurance fund	CHERIF Leila	Doctor, Assistant Director	■	■	■
MESO Management Level					
Tunisian Association of Alzheimer (AAT)	ALOUANE Leila	Professor of University, President of AAT	■	■	■
Tunisian Association for Research and Study in Geriatrics and Gerontology (ATEREGG)	HAJJEM Said	Doctor of Medicine, Geriatrician, President of ATREGG			
Tunisian Association of Gerontology ((ATUGER))	GOUIAA Radhouene	Professor of Medicine, Geriatrician, President of ATUGER	■	■	■
Association d'assurance aux Grand Handicapés à Domicile (AAGHD)	ZMANTAR Belsem	Psychologist. AAGHD President	■	■	■
Société Tunisienne de Médecine de Famille	BELLAMINE Zied	Doctor, STFM President	■	■	■
	ZITOUN Khadija	Secrétaire Général	■	■	■
Centre de protection des personnes âgées de la Manouba	SGHAIER Mezri	Médecin généraliste			
	SAFFEN Nabil Yassine	Director of the Centre			

DAR BABA Maison de retraire et de convalescence	BEN MARZOUK Adel	Geriatrician			
Research-Light Agency	BOURASSI Amel	Media Manager			
MICRO Management level					
Hôpital Mahmoud Matri, Ariana	BACCAR Sondos	Doctor, Geriatrician			
Hôpital La Rabta	LAMLOUM Mounir	Professor of Medicine, Head of Internal medicine Department			
Hôpital Habib Thameur, Tunis	BOUSSEMA fatma	Professor, Geriatrician			
Hôpital Charles Nicolle	AZZABI Samira	Professor of Internal Medicine and Geriatrician			
Faculté de Médecine de Sfax	KAMMOUN Samy	Professor, Dean of the Faculty of Medicine of Sfax. Geriatrician and responsible for geriatric training			
Hôpital Sahloul, Sousse	BEN FRADJ Fatma	Professor of Internal Medicine and Geriatrician			
	LAOUANI Chédia	Professor of Internal Medicine and Geriatrician			
Hôpital Fattouma Bourguiba, Monastir- Société Tunisienne de Gériatrie	OUALI HAMMAMI Sonia	Professor, Geriatrician-Internal Medicine			
Direction régionale de la santé de Tunis. Ministère de la Santé	LASSOUED Fatma	General practitioner. Geriatrician. Head of health constituency			
National Institute of Nutrition and Food Technology	DOUIRI Wafa	Psychologist in the outpatient service			
Institut des Hautes Etudes stratégiques	MNASRI CHENIK Lamia	MG - Gériatre, S/D D. PA MFFE			

3. Participant profiles

The Invited participants were profiled as follows

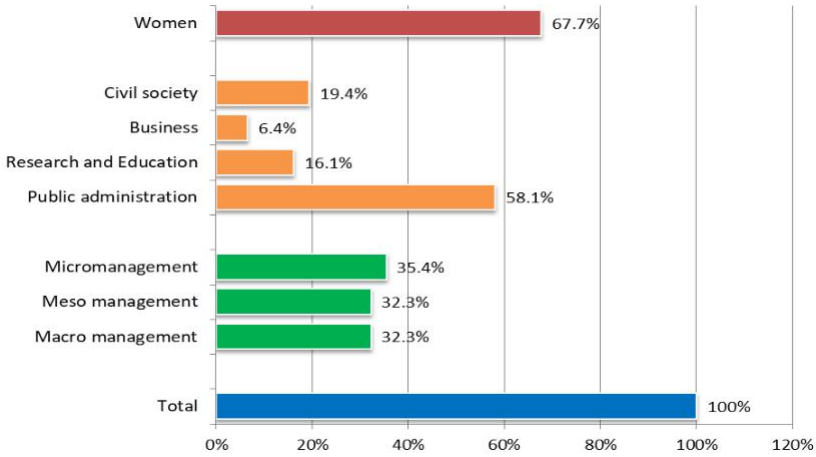


Figure 2: Frequency of invited participants by gender, management level and quadruple helix

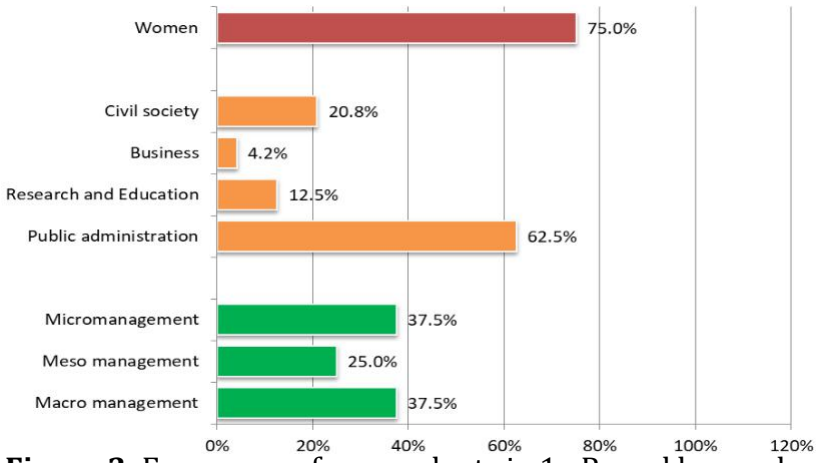


Figure 3: Frequency of respondents in 1st Round by gender, management level and quadruple helix

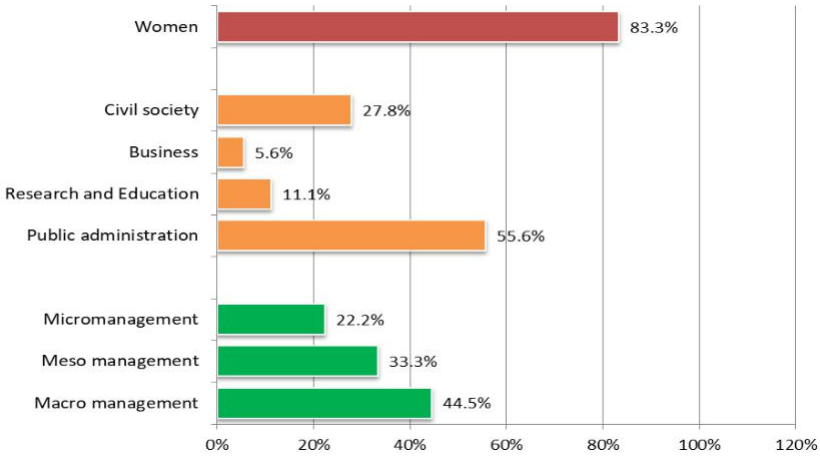


Figure 4: Frequency of respondents in the 2nd and 3rd Rounds by gender, management level and quadruple helix

4. Results from the Delphi survey

4.1. 1st Round of Delphi method

In the first round, respondents answered open-ended questions that helped us define the current situation, desired state and the initiatives helped elicit the priorities, and the answers regarding the GAP dimensions helped elicit the Gaps.

Link to the questionnaire https://forms.gle/Sch7UcbuvUKwoByc9

For the first round, participants were asked to answer the following questions:

1. Veuillez énumérer tous les points (ou enjeux) qui, selon vous, constituent une priorité pour la prise en charge des personnes âgées vulnérables. *[Please list all the points (or issues) that you consider to be a priority for the care of vulnerable elderly people].*

2. Définir la situation actuelle à analyser en répondant à la question « Où sommes-nous? » (État actuel). *[Define the current situation to be analyzed by answering the question "Where are we?" " (Current state)]*

3. Donner des objectifs futurs en répondant à la question « Où voulons-nous arriver? » (État désiré). *[Set future goals by answering the question "Where do we want to go?" (Desired state)].*

4. Cernez l'écart qui nous sépare de notre objectif final en répondant à la question « À quel écart sommes-nous de notre objectif? » (Écart). *[Identify the gap that separates us from our final objective by answering the question "How far are we from our goal?" " (GAP)].*

5. Déterminer les plans d'action nécessaires pour atteindre notre objectif final en

répondant à la question « Comment atteindre l'objectif fixé? » (Initiatives).
[Determine the action plans required to reach our final objective by answering the question "How to reach the stated objective?" "(Initiatives)]

The information gathered helped us identify the variables affecting the current model the most and those which will be the most likely to improve it until the Gap is filled and the ideal situation is reached, those included among other things: elements of social inclusion, legislation and norms, economical, financial and educational aspects, evaluation and strategizing, and cultural and infrastructural elements.

And so, priority areas have been identified in relation to the aspects highlighted, with regard to health care and social services for the elderly population.

The Tunisian team has gathered 24 Responses to the first questionnaire. The results we've gotten are indicative of the situation of the elderly population in Tunisia and they let us draw conclusions on the different priorities on the economic, health, legislative, institutional, social and cultural level.

Among what was the most reiterated we can cite training and academia, including geriatrics, auxiliaries, nursing staff etc. The financial side was also brought up a lot, with a focus on financial autonomy and economic security, while affirming the government responsibility on this point in particular.

Many participants consider fighting dependence a priority, with different proposed solutions such as reinforcing the preventive care offer, and while adapting care structures and systems of care to the needs of the elderly is considered a necessity, initiatives that can help improve the quality of life for the elderly like strengthening of entertainment facilities (such as the day leisure centers) were suggested.

Indeed, the mental well-being of the elderly was also brought up multiple times, as it's considered to be something that needs to be thought upon more in Tunisia, with tools like social and psychological support, and work that needs to be done regarding seniors integration into society.

Finally, in order to render all the listed priorities feasible, participants stated that a multi sectoral strategy is required with a body or institution high up in the ministry specializing in the promotion of the health of the elderly. While asserting that a national action plan supported by regional plans are the most effective, including a study on the quality of life of the elderly as well as studies and statistics concerning the current situation of vulnerable elderly people in Tunisia will help push those initiatives up in the political agenda.

4.2. 2nd Round: Building Consensus

In the second round, after having identified the relevant questions, it was necessary to reach a consensus on the priorities, by evaluating the elements derived from the first round: 28 Priorities identified and 12 Gaps were identified.

Link to the questionnaire: https://forms.gle/ZdErUgBhddYWvVJh6

Analyse du modèle de protection sociale et sanitaire des personnes âgées en Tunisie.

2ème étape: bâtir un consensus sur les priorités

* Required

Cher expert,

Tout d'abord, nous souhaitons vous remercier pour votre précieuse participation et contribution au développement du modèle de protection sociale du projet TEC-MED.
Comme vous le savez, la présents méthode Delphi vise à analyser le modèle de protection sociale développé en Tunisie pour la population âgée dépendante et / ou à risque d'exclusion sociale.
Plus précisément, l'objectif est de répondre aux questions: Où en sommes-nous (état actuel)? Où voulons-nous arriver (état souhaité)? À quel écart sommes-nous de notre objectif (écart)? Comment atteindre l'objectif fixé (initiatives)?
Dans le PREMIER TOUR, avec vos collaboration, des domaines prioritaires ont été identifiés par rapport aux aspects mis en évidence, en ce qui concerne les soins de santé et les services sociaux pour la population âgée.
Dans le DEUXIÈME TOUR, après avoir identifié les questions pertinentes, il est nécessaire de parvenir à un consensus sur les priorités selon le point de vue des participants, en évaluant les éléments dérivés du premier tour.
L'équipe de recherche vous remercie encore pour votre précieuse participation.
N'oubliez pas que si vous avez des questions concernant cette étude, vous pouvez contacter l'équipe TEC-MED (e-mail: haroun.chamli@gmail.com).

Experts that participated in the first round were invited to assess the priorities and the Gaps that we identified following the first round. We used a seven points Likert scale, ranging from 1 (not important at all) to 7 (very important) regarding the priorities and ranging from 1 (not close at all) to 7 (very close) regarding the GAP dimensions.

To assess the degree of consensus on the different priorities, the median score (Mdn), was calculated to indicate its importance and the interquartile deviations (IQD) was calculated to get an impression of the degree of consensus. IQDs with a value of ≤1, indicate a good consensus.

These are the results obtained from the priorities analysis:

Priority	Median	IQR
Élaborer et mettre en place une stratégie nationale multisectorielle de prise en charge des personnes âgées. [*Develop and implement a national multisectoral strategy for the care of the elderly].*	7	0.75
Renforcer l'offre de soins préventifs auprès des personnes âgées. [*Strengthen the preventive care offer for the elderly].*	6	0.75
Renforcer les activités de communication avec les personnes âgées pour mieux identifier leurs besoins, les éduquer pour améliorer leur hygiène de vie. [*Strengthen communication activities with the elderly to better identify their needs, and educate them to improve their lifestyle].*	6	0.75
Vulgariser la culture de droit des personnes âgées afin d'éviter les pratiques âgistes (pratique incitant 'exclusion) des personnes âgées. [*Popularize the culture of the elderly rights in order to avoid ageist practices (practices encouraging the exclusion) of the elderly]*	6	0.75
Création de la spécialité de Gériatrie dans le cursus des médecins de	7	1

famille. [*The creation of a Geriatrics speciality in the curriculum of family doctors].*		
Formation du personnel médical et paramédical aux soins des personnes âgées dépendantes et/ou à problèmes de santé. [*Training of medical and paramedical staff in the care of dependent elderly people and / or with health problems].*	7	1
Créer des structures dans les gouvernorats du pays pour la prise en charge sanitaire, sociale, nutritionnelle, psychologique des personnes âgées. [*Create structures in the country's governorates for the health, social, nutritional and psychological care of the elderly].*	7	1
Promouvoir le mode de vie sain en renforçant la mise en place de la stratégie nationale multisectorielle de prévention et contrôle des maladies non transmissibles. [*Promote healthy lifestyles by strengthening the implementation of the national multisectoral strategy for the prevention and control of noncommunicable diseases].*	6.5	1
Lutter contre les inégalités géographiques des soins et de prise en charge sociale. [*Tackle geographic inequalities in health care and social care].*	6.5	1
Créer des mécanismes pour garder les personnes âgées en activité et capitaliser leurs expertises afin de promouvoir leur bien être mental et financier. [*Create mechanisms to keep the elderly in activity and capitalize on their expertise in order to promote their mental and financial well-being].*	6	1
Créer et mettre en place un modèle d'hospitalisation à domicile. [*Create and implement a home hospitalization model].*	6	1
Renforcer la formation et la spécialisation du personnel social et des auxiliaires de vie pour une meilleure organisation et planification des interventions auprès des personnes âgées et en particulier celles vulnérables*. [Strengthen the training and specialization of social staff and carers for better organization and planning of the interventions with the elderly and in particular those who are vulnerable].*	6	1
Concevoir un programme d'intervention spéciale pour améliorer les conditions de logement des personnes âgées pauvres et leur fournir le minimum de confort nécessaire. [*Design a special intervention program to improve the housing conditions of poor elderly people and provide them with the minimum necessary comfort].*	6	1
Favoriser la couverture sanitaire des personnes âgées pauvres à travers la gratuité des soins. [*Promote health coverage for poor elderly people through free healthcare].*	6	1
Renforcer les équipes mobiles qui interviennent auprès des personnes âgées pauvres. [*Strengthen the mobile teams that work with poor elderly people].*	6	1
Développer des programmes d'intervention psychosociale au profit des familles assumant la responsabilité de protection d'un membre âgé vulnérable atteint d'une incapacité ou d'une maladie chronique. [*Develop psychosocial intervention programs for families taking care of a vulnerable elderly member suffering from a disability or a chronic illness].*	6	1
Renforcer la collaboration intersectorielle et interinstitutionnelle en	6	1

relation avec les besoins des personnes âgées. [*Strengthen intersectoral and inter-institutional collaboration in relation to the needs of the elderly].*		
Multiplier les centres de soins spécialisés pour la prise en charge des personnes âgées dans tous les gouvernorats. [*Increase the number of specialized care centers for the care of the elderly in all governorates].*	6	1
Renforcer la formation continue des médecins de santé publique de première ligne concernant les pathologies gériatriques. [*Strengthen the ongoing training of primary health doctors regarding geriatric pathologies].*	7	1.75
Inclure les personnes âgées dans la couverture sanitaire universelle. [*Consider the elderly in the universal health coverage].*	6.5	1.75
Utiliser l'approche participative avec les personnes âgées pour l'élaboration de la stratégie nationale multisectorielle de prise en charge des personnes âgées. [*Use a participatory approach with the elderly for the development of the national multisectoral strategy for the elderly care].*	6	1.75
Mener une enquête nationale sur les conditions de vie des personnes âgées vulnérables et identifier les facteurs de risque de leur situation précaire. [*Conduct a national survey on the living conditions of vulnerable elderly people and identify the risk factors for their precarious situation].*	6	1.75
Adopter l'approche d'autonomisation qui soutient les groupes vulnérables de personnes âgées aux niveaux économique, social. [*Adopt the empowerment approach which supports vulnerable groups of the elderly at an economic and social level].*	6	1.75
Créer des unités gériatriques au niveau de la première ligne. *Create geriatric units at the primary health care level].*	6	2
Développer et mettre en place des programmes de protection spécifiques des personnes âgées handicapées. Les programmes jusqu'ici mis en œuvre en faveur des handicapés ne tiennent pas compte des besoins et des caractéristiques propres aux vieilles personnes. [*Develop and implement specific protection programs for the elderly with disabilities. Programs so far implemented for the disabled do not take into account the needs and characteristics of the elderly].*	6	2
Revoir la réglementation qui gère les droits des personnes âgées en matière de soins de santé et de protection sociale. [*Review the regulations that manage the rights of the elderly in health care and social protection].*	6	2
Assurer la disponibilité des besoins des personnes âgées en matière de médicaments, d'outils informatiques de surveillances, de suivi et de protection. [*Ensure the availability of the needs of the elderly in terms of medicine, tools for surveillance, follow up and protection].*	6	2
Adopter l'approche « Economie Sociale et Solidaire » qui se caractérise par sa capacité à créer des projets de développement et de services garantissant un grand bien-être dans ses dimensions sociales et sanitaires. [*Adopt the Social Economy approach, which is characterized by its ability to create development and service projects guaranteeing great well-being in its social and health dimensions].*	6	2

Results obtained from the GAP analysis:

GAP	Median	IQR
Les soins sanitaires et les infrastructures des établissements sanitaires et les cotisations ne sont pas suffisamment adaptés aux personnes âgées vulnérables. [*Health care, the infrastructure of health establishments and the contributions are not sufficiently adapted to the vulnerable elderly] ;*	7	0.75
Sur le plan qualitatif, je crois que nous sommes encore loin de couvrir l'ensemble des besoins des PA (aide financière, urbanisme adapté, moyens de transport, médecins de famille formés en gériatrie, consultation gériatrie dans toutes les structures de première ligne). [*In terms of quality, we are still far from covering all of the needs of the elderly people (financial aid, adapted town planning, means of transport, family doctors trained in geriatrics, geriatrics consultation in all first-line structures].*	7	1
La politique sociale actuelle est une politique d'ASSISTANCE, il manque une vision de planning national de DÉVELOPPEMENT social qui permet aux personnes vulnérables de planifier une sortie de la précarité et non une assistance dans la pauvreté. [*The current social policy is a policy of assistance, it lacks a vision of national planning of social development which allows vulnerable people to exit precariousness and not just assist them while in poverty].*	6	2
Mesurer l'écart entre la situation actuelle et la situation désirée nécessite d'abord d'avoir un état et des données actualisées, ce qui n'est pas le cas pour le moment. [*Measuring the gap between the current situation and the desired situation first requires having a state and updated data, which is not the case at the moment] ;*	6	2
Absence d'un "registre national de précarité" ou d'une base de donnée centralisée et partagée entre tous les acteurs sociaux et sanitaires. [*Absence of a "national precariousness register" or a centralized database shared by all social and health actors].*	5.5	2
Absence d'une analyse sur la pauvreté et la vulnérabilité en Tunisie afin de pouvoir proposer un modèle politique et social. Cette analyse permettra d'établir une stratégie ciblée avec un MODÈLE QUI RÉPOND AU BESOIN. [*Absence of an analysis on poverty and vulnerability in Tunisia in order to be able to propose a political and social model. This analysis will establish a targeted strategy with a model that meets the needs].*	5.5	2
Absence d'une promotion des droits sociaux existants des catégories vulnérables. [*Lack of promotion of the existing social*	5	2

rights of vulnerable groups].		
Il nous faut au moins 10 ans pour former et informer en matière de prise en charge des personnes âgées. [*We need at least 10 years to train and inform on the care of the elderly].*	4	2.75
Nous sommes à 30 % de notre objectif bien que l'arsenal législatif existe. [*We are at 30% of our target although the legislative arsenal exists].*	4.5	3
Le personnel soignant n'est pas suffisamment formés dans la prise en charge des personnes âgées manque de communication avec les personnes âgées. [*Caregivers are not sufficiently trained in the care of the elderly, and lack of communication with the elderly].*	6	3.25
L'écart qui nous sépare de notre objectif est difficile à estimer dans les conditions actuelles, post révolutionnaire et en période d'épidémie de la Maladie COVID19. [*The gap which separates us from our objective is difficult to estimate in the current, post-revolutionary conditions and in the period of the COVID19 disease epidemic].*	6	3.5
Nous avons atteint uniquement 10% de nos objectifs. [*We have achieved only 10% of our objectives] ;*	3.5	3.75

4.3. 3rd Round: Reaching Consensus

Participants of the second round were sent the priorities on which consensus couldn't be reached (IQDs > 1) in order to reassess them and potentially reach consensus).

Link to the questionnaire: https://forms.gle/zQt66ChZ5qJe3Shg7

Through the 3rd round, a consensus was observed concerning the priority of the five following items which were perceived important:

- Ensure the availability of the needs of the elderly in terms of medicine, tools for surveillance, follow up and protection.
- Strengthen the ongoing training of primary health doctors regarding geriatric pathologies.
- Consider the elderly in the universal health coverage.
- Adopt the empowerment approach which supports vulnerable groups of the elderly at economic and social levels.
- Review the regulations that manage the rights of the elderly in health care and social protection.

However, we didn't reach any consensus concerning the following priorities although half of the participants considered them important:

- Adopt the Social Economy approach, which is characterized by its ability to create development and services projects guaranteeing a great well-being in its social and health dimensions.
- Create geriatric units at the primary health care level
- Conduct a national survey on the living conditions of vulnerable elderly people and identify the risk factors for their precarious situation
- Develop and implement specific protection programs for the elderly with disabilities. Programs so far implemented for the disabled do not take into account the needs and characteristics of the elderly.
- Use a participatory approach with the elderly for the development of the national multisectoral strategy for the elderly care

The results obtained are as follows:

Priority	Median	IQR
Assurer la disponibilité des besoins des personnes âgées en matière de médicaments, d'outils informatiques de surveillances, de suivi et de protection. [*Ensure the availability of the needs of the elderly in terms of medicine, tools for surveillance, follow up and protection].*	6	0.25
Renforcer la formation continue des médecins de santé publique de première ligne concernant les pathologies gériatriques. [*Strengthen the ongoing training of primary public health doctors regarding geriatric pathologies].*	6	1
Inclure les personnes âgées dans la couverture sanitaire universelle. [*Consider the elderly in the universal health coverage]*	6.5	1
Revoir la réglementation qui gère les droits des personnes âgées en matière de soins de santé et de protection sociale. [*Review the regulations that manage the rights of the elderly in health care and social protection].*	6	1
Adopter l'approche d'autonomisation qui soutient les groupes vulnérables de personnes âgées aux niveaux économique, social. [*Adopt the empowerment approach which supports vulnerable groups of the elderly at an economic and social level].*	5.5	1
Adopter l'approche « Economie Sociale et Solidaire » qui se caractérise par sa capacité à créer des projets de développement et de services garantissant un grand bien-être dans ses dimensions sociales et sanitaires. [*Adopt the Social Economy approach, which is characterized by its ability to create development and service projects guaranteeing a great well-being in its social and health dimensions].*	6	1.25
Créer des unités gériatriques au niveau de la première ligne. [*Create geriatric units at the primary healthcare level].*	7	2

Mener une enquête nationale sur les conditions de vie des personnes âgées vulnérables et identifier les facteurs de risque de leur situation précaire. [*Conduct a national survey on the living conditions of vulnerable elderly people and identify the risk factors for their precarious situation].*	6	2
Développer et mettre en place des programmes de protection spécifiques des personnes âgées handicapées. Les programmes jusqu'ici mis en œuvre en faveur des handicapés ne tiennent pas compte des besoins et des caractéristiques propres aux vieilles personnes. [*Develop and implement specific protection programs for the elderly with disabilities. Programs so far implemented for the disabled do not take into account the needs and characteristics of the elderly].*	6	2
Utiliser l'approche participative avec les personnes âgées pour l'élaboration de la stratégie nationale multisectorielle de prise en charge des personnes âgées. [*Use a participatory approach with the elderly for the development of the national multisectoral strategy for the elderly care].*	6	2

The results obtained regarding the GAP dimensions are as follows:

GAP	Median	IQR
La politique sociale actuelle est une politique d'ASSISTANCE, il manque une vision de planning national de DÉVELOPPEMENT social qui permet aux personnes vulnérables de planifier une sortie de la précarité et non une assistance dans la pauvreté. [*The current social policy is a policy of assistance, it lacks a vision of national planning of social development which allows vulnerable people to exit precariousness and not just assist them while in poverty].*	7	1
Absence d'une analyse sur la pauvreté et la vulnérabilité en Tunisie afin de pouvoir proposer un modèle politique et social. Cette analyse permettra d'établir une stratégie ciblée avec un MODÈLE QUI RÉPOND AU BESOIN. [*Absence of an analysis on poverty and vulnerability in Tunisia in order to be able to propose a political and social model. This analysis will establish a targeted strategy with a model that meets the needs].*	6	1
Le personnel soignant n'est pas suffisamment formés dans la prise en charge des personnes âgées manque de communication avec les personnes âgées. [*Caregivers are not sufficiently trained in the care of the elderly and lack of communication with the elderly].*	6.5	2
Absence d'un "registre national de précarité" ou d'une base de	6	2

donnée centralisée et partagée entre tous les acteurs sociaux et sanitaires. [*Absence of a "national precariousness register" or a centralized database shared by all social and health actors].*		
Nous sommes à 30 % de notre objectif bien que l'arsenal législatif existe. [*We are at 30% of our target although the legislative arsenal exists].*	4.5	2
Absence d'une promotion des droits sociaux existants des catégories vulnérables. [*Lack of promotion of the existing social rights of vulnerable groups].*	6	2.25
Il nous faut au moins 10 ans pour former et informer en matière de prise en charge des personnes âgées. [*We need at least 10 years to train and inform on the care of the elderly].*	4	2.25
Nous avons atteint uniquement 10% de nos objectifs. [*We have achieved only 10% of our objectives].*	4	2.5
Mesurer l'écart entre la situation actuelle et la situation désirée nécessite d'abord d'avoir un état et des données actualisées, ce qui n'est pas le cas pour le moment. [*Measuring the gap between the current situation and the desired situation first requires having a state and updated data, which is not the case at the moment].*	6	2.75
L'écart qui nous sépare de notre objectif est difficile à estimer dans les conditions actuelles, post révolutionnaire et en période d'épidémie de la Maladie COVID19. [*The gap which separates us from our objective is difficult to estimate in the current, post-revolutionary conditions and in the period of the COVID19 disease epidemic].*	4	3

Concerning Gaps, the participants agreed that the following items are very important:

- the current social policy is a policy of assistance, that it lacks a vision of national planning of social development which allows vulnerable people to exit precariousness and not just assist them while in poverty.
- Absence of an analysis on poverty and vulnerability in Tunisia in order to be able to propose a political and social model. This analysis will establish a targeted strategy with a model that meets the needs.

Besides the following items were important but the consensus was rather absent:

- Caregivers are not sufficiently trained in the care of the elderly, and lack of communication with the elderly.
- Absence of a "national precariousness register" or a centralized database shared by all social and health actors.
- Lack of promotion of the existing social rights of vulnerable groups.

- Measuring the gap between the current situation and the desired situation first requires having a state and updated data, which is not the case at the moment

There was no agreement about the assessment of the goal achievement level, which was perceived less important.

Following the final round of Delphi Study, the participants reached consensus on the following priorities, (ranked in order of importance):

1. Élaborer et mettre en place une stratégie nationale multisectorielle de prise en charge des personnes âgées. *Develop and implement a national multisectoral strategy for the care of the elderly.*

2. Création de la spécialité de Gériatrie dans le cursus des médecins de famille. *The creation of a Geriatrics specialty in the curriculum of family doctors.*

3. Formation du personnel médical et paramédical aux soins des personnes âgées dépendantes et/ou à problèmes de santé. *Training of medical and paramedical staff in the care of dependent elderly people and / or with health problems.*

4. Créer des structures dans les gouvernorats du pays pour la prise en charge sanitaire, sociale, nutritionnelle, psychologique des personnes âgées. *Create structures in the country's governorates for the health, social, nutritional and psychological care of the elderly.*

5. Promouvoir le mode de vie sain en renforçant la mise en place de la stratégie nationale multisectorielle de prévention et contrôle des maladies non transmissibles. *Promote healthy lifestyles by strengthening the implementation of the national multisectoral strategy for the prevention and control of non-communicable diseases.*

6. Lutter contre les inégalités géographiques des soins et de prise en charge sociale. *Tackle geographic inequalities in health care and social care.*

7. Inclure les personnes âgées dans la couverture sanitaire universelle. *Consider the elderly in the universal health coverage*

8. Assurer la disponibilité des besoins des personnes âgées en matière de médicaments, d'outils informatiques de surveillances, de suivi et de protection. *Ensure the availability of the needs of the elderly in terms of medicine, tools for surveillance, follow up and protection.*

9. Renforcer l'offre de soins préventifs auprès des personnes âgées. *Strengthen the preventive care offer for the elderly.*

10. Renforcer les activités de communication avec les personnes âgées pour mieux identifier leurs besoins, les éduquer pour améliorer leur hygiène de vie. *Strengthen communication activities with the elderly to better identify their needs, and educate them to improve their lifestyle.*

11. Vulgariser la culture de droit des personnes âgées afin d'éviter les pratiques

âgistes (pratique incitant 'exclusion) des personnes âgées; *Popularize the culture of the elderly rights in order to avoid ageist practices (practices encouraging the exclusion) of the elderly.*

12. Créer des mécanismes pour garder les personnes âgées en activité et capitaliser leurs expertises afin de promouvoir leur bien être mental et financier. *Create mechanisms to keep the elderly in activity and capitalize on their expertise in order to promote their mental and financial well-being.*

13. Créer et mettre en place un modèle d'hospitalisation à domicile. *Create and implement a home hospitalization model.*

14. Renforcer la formation et la spécialisation du personnel social et des auxiliaires de vie pour une meilleure organisation et planification des interventions auprès des personnes âgées et en particulier celles vulnérables*. Strengthen the training and specialization of social staff and carers for better organization and planning of the interventions with the elderly and in particular those who are vulnerable.*

15. Concevoir un programme d'intervention spéciale pour améliorer les conditions de logement des personnes âgées pauvres et leur fournir le minimum de confort nécessaire. *Design a special intervention program to improve the housing conditions of poor elderly people and provide them with the minimum necessary comfort.*

16. Renforcer la formation continue des médecins de santé publique de première ligne concernant les pathologies gériatriques. *Strengthen the ongoing training of primary health doctors regarding geriatric pathologies.*

17. Favoriser la couverture sanitaire des personnes âgées pauvres à travers la gratuité des soins. *Promote health coverage for poor elderly people through free healthcare.*

18. Renforcer les équipes mobiles qui interviennent auprès des personnes âgées pauvres. *Strengthen the mobile teams that work with poor elderly people.*

19. Développer des programmes d'intervention psychosociale au profit des familles assumant la responsabilité de protection d'un membre âgé vulnérable atteint d'une incapacité ou d'une maladie chronique. *Develop psychosocial intervention programs for families taking care of a vulnerable elderly member suffering from a disability or a chronic illness.*

20. Renforcer la collaboration intersectorielle et interinstitutionnelle en relation avec les besoins des personnes âgées. *Strengthen intersectoral and inter-institutional collaboration in relation to the needs of the elderly.*

21. Multiplier les centres de soins spécialisés pour la prise en charge des personnes âgées dans tous les gouvernorats. *Increase the number of specialized care centers for the care of the elderly in all governorates.*

22. Revoir la réglementation qui gère les droits des personnes âgées en matière de soins de santé et de protection sociale. *Review the regulations that manage the rights of the elderly in health care and social protection*

23. Adopter l'approche d'autonomisation qui soutient les groupes vulnérables de personnes âgées aux niveaux économique, social *Adopt the empowerment approach which supports vulnerable groups of the elderly at an economic and social level.*

Regarding the Gap dimensions, the participants reached consensus on the following: (ranked in order of importance):

1. Les soins sanitaires et les infrastructures des établissements sanitaires et les cotisations ne sont pas suffisamment adaptés aux personnes âgées vulnérables. *Health care, the infrastructure of health establishments and the contributions are not sufficiently adapted to the vulnerable elderly*

2. La politique sociale actuelle est une politique d'ASSISTANCE, il manque une vision de planning national de DÉVELOPPEMENT social qui permet aux personnes vulnérables de planifier une sortie de la précarité et non une assistance dans la pauvreté. *The current social policy is a policy of assistance, it lacks a vision of national planning of social development which allows vulnerable people to exit precariousness and not just assist them while in poverty.*

3. Sur le plan qualitatif, je crois que nous sommes encore loin de couvrir l'ensemble des besoins des PA (aide financière, urbanisme adapté, moyens de transport, médecins de famille formés en gériatrie, consultation gériatrie dans toutes les structures de première ligne). *In terms of quality, we are still far from covering all of the needs of the elderly people (financial aid, adapted town planning, means of transport, family doctors trained in geriatrics, geriatrics consultation in all first-line structures.*

4. Absence d'une analyse sur la pauvreté et la vulnérabilité en Tunisie afin de pouvoir proposer un modèle politique et social. Cette analyse permettra d'établir une stratégie ciblée avec un MODÈLE QUI RÉPOND AU BESOIN. *Absence of an analysis on poverty and vulnerability in Tunisia in order to be able to propose a political and social model. This analysis will establish a targeted strategy with a model that meets the needs.*

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TEC-MED Model Final report

TEC-MED final report

1.INTRODUCTION

Nowadays, 200 millions of people in the world have reached or surpassed the health life expectancy (60 years), that is the 12% of the world population. These figures will increase in the following three decades, where people older than 60 years old will duplicate in number, and octogenarians will quadruplicate (World Health Organization, 2020). The higher life expectancy, become an achievement of the public health policies and of the socioeconomic development; and has also brought the existence of a higher elderly population but not with a consistent life quality, showing high rate of fragility and dependence (Brañas et al., 2018).

The age increase in the population, has also brought an increase of dependent people. The dependence can be defined as the loss of physical, psychological and functional capacity. This situation increases the complexity of the care process and the care demand (Martins et al, 2013).

In accordance to the current demographic development, over 50 million people in Europe have more than one chronic disease, and over 100 million are at risk of poverty or social exclusion. As a consequence, health care spending will increase to a staggering 20% of the country specific budget (Eurostat Statistics Explained, 2018).

The World Health Organization identified some key components of well- functioning health system, responding in a balanced way to a population's needs and expectations by improving the health status, protecting people against the financial consequences, and providing equitable access to person-centered care. These components are: leadership and governance, health information systems, health financing, human resources for health,

essential medical products and technologies, and service delivery (WHO, 2010).

Some of European Projects, regarding to dependent elderly people, wellbeing and quality of life have developed their frameworks based on these concepts, like ICARE4 (Melchiorre et al, 2018), We DO Project (European Commission, 2012), and Sustain Project (de Bruin et al, 2018). All of them are based on the use of new technologies, governance importance and human resources improvement. Some of them as well as other initiatives based their frameworks also in the integrative care, like Selfie (Leijten et al., 2018), Integrate (Borgermans et al, 2017), Chrodis (Palmer et al, 2019), Pilares Foundation (Fundación Pilares, 2018), Aging Lab Foundation (Rodríguez & Cruz, 2016), Borough model (Turner & Murray, 2019) and Sant John of God Model (Orden Hospitalaria de San Juan de Dios, n.d.). The integrative care appears a core element in an elderly quality life improvement projects. By the other hand, other projects based its approaches on the multi-professional intervention and multidimensional assessment of elderly people, like Comunità di Sant'Egidio (Marazi et al, 2015), Lebanese Center for Palliative Care-Balsam (The Lebanese Center for Palliative Care, 2018), Open Care Centers por older people KAPI (Sourtzi ET AL 2010) and Sekem Medical Center (Sekem Medical Center, 2019).

Nevertheless, all of them consider the multidisciplinary approach to improve the dependent elderly people or in social risk in their model frameworks.

A table with an analysis of the main themes of a total of 20 most promising initiatives that were reviewed from the European Union and Mediterranean Basis in relation with the dimensions of the TEC-MED Model can be found at **annex 1.**

Additionally, Integrated and Person-Centered Care (PCC) stands as an innovative line, which requires integrated socio-health care in recognition and value of the uniqueness of each individual (Martínez, 2020).

In this sense, the countries of southern Europe, cradle to some of the oldest civilizations in the world, in addition to sharing cultural ties, are now more than ever facing these needs. The current health crisis situation has highlighted the need to work towards a model that increases the capacities and competences of care providers related to vulnerability and the elderly, to incorporate them into Social and Health Policies.

The TECMED research project of the ENI CBC 2014-2020 call addresses these challenges, developing a model of cross-cultural, ethical and social care for the dependent population in the Mediterranean basin. With an approach based on justice, privacy, confidentiality, gender, universal accessibility, active community participation and the values of the welfare state and governance.

2. SCOPE OF THIS DOCUMENT

This document answers to the objectives of WP3 to Create the TEC-MED Model. For achieve this first draft, formative research was carried out with the following objectives:

- To know which are the most promising social assistance initiatives for older people who depend on the risk of social exclusion in the countries of the European and Mediterranean basin through an extensive literature review.
- To recognize social care practices in each of the countries involved in the Project as well as their strengths, weaknesses, opportunities and threads through semi-structured interviews and SWOT analysis in the participant countries participants in the TEC-MED project.
- To analyze the Gap in the participant countries in the TEC-MED project through a Delphi panel.

With this all formative researches together with a meeting that was carried out in the 29th of June of 2020 (annex 2) with international experts from the Mediterranean Basis was refined the Definition of the TEC-MED Intervention Framework to propose the TECMED Model.

An Intervention Framework is the pillars that guide the construction of a model. A model is the way of understanding or interpreting these pillars or conceptual bases. Therefore, in this document, the pillars are first presented (Theoretical framework or metaparadigm) and then are interpreted with the TECMED vision (TECMED Model) to respond to the model's mission:

- **Vision:** Worthy care for the elderly.

- **Mission:** Serve as a catalyst to promote quality services based on a socio- ethical and cross-cultural model for the elderly in the Mediterranean basin.

3. THEORETICAL FRAMEWORK OR METAPARADIGM

The term of paradigm provides the basic parameters and framework for organizing a discipline knowledge. The metaparadigm of a discipline is distinguished from a paradigm because of it is global, philosophically neutral and fairly stable (Peterson & Bredow, 2009). The fundamental notion of that a metaparadigm presents a distinctive domain with a unique perspective. The core concepts of the metaparadigm, that should be well defined before designed and structuring a model are: health, subject, rol, and context (Fawcett, 2013). Subsequently, the less abstract level, and more specific and explicit are the conceptual models (Benner et al., 2003).

3.1. Theoretical Framework and levels FRAMEWORK TECMED

The dimensions of the theoretical framework of the model are: 1. Subject of care; 2. Health and social care providers; 3. Care environment and Service delivery; 4. Governance; 5. Financing and 6. Technology.

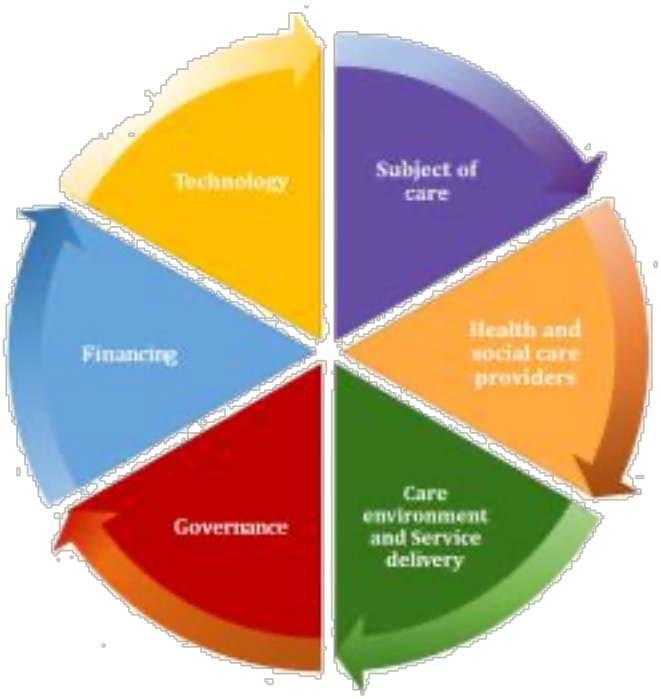

Fig. 1. Theoretical Framework TECMED Model

For each of the dimensions, three levels of action are defined: macro, meso and micro (UNESCO, 2012; Barrientos-Trigo et al. 2018):

- Macro management: Macro refers to the government, political or legislative level, leadership position in public administration which provides social-care services (may include policy makers and other stakeholders).
- Meso-management: refers to the organizational level such as local government or care management in the hospital, nursing home, etc.
- Micro management: refers at the individual level. Person, social professional attending dependent, health and social care provider, family caregiver.

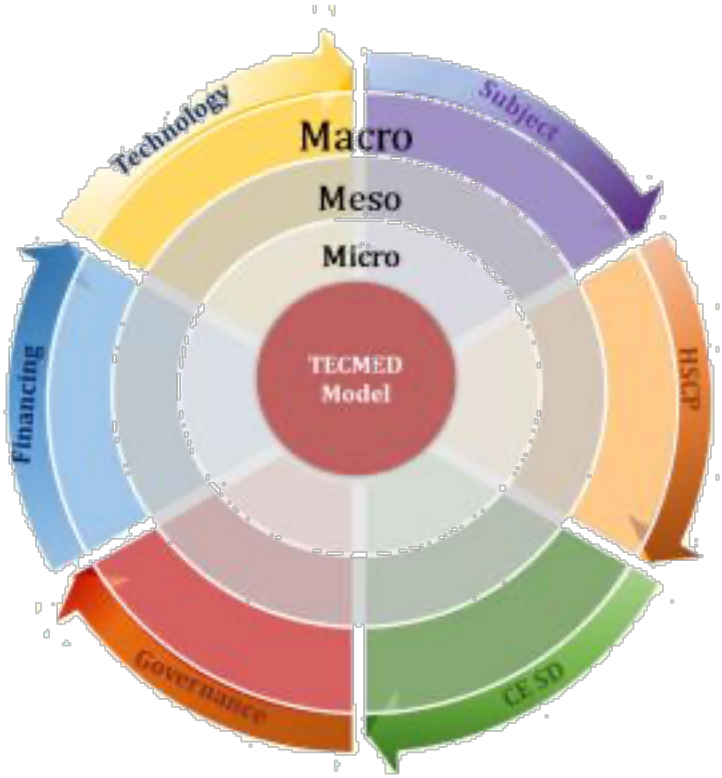

Fig.2. Theoretical Framework Level of Dimensions (macro, meso, micro)

The dimensions of the framework are described below:

I. Subject of care:

- Person is the subject of attendance. Person should be placed in the center of the system, and his needs should be the starting point of the care process. Moreover, person is not (only) a patient or client of health or social care; is a person living a life connected with other people in and social environment. Nevertheless, the family, societal resources and networks in the community may be considered as the object of the attendance and caring.
- Well-being perception and daily functioning, autonomy, and participation in society are highly relevant goals from a patient perspective. A holistic understanding of their individual health and well-being, capabilities, self- management abilities, needs, preferences, and their direct socio-economic environment is mandatory. The health of an individual not only includes the whole spectrum of physical, mental, and social

well-being, but also the ability to adapt and self-manage. The capacity for resilience and the ability to cope and restore a balance are also part of this broader definition of health.

- It is extremely the importance of addressing the Social determinants of health, in particular for health inequities. Since 2018, a renewed WHO organization-wide commitment to acting on determinants of health, and broader social determinants and health equity. These determinants are including in WHO's 13th General Programme of Work 2019-2023. The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. The 2030 Agenda for Sustainable Development underlines the importance of addressing social determinants. At this respect, social inclusion, and social protection of vulnerable people must be addressed.
- Levels:
    - Macro: Community
    - Meso: Family; Caregiver (formal/family)
    - Micro: Individual; Caregiver (formal/family)

II. Health and social care providers:

- Health and social providers are central for the person achieving the better state of health and well-being. They should focus the attention on the person with an integrative, multi and interprofessional perspective. For a well and efficient performance focus on the quality and the outcomes of the client it is necessary there should be available the sufficient resources (number, diversity, competencies, well-payment, balance and stability over time of workloads). Professional should be training focus in capacity building from a interprofessional perspective with equity in the treatment of all workers, they should participate in decision-making processes decisions, care guideline must be developed to guarantee the quality of care, should

be have a favorable vision of their social contribution.

- Levels:
  - Macro: Workforce policy and planning, capacity building and training planning.
  - Meso: Social care team's management, staff management
  - Micro: Multi and interdisciplinary teams including health and social professional, formal and family caregivers.

III. Care environment and Service delivery:

- **Care environment:** It is the context where the care is delivery, which refers not only to the physical environment, that includes, accessibility, accommodation (including services, cleaning, no architectural barriers), if not also to the conditions in which the care is development, including the social environment, psychological and human aspects (humanization), hospitality, warm, affection, response to the person-needs and, among others issues.

  The care can be developed in their own homes, daily facilities, home cares, and other community resources, including family needs, should be considered as the intervention context. A holistic understanding cannot be seen separately from the direct socio-economic environment of an individual: environment (social networks, financial situation, housing, the physical surroundings, the availability of community services, means of transport).

- **Service delivery:** According WHO (2010) health and social systems are only as effective as the services they provide. They shape the conditions that facilitate (or hinder) the provision of patient-centered integrated care in a region or country, as well as broader society.

  The capacity of giving quality and effective services are related as having a center of the system that serves as enter point to the subject of care, this could the primary care level, having a harmonious coordination at horizontal and vertical levels (at the same and at different institutions and services). That allows to give an integrated range of health and social interventions that respond to the full range of conditions of the target populations, rules and standard practices to ensure accessibility and

quality of care related to sustainability, safety, effectiveness, continuity, and people-centeredness, having mechanisms to involve the user in the design and planning of care, including planning and decision shared.

- Levels:
    - Macro: Policy and regulation of care environment and integrative care cross organization and sectors in the Social and Care System, availability and accessibility (universal), market regulation (from an inclusive perspective), involving the community (solidarity and volunteers), bottom-up development.
    - Meso: Management of the care environment focuses on the physical, psychological and human factors from a housing perspective, local and regional networks and integrative organization, structures and processes, continuous quality improvement system, evidence based standards.
    - Micro: Adaptation of the care environment to the person's needs; proactive, individualized, shared decision and planning, family caregiver involvement, continuity.

IV. Governance:

- Governance is the process by which social care organizations guarantee good service delivery and foment positive outcomes for people who use services. It consists in a wide range of steering and rule-making related function carried out by governmental/decisional makers. The governance is oriented to develop implementation and change strategies tailored to different care settings and contexts in Europe and Mediterranean area.

  From the macro level, good governance should be oriented to be independent from political orientation, guaranteed by fair financing and with the development of legislation that universally protects with equity, throughout the national territory, all citizens regardless of their resource. An optimal governance model should count on a strong coordination network, of all actor's levels and resources.

  From the meso level, policy and action plans and political commitment are aimed at protecting the ethos of autonomous practice, integrated care programs, community-

based practice, high levels of client and staff satisfaction, financial sustainability, customer empowerment and comprehensive care with a primary focus on clients with complex health and social issues care needs.

The health service providers fallow a performance-based management and creating individualized care planning coordination tailored to complexity, counting on a less bureaucracy and offering all support functions. In this sense, the citizen is a primary and active actor in the choice of care policies sharing decision-making.

- Levels:
  - Macro: the State (government organizations and agencies at central and sub-national level)
  - Meso: the health service providers (different public and private for and not for profit clinical, para-medical and non-clinical health services providers; professional associations; networks of care and of services)
  - Micro: the citizen (population representatives, patients' associations, CSOs/NGOs, citizen's associations protecting the poor, etc.) who become service users when they interact with health service providers.

V. Financing

- Financing is the economic support system of any model. The possibilities are: public, private, mixed or nonprofit. This term includes the financial and accounting system, financial sustainability, financial performance and other question relation with financial matters. This term includes the funding priorities at the political level and the government level.
- Levels:
  - Macro: Government and political level
  - Meso: Financial management of entities
  - Micro: Financial support to the target population and funded services.

VI. Technology

- A support system to complete the model. Technology is referred to online support to record the information and to store the information. Roadmap, tools, lessons learned reports, scientific evidence and good practices can be stored in the technology platform.
- Technology can be used to train the target population, or the healthcare providers. Also, it is possible the use of monitoring the working times. Using artificial intelligence is possible to develop a roadmap and facilitate the decision- making process. This term includes telemedicine, electronic health records and other health and social platforms.
- Technology must be developed under the values of user-friendly, availability, accessibility, etc.
- Levels:
    - Macro: National support policies to improve technology development and innovation. Guaranteeing the equitable access, availability and freely available of the technology services.
    - Meso: Use of technology to coordinate the services. The coordination is possible at a local level by the City Council's health and social services or by private or nonprofit entities.
    - Micro: Use of technology to improve the well-being of the target population, e.g. telemedicine, telemonitoring. Technology support to family caregivers. Technology support to healthcare providers (training, recording, follow-up).

4. TEC-MED MODEL

A model is a symbolic representation of reality, specifically, of a phenomenon; an abstract system of interrelated concepts (Raile, 2017). Its development is needed since it becomes a conceptual context that facilitates the understanding of a complex reality (Chacín, 2008).

On the one hand, it is also needed to identify the representative core elements of the phenomenon, as well as to delve into the practical application of the theoretical relations between them (Fawcett, 2013). It allows generating new knowledge, in a grounded and reliable way, that could guide the creation of specific theories. (González & Valderrama, 2001).

On the other hand, the implantation of a conceptual framework or model guides the actions regarding the study phenomenon unequivocally, in addition to providing a common language (Chacín, 2008).

4.1. Model Basis

The model basis is a **Person-centred integrated care.**

Integrated care is defined as the structured efforts to provide coordinated, pro-active, person-centered, multidisciplinary care by two or more communicating and collaborating care providers that may work at the same or different organizations, either within the healthcare or across the health, social, or community care sector (including informal care).

A basis of **person-centred** integrated care with is a holistic understanding of their individual health and well-being, capabilities, self-management abilities, needs, preferences, and their direct socio-economic environment.

The health of an individual not only includes the whole spectrum of physical, mental, and social well-being, but also the ability to adapt and self-manage. The capacity for resilience and the ability to cope and restore a balance are also part of this broader definition of health.

It represents a comprehensive care of the health, social, spiritual and family needs of the person, and its aims are:

- Provide a benefit that simultaneously covers the social and health needs of elderly dependent person and/or at risk of exclusion, planned in the medium and long term.
- Provide accessibility, in an appropriate way to the clinical and social situation,

considering the continuity of care. This is achieved by establishing the needed measures for this purpose with the rest of the hospital's primary care and social services.

Worthy care for older people provides **decent and positive aging process** (PDE), which applies the logic on management procedures to the intervention. The principles and criteria constitute the ethical and cross-cultural framework, becoming the basis of the model, and are based on universal values that promote the dignity of the elderly, active aging and long-term care. Hence, the interrelation between theory (concept) and practice in intervention (praxis) is the key of the model development. Is also important to remark the attributes of the model, as well as its progressivity and change possibility, depending on these interrelationships (Rodríguez-González, 2016).

4.2. Key elements

The model is made up of a set of key elements that make it distinctive and at the same time have a transversal influence on its own conceptualization (Figure 3) They are: quality, research and dissemination; gender perspective, ethics, social inclusion, transcultural.

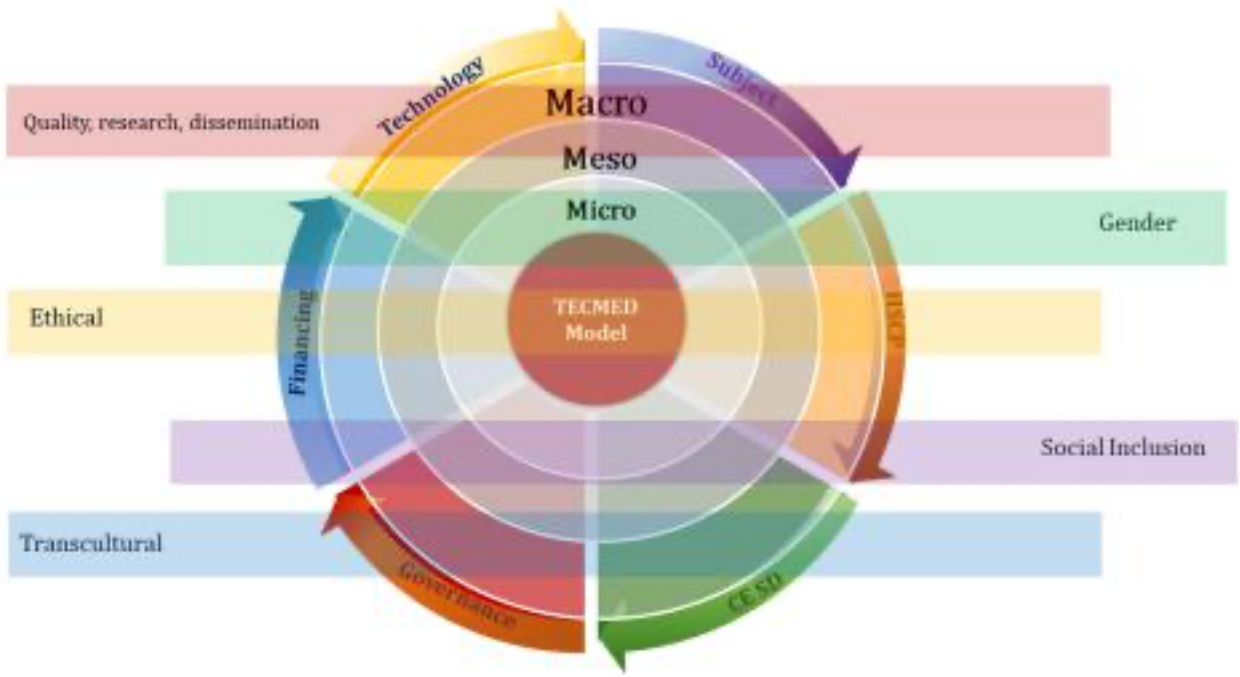

Fig.3. Theoretical Framework Level (macro, meso, micro) and transversal concepts of the model

• **Quality, research, dissemination**

Quality is a basic tool for a natural property of any good or service that allows it to be compared with any other good or service of its kind and satisfy stated or implied needs. A model of care for dependent elderly people and / or in risk of social exclusion should be linked to aspects such as respectful human rights and dignity, person-centered, preventive and rehabilitative, available, accessible, affordable, comprehensive, taking into account the transparency, bottom-up perspective. In this way it maximizes the quality of service for the elderly, the quality of professional care protecting the caregivers, and of course the quality of life of older people (Munthe et al., 2012).

Research-supported care aims to create new knowledge and / or the use of existing knowledge in a new and creative way so as to generate new concepts, methodologies and understandings, all of which contribute to increased quality and performance a social care based on the best evidence. According to European Commission (n.d.), dissemination means sharing research results and practices with potential users - peers in the research field, industry, other commercial players and policymakers, including the transfer. By sharing your research results with the rest of the scientific community, you are contributing to the progress of science in general.

• **Gender**

Gender refers to the roles, behaviors, activities, attributes and opportunities that any society considers appropriate for girls and boys, and women and men. Gender interacts with, but is different from, the binary categories of biological sex. Gender intersects with other factors that drive inequalities, discrimination and marginalization, such as ethnicity, socioeconomic status, disability, age, geographic location and sexual orientation, among others (WHO, Health topics, n.d).

Promoting equal economic independence for women and men, closing the gender pay gap, advancing gender balance in decision making, ending gender based violence and promoting gender equality beyond the EU.

If gender is taken into account, studies research how they affect the gender inequalities of the patriarchal system and how dependency and gender interact in older

couples. The possibility of changes or flexibility of gender roles and mandates is also studied.

Furthermore, in relation to this topic, the focus is placed on care relationships in old age, highlighting the role and contribution of paid care work and not paid.

- **Ethical**

Social care must meet a set of standards of conduct that guide decisions and actions based on duties derived from core values (Consejería de Igualdad, Políticas Sociales y Conciliación de la Junta de Andalucía, 2019).

In this sense, it must be taken into account the autonomy as a right of a person to determine his or her own destiny; the beneficence as a way of doing good (not only just the client but also the family and the social and healthcare professionals); the justice as a way of seeking the sharing of benefits and burdens based on fairness and equality. When any of these ethical principles are overlooked, a person may be at risk for neglect or abuse (American Society of Aging, n.d).

Based on Rodríguez-González (2016) the bioethics includes the following dimensions: justice (e.g. protocol for the use of contentions mechanics that do not compromise people rights), privacy and confidentiality (e.g. Control of confidential and own documentation of users), autonomy and empowerment (e.g. generate decision-making, based on respect for the self-determination of the user).

- **Social inclusion**

The capacity of a society to ensure the welfare of all its members, minimizing disparities and avoiding polarization (European Committee for Social Cohesion, 2004).

Social inclusion is about having access to opportunities, options and choices in life and having the resources and appropriate support as well as the personal capacity, self-confidence and individual resilience to make the most of them.

Older people should be treated fairly and with dignity, regardless of disability or other status, and should be valued independently of their economic contribution (United

Nations, 2002). Enhancing elderly people's social inclusion could be highly beneficial in terms of mental and physical health. For example, elderly people can continue participating longer in employment as a way of having higher incomes and being more active. (Yur'yev et al., 2010).

- **Transcultural**

Relating to or involving more than one culture; cross-cultural. Encompassing, or combining elements of more than one culture.

The transculturally is defined as the phenomena that result when groups of people, who have different cultures, make continuous first-hand contact, with consequent changes in the patterns of the original culture of one of the groups or both (Marrero, 2013). Transculturally does not necessarily imply a conflict, but consists of a phenomenon of cultural enrichment.

Culture, constituted by the values, beliefs, ways of living and traditions that are transmitted from generation to generation, is understood as an element that configures behaviors and ways of being and acting (Murphy, 2006). There is not only universal social and health care (aspects common to all cultures), but also diversities

(particular and specific care of each culture) that must be taken into account (Leininger, 2002). Thus, people from different cultures can inform and guide professionals to receive the type of care they need. Social and health workers should discover and acquire knowledge about the patient's world, and making use of it, make appropriate decisions to provide care consistent with culturally marked (Castrillón, 2015).

Usefulness of the Patient-Centered Culturally Sensitive Health Care Model for explaining the linkage between the provision of patient-centered, culturally sensitive health care, and the health behaviors and outcomes of patients who experience such care (Tucker et al., 2011). The delivery of care that is culturally appropriate prevents unnecessary conflicts between clients and caregivers from varied cultural backgrounds.

4.3. Conceptualization

A conceptualization of the metaparadigm of the TEC MEC Model is the basis of its creation:

Central role: The central role in the TECMED framework is given to older person's dependent or at risk of social exclusion

The core: holistic understanding and the dignity of the person

I. Subject of care

Model TECMED the subject of care is the Ederly of 65 dependence and/or risk of social exclusion.

Elderly: At the biological level, ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time. This leads to a gradual decrease in physical and mental capacity, a growing risk of disease, and ultimately, death. But these changes are neither linear nor consistent, and they are only loosely associated with a person's age in years. While some 70 year-olds enjoy extremely good health and functioning, other 70 year-olds are frail and require significant help from others.

Beyond biological changes, ageing is also associated with other life transitions such as retirement, relocation to more appropriate housing, and the death of friends and partners. In developing a public-health response to ageing, it is important not just to consider approaches that ameliorate the losses associated with older age, but also those that may reinforce recovery, adaptation and psychosocial growth (WHO, 2020b).

Dependency is defined as the permanent status, derived from age, illness or disability, and linked to the lack or loss of physical, mental, intellectual or sensory autonomy. It requires the care of other people to carry out basic activities of daily life or other supports for their personal autonomy (Boletín Oficial del Estado, 2006).

By the other hand, **social exclusion** can be understood as a number of social mechanisms leading to threats to the integrity and cohesion of the collectivity and challenges to the common identity of their members (Vykopalová,2016). According he European Unions, the factor related to social exclusion in Europe are:

- Changing family structures, urbanization and demographic and technological development
- Societal factors: different welfare systems, the political climate and culture.
- Community factors: Opportunities for neighborhood contacts, access to transport and services, activities and the living environment. Empowerment.
- Individual factors: health, personality, personal resilience and access to technology- & psychological empowerment

While the drivers are:

- Drivers: ethnicity (migrants), sexuality, poor health or disability, gender (older women, affected by widowhood, care provision and less financial resource), age (more than 80), income (deprived areas or regions with declining populations, unemployment) education (low skills) and life events such as the death of a partner, moving homes, retirement or living alone.

II. Health and social care providers

Multi and interdisciplinary teams including health and social professional, formal and family care included shared accountability and responsibility. It must be promoted the clarity about each other's expertise, roles and tasks, from a transdisciplinary horizontal perspective (equity).

Workforce policy and planning focused in capacity building and training must be considered, including the preparation for social and health interdisciplinary teams and staff management. The health and social care providers must be involved in the designing and evaluation of this policies.

The health and social workforce performance should be defined by: coverage, productivity, technical quality, service quality. The performance of the Social and Health Care should respond to the principles of: equity; effectiveness; efficiency; financial protection. These principles guide the creation of the Code of Professional Practice for Social Care. Financing and incentive for investing in an adequate workforce it is needed to assure the enough human resources.

To deal with these objectives, it's important to create an efficacy Leadership and Management Setting in Health and Social Care establishing inter-professional programmers for people able to improve the quality of health or social services and acquire the necessary skills. In our model the caregiver is one of the fundamental actors to be able to offer a digital care service, in this sense it is proposed to create a support system. Focus in construction of a solid network, exchange of knowledge and internal communications must be considered. It must be enhanced the specialization in social care as well in the basis of the Model.

III. Care environment and service delivery

The Law Commission in the UK has defined social care as 'the care and support provided for those who need extra support; it includes traditional services such as care homes, day centers, equipment and home care and can extend to non- traditional services such as gym membership, art therapy, personal assistants, emotional support, and classes or courses'. There have been subsequent discussions regarding where the boundary between health care and social care is and how broad/ambitious the scope of social care should be (Pike & Mongan, 2014). In the TEC-MED model we advocate for an integrated social and health care. The ideal is a perfect coordinated care that responds to all the patient needs and preferences, from a holistic bio-psico-social perspective, including the person in the care process with a person-centered vision.

In the Mediterranean basis the preference of the people usually is staying at home as long as they can. To achieve this is necessary that the home environment is of quality and adapted to the needs of a person that could have difficulties with carrying out some daily life activities, either basic or instrumental. So it is important to create a supportive

environment with enough resources, material and human, although the objective must be to maintain the people's autonomy as long as possible and promote positive active healthy ageing, by promoting self- management/personal skills and capabilities as resilience. The vision of the service must be focused on proactive health promotion and prevention, including the fight with the abuse, or neglect.

When it is not possible to stay at home there should be housing alternatives focused on the person's needs and preferences, which should be designed with the participation of the elderly people. Architecture in nursing homes should be designed from a “home perspective”, but the preference must be to maintain the individual at home or in housing alternatives. Moreover, should be services of medium-long stay for those frailty and multimorbidity people that, after staying in a hospital for an exacerbation of a health problem are not able yet to go back to home.

In this process which participates in different services and institutions they must be perfectly coordinated, and involve strengthening the community and capacity action involving health and social services, formal and informal social care networks, meetings, leisure and social communication, transport, financing, from a double perspective in the coordination at horizontal and vertical levels assuring the continuity of care.

For optimal coordination there should be a single point entry should be a single point of entry, preferably at the primary care level where it must be named a social--health care coordinator of multi and inter multi professional teams.

The coordination and integration must be considered from an organizational, structural and processual point of view. It is important reaching agreements, designing care standards, development of common measures and outcomes, and outcomes procedures and tools, involving the population in designing services and procedures from

a bottom-up perspective and evidence-based. An information system that includes social and health history should be used.

The focus must be the subject of care (person and family), including assessment of individual needs, stratification of care, individualized evidence-based plans with his/her involvement and participation in the care process including decision support and shared, shared planning of care, empowerment, including multiple solutions, long-term care and

palliative care.

Periodical evaluation must be developed with measurement and analysis and results based in performance and outcomes indicators, as well as financial performance indicators. Principles such as safety, efficiency, availability, accessibility, continuity, affordability, transparency and sustainability must be taken into account. Feedback mechanisms must be included with the staff and the population from a bottom-up perspective.

IV. Governance

Users and family members must participate in the design of policies to ensure that they truly meet the real needs of dependent elderly people and / or at risk of social exclusion. Leaders representing these groups should be on the governance teams and taking part raising awareness of social determinants and gender. Policies must have continuity over time, beyond political changes at the local or national level. The management and availability of services and resources should be adequate to the needs of the population according to territoriality. It is recommended that policies based on active and positive aging (WHO, 2002) and long-term care predominate. Governance should include planning and management of needs assessment studies and quality assessment systems for policies and the care provided.

V. Financing

To promote financing public, universal and transparency. Transparent entrepreneurship concentrates on innovation, leadership responsibilities for performance achievement and joint financial agreements to guarantee the covering and integrated care. Bet on the inclusion of a social and solidarity economy (Askunze, 2013), as an integrating concept of different perspectives of the alternative economy, such as the approach to sustainable human development, the feminist economy and the ecological economy, in order to put people and their living conditions at the center of the analysis and linking jobs with socially necessary production, with the satisfaction of basic needs, betting on "another fairer economy". Some initiatives of the

implementation are care cooperatives, social immersion companies, social currencies, time banks, barter markets, etc.

VI. Technology

Digital social interventions should be accessible at a minimum via mobile devices. Technology platform to support the population care, the training of the health and social care providers, the recording of the information, the alert notifications for users and professionals, the communication and coordination between public and private agents or actors, and for evaluating the quality of the care provided, and the policies developed and implemented (WHO, 2019).

Use of artificial intelligence and robotics to help older people manage and create a better and safer quality of life, allowing the management of activities in their environment and data management. Home Automation and Smart Home: advanced technological systems that monitor basic activities of daily life of the elderly, to cover the growing gap between the deterioration of an individual's abilities and the domestic and social demands as age advances (video surveillance systems, bracelets, smart speakers, etc.).

Technological support for monitoring and sustainable assistance (sensors and devices that allow the gas to be closed, lights to be turned on or off, or air conditioning to be managed).

4.4. Operationalization

For the operationalization of the TECMED Model, they were conducted two Steering Committee with the participation of all the PPs, the task was developed, revised and refining in several times. In this process, also collaborated the researchers of the TECMED model in Spain. In the following pages is shown the operationalization of the six dimensions of the TEC-MED model, taking into account the three level of management and the five key cross-sectional elements. The tables represent all the common views and perspectives of all countries working on the TECMED Project, in an overall effort to create a Transcultural-social-ethical-care model for dependent population in the

Mediterranean Sea basin.

I. Subject of care

Subject of Care should be placed in the center of the system, and his needs should be the starting point of the care process.

Moreover, the subject of care is not (only) the person, a patient or client of health or social care; the person living a life connected with other people in a social environment. Therefore, the family, societal resources and networks in the community may be considered as the object of the attendance and caring.

The following aspects should be considered in relation to the subject of care:

- Well-being perception and daily functioning, autonomy, and participation in society are highly relevant goals.
- A holistic understanding of health and well-being, capabilities, self-management abilities, needs, preferences, and their direct socio-economic environment is mandatory. The health of an individual not only includes the whole spectrum of physical, mental, and social well-being, but also the ability to adapt and self-manage. The capacity for resilience and the ability to cope and restore a balance are also part of this broader definition of health.
- It is very relevant the importance of addressing the Social determinants of health, in particular for health inequities. At this respect, social inclusion, and social protection of vulnerable people must be addressed. In this sense, to approach the well-being of the person in its complexity, the approach of assets for health is chosen from the beginning of social inclusion, including the population with territory inequities, especially the urban spaces in whose population there are structural situations of serious poverty and social marginalization.

Definition of the levels of managements

For the TEC-MED we considered three levels in relation with the persons as

subjects of care:

- **the Individual**: describe the state of wellbeing of the individual human being as a unitary being as center or socio-health care.
- **the Family:** describe the state of wellbeing of the family as a whole or of an individual as a family member as center or socio-health care. Family is considered as a system of which health is more than the sum of their parts and is considered as center of care, from a bio-psycho-social perspective, focus in its needs rights and considering its dignity and preferences. More specifically, two or more people who maintain continuous relationships, who perceive reciprocal obligations, a sense of common meaning and share certain obligations towards others: in relation to consanguinity or by choice" (North American Nursing Diagnosis Association, 2020)
- **the Community:** describe the state of wellbeing of a community or population as center or socio-health care.

In this sense, the individual, family and community should be our subject of care, trying to answer with our model to these questions "what needs does our community have? Our families? Our individuals?"

The operationalization of the dimension is in the table 1

Table 1. Operationalization of the Subject of Care

Community	Family	Individual
Promoting health in the community as central to sustainable human and economic development (health in all the policies) Civic participation and Public consultation about needs of the elderly (employability, lifelong learning, senior volunteering, health and wellness, social inclusion; aged care	Promoting of family health: adequate family communication, climate, coping, resilience, functioning (create social and physical environments	Awareness an active social subject and deserving of respect, support and care from a real active aging model, which considers people in all their complexity and with a focus on well-being (physical, cognitive and emotional, socio-relational) and quality of life, as well as the

services; housing; transport, research on elderly; public spaces) Community orientation to preventing an active and healthy aging and a positive vision of the elderly; healthy living habits Community develop health assets mapping and promote them, including community resilience, social support, capacity building Community focus in educational development of the elderly: social accompaniment and socio-educational intervention, cultural offer, including the learning of new skills and digital competence; Physical Environment: Safer, barrier-free buildings and streets; better access to local businesses/facilities; more green spaces; nutrition security, safe, active and accessible transportation, etc.) Promoting networking and information exchange with the objective of creating a solid net of solidarity and support including inter and intra-generational solidarity and social altruism (exchange of goods, sharing of knowledge, time banks; Program offering social, recreational, and health-related services in congregate setting; support groups; community centers for all ages; intergenerational practice in schools and other educational institution, local government instrumentalities, sports clubs, churches, voluntary and community groups, and ethnic and cultural development groups; programs in which adults serve children and/or young people (such as	that promote good health for all) Promote gender co-responsibility in the field of care Family involvement in the process and decision-making Formation to family self-care Physical environment: Safer and barrier-free home; nutrition security Considering the gender and social determinants of health in the process of care of families, for example, caregiver profile (woman, non-employed…) Social inclusion of families with low resources is promoted Research and innovation is development focus in social and health needs of families	promotion of activity and autonomy. Promoting empowerment capabilities, self-management abilities, needs, preferences. For instance, the capacity for resilience and the ability to cope and restore a balance from a preventive and rehabilitative vision Emphasis on the contribution of the older person based on life history and in our society through interactions, Individuals have to be considered under the professional codes of ethical issues by all disciplinaries involved. In this way, transcultural perspective and gender equality must be guaranteed. Raise awareness and incorporate ethical, cultural, spiritual aspects, empathy, compassion values, humanization, right to information, protection of autonomy, privacy and advance directives Promote the preferences of the person in relation to the residence alternatives, focus with a home accompaniment Focus in attention and social inclusion of more vulnerable individuals (women, older than

tutors, mentors, preceptors and friends, caregivers); Promotion of local care ecosystems, including both the public sector and community-based initiatives, such as a care cooperative; cohousing initiatives Community promotes the respect to the human and community rights of the elderly and promote inter-national harmony, including the fight with the abuse of negligence Research and innovation about the implication of the community to the positive promotion of the elderly and from the perspective of gender and social determinants Socialization and democratization of care; social dissemination of knowledge generated by self-organized social groups, and community network	Free access to activities as companions of elderly people Support groups for caregivers of people in situations of dependency. Family-centered approaches with active learning strategies, transitional care, and follow-up Provide programming available and accessible to all family types based on culture, geography, and structure	80, without home, living alone, migrants, ethnic diversity…) Special attention to the fragile population and promotion of palliative and end-of-life care at home Participation of the elderly in the care process Research and innovation focus in needs and preferences of elderly and vulnerability

II. Health and social care providers

Health and social providers are central for the person achieving the better state of health and well-being. They should focus the attention on the person with an integrative, multi and inter-professional perspective. For a well and efficient performance focus on the quality and the outcomes of the client it is necessary there should be available the sufficient resources (number, diversity, competencies, well-payment, balance and stability over time of workloads). Professional should be training focus in capacity building from an inter-professional perspective with equity in the treatment of all workers, they should participate in decision-making processes, care guideline must be developed to guarantee the quality of care, should be have a favorable vision of their social contribution.

Multi and interdisciplinary teams including health and social professional, formal and family care, NGO should include shared accountability and responsibility. It must be promoted the clarity about each other's expertise, roles and tasks, from a transdisciplinary horizontal perspective (equity). Workforce policy and planning focused in capacity building and training must be considered, including the preparation for social and health interdisciplinary teams and staff management. The health and social care providers must be involved in the designing and evaluation of these policies.

The health and social workforce performance should be defined by: coverage, productivity, technical quality, service quality. The performance of the Social and Health Care should respond to the principles of: equity; effectiveness; efficiency; financial protection. These principles guide the creation of the Code of Professional Practice for Social Care. Financing and incentive for investing in an adequate workforce it is needed to assure the enough human resources.

To deal with these objectives, it's important to create an efficacy Leadership and Management Setting in Health and Social Care establishing inter-professional programmes for people able to improve the quality of health or social services and acquire the necessary skills. In our model the caregiver is one of the fundamental actors, in this sense it is proposed to create a support system. Focus in construction of a solid network, exchange of knowledge and internal communications must be considered. It must be enhanced the specialization in social care as well in the basis of the Model.

Having clarified the terms "Health care" and "Social care" providers, it is essential according to the TECMED Project to evolve them into three fundamental levels: Macro, Meso and Micro intervention. Specifically,

- **Macro:** Workforce policy and planning, capacity building and training
- **Meso:** Social Care team's management, staff management
- **Micro**: Multi and interdisciplinary teams including health and social professional, formal and family caregivers

The operationalization of the dimension is in the table 2

Table 2. Operationalization of Health and Social Providers

Workforce policy and planning, capacity building and training	**Social Care team's management, staff management**	**Multi and interdisciplinary teams including health and social professional, formal and family caregivers**
To align investment in **(H&SP)** with the current and future needs of the population and of social care systems through effective workforce policy planning To improve prioritization and planning of investment in the development of a sustainable H&SP workforce towards universal health coverage with sufficient resources (coverage, productivity, diversity, competencies). To Promote favorable labor (specializations, increased training; promoting equity, Social recognition for professionals) and economic (well-payment, stability, appropriate work balance, financial protection) conditions for workers in the sector. That should lead to a Code of Professional Practice for Social Care To Promote emerging professionals in the sector: physical therapists, occupational therapists, nurses, health educators, without falling into the medicalization of social structures; To transform professional, technical and vocational education and training oriented to optimize the performance, quality and impact of H&SP Taking account gender and social determinants of health promoting the inclusion and the equality for the workforce	Strength S&HP from a broad, transdiciplinar and horizontal perspective; including formal and formal providers, volunteers, caregivers, etc. Adequate training programs for staff and caregivers, focus in the social care, the basis of the TECMED model, and the main cross-sectional themes: quality, research and innovation, gender, social inclusion, transcultural, and ethic; promoting capacity building. To promote adequately trained staff through University curricula and CPD Program promoting the specialization in social care Training in effective and interprofessional (transprofessional) work, promoting the clarity about each other's expertise, roles and tasks, considering individual differences in needs, practices and challenges amongst their team members; To Stablish inter-professional programmes to develop an efficacy Leadership and Management Setting in Health and Social Care To create support systems for formal and family caregivers Training in staff and institutional managing to promote care of high quality and focus in the need of the subject of care. Promoting solid network, exchange of knowledge, and communication (communication systems), the research and innovation to promote knowledge	Multi and interdisciplinary teams including health and social professional, volunteers, formal and family caregivers with a focus on case management and continuity of care for socio-health care, prioritising the home-based care if is the preference of the individual Incorporation of the vision of the quality and outcomes of care, person-centered focus, outcomes and satisfaction, encouraging feedback, capturing and recording evidence of the effectiveness of care and using that as part of a feedback cycle to improve care. ncorporation of ethic, transcultural and perspective of social determinants, gender and social inclusion and research and quality in the health and social care provision to facilitate collaboration between professionals and hence improve care outcomes, with shared accountability and responsibility, respecting and understanding roles: Sharing power, joint working, autonomy. establishing general practices that include generalists working alongside specialists in social care To promote the participation of all H&SP in the decision-making processes To promote the joint care planning and co-ordinated assessments of care needs. Named care co-ordinators who act as navigators and who retain

independently of their personal and social characteristics. To promote the evidence based, strengthen data and applications that support analytical approaches to H&SP policy and planning, including a better understanding of the workforce (characteristics, size and distribution, competences, technical quality, effectiveness, efficiency) To strengthened human resources information systems and research to guide policy decisions; Multistakeholder and intersectoral policy dialogue for H&SP workforce strengthening; and Mechanisms to coordinate an intersectoral H&SP workforce agenda, if possible from a central workforce unit Education and capacity building plans aligned with national social care plan To involve H&SP in the designing and evaluation of staff policies	and evidence based practice and quality decision making Institutional models for assessing health care staffing need to adapt professional/users ratios workforce needs identified by the sites: understanding the size and shape of the workforce for integration; designing and redesigning the existing workforce with the right values; skilling the workforce; developing a diverse market, focusing on workplace culture. Managing the ways in which work-related stress can impact on employees (e.g. physical and mental health, personal life, health behaviours such as excessive alcohol consumption, and job performance) threaten wellbeing; with a focus in prevention and emotional support with of adequate respite and recovery time to maintain wellbeing and optimum job performance over the long-term; developing procedures to manage stress (reactively) and build resilience (proactively); Managers working with the following **attributes**: approachability; empathy, optimism, emotional literacy, self-awareness, self-confidence, and well developed reflective skills; etc. Managers need to support frontline staff to focus on outcomes for people, not on tasks or processes: empowerment, enhancement, engagement, enablement. Facilitates recruitment of staff who demonstrate interdisciplinary competencies including team functioning, collaborative leadership, communication, and sufficient	responsibility for patient care and experiences throughout the patient journey. Leadership and management with a clear leader of the team, with clear direction and management; democratic; shared power; support/supervision; personal development aligned with line management; leader who acts and listens; with communication skis Promote the learning, training and development; training and career development opportunities; incorporates individual rewards and opportunity, morale and motivation; focus in personal (knowledge, experience, initiative, reflexive practice) and interpersonal (listening, team work, etc.) skills and values Promote a good climate: Team culture of trust, valuing contributions, nurturing consensus; need to create an interprofessional atmosphere.

	professional knowledge and experience. H&SP participate in care guideline be developed to guarantee the quality of care	

III. Care environment and service delivery

III-1 Care environment

Care environment is always a major concern in the field of social and health services. It is a complex system which encompasses both the objectively visible surrounding environment as well as the subjectively perceived environment (Wijk, 2019).

Objective aspects are measurable and comprise features such as accessibility, accommodation (the size of the room, whether it is clean or not, light or dark, hot or cold, if there are views and nature). The psychosocial environment refers to hospitality, warm, affection, response to the person-needs, the atmosphere and ambience in the room, the way it feels. Therefore, the same environment can be perceived completely different by different people. In addition of public care facilities such as clinics, health centres, hospitals, dispensaries, mobile clinics, pharmacies, other types of care settings are developed including welfare services, care homes, day centers, and social network.

Vulnerable older people because of disability or disease are particularly dependant on an environment that can be easily understood and which contributes to security, independence and well-being. That is why one of the priorities of the health care system is to help seniors live in the comfort of their own homes and to create spaces for leisure, meetings and social communication to break their isolation and support their families.

A holistic approach of care environment takes into consideration individual socio-economic environment (social and cultural differences and preferences, housing, community services)

III-2 Service delivery

Service delivery in health care can be defined as the act of providing patient-centred services (Gilson, 2012). According to WHO (2010) health and social systems are only as effective as the services they provide. They shape the conditions that facilitate (or hinder) the provision of patient-centred integrated care in a region or country, as well as broader society (WHO, 2010).

The capacity of giving quality and effective services are related as having a center of the system that serves as enter point to the subject of care, this could the primary care level, having a harmonious coordination at horizontal and vertical levels (at the same and at different institutions and services). That allows to give an integrated range of health and social interventions that respond to the full range of conditions of the target populations, rules and standard practices to ensure accessibility and quality of care related to sustainability, safety, effectiveness, continuity, and people-centeredness, having mechanisms to involve the user in the design and planning of care, including planning and decision shared.

Ageing populations with multiple co-morbidities of chronic diseases such as NCDS, mental diseases, disabilities, are further challenges to social and health care systems. Globalisation is shifting the requirements for health care and control to reach across borders. The global financial crisis is having a direct negative impact on the size, quality, reliability and population coverage of health services. Adapted model care delivery must continue, in an uninterrupted and coordinated way, to address people's needs, not only as patients but also beyond, such as through prevention and monitoring

Definition of the levels of management

According to the UK Law Commission Review 2011 (Law Commissions Act, 1965) *adult social care was defined as "the care and support provided for those who need extra support; it includes traditional services such as care homes, day centers, equipment and home care and can extend to nontraditional services such as gym membership, art therapy, personal assistants, emotional support, and classes or courses*".

According to WHO **health care systems** is "*divided into micro-, meso-, and macro-levels that provide a reasonable framework and refer to the patient interaction level, the*

health care organization and community level, and the policy level, respectively. Each of these levels interacts with and dynamically influences the other two"(WHO, 2002).

For the TEC-MED project we considered both definitions in relation with the **Care environment and service delivery**.

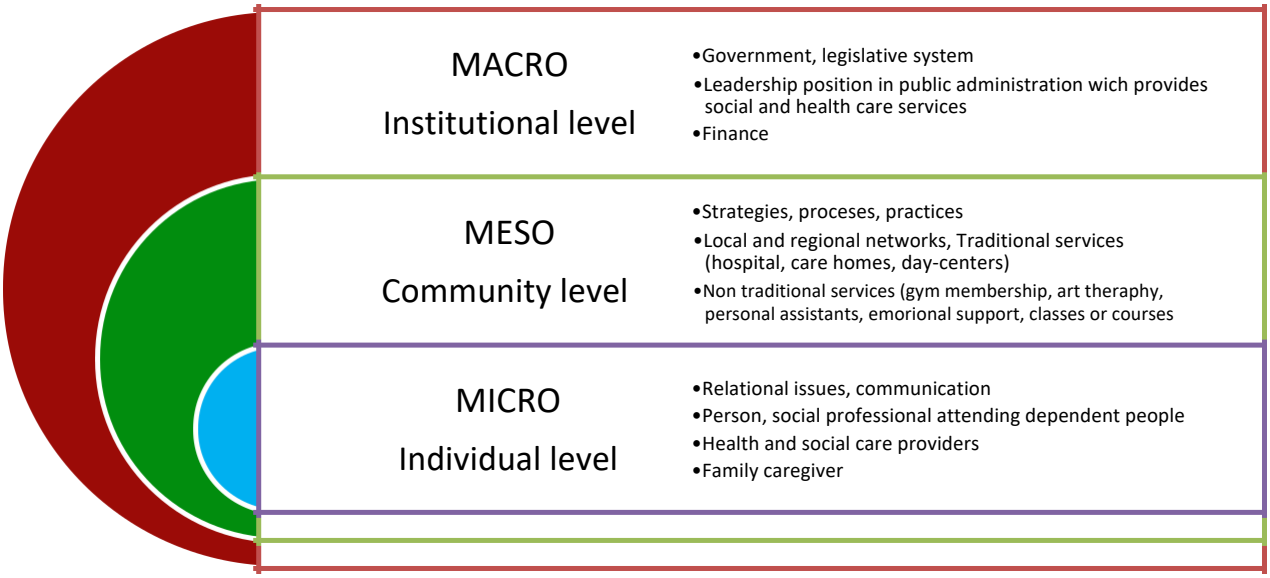

Figure 1: Management levels of care environment and service delivery

In the TEC-MED model we advocate for an integrated social and health care. The ideal is a perfect coordinated care that responds to all the patient needs and preferences, from a holistic bio-psycho-social perspective, including the person in the care process with a person-centered vision.

The operationalization of the dimension is in the table 3.

Table 3: Operationalization of Care environment and Service delivery

Macro	Meso	Micro

Regulation of care environment and service delivery to: – Integrated service delivery systems to improve continuity and increase the efficacy and efficiency of services. – Tackle geographic inequalities in health care and social care. – Coordination between decision makers and managers of different organizations and services at local and regional level. – Implement coverage of basic needs guaranteeing universal rights (housing, health, medical treatment, retirement plan and pension). – Integration in a single model of social and health care, managed from the same body.	Strengthen multisectoral and inter-institutional collaboration in relation to the needs of the elderly. Strengthen the community and capacity action involving health and social services, care networks, meetings, leisure and social communication, financing. Involve community in care environment and service planning. Home environment will be of quality and adapted to the needs of a person that could have difficulties with carrying out some daily life activities. A supportive age-friendly infrastructure, i.e. environment with enough material and qualified human resources. Housing alternatives focused on the person's needs and preferences, which should be designed for elderly people who are unable to stay at home. Develop and implement specific protection programs for the elderly with disabilities Care environment at the primary level should be preventive and rehabilitative, available, with technology support, accessible, affordable, comprehensive, outcome - oriented and evidence-based, transparent, developing physical infrastructure. Choose the most appropriate level of care according to care needs and not based on the resources available in a sectorized area of care. Develop a standard approach to social and health ethics based on main ethical principles (autonomy, beneficence, non-maleficence, and justice).	Focus on the subject of care (person and family), including assessment of individual needs, stratification of care, individualized evidence-based plans with his/her involvement and participation in the care process including decision support. Implement integrated care, patient-centred, bio-psychosocial model, proactive. Assessment of individual needs, stratification of care, individualized evidence-based plans with his/her involvement and participation in the care process including decision support and shared, shared planning of care,. Empowerment, including multiple solutions, long-term care and palliative care Choose the most appropriate level of care according to care needs and not based on the resources available in a sectorized area of care. Unique way of access, case management, continuity between levels, family and community support. Take into account gender dimension by identifying gender and other inequalities and addressing gender equity regarding care environment and service delivery. Take into account cultural, religion and transcultural aspect in the service delivery Support research, data Collection and Development Strategies to guide family members in goal setting activities related to supporting patients, teach family members supportive communication techniques and how

	Care environment and service delivery will be adapted to different languages and culture aspects. Accreditation for the new care environment and service delivery developed within the TEC-MED project will be obtained. Develop and set up a guideline for good practices in service delivery.	to monitor symptoms and treatments associated with chronic conditions Early diagnosis and treatment while tertiary is rehabilitation. These efforts can encourage maintaining and/or adopting household health practices Develop caregiver Training Programs

IV. Financing

Financing is the economic support system of any model. The possibilities are: public, private, mixed or nonprofit. This term includes the financial and accounting system, financial sustainability, financial performance and other question relation with financial matters. This term includes the funding priorities at the political level and the government level.

Macro: Government and political level in terms of laws that maintain financial support E.g. pensions (an example is Takaful and Karama project from Egypt in collaboration with World Bank)

Meso: This means the intermediate levels of authority that facilitates transfer of economic support and creating financial support opportunities e.g. applying for grants, capacity building. In addition, designing and implementing systems e.g. health insurance piloting in Port Said City by the regional Health Insurance Authority

Micro: This is the level at the interface of target beneficiary i.e. the final step for financial support system or hierarchy e.g. geriatric houses, social solidarity employees and

offices. The milestone for this level is the transparency and auditing that assures accurate delivery of required support in a user friendly approach.

To promote financing public, universal and transparency. Preferably promote public financing, without ignoring the public-private possibilities for the greater benefit of the recipients. Everything based on the principles of distributive justice, universality, transparency, fair communication and proper use of resources (efficiency). Transparent entrepreneurship concentrates on innovation, leadership responsibilities for performance achievement and joint financial agreements to guarantee the covering and integrated care.

Reviewing the different initiatives reveals the multi-layered nature of finance, e.g. encouraging achievement and joint financial agreements in ICARE4EU, which necessitate action on macro management level, same as in San Juan de Dios, where macro level intervention is sought to guarantee economy rights and BURTZORG for maintaining financial sustainability for elderly.

On the other hand, in Integrate, as a people centered approach, Financing and incentive, investing in an adequate workforce represents a good example on micro as well as meso level of financing.

In conclusion, financial domain plays an important role in the development of a successful model, however, the assurance of multi-levels of financial solutions and initiatives is mandatory to cover the different domains and needs. A model that creates sufficient funding resources (through macro management level e.g. official agreement and multinational partnerships) for empowering initiatives that targets vulnerable populations aiming to provide support on personal levels with assurance of sustainability and maintenance of finance and delivered through meso and micro level of management is invaluable.

The operationalization of the dimension is in the table 4

Table 4. Operationalization of Financing.

Macro level	Meso Level	Micro Level
– Universal access to services promoting social inclusion. – Territorial and political fiscal solidarity – Coverage of basic needs guaranteeing universal rights (housing, health, etc.) – Adequate financing system that favors social inclusion, eliminating copay (pharmaceutical, orthoprosthetic). – Review of the criteria for economic participation of users with the elimination of the copayment. – Incorporation of financing and public contracting of resources and services necessary for socio-health care – Provide appropriate pension systems that offer support depending on the needs and situation of the elderly population. [– Providing opportunities for financing, for instance: improve work access for and participation by people with chronic diseases, to support employers in implementing health promotion and chronic disease prevention activities in the workplace, and to reinforce decision-makers' abilities to create policies that improve access, reintegration, maintenance and stay at work of people with chronic diseases – Ensure gender equity in financing Policies that are	– Decrease the cost rate of the institutionalization of the elderly as families prefer caring for their relatives in order to avoid huge expenses. Entities focusing on community development should focus more on enhancing the current status of the elderly, especially in rural areas. – Decommodification of socio-health care, without exclusively prioritizing the business benefit – Control of companies regarding the quality of care – Restriction of entry into the sector to speculative financial groups – Incorporation of the culture of evaluation of process results and impact. – Evaluate and control the quality of care in concerts	– Collaboration with companies to fund different services in elderly care centers. – Developing an auditing system to monitor the delivery of required support to target population. – User friendly approaches to support with preservation of dignity e.g Takaful and Karama [assurance of gender equality of delivery of support] – Distribution of money taking into account the gender differences: – Funding must be based on differentiated estimates incorporating women's values, contributions and time

based on, and respond to, the practical and strategic needs of men and women can lead to more effective responses. – Streamline management and promote urgent care to those households that are in a situation of social emergency		

VI. Technology

In accordance with WHO (2019), digital social interventions aim to support population care, training, recording of the information, the alert notifications, communication and coordination, and for evaluating the quality of the care provided, and the policies.

The term technology1 spans different definitions and applications that include- but not limited to- telemedicine, tracing technology, data entry software and applications of Artifical Intelligence (AI) to predict risks. Again, adoption of technology in any model must be developed under the values of user-friendly, availability, accessibility, etc. It is considered that digital social interventions should be accessible at a minimun via mobile devices.

Additionally, transversal concepts of the TEC-MED Model should be taken into account, such as quality, research and dissemination, gender perspective, ethical aspects, social inclusion and transculturality. This means that TEC-MED model should be linked to aspects such as respectful human rights and dignity, person centered, preventive and rehabilitative, available, accessible, affordable, comprehensive, taking into account the transparency, gender and the culture. Furthermore, it is considered very important to share research/good practices results with potential users-peers in different fields (research, industry, policymakers) and transfer.

It seems important to highlight, in the context of the use of technology, compliance with bioethical principles related to privacy, confidentiality and empowerment, in addition to those already known, autonomy, beneficence and justice.

Another aspect which should be kept in mind is related with the technological gap, so the model should guarantee access to technological solutions by facilitating the social inclusion of the target users of the model.

In addition, it should be kept in mind the transverse involvement of different levels of management in developing and endorsing technological solutions or innovations i.e.:

- Macro: National support policies to improve the technology development and the innovation. Guaranteeing the equitative access, availability and freely available of the technology services. Impact of technology on the economic and social protection systems, and the health and social care systems Cultivating diversity and promote inclusion while respecting cultural, ethnic and gender differences
- Meso: Use of technology to coordinate the services. The coordination is possible at a local level by the City Council's health and social services or by private or nonprofit entities. Impact on organizations, interoperability, and health and social providers
- Micro: Use of technology to improve the well-being of the target population, e.g. telemedicine, telemonitoring. Technology support to family caregivers. Technology support to healthcare providers (training, recording, follow-up). Impact on careers and care recipients

Implementation of technological solutions can be observed in the different successful initiatives reviewed, most pronounced in tracking and follow-up (COMUNITÀ MONTANA GRAND PARADIS- Italy; Aging Lab Worthy and Positive Aging Model, EDP- Spain; as well as SELFIE and INTEGRATE –EU). In addition, emerging tele-medicine solutions are emerging as a valid and valuable alternative (partially) especially in situations like COVID-19, this has been traced as well in (COMMUNITY OF S EGIIDIO “Long Live the Elderly!”- Italy and San Juan de Dios-Spain [providing HIS TICARES: management of care and professional, users training]).

An interesting application for AI has been in development stage at the Institute of the global Health and Human Ecology (I-GHHE), in Egypt, where through collaboration between different partners (EGY, US, EU), an AI developed model can be used to assess the degree

of cognitive impairment based on data derived from social media activities for elderly subjects that can provide a risk assessment strategy for early detection of dementia or MCI.

In conclusion, the introduction of technology is one milestone for a successful model on different fronts, management, follow up and risk prediction. The successful adoption of technological innovations/solutions however, depends on the integrated approach between different levels of management starting from regulations and laws set by macro level, active implementation on meso-level, and finally participation and engagement with target population through micro level of management.

Based on the previous lessons learnt from different promising initiatives in the partner countries, we can suggest the following approaches for Technology to be implemented in TEC-MED Model (table 5)

Table 5. Operationalization of technology

Macro	**Meso**	**Micro**
Laws that facilitates implementation of technologies in care is essential to control this emerging practice. Eg privacy of data, regulations for remote medical consultation (to what extent, what is acceptable and what is not). [Acceptance of transcultural difference] AND[laying foundation for ethical basis] Investment in socio-educational interventions to improve the skills of the group in order to improve their	Promote collaborative work between the different institutions for better use of available technological resources through the exchange of information and experiences Implementation of technological solutions for tracking and follow-up, tele-medicine especially in situations like COVID-19, providing social and health care history, management of care	Improve the environmental conditions so that they help and favor the equitable use of technology. Customize technologies to allow greater accessibility for all users. Promote digital literacy to help develop technical and social skills in the use of technology Promote the integration of people as critical and active subjects, and not as mere consumers of technologies and digital content (Travieso, J.L. & Planella 2008) Use of app for assessment, for instance, assessing the cognitive impairment based on data derived from social media activities for elderly subjects that can provide a risk assessment strategy for early detection of dementia or MCI.

autonomy, including digital competence Invest in technology and trial innovative ways of supporting clients and their families Smart city initiatives (adult social care chat bot, an in-house development that is designed to provide people with adult care information 365 days a year; collaborative maps which as well as tracking the most appropriate route for a pedestrian's needs; smart beches) Economically accessible tic tools (smartphone, tablet) Promotion technology at national level, for instance Nationwide Health Information Network (NwHIN)	and professional, users training]. Detailed database of elderly with their files (medical, social), social and health services Staff and resources management systems Evidence based tools and clinical decision support systems	Remote medical consultations and well-being (smart app) for elderly (for example, Doktori Platform, Egypt). Telehealth for cognitive behavioural therapy Use of ICT for Electronic treatments to decrease social isolation/loneliness for older people living in the community/residential care. Social tools (e.g. online forums, video-chats) that address both personal and social integration needs assist the family carers to reduce their social isolation as well as improving their social activities and intergenerational relationships (ej. Action, in Sweden (Bergström et al., 2010); Cuidadoras en Red, in Spain (Carrión and Armayones 2006). The "IPPI", in Sweden (Östlund and Lindén 2011).) ICTs for independent living that help family carers to reconcile care and work(such as "Action", "E-Care", "Emergency Alarm", "IPPI", "Just Checking", "Sophia", and "Telecare Scotland") Person Centred software for care home (Mobile care Monitoring resindecial care, nursing homes, supported living, learning disabilities, mental health support (Person Centred Software, 2020) Adapted tic courses to facilitate access to program and services (Marziali & García, 2011) Web-based Electronic health records (EHR) system that offer various benefit for both patients and doctors and increase efficiency and better quality of care (WHO, 2007; Bajwa, 2014)

VI. Governance

Governance is the process by which social care organizations guarantee good service delivery and foment positive outcomes for people who use services. It consists in a wide range of steering and rule-making related functions carried out by governmental/decisional makers. Governance is oriented to develop implementation and change strategies tailored to different care settings and contexts in Europe and Mediterranean area.

As identified in the TEC-MED model document, for the macro level, good governance should be oriented to be independent from political orientation, guaranteed by fair financing and with the development of legislation that universally protects with equity, throughout the national territory, all citizens regardless of their resource. An optimal governance model should count on a strong coordination network, of all actor's levels and resources. From the meso level, policy and action plans and political commitment are aimed at protecting the ethos of autonomous practice, integrated care programs, community-based practice, high levels of client and staff satisfaction, financial sustainability, customer empowerment and comprehensive care with a primary focus on clients with complex health and social issues care needs. Autonomy, in fact, is a key variable for a profound transformation, it also includes accountability mechanisms (to political groups, regulatory bodies, local authorities, boards of directors and the general population), changes in the status and roles of human resources and the impact on social health information systems.The health service providers follow a performance-based management and creating individualized care planning coordination tailored to complexity, counting on less bureaucracy and offering all support functions. In this sense, the citizen is a primary and active actor in the choice of care policies sharing decision-making.

Definition of the levels of managements

For the TEC-MED model we considered three levels in relation with the governance:

- **Macro**: the State (government organizations and agencies at central and sub-national level)
- Meso: the health service providers (different public and private areas for and not for

profit clinical, para-medical and non-clinical health services providers; professional associations; networks of care and of services)

- Micro: the citizen (population representatives, patients' associations, CSOs/NGOs, citizen's associations protecting the poor, etc.) who become service users when they interact with health service providers.

The operationalization of the dimension is in the table 6.

Table 6. Operationalization of Governance

The State	The Health Service Providers	The Citizen
Establishment of active committees which support the national strategies for old age and related projects and initiatives while enforcing political commitment to old age matters and taking into account ethical, transcultural, gender and social inclusion aspects Establishment of policies, action plans and initiatives oriented to integrate the health and social care and services Initiation of needs assessment activities for older age at the national level to get data about older' needs of care. Building age friendly public policy standards and procedures. Creation and design of age friendly cities. Establishing good governance systems within governing organizations.	Active participation of service providers in the design of laws and policies for dependent elderly and/or at risk of social exclusion taking into account ethical, transcultural, gender and social inclusion aspects. Involvement in quality health-related research for old age and to identify the needs and gaps of old age care while sharing results with the state and the community while taking into account ethical, transcultural, gender and social inclusion aspects Training of service providers on good governance systems, performance-based management, and leadership. Providing comprehensive health care focusing on older adults' health and social needs while setting important indicators such as satisfaction from services, integrated care,	Active participation of population representatives, patients' associations, CSOs/NGOs, caregivers and family members in the design of laws and policies for dependent elderly and/or at risk of social exclusion taking into account ethical, transcultural, gender and social inclusion aspects. Involvement and collaboration in local community governance programs. Training on good governance practices, leadership, transparency and accountability. Involvement in monitoring and evaluation practices for quality assurance of old age care. Involvement in advocacy and awareness projects to address the needs of older adults. Participation and collaboration in old age research efforts on the local and national levels. Networking with health service providers and national committees for better

Involving stakeholders in the design of programs and policies which promote multi-sectoral partnerships, governance and accountability. Working on strategies and standards for population health management and specialized geriatric health care. Involving stakeholders in building awareness on the importance of good governance, transparency and leadership. Active presence, involvement and collaborative commitment of leaders in community programs. Supporting new laws and policies which protect the rights of older adults and support the concept of active and positive aging. Networking with local organizations (health and other) and local communities to manage and develop old age programs. Empowering local organizations to address the needs of older adults and demonstrate good governance practices. Improvement of training of health and social care providers at the national levels. Establishing a governing body for monitoring and evaluation measures as well as quality assurance protocols for older age care	financial sustainability, etc … Participating in high-level individualized care planning and coordination with local and national bodies. Building awareness on good governance, transparency and leadership. Advocacy efforts for the (health and social) needs and rights of older adults. Networking efforts with local and national committees for better governance of old age programs.	governance of old age programs.

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TEC-MED

Regional High-Level meeting TEC-MED first draft model,
Date: Monday, 29 June 2020
Started from 9:30 AM to 4:20 PM

Activity 3.1.3b

WP3

This project has received funding from the European Union's ENI CBC MED Programme under Grant Agreement No A_A.3.2_0376

This project has received funding from the European Union's ENI CBC MED Programme under Grant Agreement No A_A.3.2_0376

STATEMENT ABOUT THE PROGRAMME:

"The 2014-2020 ENI CBC Mediterranean Sea Basin Programme is a multilateral Cross-Border Cooperation (CBC) initiative funded by the European Neighbourhood Instrument (ENI). The Programme objective is to foster fair, equitable and sustainable economic, social and territorial development, which may advance cross-border integration and valorise participating countries' territories and values. The following 13 countries participate in the programme: Cyprus, Egypt, France, Greece, Israel, Italy, Jordan, Lebanon, Malta, Palestine, Portugal, Spain, and Tunisia. The Managing Authority (MA) is the Autonomous Region of Sardinia (Italy). Official Programme languages are Arabic, English and French. For more information, please visit: www.enicbcmed.eu".

STATEMENT ABOUT THE EU:

"The European Union is made up of 28 Member States who have decided to gradually link together their know-how, resources and destinies. Together, during a period of enlargement of 50 years, they have built a zone of stability, democracy and sustainable development whilst maintaining cultural diversity, tolerance and individual freedoms. The European Union in committed to sharing its achievements and its values with countries and peoples beyond its borders.

Executive summary

The 29th of June of 2020 the Partners of the TEC-MED Project joint with a number of stakeholders (a list of 45 attendees) from 6 countries in the Mediterranean Basin (Spain, Italy, Greece, Egypt, Lebanon and Tunisia) held a meeting with the objective of the present and improve, taking the considerations of the different stakeholders, the TEC-MED model. For this purpose, the preceding formative research that was made during the first year of the implementation of the project was presented followed for the definition of the TEC-MED model. An open discussion was performed with the stakeholders, who previously it was sent the document, to know its strengths, weaknesses and opportunities of improvement. Later, in a Steering Committee they were decided the following steps for finishing the Model.

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List of attendees

Last Name	First Name	Country	Organization	Job Title
1. Alonso Trujillo	Federico	Spain	Assda - Agencia De Servicios Sociales Y Dependencia De Andalucia	Md - Médico Y Técnico De Acción Exterior E I+D+I
2. Anastasiou	Eugenia	Greece	Social Worker	Social Worker
3. Alouane	Leila	Tunisia	Association Alzheimer Tunisie	President
4. Arroyo Rodríguez	Almudena	Spain	Orden Hospitalaria De San Juan De Dios	Jefa De Estudios. Centro Universitario De Enfermería "San Juan De Dios"
5. Awad	Samar	Egypt	Academy Of Scientific Research And Technology	Communication Officer
6. Ayman Moustafa	Sara	Egypt	The American University In Cairo	Research Assistant/Phd Student
7. Azar	Jihan	Egypt	The American University In Cairo	Pharmd
8. Badanta	Bárbara	Spain	University Of Seville	Professor And Researcher
9. Barrientos-Trigo	Sergio	Spain	Universidad De Sevilla	Assistant Professor
10. Barroso Fuentes	Emilia	Spain	Ayuntamiento De Sevilla	Directora General De Acción Social
11. Ben Mansour	Nadia	Tunisia	National Institute Of Health	Associate Professor In Preventive Medicine
12. Bourassi	Amel	Tunisia	Iba	Media Manager
13. D'agostino	Fabio	Italy	Unicamillus	Assistant Professor
14. El Ati	Jalila	Tunisia	National Institute Of Nutrition And Food Technology	Professor, Head Of Department, Responsible Of Research Laboratory
15. Elfawal	Hassan	Egypt	American University In Cairo	Dean, Science & Engineering; Director Institute Of Global Health And Human Ecology
16. Ferentinou	Eleni			
17. Fernández García	Elena	Spain	Universidad De Seville	Nursing Professor
18. Frantzi	Chrysanthi	Greece		
19. García	Silvia	Spain	Universidad de Sevilla	Communication Technician
20. Hossam	Marwa	Egypt	ASRT	
21. Hussein	Shereen	United Kingdom	University Of Kent	Professor Of Health And Care Policy
22. Karam	Georges	Lebanon		
23. Korh	Lea	Lebanon		
24. Lima-Serrano	Marta	Spain	Universidad De Sevilla	Associate Professor
25. Maniati	Aggeliki	Greece	Omnes	Social Worker
26. Mirete Valmala	Carlos	Spain	Fundación Pilares Para La Autonomía Personal	Responsable Del Área De Formación
27. Neofytoy	Agisilia	Greece	Social Worker	Social Worker
28. Ounaissy	Roula	Lebanon	Idraac	Registered Nurse
29. Porcel Gálvez	Ana María	Spain	University of Sevilla	TECMED project coordinator
30. Pura	Diaz Veiga	Spain	Matia Instituto	Researcher
31. Sami	Saly	Egypt	Sekem For Development Foundation	Projects Manager

32.	**Xenou**	Mary	Greece	Public Health And Social Welfare Department Of Western Greece Prefecture	Msc Public Health Inspector , Speech Therapist
33.	**Beji**	Chiraz	Tunisia	National Institute Of Nutrition And Food Technologie	Public Health Doctor
34.	**Lassoued**	Fatma	Tunisia	Ministry Of Health	Family Doctor, Head Of District
35.	**Liotta**	Giuseppe	Italy	Biomedicine And Prevention Dept, University Of Rome "Tor Vergata"	Prof
36.	**Mac Fadden**	Isotta	Spain	Universidad De Sevilla	Researcher
37.	**Mattoussi**	Khaled	Tunisia	The Ministry Of Women, Family, Children, And Senior Citizens	Assistant Director For Senior Citizens
38.	**Aounallah-Skhiri**	Hajer			
39.	**Domínguez**	Isabel	Spain	Universidad De Sevilla	Nurse
40.	**El-Khamisy**	Sherif	United Kingdom	University Of Sheffield	Director Of Research And Innovation
41.	**Ibrahim**	Hany	Egypt	Ain Shams University	Senior Lecturer/Consultant Geriatrician
42.	**Kammoun**	Ines	Tunisia	National Institute Of Nutrition	Doctor
43.	**Neofytou**	Agisilia	Greece	Social Worker	Social Worker
44.	**Salama**	Mohamed	Egypt	Auc,Pp8	
45.	**Zafiropoulou**	Maria	Greece	Merimna /Researchscope	Senior Researcher Healt

Welcoming Note and the meeting opening

The meeting started at 9:30am, Ms. Salma Essaw ,WP3 Leader, gave a welcoming note on behalf of the Project Team Then she started the day by presenting a brief overview of the TEC-MED Project and its structure and funding agency.

Then Ms. Salma Essawi gave a swift instruction on how we should use the control panel of GOTOWEBINAR and encouraged all attendees to post on the social media using the hashtag proposed.

Ms. Salma Essawi Left the floor to the Lead Beneficiary welcome note & Introduction of project new partners PP2 represented by Dr. Fabio D'Agotino (University of Sant Camillus) by Dr. Ana María Porcel**,** the project coordinator. PP6 couldn't attend.

Then Dr Mohamed Salama, PP8 gave a few words on How will the outputs from the workshop feed in the process of preparing the TEC-MED first draft model?

WP3 Overview

Ms. Salma Essawi gave an overview of Work package 3 activities like, 3.1.1 Analysis of the most promising social care initiatives already existing in MED Basin, 3.1.2 Analysis of the current social care practices in the six countries involved in the project and 3.1.3the Gap analysis and TEC-MED intervention framework definition.

Activity of Analysis of the most promising Social Care Initiatives. (LB)

After that Dr. Isotta Mac Fadden, researcher from Spain-LB, has given a detailed overview on the first activity in WP3 "Analysis of the most promising social care initiatives" as results of the activity "3.1.1.a Literature Review & 3.1.1.Case studies", which main objective was To Know what are the most promising social care initiatives for elderly, dependent and/or in risk of social exclusion in European and the Mediterranean Basin countries. More Specifically, to know the characteristics of the social initiatives directed to the target population. And, to determine, when possible, the outcomes/impact of the social care initiative.

For this objective, it was developed a literature review to identify case studies on the best social-care initiatives in the Mediterranean basin countries and the European Union, and social care practices, characteristics and trends in each participating country.

She gave a specific detail about the distribution of work and the methodology for

a) The General literature review (English and native languages of the countries in the project): Scopus and Pubmed literature search

b) The Gray Literature (English and native languages of the countries in the project)
c) The Unified document.

The Selection criteria of the literature were:

Articles that describe, explore, analyze, evaluate specific social care practices and initiatives for elderly (more than 60-5550 years old), dependent in risk of social exclusion, cultural and transcultural, ethic and social-ethic.

Social care initiatives include either implemented programmes or theoretical models which exemplify best practices and innovative aspects of social-care for primary target population. Population target must include dependent, elderly population with chronic illness or lack of family support. The Time frame from 2000 to 2019: from 2000 to 2019. Languages: English, Spanish, French, Italian, Greek, Arabic. And finally, the Design: Qualitative, quantitative, case studies, theoretical.

The models were selected based on the following criteria**:**

- Territorial: National proposals of the countries of the project PPs and European International projects.
- Scientific evidence and expertise: Models that have been implemented with concrete initiatives, duration and with some support for effectiveness and/or evaluation.
- Integrated vision: model with services that contemplate an integrated care and not focused on a specific service. (20 care models)
- The model should include thoritical framework, Main Objectives, management , stakeholders, strengths and weaknesses.

She clarified also that we have used PRISMA 2009 Diagram flow charts for refining data

Through these models many lessoned learned has been noted and the most interesting aspects are for example in the Framework that should **include**

- Holistic and interdisciplinary approach (medical services, psychological, social practical and spiritual support) within the family and home environment; and well-coordinated multidisciplinary care.
- Integrate care: person centered care, clinical, professional, normative, organizational. Systemic integration levels.
- Proactive, empowerment of elderly people, involvement of elderly in health promotion activities, promoting and preserving the family framework for elderly people.
- Multidimensional assessment of bio-psycho-social family.
- Home care model.
- Investments in human capital development.
- Quality of service for the elderly and protecting the caregiver's well-being.

And the most interesting aspects that should be included in the Main Objectives part based on three dimensions (Client, Family/ Professional / Public care)

- Quality of life and prevention.
- Deep knowledge of the legislative and operative (social, health) context.
- Needs of elderly and counteract social isolation in the population age of ’80.
- Improvement of established integrated care initiatives (at patients’ home, training of professionals, improve public care awareness).
- Improvement of person-centered care for persons with multi-morbidity.
- Innovative approaches in multidisciplinary care.
- Leadership, management and delivery of integrated care.
- Build communities of practice.
- Provide evidence-based advice on matching financing/payment schemes with adequate incentives/Evidence based guidelines.
- Criteria to choose and assess national health promotion programs
- Investigation for success of health promotion and programs criteria that contribute to the success of health.
- Dissemination of the knowledge.
- Build a common set up of European partnership of European Countries.
- Creation of common territory and common development objectives.

Moreover, the Management aspect should include:

➢ Intervention (Improvement plans for social and health professional, assessment of older people’s need, involvement of older people, creation of platform).

➢ The participatory implementation process (research partners + stakeholders).

➢ Practical measure (qualitative-quantitative tools).

➢ Adaptation (set up monitoring procedure): adaptation to local community, capacity building, community network building, improvement plans for social and health professional, assessment of older people’s need, involvement of older people, creation of platform.

➢ Planning (steering group; assess of need and framework; targets and objectives; action plans; indicators of monitoring; Nursing teams self-managed; coaching).

➢ Progress evaluation (external feed-back of experts; improvement cycle, analyzing of methods, people, cost, etc.; evidence-based, evaluation and dissemination; ej/; Evaluation of social care services in different European countries, transferability effectiveness, coordination, communication and evaluation).

And in the most interesting aspects in the Stakeholders dimension:

➢ Micromanagement: elderly population with risk of social exclusion, Social professional attending dependent (at a social-enterprise, NGO, etc.)

➢ Meso-Management: Leadership position of social-enterprise providing social-care services, leadership position of NGO providing social-care services, leading academic figure studying or working in social-care services.

➢ Macro management: Leadership position in public administration which provides social-care services (may include policy makers and other stakeholders).

The Strengths in the models has included:

- Multidisciplinary and holistic approach strong support to patients' families.
- Development of national health promotion programmes for the elderly continuing training for the involved professionals list of programmes and contact details improve patient care in the community.
- Strong networking and collaboration with governmental and research centers Campaigns focusing on the positive effects of the initiatives.
- Management improved continuity in nurses/impact on care/longer visits/improved follow-up/improved contact with nurses Integrated care activities maintained or enhanced person centredness, prevention orientation, safety, Efficiency and coordination in health in health and social care.
- Maintaining aged persons within their living environment.
- European network common framework public found and support full and uniform application of the employment contract to increase the welfare of operators; work plan for each micro community.

And the Weaknesses in the models included:

- Lack of implementation of the models with a solid framework.
- Lack of research and data on the implementation effects of models (lack of verifiable data to confirm impact on patient outcome).
- Cultural adaptation/ transferability.
- Territorial inequality.
- Lack of national coordinated and integrated plan.
- Limited specialized care services.
- Lack of information between professionals.
- Unsupportive policy and legislation.
- Insufficient funding and resources.

With this, Dr. Issotta Mac Fadden concluded that the analysis carried out has created the basis for the draft models, showing the most specific aspects of the most promising social care models in Europe and in the Mediterranean area**.**

Analysis of Current Social Care Practices in 6 participating countries (PP7)

The session after was given by **Ms. Lea korh (PP7)** displaying in detail the second activity of WP3 as they were the leaders for the task 3.1.2"Analysis of the current social care practices in the six countries involved in the project"

Ms. Lea Elaborated that Mediterranean countries are showing common trends and needs of social care to elderly dependent populations. To respond to the needs of the countries (Greece, Egypt, Lebanon, Spain, Tunisia) involved in the project, a country assessment of the social practices of each country was initiated and a final report was compiled, that was through Semi-Structured interviews with stakeholders. Each country was in charge of performing at least 3 semi-structured interviews with key stakeholders on the social care process in each country based on a pre-defined checklist and template approved by the lead beneficiary (translated and adapted to local context). Finally, 25 stakeholders participated in the interviews (5 from macro-management profile, 9 from meso-management, 9 from micro-management and 2 representatives from the target population) All interviews were transcribed, analyzed and summarized.

For the semi-structured interviews, questions were divided into different parts:

1. Part I Background Questions.
2. Part II General Questions on Social Care for the Target Group.
3. Part III Specifics of The Country's Social Care Model.
4. Part IV Outcomes Impacts and Evaluation of the Current Social Model.
5. Part V Challenges and Bottlenecks.
6. Part VI Success Factors and Lessons Learned.
7. Part VII Ideal Social Care Model Transcultural, Social-ethical and Gender Perspective.
8. Part VIII Ideal Platform to Implement the Social Care Model.

➢ **SWOT Analysis of the social care practices in each country**

Each country, based on the previous literature review and the results from the interviews they carried, conducted a SWOT analysis for the social care in their country where they identified the: Strengths, Weaknesses, Opportunities and Threats

All the information shared by the partners were compiled in 5 separate country reports for each of the project partners. The initiatives and practices in different countries were mainly responding to the needs of each. Some Examples identified through this report were as follows:

1. Egypt: a longitudinal survey of the aging population with a 10year follow-up to identify the needs of this population.
2. Greece: ACTIVAGE for active aging & FRAILSAFE to assess frailty using the latest technologies.
3. Lebanon: national strategy for old age, national standards for organizations working with older adults, palliative care services, social services (governmental and NGOs.) etc…
4. Spain: model of intervention Decent and Positive Aging (EDP) with a well-developed social security system offering trends for proceeding with better quality of aging through increased activity, engagement and autonomy of elderly population through several steps/initiatives.

5. Tunisia: Social & Health Integration Model and new initiatives and reform, National Program of Education for Adults (PNEA), national volunteering database etc…

Ms. Lea Continued to share the in-depth SWOT analysis and she presented the common aspects between the countries.

- Strength
  1. General trend to a long-term social care system,
  2. Governmental commitment to provide services,
  3. Trends toward active engagement of elderly in community,
  4. Trends toward active aging,
  5. Increased attention paid to healthcare system and unique aging related morbidities.
- Weaknesses
  1. Economic situation and crisis in different countries.
  2. Lack of financial resources and age-friendly infrastructure.
  3. Centralization of services (in most of the countries with government as the sole provider of service) could lead to overwhelming and crashing of system in certain conditions.
  4. Low engagement of private sector and NGOs and collaboration with government.
  5. Shortage in human resources and specialization of human resources in elderly care.
  6. Lack of specialized services in specific conditions related to older adults.
  7. Limited Information and Communication Technology (ICT) services for elderly care in some countries.
  8. Legal and policy issues in relation to older adult's care.
  9. Sociocultural issues related to old age.
- Opportunities
  1. Collaboration and networking between countries and partners.
  2. Funding for improvement of services.
  3. Identification of best practices (active aging initiatives, engaging of elderly into community).
- Threats
  1. Any incident/emergency that overwhelm country resources could endanger the system e.g. COVID-19 pandemic.
  2. Political instability.
  3. Changes in population demography e.g.: increased aging population which could exceeds allocated resources.

- **Suggested Actions**
  1. Using the available networks and infrastructure to facilitate exchange of experiences and collaborate between partner countries.
  2. Translating successful experiences from one country into other countries.
  3. Expanding the networks to include other countries.
  4. Involving more stakeholders.

5. Informing decision makers to push for improving/issuing regulations that facilitate health & active aging engagement.

- **Characteristics of the platform**
  Partner countries have shared some important features and characteristics that could be characteristics of the new model of care and ICT platform and include:
  1. Ease of use of the platform environment.
  2. The importance of networking with all stakeholders (governmental, non-governmental, medical, academic, social, media, etc…)
  3. Social networking and social integration of older persons within the new model and platform.
  4. Registration process for the dependent older persons in the platform including medical history, clinical record, specific indicators (daily or other), social status, financial status and family status.
  5. Integration of technological solutions within the new model and platform (telecare, telemedicine, monitoring, decision-making platforms for individualized social care, information systems/health history).
  6. Availability of trainings and training modules/materials within the new model and platform to empower caregivers, family members and older persons.
  7. Support of homecare and home caregivers integrated within the new care model
  8. Availability of services, economic empowerment opportunities and social activities related to older persons on the platform for proper referral.
  9. The importance of building a monitoring and evaluation system for the new model of care.

➢ **Ms. Lea at the end concluded that** the differences in the social care systems among countries are clear on the: Political, Legal, Cultural, Economic Levels. Moreover, some of the common issues among the countries include: Economic situation; Political instability; Staff shortage & distribution of services issues; Global changes in family structures; Culture of Aging.

➢ A lot of interest was shared on the integration of information and communication technology in the social care of older adults.

➢ Important stakeholders were identified; Governmental; Non-governmental.; Local Community Groups; Private sector.

Finally, Ms. Lea Mentioned that the gap analysis which will follow will surely provide a clearer understanding of the needed changes and actions in each country and provide a transcultural solution.

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After Ms. Lea's intervention, a poll was launched to increase the engagement of the attendees the first poll:

How practical-do you think one model can work for all TEC-MED Countries?

I don't think so 7%

It can work with some individual customization 67%

All TEC-MED countries share same situation and culture 27%

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Success of Delphi process & Gap analysis conducted in each country.

After a short break attendee has returned to the meeting slot which was titled" Success of Delphi process & Gap analysis conducted in each country" activity 3.1.3 an overview of the process was given by Ms. Salma Essawi before each partner country presented the outcome of this activity

The Delphi method is a structured process that uses an iterative series (or rounds) of questionnaires to gather information, and rounds are continued until group consensus is reached. This widely used method allows for the inclusion of a large number of individuals across diverse geographic locations and, unlike a face-to-face meeting, avoids the situation where a specific expert may dominate the consensus process.

Ms. Salma Essawi has highlighted the objectives of the Delphi technique and the questions that needs to be answered

- Where are we? (current state)
- Where do we want to go? (Desired state)
- How far are we from our goal? (GAP)
- How do we reach the stated objective? (Initiatives)

Egypt

Then Ms. Salma Essawi Gave the floor to Ms. Saly Sami, SEKEM foundation PP9, the other Egyptian Partner to present the success of the Delphi in Egypt and its outcome

The presentation included an overview on the Participants profiles: Macro management group (3 participants), Meso Management Group (5 participants), Micro management group (9 participants).

➢ **Ms. Saly has mentioned the Priorities regarding the current state That has** emerged from the responses in the First and second Delphi rounds in relation to the social model of care for the elderly dependent population and / or at risk of social exclusion:

1.Geriatric health curricula at medical and nursing school.
2. Geriatric specialized health care.
3. Aging related Multimorbidity.
4. Emphasizing role of healthy lifestyle (Diet, exercise, smoking, drug abuse) and life course approach for disability prevention.
5. Well trained health and care workforce.
6. Improving Laws and policies regarding elderly care.
7. Socioeconomic characteristics (Education, occupation, living situation, social network, income) and demographic (Age, gender, geographic location, old age dependency ratio).

➢ **Priorities regarding the desired state**

Topics identified in the first and the second Delphi rounds were assessed in the third Delphi round and classified into:

1. Geriatric specialized health care.
2. Emphasizing role of healthy lifestyle (Diet, exercise, smoking, drug abuse) and life course approach for disability prevention.
3. Socioeconomic characteristic.
4. Well trained health and care workforce.

➢ **Priorities regarding the GAP**

Topic 1: few specialized doctors and centres for geriatric health, there are some specialized health care centres, like for Parkinson's or Alzheimer's and there are many general healthcare homes for geriatrics which are not specialized at all.

Topic 2: Healthy lifestyle is not embedded in the society at all. The healthy life style is not linked to disability, Elders rarely follow good life style and many continue smoking even at an old age.

Topic 3: The current situation lacks information regarding socioeconomic and demographic characteristics.

Topic 4: Informal arrangements are the normal situation. Many families rely on uneducated (usually internally migrant) young female workers to provide care. Private agencies that have been organizing home care are increased in number. However, with no quality assurance measures nor standard training, the risk for older people is increased. There are some limited charitable efforts (mainly religious or international organizations).

The gaps between the 2 states and the steps to close those differences:

Topic 1: Considerable gap. Changing laws, policies, and incentives towards geriatric specialized care. Introducing topics related to aging and providing respect and understanding towards the elderly within school curricula.

Topic 2: Considerable gaps in both the availability and accessibility. Continuous education and raising public awareness in TV programs and internet advertising for the importance of healthy food, exercise and regular medical care to improve the quality of life. Availability of public places that are equipped to help the elderly.

Topic3: The data could be hard to collect. The steps can include cooperating with other organizations, requesting hospitals to collect such data is a must. These data also must be filled by all patients. Well-designed questionnaires could be helpful tools. A national efficient health information system is an utmost priority.
Topic 4: Significant gaps: Offering more specialized curriculums in the universities and providing relevant job positions at different hospitals. None of these points are available in Egypt nor in a prominent way in the MENA region.

Ms. Sally has highlighted the Priorities regarding the most interesting initiatives in Egypt

Takaful and Karama Cash Transfer Program:

1. The Takaful and Karama program is implemented by the Ministry of Social Solidarity and has covered to date 2.26 million households which amounts to approximately 9.4 million individuals, or approximately 10% of Egypt's population.
2. Part of the program aims to protect Egypt's poor elderly citizens above 65 years of age and citizens with severe disabilities and diseases as well as orphans.
3. These vulnerable citizens receive a monthly pension of 450 EGP with no 'conditions'. The original pension amount was 350 EGP but recently got increased to 450 EGP to enable beneficiaries to cope with price hikes.

Middle East and North Africa Research on Ageing Healthy (MENARAH) Network

1. (MENARAH) Network was established in 2020 to raise awareness and mobilize research related to population ageing in the region.
2. The MENARAH network aims to pave the way for countries within the region to contribute to these regional and international developments. There is a need for building capacity at different levels and across various stakeholders including the academic body; policymakers; the market as well as awareness raising of the public.
3. It is paramount to facilitate further constructive dialogues to establish clear and multi-sectorial plan of action that is able to facilitate an active role of the

family, older people, the third sector and the state within a coherent, integral and holistic approach.

Sekem Elderly Care Model:

1. The Elderly care booklet and the software for collecting patient's history in a specific database are formulated as part of the geriatric care system in Sekem Medical center.

This initiative properties:

1. Focus on people aged 60 years and older, who live in their own homes alone or with a caregiver.
2. Focus on elderly who have multiple health and social care challenges.
3. Focus on elders with disabilities.
4. Address older people's multiple needs (not only diseases or health problems).
5. Involve professionals from multiple health and social care disciplines working in multidisciplinary teams (e.g. nurses, social workers, pharmacists, dieticians, general practitioners);

Ms. Saly has concluded that

- all general practitioners must have basic knowledge of ageing related health issues and are able to refer to specialist physicians. Geriatric specialized health care must be available at high standard and accessible to all regardless of income of socio-economic status.
- A Full understanding of health ageing among older people and their care givers. More importantly the availability of opportunities to make elders remain active both mentally and physically.
- Models from other countries, such in Turkey, with open gyms targeting older people and public acceptance could be replicated.
- Care agencies (both home and residential care) to be subjected to quality assurance measures.
- Care workers to be registered and subjected to background checks.
- Local authorities to be involved in the process. Better coordination between training institutions and employment agencies and care providers.

Lebanon

Second presentation was by PP7 Ms. Lea El Korh from Lebanon. The Delphi Process in Lebanon was organized in two rounds of online surveys to a total of 16 participants in round 1 and 12 in round 2 (so far). The first round helped in identifying the main themes and priorities and the second allowed the prioritization and validation of information.

Participants were from different backgrounds: Non-Governmental, Governmental, Medical, Paramedical, Private Organizations, Academic, Social. 4 Marco-management, 8 Meso-managemnt, 4 Micro-management

Ms. Lea has highlighted the Priorities regarding the current state in Lebanon

1. Health coverage and health services utilization
2. Financial security
3. Food security and malnutrition
4. Capacity building of staff working in old age
5. Protection of human rights of older adults (through laws and legislations)
6. Social security for old age
7. Emergency Preparedness
8. Empowerment of older people (social/activities, educational/trainings and financial/jobs)
9. Comprehensive and equitable retirement plans and pensions
10. Support of nursing homes (comprehensive services including rehabilitative, preventive, and curative services.)
11. Home-based and family-based support and care
12. Primary care development
13. Social inclusion activities and support
14. Involvement of older adults in their plan of care/ participatory approach
15. Listening to the needs of older adults
16. Empowerment of older women in particular
17. Infrastructure and friendly facilities/cities/transportation for old age
18. Networking and collaboration between stakeholders dealing with older adults (private and public)
19. Old age research development
20. Preventive care development
21. Stigma related to old age and cultural issues

Priorities regarding the desired state in Lebanon

1. Comprehensive health coverage and health services utilization
2. Legislations and laws for protection of human rights of older adults
3. Social security for old age
4. More empowerment of older people (social/activities, educational/trainings and financial/jobs)
5. Comprehensive and equitable retirement plans and pensions
6. Home-based and family-based support and care
7. Listening to the needs of older adults
8. Infrastructure and friendly facilities/cities/transportation for old age
9. Networking and collaboration between stakeholders dealing with older adults (private and public)

Priorities regarding the Gap in Lebanon

1. Infrastructure and City Planning (Elderly friendly)
2. Comprehensive Old Age Care (Health, Financial & Social)
3. Governmental Support and Resource Allocation
4. Research, Data Collection and Development

Ms. Lea has highlighted the Priorities regarding the most interesting initiatives in Lebanon

1. National Strategy for Old Age Care (including basis for old age care, financial & social support, retirement, pension plans and safety nets)
2. Disease Management Programs for Conditions Related to Old Age (Alzheimer's, Dementia, Chronic Diseases, Terminal Illnesses requiring Palliative Care,...)
3. Laws and Regulations Related to Old Age
4. Emergency Plan for Old Age
5. Centralized Unit for Old Age Affairs and Programs
6. Elderly Friendly Cities
7. Governmental Support and Services
8. Community Mobilization and Partnerships with Municipalities
9. Advocacy with Policymakers and Legislators
10. Awareness programs: schools, media, community and professionals
11. Intergenerational Activities and Programs
12. Social and Financial Support Initiatives (work, volunteering opportunities, social activities)
13. Training and Capacity Development of Staff and Professionals working with Elderly Senior Citizens Programs and Benefits

Ms. Lea has concluded that Priorities for Lebanon's older adults are related to the following themes: Health; Financial; Legal; Social; Retirement; Infrastructure; Emergency planning; Training; Education; Networking; Empowerment

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Tunisia

The floor was given to our Tunisian partners PP5 **Dr Jalila El. Ati**, **& Dr. Hajer Aounallah-skhiri** Association Partner.

Currently they developed the first round of the Delphi Panel, the **list of stakeholders participating in the 1st round of Delphi survey** consists in: Macro management (6 different governmental stakeholders); meso-Management (5 Different Civil Society institutes); micro-Management (9 stakeholders include Hospitals, Faculties and private institutes).

The following priorities emerged from the responses in the first round of Delphi survey in relation to the social model of care for the dependent elderly and/or at risk of social exclusion:

- **Regarding the current state**
  1- Economic security issue, in particular for those at risk of exclusion.
  2- Problem of social security.
  3- Geriatric care offer (availability and accessibility to specialized care facilities, qualified health care providers).
  4- Problem of autonomy.
  5- Environmental problem unsuitable for the elderly persons.
  6- Social exclusion (lack of spaces favoring extra-domestic activity).

- **Regarding the desire state**
  1- Develop quality of care offer (develop geriatric services, consultations...)
  2- Develop a geriatrics as a specialty.
  3- Promote primary prevention and control of NCDs (non-communicable disease)
  4- and dependency.
  5- Reinforce social security (home care/adequate needed equipment)
  6- Adapt social security laws for elderly care.
  7- Provide integrated multidimensional care (health, social, ethical) for elderly (comprehensive bio-psycho-socio-economic approach).
  8- Establish a dependency insurance system in the same way as disease or work accident insurance for effective care at best in the family environment or if necessary, in an institution.

- **Regarding the gap**
  The majority of stakeholders recognize the existence of huge GAPs
  1- Only 10 to 15% of the objectives were achieved or far away or need for 10 y for information and training.
  2- Monitoring and evaluation of the existing programmers are shortcomings.
  3- Database on depend elderly persons and/or at risk of exclusion is shortcoming (number, location).
  4- Lack of respect of norms within accommodation centers (services, hygiene, ethic) and communication with elderly persons.
  5- Insufficiency of legislative framework, weakness of its application and ignorance by elderly persons.
  6- Health care and health facilities are not sufficiently adapted to vulnerable elderly people.
  7- Nursing staff are not sufficiently trained to assure elderly care.

Dr. Hajer has elaborated on the most interesting initiatives in Tunisia, the most important of them were undergoing until now are:

1. Family placement: This programme is based on giving foster families monthly pension to accommodate dependent or excluded elderly persons.
2. Homecare financing: Family assistance is provided in cash to facilitate home care of elderly and dependent people.
3. Daytime clubs: which offer for elderly persons leisure activities, meetings and social communication.
4. Multi-disciplinary mobile teams: to provide elderly homecare.
5. Institutional Care: for elderly with creation of 12 public and 19 private centers for elderly care.

   Example: Homecare financing:

   Main axis of the national social program of assistance to needy families.

   1- Assistance is provided in cash (200 TND = 65 €) to facilitate homecare for elderly and dependent people.

   2- Other resources and help are allocated to facilitate the medical and social follow-up of elderly people at home and avoid or reduce the hospitalization periods, e.g. aid in-kind, social worker assistance at home, free care in public hospitals, and domestic help.

   3- Multidisciplinary mobile teams made up of medical, paramedical and social staff are working in each governorate to assure vulnerable elderly needs through this program.

   For these initiatives we can highlight the following strengths and weaknesses:

- Strengths:

1. Involvement of the government.
2. Maintaining of aged persons within their living environment.
3. Preserving of family and strengthens the fabric of families and communities.
4. Protection of elderly against exclusion, marginalization and discrimination.

- Weakness:

1- Issue of human resources and financial availability.
2- Depends on both political and civil society willingness.
3- Monitoring and evaluation system is shortcoming.

Greece

Ms. Salma Essawi Thanked Dr. Hajer for her presentation and gave the floor to our Greek Partners PP4 Dr Eleni Ferentinou, Clinical lead psychologist T.E.C. “Merimna”, Patras, Greece

Dr. Eleni, has started by **Delphi process description conducted in Greece** that consisted in two rounds of Online questionnaires, where there were invited participants are still

filling the questionnaires in (number of successful participants so far is 15 and 12, and 45 more are invited). The results of the process presented today will keep being adjusted according to the feedback from more replies coming in:

- First round: Identification of main problems and priorities that need to be tackled.
- Second round: Validation of the information and setting priorities on each problem identified on the first round.

Regarding the profiles of the participants, they were Policy makers and regional government bodies (e.g. Regional policy office of Western Greece, 6th Regional Health Office); Local executive administration (municipality health offices); Representatives from open health care centers and institutions (e.g. Geriatric and Gerontology Association, University Hospital of Patras); Health care and therapy providers (Public and private sector) (e.g. Therapy clinics, Open Health centers, old people's care homes); andHealth Professionals working in the health sector (e.g. Medical doctors, social workers, psychologists).

- **Priorities regarding current state in Greece**
  1- Need of adequate primary Medical care and health coverage.
  2- Targeted training for Health professionals.
  3- Health care services that are home-based and family-based.
  4- Inadequate social benefits.
  5- Much needed government intervention for laws and policies for social care.
  6- Need for research and assessment (resources and funding) regarding the population group.
  7- Minimal social activities for elderly.
  8- Much needed support at home and in the family.
  9- Empowerment of the elderly and abolishing the stigma related to old age.

- **Priorities regarding desired state in Greece**
  1- Adequate Medical Care, Comprehensible health coverage and services utilization.
  2- Home-based and family-based support and care.
  3- Social integration / care outside (closed) institutions.
  4- Increased state intervention and adequate financial resources / program funding.
  5- Improving the quality of life of the elderly (physical and psychological health).
  6- Covering psycho-emotional needs.
  7- Continuous assessment and recording of needs.
  8- Adequately trained staff through University curricula and CPD programs.
  9- Enhancement of tele-tools and technological familiarity.

- **Priorities regarding the gap in Greece**

The gap between the current and the desired state in Greece appears to be chaotic. All of the issue presented were deemed of being far from the desired state. The need and immediate intervention is apparent for:

- A reform in the Health care system for adequate medical care to vulnerable groups, such as the elderly. (focus on geriatric medicine, specialized geriatrics courses and syllabi that focus on prevention).
- Research and assessment bodies that can gauge the situation and needs at any given time.
- Development of adequate social care policies and measures to abolish social exclusion.
- Psychosocial needs to be met in a number of ways.
- Development of technological tools and training of careers and elderly citizens that would make their everyday life easier.
- Education of the elderly population, Their families and careers on healthy habits and changes in their lives.

Dr. Eleni has identified the Priorities regarding initiatives in Greece

The implementation of the initiatives needed to be taken should begin with the cooperation government bodies and policies. The priorities include:

1- A national strategy for a reform on the elderly care (legislation, better pension schemes and benefit plans, social care models and structures).
2- Introduction of research and assessment bodies to promote a deeper and more organized evaluation of needs.
3- Better cooperation and communication of local policy and executing bodies.
4- Dialogue with health services for the elderly and recommendations to policy makers for new targeted programs, and restructuring/ financing of existing programs.
5- Partnerships with municipalities for the organization of empowerment programs for the community and senior citizens, and ways of including them to social and volunteering events.
6- Better training programs for staff, family and individuals (medical professional trainees, general population).
7- Focus on psycho-social health and introduction of new bodies, such as psychological support teams in and out of already established institutions.
8- Model recommendations for better state intervention and care.
9- Creation / strengthening of structures that will meet the needs of the elderly.
10- Development of tele-tools and familiarization with technology.

Dr. Eleni has Concluded by Summarizing the responses of the participants, three essential goals have been distinguished:

- A well-rounded and holistic assessment of need, so that
- A future implementation of an organized and targeted intervention of the policy bodies is meaningful,

- Towards an adequate social care model that:

1. Supports the elderly sufficiently in the long run.
2. Has a long term goal of abolishing management and
3. Promotes the inclusion of the elderly in the society.

Always with respect to the uniqueness of the population group of the elderly.

Spain

The last presentation in Delphi process and its outcome was for the **Lead beneficiary Spain and it was presented by Dr. Barbara Badanta**

Dr. Barbara started by highlighting the Characteristics of the participants from Civil Society, Public administration, Business, Research and education.Ms. Barbara has described the Delphi rounds conducted in Spain and stated that 54 invitations sent, for the second round 32 and for the third round 26 responses. In the first round, 64% were women, 18,4% from macro-management, 31,6% from meso-management, and 50% from micro-management; 23,7% from civil society, 21,4% from business, 7,9% from public administration, and 47% from research and education.

In the first round, through open-ended questions priorities were identified for the Social Care Practice in the Countries regarding the Principles/ theoretical basis, Legislation and norms, Economic aspects or finances, Target population, including educational aspects, Strategies and tools, settings and/or evaluation. In the second and third round, the list with all the priorities, after content analysis of the first round, were ranging with 7-likert scale ranging from 1 (not important at all) to 7 (extremely important). Except for the GAP dimensions that will assess how near we are from the desire state (the difference between the current state and the desire state) ranking from 1 (not near at all) to 7 (extremely near). Only items not accepted in the second round subject to new review in the third. They were categorized in the following emerging categories: Governance, Model Characteristics, Professionals and User and Family and according the following aspects: Current state, Desired State, GAP and Initatives.

Interquartile deviations (IQD) was used to assess the degree of consensus of the experts on the priority.

In the second round the priorities, according the experts are shown following table, highlighting the more important for them:

Governance

- **Current state: Territorial differences, Universal coverage problems and guarantee of rights**

- **Desired state: State agreement for attention, Accessibility, Integrated policies - long-term care promotion Universal access and rights coverage, Territorial equity,** User empowerment / participation, Public procurement
- **GAP:** Bureaucracy
- **Initiatives: State agreement and regulations; Universal and integrated coverage; Territorial equity; Public financing; Person-centred long-term care;** User participation; Raising awareness of social determinants and gender; Diagnostic studies; Social protection policies; Socio-educational interventions

Model characteristics

- **Current state: Home support is missing; Absence of medium-long stay centers;** Poor evaluation; Lack of public-private coordination
- **Desired state: Person centred model (biopsychosocial needs); Residential alternatives; Respect for rights and values; Promotion of autonomy; Gradual and flexible care adapted to gravity; Quality assessment; Interdisciplinary team; Make best practices visible; Prevention of abuse;** Home care; Integration of key agents in programs; Attention for medium-long stay; Quality versus business profit
- **GAP:** Professionalization of services
- **Initiatives: Person centred model (biopsychosocial needs); Scientific basis; Home care and professionalization of these services; Reform home care services; Collaborative space design; Residential alternatives; Intermediate care resources; Waiting list coverage; Eliminate bureaucracy; Free-clamping centers;** Primary health care – socialhealth care; Supply-demand adjustment; Portfolio-services protocols; Incorporation of ICTs; Coordination structures (socio-sanitary commissions); Model evaluation; Homogenize initiatives; Ethical considerations; Care cooperative

Professionals

- **Current state: Job insecurity;** Professional stigma; Need of training
- **Desired state: Favorable working conditions, recognition; Adequate professional-user ratio; Socio-sanitary specialization and professionalization;** Research
- **GAP**
- **Initiatives: Interdisciplinary teams**; **Specialization and training; Research; Improve working conditions; Adequate professional-user ratio;** Management specialization; Professional accreditation

User and family

- **Current state:** Greater needs as life expectancy increases; Fragility; Social isolation
- **Desired state: Personalized attention; User / family participation; Promote autonomy; Caregiver care;** Dependency as part of the life cycle
- **GAP**
- **Initiatives:Empowerment; Inclusion in integrative activities; Self-care promotion**

In the third round new priorities were reached by consensus:

Governance

- **Current state:**
- **Desired state: State Pact for health care; User empowerment / participation; Integrated policies; Active aging and palliative / long-term care promotion; Universal access and rights coverage; Accessibility: Territorial equity**
- **GAP:**
- **Initiatives: State Pact for health care; Universal access and rights coverage; Integrated policies; Territorial equity; Active aging and palliative / long-term care promotion; Social awareness;** State regulations on quality of services; Intergenerational solidarity; Social protection policies; Public financing

Model characteristics

- **Current state:** Lack of support to stay at home; Lack of medium-long stay centers; Public-private coordination
- **Desired state: Home care; Residential alternatives; Respect for rights and values; Active aging; Gradual and flexible care adapted to severity; Socio-health integration; Prevention of abuse;** Home care; Public and private coordination; Leadership of social agents and horizontal management; Companies audit regarding the quality of care; Model based on scientific evidence
- **GAP:**
- **Initiatives: Integrated and person / family focused care; Residential alternatives; Demand coverage waiting list dependency; Prevention of abuse; Reduce bureaucracy; Flexibility of care according to needs and severity; Professionalized home services;** Care quality assessment; Increase in residential places; Home care and local / community care; Primary health care: provision for social health care; Architecture of institutions similar to the user context

Professionals

- **Current state: Job insecurity**
- **Desired state: Improvement of working conditions; Specialization and professionalization; Social recognition; Adequate professional / user ratio**
- **GAP**
- **Initiatives: Adequate professional / usurious ratio;** Training; Research; Professional development

User and family

- **Current state:** Increased needs due to longer life expectancy; Social isolation
- **Desired state: Personalized attention**; **Promote autonomy**; **Family participation in decision-making; Caregiver care; Dependency as part of the life cycle**

- **GAP**
- **Initiatives: User / family empowerment**; **Development of integrative activities**; Self-care promotion

Dr. Barbara has concluded that According to experts a social care model should be based on the following:

Governance:

- State agreement
- Universal access and rights coverage
- Integrated policies
- Territorial equity
- Public financing
- Long-term care promotion
- User participation
- Social awareness

Model Characteristics

- Person centred model
- Active aging
- Scientific basis
- Reform home care services
- Professionalized home services
- Collaborative space design
- Residential alternatives
- Intermediate care resources
- Waiting list coverage
- Respect for rights and values and prevention of abuse
- Reduce bureaucracy
- Flexibility of care
- Quality assessment
- Make best practices visible

- Socio-health integration

Professionals

- Improve working conditions and social recognition
- Interdisciplinary teams
- Adequate professional-user ratio
- Specialization and training
- Research

User and Family

- Personalized attention
- Self-care promotion/ Autonomy
- Inclusion in integrative activities
- User / family empowerment and participation in decision-making
- Caregiver care
- Dependency as part of the life cycle

4

After Thanking Dr. Barbara on her presentation, Salma Essawi has launched the second poll in the meeting: What is your specialization field?
Social sciences 31%
Medical Care 54%
Politics 0%
Economics 0%
Other 15%

Present the TEC-MED first Draft model (LB)

It was then the time for Dr. Marta Lima Serrano from the Leader Beneficiary University of Seville, Spain **to present the theoretical TEC-MED Draft model. Dr. Marta has started her presentation by introducing the team that has worked on the model Dr. Ana Mª Porcel, Dr. Marta Lima, Dr. Barbara Badanta, Dr. Isotta Fadden, D. Silvia Silva, Dra- Elena Fernández, Dra. Regina Allande Sergio Barrientos .**

After that she gave an Introduction on the elderly population worldwide, 200 million in the world (12% of the world population) have reached or surpassed the health life expectancy (60 years). These figures will increase in the next three decades, where older than 60 years old will duplicate and octogenarians will quadruple. (WHO, 2020).

The higher life expectancy is as result of public health policies and of the socioeconomic development. However, elderly population is not always with good quality of life, showing fragility and dependence. (Brañas et al., 2018)

Over 50 million persons in Europe have more than one chronic disease, and over 100 million are at risk of poverty or social exclusion, which suppose an increase in health care spending to a 20% of country budget. (Eurostat Statistics Explained, 2018)

The countries of southern Europe, support to some of the oldest civilizations in the world, in addition to sharing cultural ties.

The current health crisis has highlighted the need to work towards a model that increases the capacities and competences of care providers related to elderly and vulnerability that can be incorporated into Social and Health Policies.

The TECMED research project of the ENI CBC 2014-2020 call addresses these challenges, developing a model of cross- cultural, ethical and social care for the dependent population in the Mediterranean basin. With an approach based on justice, privacy, confidentiality, gender, universal accessibility, active community participation and the values of the welfare state and governance.

Marta gave a deep overview on the **Scope of the document to** know which are the most promising social assistance initiatives for older people who depend on the risk of social exclusion in the countries of the European and Mediterranean basin through an extensive literature review. To recognize social care practices in each of the countries involved in the Project as well as their strengths, weaknesses, opportunities and threads through semi-structured interviews and SWOT analysis in the participant countries participants in the TEC-MED project. To analyze the Gap in the participant countries in the TEC-MED project through a Delphi panel.

With this all formative research together with a meeting with international experts from the Mediterranean Basis will be refined the Definition of the TEC-MED Intervention Framework to propose the TECMED Model. An Intervention Framework is the pillars that guide the construction of a model. A model is the way of understanding or interpreting these pillars or conceptual bases. Therefore, in this document, the pillars are first presented (Theoretical framework or metaparadigm) and then the pillars are interpreted with the TECMED vision (TECMED Model) to respond to the model's mission.

She has stated that the **Vision of the draft model is the** *Worthy care for the elderly*.

The **Mission of the model is to** *Serve as a catalyst to promote quality services based on a socio-ethical and cross-cultural model for the elderly in the Mediterranean basin*.

In the definition of the model we can difference the theoretical framework or metaparadigm that represents the distinctive domain with a unique perspective distinctive of others. Subsequently, the less abstract level, and more specific and explicit are the conceptual models (Benner et al., 2003).

In the TEC-MED Model the Theoretical Framework includes six dimensions (fig 1):

Figure 1. TEC-MED Model Theoretical Framework

Then she gave an in-depth overview on the TEC-MED model sections which include

- Subject of Care; it is highlighted that person is the center of care.
- Health and social care providers; with Inter-professional perspective
- Care environment service delivery; where the Physical and socio-cultural coordinated and integrated
- Governance; Steering and rulemaking must be focused in the person and integrated care
- Financing; Funding priorities at the political level and the government level
- Technology; Telemedicine, Electronic health records and other health and social platforms

Dr. Marta Lima has introduced the Theoretical framework levels TECMED model (macro, meso, micro) and transversal concepts of the model.

Regarding the model, she highlighted that the model should be Person centered integrated care focused. And she showed the key transversal concepts in more details as follows (fig 2);

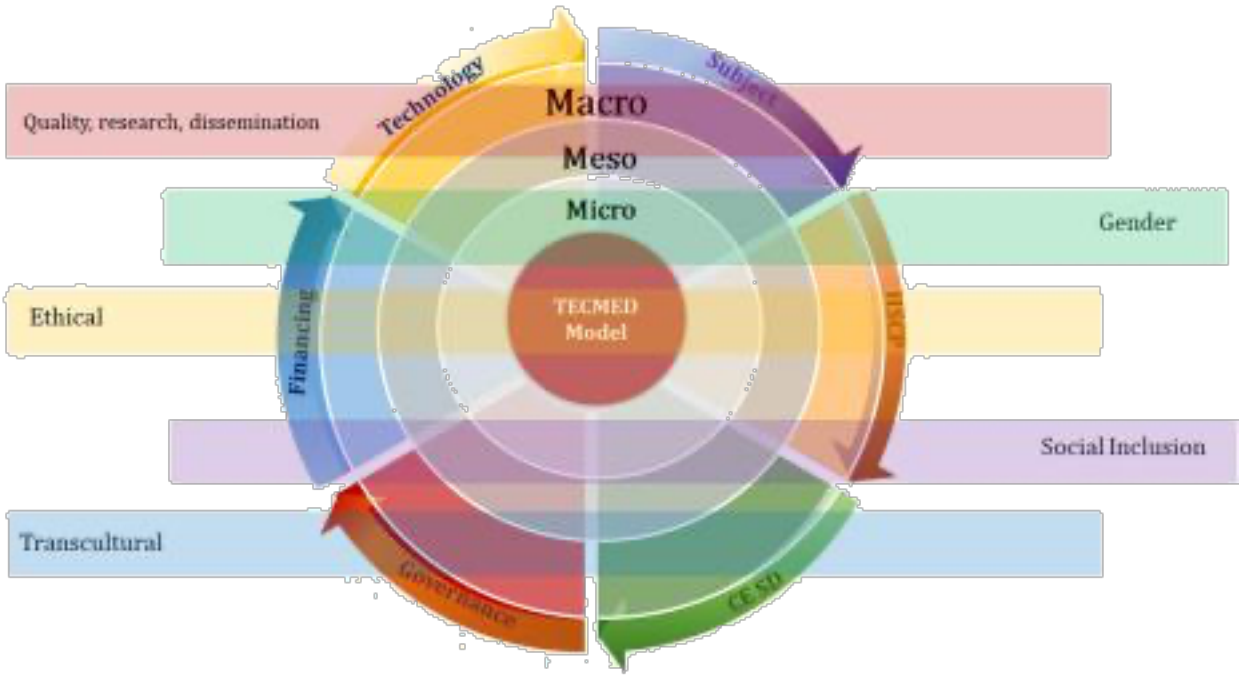

Figure 2 Theoretical Framework Level (macro, meso, micro) and transversal concepts of the model

- **Quality, Research, Dissemination.**
  Quality: Should be linked to aspects such as respectful human rights and dignity, person-centered, preventive and rehabilitative, available, accessible, affordable, comprehensive,

  taking into account the transparency, gender and the culture.

  Research-supported care aims to create new knowledge and /or the use of existing knowledge/ good practices in a new and creative way so as to generate new concepts, methodologies and

  understandings, all of which contribute to increased quality.

  Dissemination means sharing research/good practices results with potential users - peers in the research field, industry, other commercial players and policymakers and transfer.

- **Gender.**
  Gender refers to the roles, behavior's, activities, attributes and opportunities that any society considers appropriate for girls and boys, and women and men. Gender interacts with, but is

  different from, the binary categories of biological sex.

  Promoting equal economic independence for women and men, closing the gender pay gap, advancing gender balance in decision making, ending gender-based violence and promoting

gender equality beyond the EU.

- **Ethical**
  Autonomy as a right of a person to determine his or her own destiny; the beneficence as a way of doing good (not only just the client but also the family and the social and healthcare

  professionals); the justice as a way of seeking the sharing of benefits and burdens based on fairness and equality. When any of these ethical principles are overlooked, a person may be at

  risk for neglect or abuse.

  In addition, others bioethical principles are related with privacy and confidentiality and empowerment. (American Society of Aging, n.d; Rodriguez González, 2016)

- **Social inclusion**
  The capacity of a society to ensure the welfare of all its members, minimising disparities and avoiding polarization. (European Committee for Social Cohesion, 2004).

  Social inclusion is about having access to opportunities, options and choices in life and having the resources and appropriate support as well as the personal capacity, self-

  confidence and individual resilience to make the most of them.

  Older persons should be treated fairly and with dignity, regardless of disability or other status, and should be valued independently of their economic contribution (United Nations, 2002).

- **Transcultural**
  The transculturality is defined as the phenomena that result when groups of people, who have different cultures, make continuous first-hand contact, with consequent changes in the
  patterns of the original culture of one of the groups or both (Marrero, 2013).
  Transculturality does not necessarily imply a conflict but consists of a phenomenon of cultural enrichment.

Sensitive Health Care Model for explaining the linkage between the provision of patient-centered, culturally sensitive health care, and the health behaviors and outcomes of patients who experience such care (Tucker et al., 2011). The delivery of care that is cultural appropriate prevents unnecessary conflicts between clients and caregivers from varied cultural backgrounds.

- **TECMED Model I. Subject of care**

  Dependency: permanent status, derived from age, illness or disability, and linked to the lack or loss of physical, mental, intellectual or sensory autonomy. (Boletín Oficial del Estado, 2006).

  Social exclusion: can be understood as a number of social mechanisms leading to threats to the integrity and cohesion of the collectivity and challenges to the common identity of their members. (Vykopalová,2016).

  Elderly: Ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time. These changes are neither linear nor consistent.

  While some 70-year-olds enjoy extremely good health and functioning, other 70-year-olds are frail and require significant help from others (WHO, 2020).

- **TECMED Model: Health and social care providers (HSCP). 12:27 PM**
  - Multi and interdisciplinary teams including health and social professional, formal and family carers .
  - Clarity about each other's expertise, roles and tasks, from a transdisciplinary horizontal perspective (equity).
  - Workforce policy and planning focused in capacity building and training must be considered. The workers must be involved in the designing and evaluation of this policies.
  - The health and social workforce performance should be defined by: coverage, productivity, technical quality, service quality.
  - Financing and incentive for investing in workforce it is needed to assure the enough human resources.

- **TECMED Model: Care environment and service delivery (CESD). 12:28 PM**
  - Integrated social and health care responds to person needs and preferences, holistic perspective, a person-centred vision.

- Supportive environment with enough resources, material and human focusing in housing alternatives
- Maintain the people's autonomy, promote positive active healthy ageing (self-management/personal skills).
- Proactive health promotion and prevention, fight with the abuse, or neglect.
- Different services and institutions they must be perfectly coordinated, involving the community resources assuring the continuity of care.
- Periodical evaluation must be developed with measurement and analysis and results based in performance and outcomes indicators, financial performance and feedback (bottom-up).
- Principles such as safety, efficiency, availability, accessibility, continuity, affordability, transparency and sustainability must be taken into account.

- **TECMED Model IV. Governance**
  - Users and family members must participate in the design of policies to ensure that they truly meet the real needs.
  - Raising awareness of social determinants and gender.
  - Policies must have continuity over time, beyond political changes at the local or national level.
  - The management and availability of services and resources should be adequate to the needs of the population according to territoriality.
  - It is recommended that policies based on active and positive aging (WHO, 2002) and long-term care predominate.
  - Governance should include planning and management of needs assessment studies and quality assessment systems for policies and the care provided.

- **TECMED Model V. Financing**
  - To promote financing public, universal and transparency.
  - Transparent entrepreneurship concentrates on innovation, leadership responsibilities for performance achievement and joint financial agreements.
  - Bet on the inclusion of a social and solidarity economy (Askunze, 2013), sustainable human development, the feminist economy and the ecological economy, betting on "another fairer economy".
  - Some initiatives of the implementation are care cooperatives, social immersion companies, social currencies, time banks, barter markets, etc.

- **TECMED Model VI. Technology**
  - Digital social interventions should be accessible at a minimum via mobile devices
  - To support: population care, training, recording of the information, the alert notifications, communication and coordination, and for evaluating the quality of the care provided, and the policies (WHO, 2019).
  - Use of artificial intelligence and robotics to help older people manage and create a better and safer quality of life, allowing the management of activities in their environment and data management.

- Technological support for monitoring and sustainable assistance (sensors and devices that allow the gas to be closed, lights to be turned on or off, or air conditioning to be managed).

In summary the TEC-MED model is a person-centred integrated care model which consists in 6 dimensions of the theoretical framework, divided in three levels of managements and five transversal concepts.

Interactive "Group" Discussions

After 20 min break we started the "Interaction Group Discussion" **12:47 pm**

Ms. Salma Essawi has started the session by describing some ground rules for participants, and how to use the mic and raise their hands or even use the questions tab. Then she gave the floor to Dr Mohamed Salama the moderator of the session Dr Mohamed Salama Said : we need to Listen to experts to learn more and to know their feedback.

First intervention was from **Dr Shereen Hussein:** The founder of Minara initiative in Egypt reply: it is very interesting being part of this project and attended to see what you doing , we all know that southern European countries has strong social care model of elderly and that's links very well to our country to communicate. It was also interesting to see the communality between countries and maybe you need to hear more the voices of elderly themselves not only the higher level. To make sure we integrate that in our model. We aspire to have long term supporting to elders the reality of day to day practical, Availability of support to aging, Participation opportunity, to communicate more with old people themselves, We need to work more for care elders. We need highly level of integration. Dr Mohamed said that Dr Shereen involved in social care and care for elderly for long time in Middle East as well as in UK and in Europe. **Ms. Shereen Hussien**: to Draw well on what the kind common that element connect well and works well. She takes about problem of implementation and different culture of each country. And Look in different sections in our region and the presentation when they share the players and the integration of governmental and the element to connect.

Dr Federico Alonso: Director of agency Social services and Andalusia government, continues his intervention thanking to participate in this meeting, he also wants to highlight the importance of this activity specially after COVID 19 as In Spain more than 28% people retired many of this people don't have a care. The right of confidentiality and participate in decision-making process. Need high quality of care and he identified by ethical right. The digitate evaluation to monitoring in this process. More important to be autonomy respect.

Dr. Almudena Arroyo reply from Spain : In Spain there is no model for care elderly, depend on the Spain institution care but not from the people. Need autonomy and dependency. Covering the development of the person. Integrated approach for the person. The approach which we Need dynamic interventional model insert integrating to the community. Charity person in this area. The participate patient of people in organization of cooperation services. Economy dependency. Training to care elder. Dynamic flexible model to use. Particle model is very important. The weakness of the model related to culture of each country. And use the technology is very important, support of Public institution of social care

Dr. Jalila El Ati from Tunisia commented: we have some comments and some questions about this draft model:

First comment: the theoretical level the model and respect of the issue but the model doesn't highlight the specification of each country in the model care.

Second comment: the disability ruler for the elder we need to take to count in the model and in the media.

We need to highlight for implementation and sustainability of function model.

Within discuss with the team we didn't find the practical aspects model.

Dr Nadia Mansour from Tunisia commented, The model is comprehensive but she needed to take about implementation specially in our countries in economic crisis that is why she highlighted the prevision and promoting how the life styles more general population that will decrease problem of care and social intervention.

Ms. Pura Díaz-Veiga from Matia Instituto: First of all, she thanked to those responsible for this project for the opportunity to have participated. she believes that the TECMED Model that you propose includes the main keys that must be integrated into care for the elderly. It also seems to me that it can be very relevant in the current Spanish context. She does some suggestions for improvements: The first is related with ageism. I think that the TECMED model must consider the importance of beliefs and stereotypes associated with age at all levels. Ageism is present in our societies and in the current crisis it has been present in many decisions that have discriminated old people and have reinforced stereotypes based on a homogeneous and deficient characterization of old age. From this point of view, the TECMODEL should to include specific measures to promote a social image of aging, adjusted to the diversity of elderly people. My second suggestion is to promote the participation of the old people to contrast the lasts version of TECMED Model. I think it's important to include them in a proposal like this that wants to be inclusive and old people-centered. In the other hand, the profesional training is a an important topic to be considered in the development of Model. Most of today's professionals come from a healthcare model and have to acquire new skills with person-centered care

The next intervention comes from **Vicente Pérez Cano** and **Luján Japón Belmonte.** In Spain there is no style or model of care for the elderly. What we do is not based on the needs of the people but on those of the institutions, professionals, unions or the business, and is conditioned by certain paternalistic and overprotective nuances. These lines are a very brief reflection of a person-centered, more humane, and more efficient model that we have already experienced. Its keys are the following:

- From autonomy to dependency.
- Favoring the development of the person.
- Each person in the environment where he lives.
- With an interdisciplinary, integral and integrating approach to the person.
- With varied answers, adapted to the changes of each person.
- Counting on the participation of the elderly.

The approach we propose is a dynamic model of intervention, inserted and integrated in the community, carried out by a team of professionals who, with an interdisciplinary approach, responds to the needs of all the elderly in their environment, from before access retirement until the end of life.

People want to age in our environment and we have the right to choose where and how to age. This need can be met since in almost all towns and neighborhoods there are varied resources for the elderly: leisure and cultural resources, day centers, home supports, residences ... among other resources.

The key is that the needs are analyzed, in each town or neighborhood, as a team, and as a team the type of intervention most appropriate to each evolutionary moment of each person is determined. This way of working guarantees something very humanizing because the team knows each elderly person in their area and is dosing resources as needs evolve with agile, flexible and effective responses at all times. The participation of people in the organization and operation of services is fundamental in this model.

The different resources must be articulated, from autonomy to dependency, as part of an integrated whole so that people use a leisure, training or care center both at home and in Day Stay Units or residence. In addition, this is a dynamic and flexible model that allows rational and variable use according to the person's condition.

Ms. Emilia Barroso focus in the preventive perspective, promoting health ageing. Respecting of independency is very important aspect, Need to interconnection between 3 levels Marc – Meso- Micro levels because every other models concern only in micro level only.

Dr Mohamed Salama reply : We will start with the pilot and questionnaire in the first to transfer from theoretical model to practical.

Ms. Fatma Lassoued: Question: she join professor El- Ati, in the idea of disability between countries in Tunsia for example need for north Tunsia the same for South Tunisa and in this model she didn’t find the specific for the districts for cities.

Ms. Hajer Aounallah-Skhiri from Tunisa: We need to take into account the disparities according to area and to countries and economic and geographic and accessibility to have care to social care and we need to work in these aspects, and we need to implement, and when we do the pilot we need to take care about this aspects.

Dr George Karam from Lebanon: Move from theoretical step to be practical and he don't know what are we going because it is still very theoretical and we need to be more practical, and each country have specificity, and needs to fast start to be practical not to be theoretical.

Ms. Salma Essawi Said : that Dr. **Marta Lima** first draft model proposal is an overall theoretical framework , but actually after our today's meeting we have more the outcome of each country identified priorities , and the gap analysis which give us a clearer vision to proceed with the creation of the practical pragmatic TEC-MED model .**Dr. Marta Lima** agrees, more important that we found formal research and analysis, so in the next step is how to implement principle in the different country.

Ms. Salma Essawi: we need the partners to tell what the next step and how to put every thing on the table to will identify and to organize our work together, to reach the TEC-MED model.

Mr. Carlos Mirete considers that the model covers a wide and complete view of most areas involved in improving care. Key subjects are also well identified.The subject of care, as the centre of the model, is not only well identified but there is a chance of strength this message Is aimed through this holistic approach to all critical agents involved in care and in changing the content of how we approach care.

Regarding the weaknesses, the scope when we talk about the subject of the model. We should integrate rights as the way of measure every care approach. We should enforce the view of rights and the enjoyment of them considering autonomy and dignity and its relation to a life deserved to be lived in all actions we should take from now Macro-meso-micro levels are not consistent through areas. Although i acknowledge the differences among each of them, we should make a more consistent approach in every field. Cultural values should be better address, not only from the government side, but changing them.

How could it be improved? A focus on rights, cultural views and mores, and how the latter determines the former should have bigger presence Include "transdisciplinary" as a complementary approach to find new solutions

What are the main suggestions regarding the strategies for the implementation of the Tec-med model? Considering cultural change starting from behavioral changes in all of the 6 dimensions from ground levels to social levels (action at micro for changes in meso and macro) A focus in rights cultural view and find new solutions.

Sometime was given to Barbara and Lea to generate and conclude participants' comments, Ms. Salma Essawi has launched two polls

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Now, how much do you know about TEC-MED?
Nothing 0%
I think I know some data 46%
I think I know the whole story 54%

How did you know about TEC-MED? **13:46 PM**
Our emails 6%
Social Media 0%
Press release 4%
Colleagues 90%

Interactive Discussion Conclusion

Dra. Barbara has concluded and shared some general idea for all questions. They are paternalistic models, focused on the needs of institutions, professionals, or business.

The characteristics of a good model of social care must consider the rights of the person, take into account the person in a unique way, with their environment, family, dignity and culture. Also the model must promote autonomy, active aging, the person should remain in her environment and home if the person wishes, even to die at home, the team of professionals must be interdisciplinary. Social and health care must be humanized, be more integrated to provide quality care, respecting the dignity of the person and the right to receive information. The needs must be covered taking into account the differences according to territories, neighborhoods and others.

It is important to integrate the views of older people, informal caregivers and technical professionals in the development of the final model. In some countries with economic and political problems, it is very important to detail how the actual implementation of the model will be possible. Investing in social capital is crucial. We must clarify how we are going to overcome socioeconomic disparities, accessibility barriers, etc. For example, from Tunisia and Lebanon, they propose to include and discuss more practical aspects of the model.

Some participants propose a better connection or coordination between the macro, meso and micro levels.

Ms. Lea has added : few points regarding the improvement : Participant gave important feedback during common elements and working well in different countries and adapting to the local context so we can start by a pilot and important interventions at different levels so as not have too many points to implement and to be not able to deliver more, and the importance of having practical steps to move forward and to take in the account the dynamic in different levels specially in 6 dimensional in the theoretical model .

Break from 2:00 PM to 3:30 PM

Steering Committee. From 3:30 PM to 4:17

Participants: LB, PP5, PP7, PP8 and PP9.

Dr. Sergio gave a brief introduction of the Meeting of what is expected next, that must be the inclusion of new proposal to improve the model and to do it more operative. This should be included the following aspects:

- Attention to the needs of the population: physical, psychological and social needs, non-marginalization, promotion the inclusion

- To promote legislation and laws for the protection of human rights of older adults

- To promote the geriatric specialised health care available at a high standard and accessible to all regardless of income or socioeconomic status

- To promote healthy ageing

- To improve care attention for elderly people with centres subjected to quality assurance measures and the improvement of training of the health and social care providers.

Other aspects that we want to highlight are:

- Coverage

- Financial matters

- Incorporation of technologies

- Coordination and cooperation

- Research

- etc.

- Importance of the incorporate of experts in different points of our project development. Opinions have been very interesting and they have incorporated some points of view such as:

- There is no unified model of care for the elderly.

- The characteristics of a good model of social care must consider the rights of the person, take into account the person in a unique way, with their environment, family, dignity and culture.

- It is important to integrate the views of older people, informal caregivers and technical professionals in the development of the final model.

- Better connection or coordination between the macro, meso and micro levels.

He asked Salma Essawi as the work package leader to start preparing the technical model gathering information from all activities that has been done so far. Salma Essawi as a leader of our activities in this work package coordinate the activity too , We share all suggestions by email later which consists in to divided the different dimensions by countries in order they can be improved and operationalized; later we will have a new Steering Committee where the Model will be reviewed again by all the partners to prepare the final version of the TEC-MED Model.

Then an open discussion was allowed to all partners to Discuss the step forward in order to create the TEC-MED model. Marta has talked about finalizing our target and finish Delphi rounds as soon as possible. Tunisian Team suggest finishing these tasks within 2 weeks for the sake of including high profiles stakeholders. Finally, one week was given to finish this task. And we must have action plan and work in parallel to finish the Model as all other activities of the project based on it.

A group photo was taken in the end.

Thank you

Salma Essawi

GROUP Photo


Ana María Porcel Gálvez
Georges Karam
ASRT EG
Jalila EL ATI
Saly Sami
Dr. Mohamed Salama

Annex1 Meeting Agenda

TEC- Med Social-care Cross-Cultural Model (TEC-MED Intervention Framework)

Date: Monday 29th June 2020 – 9.00am to 14:15 - **All times are EET (GMT+2) (for all participants)**

9.00 to 16.30 (for Project Steering Committee)

Programme

Plenary Session (Morning)

Link to the Meeting Room: https://attendee.gotowebinar.com/register/8233018131759505935

9.30am: Welcome & Ground Rules
9.40am: Plenary Session – Setting the Scene

- Introduction: How will the outputs from the workshop feed in the process of preparing the TEC-MED first draft model (PP8)
- WP3: Overview (PP8)

10.00 -10.20Activity of Analysis of the most promising Social Care Initiatives. (LB)

10.20-10.40 Analysis of Current Social Care Practices in 6 participating countries (PP7)

10.40-11.00 Break

11.00-12:10 Success of Delphi process & Gap analysis conducted in each country (PP8).

Delphi GAP introduction (PP8): Introduction+ methodology

- Egypt (PP9)
- Lebanon (PP7)
- Tunisia (PP5)
- Greece (PP4)
- Spain (LB)

12:10-12:30 Present the TEC-MED first Draft model (LB)

12.20-12.45 Break & Reflection
12.45-14.00 Interactive "Group" Discussions

(Dr. Mohamed Salama, Moderator /Rapporteur, Barbara)

- What are the strengths/ weaknesses of the TEC-MED model?
- How could it be improved?
- What are the main suggestions regarding the strategies for the implementation of the TEC-MED model?

14.00-14.15 Wrap-Up, (PP7)
End of Meeting

14.15-16.30(Closed meeting) Steering Committee

14.15-15.30 Lunch Break and Reflection

15.30- 16.30 Steering Committee for conclusion about the Creation of the TEC-MED Model & The Next Steps.

Link to the Meeting Room: https://attendee.gotowebinar.com/register/8233018131759505935

LEAD BENEFICIARY:

PROJECT PARTNERS:

PP=Participant partner

LB=Lead beneficiary