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

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WP6 TEC-MED Project:
COMMUNITY BUILDING, STAKEHOLDER ENGAGEMENT AND CAPACITY BUILDING

Capacity building plan Final Report

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"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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Cooperating across borders in the Mediterranean

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TEC-MED

TEC-MED Model: Capacity Building Plan in Spain

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ÍNDICE

1. INTRODUCTION

1.1. Project and TEC-MED Model

The TEC-MED socio-ethical and cultural model is based on comprehensive person-centred care. A foundation of person-centred integrated care is a holistic understanding of the person's health and well-being, abilities, self-management skills, needs, preferences, and direct socio-economic environment. The health of an individual not only includes the entire spectrum of physical, mental, and social well-being, but also the ability to adapt and self-manage. Resilience and ability to cope and restore balance are also part of this broader definition of health (TEC-MED d, 2020). Therefore, the TEC-MED model is an integrated model, person-centred, oriented on 6 dimensions (Subject of care, Health and social care providers, Care environment and Service delivery, Governance, Finance and Technology), on three levels of management (macro, meso and micro) and 5 transversal keys (Quality, research and dissemination, gender, Ethics, Social Inclusion, and Transculturality) (fig.1) (TEC-MED e, 2020).

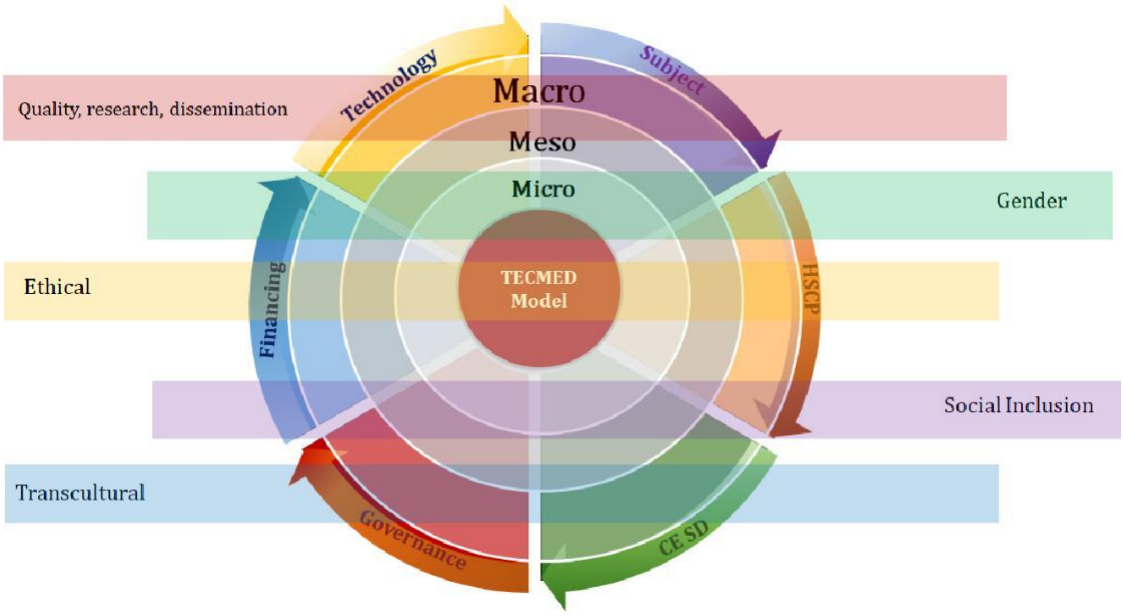

Fig. 1 TEC-MED Model. Theoretical framework.

The dimensions of the frame are described below (TEC-MED d, 2020):

1. *Subject of care*: the subject of care of the TEC-MED model are people over 65 years of age in a situation of dependency or at risk of social exclusion. The person is the subject of assistance and must be placed in the centre of the system. Her needs should be the starting point of the care process. Furthermore, the person is not (only) a patient or client of health or social care, he is a person who lives a life connected with other people in her social environment. In the same way, the family, social resources, and community networks can be considered objects of attention and care.
2. *Health and social care providers*: Health and social care providers are essential for the person to achieve a better state of health and well-being. They must focus on the person with an integrative, multi and interprofessional perspective. For a good and efficient performance focused on quality and user results, it is necessary that sufficient resources are available (number, diversity, skills, good remuneration, balance, and stability over time of workloads). Professionals must have a training approach in the development of capacities from an interprofessional perspective with equality in the treatment of all workers, they must participate in decision-making processes, and they must develop guidelines of attention to guarantee the quality of the Attention.
3. *Care environment and Service delivery*: The context where care is delivered refers not only to the physical environment, which includes accessibility and accommodation (including services, cleanliness, without architectural barriers), but also to the conditions in which care is developed, including the social environment, psychological and human aspects (humanization), hospitality, warmth, affection, response to the needs of the person and, among other topics. Care can take place in their own homes, daily facilities, home care and other community resources, including family needs, should be considered as the context of intervention. On the other hand, the ability to provide quality and effective services is related to having a system centre that serves as an entry point for the care subject.
4. *Governance*: Governance is the process by which social care organizations ensure good service delivery and promote positive outcomes for people who use services. It consists of a wide range of governance and standard-setting functions carried out by government officials. Governance is aimed at developing implementation and change strategies adapted to different care settings and contexts in Europe and the Mediterranean area.

5. *Financing*: Financing is the economic support system of any model. The possibilities are public, private, mixed, or non-profit. This term includes the financial and accounting system, financial sustainability, financial performance, and other matters related to financial matters. This term includes funding priorities at the political and government level.
6. *Technology*: Technology refers to the online support to record information and store it. The roadmap, tools, reports of lessons learned, scientific evidence and good practices can be stored on the technology platform. The technology can be used to train stakeholders or health care providers. In addition, it must be developed under the values of ease of use, availability, and accessibility.

A dignified care for the elderly provides a dignified and positive aging process (PDE), which applies the logic of management procedures to intervention. The principles and criteria constitute the ethical and transversal framework, constituting the basis of the TEC-MED model and are based on universal values that promote the dignity of the elderly, active aging, and long-term care. Therefore, the interrelation between theory and practice in the intervention is the key to the development of the model, defining the actions at three levels of management, that is, macro, meso and micro (TEC-MED d, 2020):

Macromanagement: Macro refers to the government, political or legislative level in the public administration that provides social care services (may include policy makers and other stakeholders).

Meso-management: It refers to the organizational level such as local government or healthcare management in the hospital, nursing home, etc.

Micromanagement: It refers to the individual level, including people at a professional or non-professional level who provide health and social assistance.

As previously mentioned, the TEC-MED 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 (TEC-MED d, 2020):

Quality: It must be linked to aspects such as respect for human rights and dignity, centred on the person, preventive and rehabilitative, available, accessible, affordable, comprehensive, considering transparency, gender, and culture.

Research: Research support aims to create new knowledge and use existing knowledge good practices in a new and creative way to generate new concepts, methodologies, and understandings, so that they contribute to higher quality.

Dissemination: It refers to sharing research results and good practices with potential users in the field of research, industry, and with commercial and political actors.

Gender: This is about promoting equitable economic independence for women and men, closing the gender pay gap, promoting gender balance in decision-making, ending gender-based violence and promoting gender equality beyond the EU.

Ethics: This concept refers to autonomy as the right of a person to determine their own destiny; charity as a way of doing good (not only for the client, but also for the family and professional social and health care); justice as a way of seeking the distribution of benefits and burdens based on equity and equality. When any of these ethical principles is ignored, a person may risk neglect or abuse. Furthermore, other bioethical principles are related to privacy and confidentiality and empowerment.

Social inclusion: According to the European Committee for Social Cohesion (2004), social inclusion is the ability of a society to guarantee the well-being of all its members, minimizing disparities and avoiding polarization. It's about having access to opportunities, options, and choices in life and having the right resources and support, as well as personal capacity, confidence, and individual resilience. Older people should be treated with fairness and dignity, regardless of their disability or other condition, and should be valued regardless of their financial contribution.

Transculturality: Transculturality consists of a phenomenon of cultural enrichment. The sensitive health care model to explain the link between the provision of patient-centred and culturally sensitive health care is based on a provision of care that is culturally appropriate, avoiding unnecessary conflict between users and caregivers of diverse cultural backgrounds.

1.2. Protocol of the development of the Capacity Building Plan

The earlier references in the literature about the training plan are from the early 1990s, by the UNCED (United Nations Conference on the Environment), which suggests that the promotion of training "encompasses human capacities, scientific, technological, organizational, institutional and resources of the country "(UNCED, 1992 in TEC-MED c, 2020). Subsequently, capacity building moved to a “more participatory mode” and evolved in the policy discourse towards community capacity building, whereby “Community” we mean a “specific groups and networks of groups that are organized around specific topics, not always delimited in a spatial context” (TEC-MED c, 2020).

The main objective of capacity building is to empower communities (or stakeholder groups representing communities) to define, assess and act on the issues they consider relevant, and to anchor health and social programs in a sustainable way within of the community. This main objective can be achieved through the following specific objectives in line with the theoretical framework and dimensions of the TEC-MED care model and the main transversal axes: quality, research and innovation, gender, social, transversal and ethical inclusion (TEC -MED c, 2020):

- Empowering elderly people and families, and developing elderly education by social, cultural and technological support, including self-care techniques, the learning of new skills and digital competence. (*Dimension 1 - Beneficiary health and social care and Dimension 6: Technology*);

- Training workforce policy and planning with a focus on education and capacity building plans aligned with national health and social care plans. (*Dimension 2 - Health and social care providers*).
- Providing adequate training programs for staff and caregivers with a focus in social care, the basis of the TECMED model; promoting capacity building and training programs to develop skills to working in multi and interdisciplinary teams that includes health and social professionals and caregivers. (*Dimension 2 - Health and social care providers*).
- Strengthening the quality of health and social service delivery on the basis of an integrated social and health care that responds to person and family's needs and preferences, holistic perspective and person-centred vision. (*Dimension 3 - Care environment and service delivery*).
- Enhancing the proactive health promotion and prevention, fighting with the abuse or neglect in the health and social services as well as a supportive social and physical environment with enough resources, material and human focusing in housing alternatives (*Dimension 3 - Care environment and service delivery*)
- Rising awareness of the importance of the quality of a governance that uses a bottom-up perspective to approach the elderly care from a perspective based on active and positive aging, long-term care and that approaches the gender and social determinants of health for establishing the systems of care to elderly dependent people and/or at risk of exclusion (*Dimension 4- Governance*).
- Rising awareness of the importance of financing for developing and socio-ethical and transcultural care, also focus on the importance of public and universal funding, the quality and the transparency, and investing in enough material and human resources (*Dimension 5- Financing*).
- Promoting the use of digital social intervention 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 (*Dimension 6- Technology*).

According to a review of literature, several models conceptualized community capacity relative to social and health-determining factors and conditions. The simplest and frequently used model is based on nine domains to build community capacity [3,11,17]. The nine domains of community capacity are: 1. Participation; 2. Leadership; 3. Organizational structures; 4. Problem assessment; 5. Resource mobilization; 6. Enhances critical awareness/reflexivity; 7. Links with others; 8. Role of the outside agents; 9. Program management (Labonte & Laverack 2001; Strobl, Brew-Sam, Curbach, Metz, Tittlbach, Loss, 2020; Goodman, Speers, McLeroy, Fawcett, Kegler, Parker, Smith, Sterling, 1998).

This domain approach can be used within the context of a program to better plan and implement community capacity development. Likewise, according to the Capacity protocol, the training evaluation process focuses on covering the following activities (UNDP, 2008):

- Involve stakeholders.
- Clarify objectives and expectations with primary users.

- Adapt the assessment framework to local needs.
- Determine the approach to analysis and collection of data and information.
- Determine how to conduct the assessment (equipment, location).
- Plan and estimate the cost of the capacity assessment (based on equipment composition, design, and duration).

1.3. Stakeholders, networks, and key agents

The following areas of interest for the community have been evidenced: the public (health administration), social, research, business, and administrative sectors, as well as civil society, known as community helices (Fig. 2) (TEC-MED d, 2020).

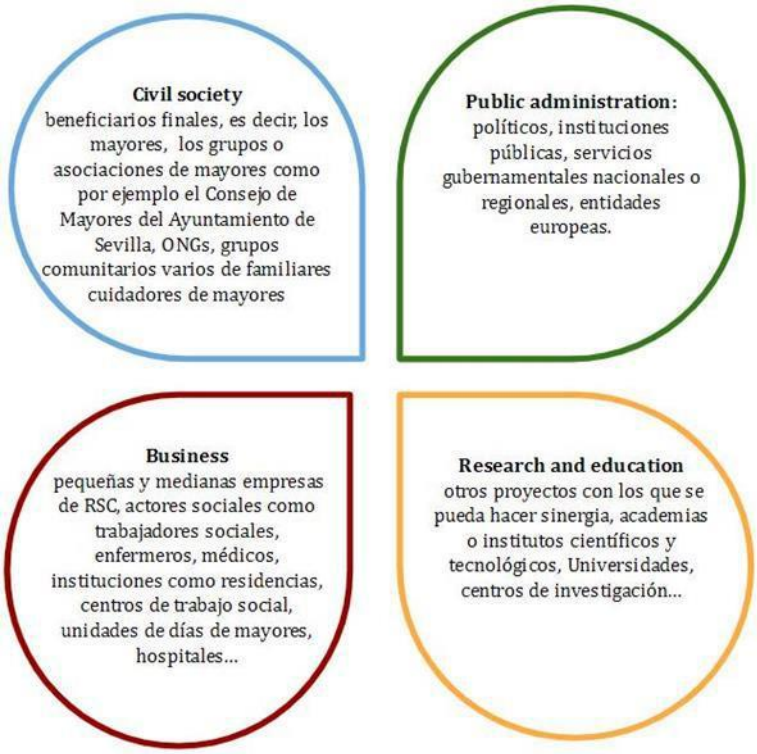

Fig.2 3 Quadruple Helix. Source: Carayannis & Campbell (2009).

Considering this approach, the following stakeholders have been identified:

I. *Final beneficiaries*: People over 65 years of age, dependents and/or at risk of social exclusion who require social and health care.
II. *Non-professional caregivers*: Individuals who dedicate themselves individually to the care of the elderly in an unpaid way, dependent and / or at risk of social exclusion (e.g., family members).
III. *Health professionals*: Socio-health personnel who dedicate themselves in a professional and paid manner to the care of dependent elderly people and / or at risk of social exclusion.
IV. *Health services companies*: Private companies dedicated to caring for the elderly.
V. *Community groups*: associations, foundations, dedicated to socio-health care:

VI. *Public administrations*: Public entities that are dedicated to the care of dependent elderly people and / or at risk of social exclusion through the creation of public care services and policies.

VII. Research and education: The centres of knowledge and university education that are dedicated to care, and in particular to care for the elderly.

1.4. Protocol of the Detection of training needs in Stakeholders and Target Groups. Workshop - February 3, 2021.

On February 3rd 2021, took place the Workshop: "*TEC-MED Model: Detection of training needs in Stakeholders*"" (Annex 1), in which more than 50 people belonging to the target groups participated and in particular:

Final user: dependent elderly person and/or at risk of exclusion. Non-professional caregiver.

Health Professional.

Manager of a socio-sanitary operating company. Community group: associations, foundations. Public administration manager.

Research and education.

To detect training needs When we approach community training in relation to the TEC-MED model, we are faced with the question: what do we expect our community capacity to look like?

The methodological technique chosen to detect training needs by promoting global participation is the ***nominal group***.

The creation of the Nominal Group technique is attributed to A.L. Delbecq and A.H. Van de Ven, and it became particularly well known in 1975. Delbecq and Van de Ven argued that the nominal group process consists of a structured meeting that aims to provide an orderly procedure for obtaining qualitative information from interested groups, who are associated with a specific problem or a specific area (Olaz, 2016). According to Huerta (2005), evaluation expert, the nominal group is a tool to obtain structured information, generating ideas in a stress-free environment, where the participants can express their ideas both orally as written.

The process is widely used in health, social service, and education institutions to maximize group participation in problem solving. The technique guarantees a balanced participation of all the people in the group, thus making the most of the knowledge and experience of each participant. **The nominal group is especially useful for identifying problems, establishing solutions, and setting priorities**, by determining the highest priority problems, deciding strategies to achieve needs, and designing quality community services, where the input of citizens is available. Compared with the focus group, it has the advantage that people of different social status can be recruited, the activity does not lend itself to the more extroverted or higher status members dominating the discussion.

The Nominal Group technique makes it possible to reach a consensus, and in a short time, on questions, problems, solutions or projects. It allows us to produce and prioritize many elements. Likewise, being a qualitative technique that encourages debate and participation, it allows avoiding sensations such as "losing" and "winning" among group members (Olaz, 2016). In this way, in the first part the opinion of the group is obtained through a debate among the participants and in the second part, the final result is the assessment of the problem with its priorities (Olaz, 2012).

The nominal groups of the Workshop were 7 and each group made up of 7 participants in relation to the **7 main profiles of interested groups**:

Final beneficiaries.

Non-professional caregivers.

Health professionals.

Health services companies.

Community groups: associations, foundations, dedicated to social and health care.

Public administrations.

Research and education.

In the seven work groups, 2 hours of duration, 2 questions were answered:

I. **What are the training needs of "each profile"?** (In each group the question will be presented with a different profile, for example: group 1- What are the training needs of final beneficiaries; group 2- What are the training needs of non-professional caregivers - group 3- What are the training needs of Health professionals, etc.).

II. **What strategies can be carried out to meet the needs detected, considering the Capacity Building protocol?**

In each one of the seven work groups, one person for each profile (7 people per group) participated, offering different perspectives thanks to different backgrounds, enriching the debate, and providing a complete vision.
The facilitators of the workgroups were members of the research team of the TEC-MED project. Preferably, in each workshop there were **two facilitators** encouraging the debate. They had to prioritize five answers for each question. The chosen priorities will be systematized to lay the foundation for the Capacity Building TEC-MED model.
Due to Covid-19, the Workshop will take place exclusively online, therefore, to facilitate the dynamization of each workgroup, technological tools will be used for the facilitation of an online survey in real time, through the *Blackboard* platform. Among other things, this digital platform allows users to carry out online surveys and create different work rooms, 7 seven for the parallel sessions and 1 plenary session.

The link and the questions of the workshop will be sent some days before the workshop in order to allow the participants to reflect on them.
Due to Covid-19, the Workshop took place exclusively virtually. To facilitate the dynamization of each workshop, the *Blackboard* platform was used. During the Workshop, it was possible to organize a plenary session for the beginning and a closing session, and 7 parallel sessions. In the parallel ones, some very interesting debates took place, providing important feedback on the community construction of the Capacity Building plan. Finally, the facilitators communicated the priorities established in each workshop so that they could be re-voted among all the participants with a multivalued scale from 1 to 10 in the last plenary session.

2. DETECTED TRAINING NEEDS

The following paragraph specifies the main priorities that were identified in the Workshop developed for each of the workshops, identifying the stakeholders.
These priorities are shown in order according to the results obtained in the survey, including the main statistics for each of them (mean, median, standard deviation, 25th percentile and 75th percentile).

2.1 FINAL BENEFICIARIES

Identified need	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Self-care training	7.97	8	1.781	7	10
Promote Self-determination: expression of needs, Training in managing emotions, crises, and stressful events.	7.61	8	2.046	7	9.75
Socialization training	7.22	8	2.072	6	9
Training in enhancing self-esteem, personal abilities.	7.22	8	2.153	6	9
ICT training.	7.03	7	1.978	6	8

Table 1. Detected needs in Workgroup 1.

2.2 NON-PROFESSIONAL CAREGIVERS

Identified need	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Focus on the caregiver: detection	8.33	9	1.852	7.25	10

of situation, needs, risks, knowledge, etc.					
Specific knowledge to provide quality care.	8.31	9	1.969	7	10

Table 2. Detected needs in Workgroup 2.

2.3 SOCIO-HEALTH PROFESSIONALS

Identified need	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Training in Person-Centred Care	8.75	9	1.763	8	10
Communication and observation skills.	8.36	9	1.726	8	10
Formation of support networks in care.	8.25	9	1.713	7	10
Training in ICT Resources.	8.19	8	1.687	8	9
Identification of socio-sanitary risk and action against them.	8.14	8	1.726	7	10

Table 3. Detected needs in Workgroup 3.

2.4 SOCIO- HEALTH SERVICES COMPANIES

Identified need	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Gerontological care competencies: socio-health care, case management, prevention of prevalent diseases ... etc.	8.75	9	1.763	8	10
Digital transformation: ICTs, telemedicine, telecare, and electronic processing.	8.36	9	1.726	8	10
Management of human and material resources: financing, social health coordination, centre management, innovation.	8.25	9	1.713	7	10
Bio-socio-ethics: dignified treatment, family mediation, rights, mechanical and pharmacological restraint.	8.19	8	1.687	8	9
Gender and transculturality.	8.14	8	1.726	7	10

Table 4. Detected needs in Workgroup 4.

2.5 COMMUNITY GROUPS

Identified need	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Need to create cooperation networks.	8.08	8.50	1.918	7	9.75
Training needs in the clinical field and social skills according to the profile of the participants.	8	8	1.912	7	9.75
The need for learning and the provision of resources to overcome the digital divide.	7.89	8	1.833	7	9.75
Need to reconceptualize terms related to health, community health, governance.	7.03	7	1.828	6	8
Need for participatory legislation (co-governance).	6.97	8	2.372	6	8

Table 5. Detected needs in Workgroup 5.

2.6 PUBLIC ADMINISTRATION

Identified need	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Creation of specific resources with specialized professionals.	8.14	8.50	1.759	7	10
Normative/legislative regulation that will support the model (strategic line) to give more support and facilitate the implementation / Conciliation policies to facilitate care.	8.11	8	1.582	7	10
Generate compassionate/caring administrations, training/formation of administration professionals: technologies, vulnerability, social determinants, ethics, etc. (given the gap between social and health).	7.94	7.50	1.689	7	10
Administration awareness: Ethical leadership in decision-making (Promote organizational ethics spaces / committees), Exemplarity to manage resources and prioritize projects, Transparency, Empathy, incorporate "soft indicators" (prioritization of care ...), endowment	7.78	8	2.179	6.25	10

technologies ("being connected").					
Landing, empathy before carrying out protocols (Community education towards training in self-care of vulnerable people before establishing / generating protocols, resources).	7.69	8	1.770	7	9

Table 6. Detected needs in Workgroup 6.

2.7 RESEARCH AND EDUCATION

Identified need	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Bio-psycho-social model of health centred on the person. recovery of the life project. control of situations in everyday life.	8.47	9	1.630	8	10
Good practices based on scientific evidence.	8.47	9	1.630	8	10
Communication with the elderly.	8.17	8	1.949	8	10
Training in ethical aspects with deliberative methodology.	8.06	8	1.492	7	9
Training in teamwork and interdisciplinary coordination.	8.06	8	1.772	7.25	9

Table 7. Detected needs in Workgroup 7.

3. TRAINING ACTIONS

Among the objectives of the Workshop, in addition to identifying the training needs of each profile, was the definition of strategies or actions to respond to the training needs identified and which have been collected in the previous chapter.
The most valued strategies / actions for each of the interest groups are shown below, like the previous section.
Both sections will serve as inputs for the Training Plan that will be shown in the following section.

3.1 *Strategies/actions of training.*

The following training actions have been detected to carry out:

3.1.1 FINAL BENEFICIARIES

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Workshops on care and self-care. Specific training: intelligence, emotional, mindfulness, healthy diet, exercise.	7.64	8	2.153	7	9.75
Spaces of shared experiences, also intergenerational.	7.36	8	1.973	6	8.75
Group leisure workshops.	6.61	7	2.142	5.25	8
Resource guides, Assistive products (e.g. stair lifts, mobility and communication aids) and self-care.	6.39	6	2.382	5	8
Formal meetings or informal gatherings.	6.03	6	2.063	4	7
Social volunteering.	5.97	6	2.336	4	8
Notebooks of self-esteem, expression of values and experiences.	5.92	6	2.116	4	7.75

Table 8. Proposed strategies in Workgroup 1.

3.1.2 NON-PROFESSIONAL CAREGIVERS

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Empowerment of caregivers and caregivers.	8.19	8	1.704	7	10
Existence of qualified people and resources for urgent help (APP, telephone, networks, etc.).	7.72	8	1.936	6.25	9
Use of ICT, without replacing humanized care.	7.28	8	1.966	6	8
Transfer care and caregivers to society as a social value.	7.19	7	2.660	6	10
Detection of training needs through peer groups, and then generalize the most promising results obtained.	7.14	7	1.839	6.25	8.75

Table 9. Proposed strategies in Workgroup 2.

3.1.3 SOCIO- HEALTH PROFESSIONALS

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Continuous training with phases such as reception and accompaniment of the new	8.33	8.50	1.789	7.25	10

professional, support, burnout in old professionals.					
Joint transdisciplinary training.	7.94	9	1.820	7	9
Record of the person's needs.	7.81	8	1.818	7	9
On-site training workshops.	7.67	8	1.882	6	9
Virtual training-Support networks.	7.56	8	1.796	6	9
Knowledge of the social and family environment.	7.53	8	2.249	6	9.75
Strategy that guarantees the training of professionals.	7.47	8	2.372	6	9.75
Training pills (5 minutes).	7.17	7	1.964	6	9
Study of practical cases.	7	7	2.449	6	9
On-site training.	6.92	7	2.285	6	9
Role play.	6.28	6	2.225	6	9

Table 10. Proposed strategies in Workgroup 3.

3.1.4 SOCIO- HEALTH SERVICES COMPANIES

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Centralized and/or collaborative training between centers, distributing and optimizing resources and costs.	8.06	8	1.804	8	9
Change management, supervision measures and adoption of verified and validated quality models.	7.72	8	2.023	6.25	9
Strengthening of specialized regulated training and updating of knowledge, continuous training in companies (including center management, care management and biosocial aspects).	7.64	8	1.949	6	9
Online methodologies, but with face-to-face supervision, combating the digital divide.	7.5	8	1.828	7	9
Awareness campaigns on the needs of professionals, institutions, etc.	7.44	8	1.949	6	9

Table 11. Proposed strategies in Workgroup 4.

3.1.5 COMMUNITY GROUPS

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Continuous updating workshops (clinical setting, social skills through tele-training) and the use of information pills.	7.92	8	1.763	7	9

Creating networks to connect as online forums in which experts and non-experts can participate but who distinguishes who makes each contribution (if they are an expert or not).	7.67	8	2.028	7	9
Providing resources and infrastructure to encourage people to meet.	7.53	8	2.021	6	9
Giving visibility/publicity to what is done from the different centers, associations.	7.42	8	2.116	7	9
Creation of participatory wikis so that people can consult them (reconceptualization).	6.97	7.50	2.197	5	8.75

Table 12. Proposed strategies in Workgroup 5.

3.1.6 PUBLIC ADMINISTRATION

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Including social health coordination and comprehensiveness in the regulations / legislation to guarantee inter / intra-departmental communication.	7.97	9	2.286	7	10
Prioritizing the most vulnerable people, with the most difficulties.	7.89	9	2.053	6	10
Transformative training plan (s) (that achieve effect…) (including in the academic training plans of future professionals).	7.58	8	1.888	7	9
Approach, feedback between the administration and the agents receiving the services.	7.47	7.5	1.920	6.25	9
Creating/prioritizing spaces/organizational ethics committees (make sense of these committees).	7.33	7	2.125	6	9
Defining the profile / competencies of the professionals to implement the model.	7.22	7	2.044	6	9
Motivating sensitized groups (associations, councils, etc.) to propose new rules / regulations.	7.17	8	2.210	5.25	9

Table 13. Proposed strategies in Workgroup 6.

3.1.7 RESEARCH AND EDUCATION

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Uses of practical examples and testimonials from older people.	8.06	9	1.941	6.25	9.75
Cooperative/deliberative workshops. meetings of interdisciplinary teams and with the associative movement and users. professional support groups.	7.75	8	2.247	6	9.75
System of accreditation of good practices in professional centers that represent an incentive.	7.61	8	1.777	6	9
Transversal subjects of different disciplines, careers, degrees, etc.	7.33	8	2.519	5	9
Specialty courses as a requirement to access the job.	7.31	7.5	2.162	6	9
Quarterly seminars in organizations and residential centers.	7.03	7.5	1.874	6	8
Ethical think tanks.	6.97	7	2.035	6	8.75
Health specialty proposal.	6.97	7	2.535	5.25	9
Inclusion of curricular information on subjects such as gender, evidence-based practice.	6.86	7.5	2.576	5	9
Valuations between different professionals of the same entity.	6.86	7	1.988	6	8

Table 14. Proposed strategies in Workgroup 7.

3.2 Capacity Building Plan.

After having included in this document the training needs detected within the Workshop carried out for each of the profiles, as well as the training strategies to respond to the identified needs, the Training Plan with which they are pursued is developed below. reduce said training needs identified for each of the profiles that are the object of the TEC-MED Model by applying, whenever possible, the training strategies indicated as a result of the Workshop itself.

Therefore, although the training plan of the TEC-MED Model, taking into account the beneficiary profiles, could be very extensive and diverse, it has been decided to take into account the results of the actions implemented throughout the project, counting as well as what has been defined by the experts who have participated in the process that has been carried out, this being the basis of the Training Plan that is presented below.

3.2.1 FINAL BENEFICIARIES

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to which the capacity building plan belongs
Self-care training.	**Care and self-care.**	Workshops on care and self-care. Specific training. Guide to resources, support products and self-care. Social volunteering.	Subject of care.	Improved critical awareness, reflectivity. Problem evaluation.
Training in socialization.	**Communication skills and socialization.**	Formal meetings or informal gatherings. Group leisure workshops.	Subject of care.	Links with others. Participation.
Promote Self-determination: expression of needs, Training in managing emotions, crises, and stressful events. **Training in enhancing self-esteem, personal abilities.**	**Self-determination and personal abilities.**	Shared experiences spaces. Notebooks of self-esteem, expression of values.	Subject of care.	Leadership. Role of external agents.
ICT training.	**ICT's.**	Shared experiences spaces. Formal meetings or informal gatherings. Group leisure workshops. Social volunteering.	Subject of care. Technology.	Resource mobilization.

Table 15. Results of training needs - Final Beneficiaries.

Training Actions	Educational objectives / learning outcomes	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment
Care and self-care.	Improve the empowerment of beneficiaries about their health. Acquire knowledge and techniques of care and self-care. Have tools that improve your quality of life and well-being.	Workshops. Resource guides. Training pills.	Specific workshops of approximately 1 hour per topic. Training pills (videos) lasting approximately 3-5 minutes.	Healthy lifestyle habits (food, healthy diet, etc). Postural hygiene to carry out activities of daily life. Most common ailments in the elderly and prevention activities (osteoarthritis, arthritis, prevention of falls, prevention of abuse, etc.). Mindfulness. Emotional intelligence Physical activity (strength exercises, balance, stretching). Pharmacological management. First aid.	Room equipped for group sessions with basic furniture. Tele-formation Platform. Physiotherapy material. Brochures Technical aids (articulated bed, chair, mannequin, first aid kit, etc.).	Medical. Nurse. Psychologist. Physiotherapist. Mindfulness instructor	Satisfaction survey. Survey of utility / application in daily practice.
Communication skills and socialization.	Improve the communication and empathy skills of the beneficiaries. Enhance social skills. Improve your participation in social life.	Group workshops. Role play. Informal encounters.	Face-to-face or virtual workshops / meetings with theoretical content. Role play strategies. Dynamics that encourage communication and participation for 1 hour.	Types of communication. Barriers in communication. Communicative skills. Empathy. Active listening. Assertiveness. Practical dynamics. Art therapy for people with communication difficulties	Room equipped for group sessions with basic furniture. Tele-training platform. Material for role playing dynamics.	Occupational therapist. Social worker. Social consultant Monitor / a of sociocultural activity. Coach. Advertising and public relations.	Participation in dynamics and acquisition of techniques. Satisfaction survey.

Self-determination and personal abilities	Offer techniques to improve self-determination Improve the ability to solve problems and day-to-day situations. Know and enhance the strengths of the person.	Shared experiences spaces. Notebooks of self-esteem, expression of values.	1-hour workshops / meetings. Resources on tele training platform.	Techniques for dealing with frustration or sadness. Problem solving skills. Decision making. Development of positive thinking.	Room equipped for group sessions with basic furniture. Tele-training platform Notebooks.	Social consultant. Coach. Psychologist.	Participation in dynamics. Completion of notebooks. Satisfaction survey.
ICT's	Bringing NNTT closer to the beneficiaries. Acquire knowledge related to the use of ICT devices and tools of a general nature. Have resources that eliminate their isolation and loneliness and allow them to improve their participation in society.	Group sessions Tele-training platforms. Shared experiences spaces.	1-hour sessions to increase knowledge and share experiences. Resources and guides on the platform. Group leisure workshops through the platform.	What are ICTs? Internet. Instant messaging tools. Video conferencing tools. Social media. Use of tablets and mobiles. Digital home. Telecare. Telemedicine.	Room equipped for group sessions with basic furniture and availability of computers and tablets. Teletraining platform.	Technological consultants. Advertising and public relations. Professionals in the field of communication and marketing.	Satisfaction survey.

Table 16. Results of training actions - Final Beneficiaries.

3.2.2 NON-PROFESSIONAL CAREGIVERS

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to whic the capacity buildi plan belongs
Focus on the caregiver: detection of situation, needs, risks, knowledge, etc.	**Detection of needs**	**Detection of training needs through peer groups, and then generalize the results obtained that are more promising *.**	Subject of care.	Problem evaluation.
Specific knowledge to provide quality care.	**Care techniques and tools**	**Empowerment of caregivers and caregivers.**	Subject of care.	Improved critical awareness, reflectiv Problem evaluation.
Promote Self-determination: expression of needs, Training in managing emotions, crises, and stressful events. **Training in enhancing self-esteem, personal abilities.**	**Self-determination and personal abilities.**	**Existence of qualified people and resources for urgent help (APP, telephone, networks, etc.).**	Subject of care.	Leadership. Role of external age
ICT training.	**Communicative skills**	**Empowerment of caregivers and caregivers.**	Subject of care.	Resource mobilizati

Table 17. Results of training needs- Non-professional caregivers.

* The detection of needs is a step prior to the programming of training plans. The Workshop held and shown in this document is one of the actions carried out to respond to this identified training strategy, having been distributed by peer groups. Subsequently, this strategy will be reinforced again through the evaluations of the training actions that are being developed for the profile.

Training Actions	Educational objectives / learning outcomes	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment
Care and Self-care	Empower caregivers by improving the ability to care for their family member. Acquire knowledge of techniques and tools to improve the provision of care Improve the quality of life and well-being by enhancing their participation.	Workshops. Resource guides. Training pills.	Sessions of approximately 1 hours per topic. Training pills lasting approximately 3-5 minutes.	Healthy lifestyle habits: eating, healthy diet. Postural hygiene to carry out activities of daily life. Most common ailments in the elderly and prevention activities. Mindfulness. Emotional intelligence Physical activity (strength exercises, balance, stretching). Pharmacological management. First aid.	Room equipped for group sessions with basic furniture. Tele-formation Platform. Physiotherapy material. Brochures Technical aids (articulated bed, chair, mannequin, first aid kit, etc.).	Doctor, Nurse. Psychologist. Physiotherapist	Satisfaction survey. Utility survey in daily practice.
Communicative skills	Increase the capacity of communication and caregivers. Provide tools that enhance empathy and	Group workshops. Role play. Informal encounters.	Face-to-face or virtual workshops / meetings with theoretical content, role-play strategies and dynamics that	Types of communication. Barriers in communication.	Room equipped for group sessions with basic furniture. Tele-training platform.	Occupational therapist. Social worker.	Participation in dynamics and acquisition of techniques.

	active listening of caregivers.		promote communication for 1 hour.	Communicative skills. Empathy. Active listening. Assertiveness. Practical dynamics.	Material for role playing dynamics.	Social consultant. Monitor / a of sociocultural activity. Coach. Advertising and public relations.	Satisfaction survey.
ITC's	Reduce the digital divide for caregivers. Allow the acquisition of knowledge by caregivers related to the use of ICT devices and tools.	Group sessions. Tele-training platforms. Shared experiences spaces.	1-hour sessions to increase knowledge and share experiences. Resources and guides on the platform. Group leisure workshops through the platform.	What are ICTs? Internet. Instant messaging tools. Video conferencing tools. Social media. Use of tablets and mobiles. Digital home. Telecare. Telemedicine.	Room equipped for group sessions with basic furniture and availability of computers and tablets. Tele-training platform. Telecare and telemedicine tools.	Technological consultants. Advertising and public relations. Professionals in the field of communication and marketing.	Satisfaction survey

Awareness campaigns	Sensitize the population and caregivers about the needs of the elderly. Make the reality of social exclusion visible to the population. Convey the importance of the work of caregivers in support of social and health systems.	Brochures Talks. Videos. Specifically, designed actions	Development of quarterly campaigns throughout the first year of implementation.	Needs of the elderly. How to combat social exclusion? How to combat loneliness and isolation? What can I do to take care of you? The privilege of caring. Duties of a caregiver. Thank you, notebooks and other actions.	Brochures Talks. Videos. Murals	Marketing and publicity. Audio-visual production. Psychologist.	Visualizations Probes Surveys of utility and participation and learning

Table 18. Results of training actions- Non-professional caregivers.

3.2.3 SOCIO-HEALTH PROFESSIONALS

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to which the capacity building plan belongs
Training in person-centred care. **Identification of socio-sanitary risk and action against them.**	**Person-centred care.**	On-site training workshops. Virtual training. Transdisciplinary training. Training pills. Case studies. Role play.	Providers of social and health care.	Role of external agents.
Communication and observation skills.	**Communication and observation skills.**	On-site training workshops. Virtual training. Knowledge of the social and family environment role play.	Providers of social and health care.	Improved critical awarene reflectivity. Problem evaluation.
Training of support networks in care.	**Creation and articulation of care networks.**	Face-to face training workshops. Virtual training. Study of practical cases.	Providers of social and health care.	Improve participation.
Training in ICT Resources	**ICT tools to improve people's care.**	On-site training workshops. Virtual training. Training pills.	Providers of socio-sanitary care / Technology.	Resource mobilization.

Table 19. Results of training needs - Socio-health professionals.

Training Actions	Educational objectives / learning outcomes	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment
Person-centered care	Train socio-health professionals in person-centered care and its characteristics. Make professionals aware of techniques and tools to achieve person-centered care that improves the well-being and quality of life of the people they serve.	On-site training workshops. Virtual training. Training pills. Case studies. Role play.	Sessions of 1 hour per theme. Training pills lasting approximately 3-5 minutes.	What is Person Centered Care (AICP)? The paradigm shift in care. Goals of person-centered care. Comprehensive and integrated care. Strategies for person-centered care. Bio-socio-ethical aspects of Person-Centered Care. Reception, care and accompaniment of people.	Room equipped for group sessions with basic furniture. Teleformation Platform. Videos. Material for role playing dynamics.	Doctors. Psychologists. Social workers. Nurses. Care managers.	Satisfaction survey
Communication and observation skills	Improve the capacity of active listening and empathy of professionals. Provide tools that promote active listening and communication of social health professionals.	On-site training workshops. Virtual training. Knowledge of the social and family environment. Role play.	Sessions of approximately 1 hours per topic.	Barriers in communication. Communicative skills. Observation techniques. Empathy.	Room equipped for group sessions with basic furniture. Teleformation Platform.	Occupational therapist. Social worker. Social consultant.	Satisfaction survey

	Train professionals so that, through observation, they identify people's objectives, preferences and priorities.			Active listening. Assertiveness. News broadcast. Emotional management. Practical dynamics.	Material for role playing dynamics.	Monitor / a of sociocultural activity. Coach. Advertising and public relations.	
Training of support networks in care	Train professionals to be able to create care and support networks for their beneficiaries. Provide professionals with tools for the coordination and management of networks of people and entities that participate in the care and support of the beneficiary groups of the Tec Med model. Show techniques for the dynamization of participation processes and development of actions with a community focus for the development of care networks.	Face-to-face training workshops. Virtual training. Study of practical cases.	Sessions of approximately 1 hours per topic.	What is networking? Principles and characteristics of care networks. Organization and planning of care networks. Tools for networking. Leadership in care networks. Compassionate leadership practice. Spirituality in teamwork.	Room equipped for group sessions with basic furniture. Teleformation Platform	Community promoter. Social worker. Social consultant.	Satisfaction survey
Training in ICT Resources	Reinforce the knowledge of professionals about	Face-to-face training workshops.	Specific workshops of	The importance of digital tools in care.	Room equipped for group sessions	Technological consultants.	Satisfaction survey

	technological tools and devices in their profession. Show new tools to professionals to support their daily work. Examine and practice with the different tools shown to understand how they work and when to use them based on their practical result.	Virtual training. Training pills. Study of successful cases.	approximately 1 hours per topic. Training pills lasting approximately 3- 5 minutes.	Telecare. Telemedicine. Telemonitoring. Success stories in the implementation of technological tools to improve the quality of life and well-being of patients.	with basic furniture. Teleformation Platform. Videos.	Advertising and public relations. Professionals in the field of communication and marketing.	

Table 20. Results of training actions - Socio-health professionals.

3.2.4 SOCIO- HEALTH SERVICE COMPANIES

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to which the capacity building plan belongs
Gerontological care competencies: socio-health care, case management, prevention of prevalent diseases, etc.	**Integrated care in the elderly.**	Strengthening of specialized regulated training and updating of knowledge, continuous training in companies.	Providers of socio-health care / Governance.	Improves critical awareness / reflectiveness.
Digital transformation: ICTs, telemedicine, telecare, and electronic processing	**Digital tools for social and health care**	Online methodologies, with face-to-face supervision, combating the digital divide	Technology.	Resource mobilization.
Management of human and material resources: financing, social health coordination, centre management, innovation	**Direction of socio-health centres**	Centralized and / or collaborative training between centres, distributing and optimizing resources and costs Change management, supervision measures and adoption of verified and validated quality models	Governance.	Control over program management increases.
Bio-socio-ethics: dignified treatment, family mediation, rights, mechanical and pharmacological restraint	**Bio-socio-ethics within integrated care**	Strengthening of specialized regulated training and updating of knowledge, continuous training in companies	Context and care system.	Strengthen ties with other organizations and individuals.
Gender and transculturality	**Gender, health and transculturality**	Awareness campaigns	Context and care system.	Increase the evaluation of problems.

Table 21. Results of training needs - Socio-health service companies.

Training Actions	Educational objectives / learning outcomes	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment
Integrated care in the elderly	Unify criteria with the managers of socio-sanitary companies on the fundamental concepts of comprehensive and integrated care. Define and design coordination strategies to achieve authentic integrated care among the members of the socio-health entities.	Face-to-face sessions. Virtual training. Training pills. Case studies. Shared experience spaces.	1-hour sessions Training pills lasting approximately 3-5 minutes	Characteristics of an integrated care. Responsibilities in integrated care. Ethical and legal problems. Models and tools for socio-health coordination. Case management in integrated care. Success stories in integrated care.	Room equipped for group sessions with basic furniture. Tele-formation Platform. Videos.	Care managers. Managers of social health care entities. Managers of socio-sanitary programs.	Satisfaction survey
Digital tools for social and health care	Specify the changes necessary for digital healthcare and the advantages that this brings. Present different digital care tools to the managers of socio-sanitary companies. Present success stories in the use of digital tools.	Virtual training. Case studies. Shared experience spaces.	Sessions of 1 hour for the cases and for the shared experience.	Situation of ICTs in the social health field. Main barriers to the inclusion of ICT tools. Software for its application in social and health care. Success stories in the use of digital tools in integrated care.	Room equipped for group sessions with basic furniture. Tele-formation Platform.	Managers of socio-sanitary companies. Managers of socio-sanitary programs. Technicians of entities that provide ICT solutions for the social health field.	Satisfaction survey
Direction of socio-health centres	Train attendees in the knowledge and skills necessary for strategic planning.	Face-to-face and / or virtual sessions.	Sessions of 1 hour of duration in the face-to-face plane with virtual reinforcement for	Socio-health models. Leadership. Motivation. Communication. Economic management.	Room equipped for group sessions with basic furniture.	Managers of socio-sanitary companies.	Satisfaction survey

	Provide tools for the management of spaces in the social health field. Train attendees in the main aspects of managing socio-health centres.		work according to the availability of the beneficiary.	People Management. Socio-sanitary management.	Tele-formation Platform.	Responsible for socio-sanitary units.	
Bio-socio-ethics within integrated care	Discuss with the managers of socio-sanitary companies about the ethical aspects that influence well-being. Identify the cultural aspects with an impact on the quality of life of the beneficiaries of the centres.	Face-to-face and / or virtual sessions. Case studies. Shared experience spaces.	1.5-2-hour sessions.	Bioethics in clinical care. Ethics in social intervention. Integrated care and ethical aspects. The influence of cultural aspects in a true integrated care.	Room equipped for group sessions with basic furniture. Tele-formation Platform	Doctors. Social worker. Psychologist.	Satisfaction survey
Gender, health and transculturality	Describe the fundamental aspects of gender and transculturality in the social health field. Create spaces between managers of socio-sanitary companies to share experiences in gender, transculturality and health.	Face-to-face and / or virtual sessions. Case studies. Shared experience spaces.	1.5-2-hour sessions	Transculturality in the socio-health field. The influence of gender on health. Gender strategies to implement in socio-sanitary institutions.	Room equipped for group sessions with basic furniture. Tele-formation Platform.	Doctors. Social worker. Psychologist.	Satisfaction survey

Table 22. Results of training actions - Socio-health service companies.

3.2.5 COMMUNITY GROUPS

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to which the capacity building plan belongs
Need to create cooperation networks.	**Meetings of actors of the social health system for the creation of networks**	Create networks to connect as online forums in which experts and non-experts can participate but distinguish who makes each contribution (if they are an expert or not). Give visibility / publicity to what is done from the different centres.	Context and System of care / Governance.	Organizational structures
Training needs in the clinical field and social skills according to the profile of the participants.	**Care and accompaniment.** **Participation of community groups**	Continuous updating workshops (clinical setting, social skills through tele-training) and the use of information pills.	Providers of socio-health care / Context and system of care.	Improves critical awareness / reflectiveness
The need for learning and the provision of resources to overcome the digital divide.	**ITC**	Provide resources and infrastructure to encourage people to meet	Technology.	Resource mobilization
Need to reconceptualize terms related to health, community health, governance.	**Integrated care and concepts related to its implementation and operation**	Creation of participatory wikis so that people can consult them	Context and System of care /	Improves critical awareness / reflectiveness
Need for participatory legislation (co-governance).	**Participatory processes for regulatory changes**	Provide resources and infrastructure to encourage people to meet	Governance.	Leadership

Table 24. Results of training needs - Community Groups.

Training Actions	Educational objectives / learning outcomes	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment
Meetings of actors of the social health system for the creation of networks	Make visible the different profiles of entities that actively participate in social and health care. Encourage networking among community groups. Show possible coordination mechanisms to improve the articulation of entities.	Virtual sessions. Online forums. Discussion forums	1.5-hour sessions	Social health care. Actors of social and health care. Creation and activation of community networks. Coordination of community entities for the improvement of comprehensive and integrated care.	Tele-training platform.	Directors of community groups. Doctors. Social workers. Case managers.	Satisfaction survey
Care and accompaniment. **Participation of community groups**	Train members of community groups who actively participate in caring for people in care. Present techniques and tools in order to be used to provide quality care to beneficiaries, improving their well-being and quality of life. Establish the participation of	Face-to-face sessions. Virtual sessions. Training pills. Study of practical cases.	1-hour sessions 3–5-minute training pills	Characteristics of community groups. Most common ailments in the elderly and prevention activities. Emotional intelligence First aid. Healthy lifestyle habits. Active listening and observation.	Room equipped for group sessions with basic furniture. Tele-formation Platform. Physiotherapy material. Brochures	Physician. Nurse. Psychologist. Physiotherapist. Responsible for volunteer programs. Directors of community groups.	Satisfaction survey

	community groups in care, depending on their purposes.			Care and empathy. Roles and responsibilities of members of community groups in integrated care. Volunteering. Tools to support the care of community groups.	Technical aids (articulated bed, chair, mannequin, first aid kit, etc.).		
ITC's	Provide knowledge to attendees about the possibilities of new technologies for their performance. Show tools for accompanying beneficiaries. Present successful cases of implementation of ICT tools by community groups.	Group sessions. Tele-training platforms. Shared experiences spaces. Analysis of success stories.	1-hour sessions to increase knowledge and share experiences. Resources and guides on the platform.	What are ICTs? New technologies in the accompaniment of people. Digital home. Telecare. Telemedicine. Success stories.	Room equipped for group sessions with basic furniture and availability of computers and tablets. Tele-training platform.	Technological consultants. Advertising and public relations. Professionals in the field of communication and marketing.	Satisfaction survey
Integrated care and concepts related to its implementation and operation	Provide a structure for the alignment of new socio-sanitary concepts to the participants. Allow the exchange of experiences and	Virtual sessions. Training pills. Wikis.	1-hour sessions 3–5-minute training pills	What is Person Centred Care (AICP)? The paradigm shifts in care. Definition of health.	Tele-training platform. Videos.	Physician. Nurse. Psychologist. Social worker.	Satisfaction survey Entries in Wikis.

	points of view on integrated care.			Community health. Community groups in integrated care. Health governance strategies.		Case managers.	
Participatory processes for regulatory changes	Generate spaces for the discussion of the normative changes to be implemented for a correct person-centred care. Align community groups for the implementation of participatory measures that modify current regulations.	Virtual sessions. Forums.	1.5 - 2 hour sessions	Applicable legislation in the field of person-centred care. Fundamentals of person-centred care. Regulations applicable in the field of health and in the social field applicable to those over 65 years of age who are dependent or at risk of social exclusion.	Tele-training platform.	Psychologist Social worker Lawyer. Managers of socio-sanitary companies Community group managers.	Satisfaction survey. Number of participants in the sessions. Initiatives launched.

Table 25. Results of training actions - Community Groups.

3.2.6 PUBLIC ADMINISTRATION

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to which the capacity building plan belongs
Creation of specific resources with specialized professionals.	**The scope of integrated care in the Public Administration.** **Need for resources and profiles.**	Transformative training plan (s) (that achieve effect...) (including in the academic training plans of future professionals). Define the profile / competencies of the professionals to implement the model.	Governance / Context and care system / Financing.	Program management.
Normative / legislative regulation that will support the model (strategic line) to give more support and facilitate the start-up / Conciliation policies to facilitate care.	**Regulatory review linked to integrated care. Changes to achieve the objective.**	Include social health coordination and comprehensiveness in the regulations / legislation to guarantee inter / intra-departmental communication. Motivate sensitized groups (associations, councils, etc.) to propose new rules / regulations.	Governance.	Program management.
Generate compassionate / caring administrations, training / education of administration professionals: technologies, vulnerability, social determinants, ethics, etc. (given the gap between social and health).	**Compassion as an articulation of change.**	Create / prioritize spaces / organizational ethics committees (make sense of these committees).	Gobernanza/Contexto y sistema de atención.	Estructuras organizativas de empoderamiento.
	Transversal aspects of integrated care	Create / prioritize spaces / organizational ethics committees (make sense of these committees).	Governance.	Estructuras organizativas de empoderamiento.
Administration awareness: Ethical leadership in decision-making (Promote organizational ethics spaces / committees), Exemplarity to manage resources and prioritize projects, Transparency, Empathy, Incorporate "soft indicators" (prioritization of care	**Values of integrated care**	Approach, feedback between the Administration and the agents receiving services.	Context and system.	Strengthen ties with other organizations and people.

...), endowment technologies ("being connected").				
Landing, empathy before carrying out protocols (Community education towards training in self-care of vulnerable people before establishing / generating protocols, resources).	**The role of the community in integrated care**	Prioritize the most vulnerable people, with the most difficulties.	Context and system.	Improves resource mobilization

Table 26. Results of training needs - Public Administration.

Training Actions	Educational objectives / learning outcomes	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment
The scope of integrated care in the Public Administration. **Need for resources and profiles.**	Define responsibilities and functions of the different Public Administrations within the framework of integrated care. Establish the profiles required to achieve true integrated care. Redesign the training plans with scope in integrated care.	Discussion sessions. Market studies and research. Analysis of success stories.	Sessions lasting between 2 and 3 hours.	What is integrated care? Competences of Public Administrations for the implementation of integrated care. Profiles, aptitudes, and capacities necessary for integrated care. Current training plans linked to profiles with an impact on integrated care. Modifications required for integration	Room equipped for group sessions with basic furniture. Video conferencing system.	Managers of socio-sanitary programs. Management of Public Administrations of the health and social field. Socio-health consultants.	Satisfaction survey. Measurement of the impact achieved with the implementation of the sessions.
Regulatory review linked to integrated care. Changes to achieve the objective.	Discuss the currently existing regulations in relation to integrated care and the possible changes to be proposed in order to achieve its objectives.	Discussion sessions. Analysis of reference regulations. Success stories	Sessions lasting between 2 and 3 hours.	Reference regulations in integrated care. Current situation of application and difficulties encountered in them.	Room equipped for group sessions with basic furniture. Video conferencing system.	Lawyers. Managers of socio-sanitary programs. Management of Public Administrations	Satisfaction survey. Agreements reached for the proposal of regulatory changes.

				International regulations regarding integrated care. Regulatory success stories linked to integrated care.		of the health and social field. Socio-health consultants.	
Compassion as an articulation of change.	Integrate compassion as a value within Public Administrations.	Virtual sessions. Training pills.	1-hour sessions 3–5-minute training pills	What is compassion? Mindfulness. Empathy. Self-pity. Practicing compassion in Public Administrations.	Tele-training platform. Video conferencing system	Compassion trainers. Psychologist. Social worker.	Satisfaction survey
Transversal aspects of integrated care	Define the main concepts of integrated care to achieve true socio-health coordination. Fundamental competences of health and social issues in integrated care. Socio-health coordination mechanisms.	Face-to-face sessions. Virtual sessions. Success stories	Sessions of 1 hour.	Implications of integrated care. Fundamental concepts in the field of health. Fundamental concepts of the social sphere. Competences of the public health and social administrations. Tools for socio-health coordination.	Room equipped for group sessions with basic furniture. Video conferencing system	Managers of socio-sanitary programs. Management of Public Administrations of the health and social field. Socio-health consultants.	Satisfaction survey

				Success stories in the coordination of Administrations.			
Values of integrated care	Sensitize members of public administrations on the values and aspects that should govern integrated care.	Brochures Guides. Audio-visual resources.	Quarterly campaigns throughout 1 year with the different values to be disseminated.	Ethical leadership. Empathy. Transparency. The importance of new technologies.	Brochures Guides. Audio-visual resources (training videos, personal experiences, etc.).	Technological consultants. Advertising and public relations. Professionals in the field of communication and marketing.	Visualization of the different formats generated.
The role of the community in integrated care	Sensitize members of public administrations about the role of the community. Establish awareness strategies for the community from the Public Administration on the importance of their participation.	Brochures Guides. Audio-visual resources.	Quarterly campaigns throughout 1 year with the different values to be disseminated with a focus towards the interior (public administration) and towards the exterior (community)	The importance of the caregiver. The community and care. Care networks for integrated care. Support from the Public Administration to caregivers.	Brochures Guides. Audio-visual resources (training videos, personal experiences, etc.).	Technological consultants. Advertising and public relations. Professionals in the field of communication and marketing.	Visualization of the different formats generated.

Table 27. Results of training actions - Public Administration.

3.2.7 RESEARCH AND EDUCATION

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to which the capacity building plan belongs
Biopsychosocial model of health centred on the person. recovery of the life project. Control of situations in everyday life.	**Analysis of integrated care models.**	Use of practical examples and testimonials from older people. Cooperative / deliberative workshops. Meetings of interdisciplinary teams and with the associative movement and users. Professional support groups. Health specialty proposal.	Governance	Organizational structures.
Good practices based on scientific evidence.	**Certification systems for socio-sanitary models.**	System of accreditation of good practices in professional centres that represent an incentive.	Context and care system	Equitable relationship with others.
Communication with the elderly.	**Communicative skills**	Transversal subjects of different disciplines, careers, degrees, etc.	Providers socio-health care	Improve participation.
Training in ethical aspects with deliberative methodology.	**Ethics as the basis of integrated care.**	Ethical think tanks.	Providers socio-health care	Equitable relationship with others.
Training in teamwork and interdisciplinary coordination.	**Teamwork and socio-health coordination**	Valuations between different professionals of the same entity.	Providers socio-health care	Control over the management of the Program

Table 27. Results of training needs - Research and Education.

Training Actions	Educational objectives / learning outcomes	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment
Analysis of integrated care models.	Analyze different models of integrated care to know their strengths. Learn about user experiences of integrated care models. Integrate the strengths identified through the analysis of other models into current models.	Cooperative / deliberative workshops. Meetings of interdisciplinary teams. and with the associative movement and users. Senior testimonials	Sessions of 2-3 hours face-to-face and / or virtual.	Keys to integrated care. Models of integrated care in Spain. Models of integrated care in the European Union. International models of integrated care. Participation in integrated care models. Older people's experiences in integrated care models.	Room equipped for group sessions with basic furniture. Tele-training platform. Video conferencing system.	Managers of socio-sanitary programs. Members of socio-sanitary research groups.	Satisfaction survey. Articles published about the study carried out.
Certification systems for socio-sanitary models.	Define the good practices to be carried out in an integrated care model. Design a certification system for socio-sanitary models.	Discussion sessions. Forums. Case analysis.	Sessions of 2-3 hours face-to-face and / or virtual.	Good practices in the health field. Good practices in the social field. Good practices applicable to	Room equipped for group sessions with basic furniture. Tele-training platform.	Managers of socio-sanitary programs. Members of socio-sanitary research groups.	Satisfaction survey. Articles published on the studies carried out.

				integrated care models. Health certification models. Models of social certification. Socio-sanitary certification models. Aspects to be included in a new socio-sanitary certification model.	Video conferencing system.		
Communicative skills.	Analyse the current training plans linked to the profiles that are part of the integrated care teams with an emphasis on knowledge of communication, listening and observation skills. Define the knowledge that the different profiles of the health or social field must have at the end of their regulated training plan to provide quality care in models of socio-health care.	Discussion sessions. Forums. Case analysis.	Sessions of 2-3 hours face-to-face and / or virtual.	The importance of communication in social and health care. Existing subjects in the training plans related to communication, observation, and active listening. Proposals for changing training plans.	Room equipped for group sessions with basic furniture. Tele-training platform. Video conferencing system.	Managers of socio-sanitary programs. Members of socio-sanitary research groups.	Satisfaction survey. Number of proposals for modifying currently existing training plans.

Ethics as the basis of integrated care.	Establish working groups to define the ethical aspects to be included in the formation of profiles related to integrated care. Develop proposals for the inclusion of ethical aspects in the training degrees.	Ethical think tanks. Forums.	Sessions of 2-3 hours face-to-face and / or virtual.	Ethics as the basis of integrated care. Clinical ethics methodologies. Conclusions of the deliberative groups.	Room equipped for group sessions with basic furniture. Tele-training platform. Video conferencing system	Managers of socio-sanitary programs. Members of socio-sanitary research groups.	Satisfaction survey. Proposals generated for the inclusion of ethics in the formative degrees.
Teamwork and socio-health coordination	Define the aspects that converge in an excellent teamwork. Review and analysis of successful teamwork and socio-health coordination cases. Design through work groups the methodologies to be included in the training for team cohesion and the improvement of teamwork.	Discussion sessions. Forums. Case analysis.	Sessions of 2-3 hours face-to-face and / or virtual.	Fundamentals of teamwork. Socio-health coordination tools. Success stories. Proposals for the inclusion of topics in the training plans.	Room equipped for group sessions with basic furniture. Tele-training platform. Video conferencing system.	Managers of socio-sanitary programs. Case managers. Members of socio-sanitary research groups.	Satisfaction survey. Aspects to include in current training plans. Number of proposals for modifying currently existing training plans in relation to teamwork and coordination.

Table 28. Results of training actions - Research and Education.

4. CAPACITY ASSESMENT

There are different types of evaluation, each with a different purpose. When designing an evaluation strategy, the first thing that is necessary is to identify the questions to which it is intended to answer, and therefore the type of monitoring or evaluation to be carried out (LaFond & Brown, 2003).

Regarding the results of a project and its evaluation, the UNDP (United Nations Development Program) highlights the need to design evaluation tools following some general principles (Werf, 2007):

Clarity of purpose: what, why and for whom?

Nature of information required and choice of data collection method: Specific survey questions reduce information overload).

Overall management of the evaluation process: The tools and indicators are developed for use in combination with information from other sources and good evaluations.

It should be observed that an important distinction in the nature of indicators is the difference between short-term and long-term indicators. In the literature, different terms are used to describe these various types of indicators. In general, the first type would give an idea of the "specific actions and steps" that were taken during certain activities of the training plan. The second type would seek to describe the state of enhanced training (or decreased) (Werf, 2007).

The development of a training plan is a continuous process in which many results of an intervention are not directly visible or measurable, therefore, it is necessary to establish indicators that facilitate the evaluation process. According to Werf (2007), the established indicators may not be entirely correct in measuring

the impact when the period of a project is too short. The challenge in building an adequate assessment tool is to incorporate these elements of uncertainty. In the training plan construction processes, many organizations opt for a more participatory strategy, through which the evaluation process to develop indicators involves different actors. This type of approach contributes to the improvement of the development of indicators both in the impact evaluation process and in the results (Werf, 2007).

In general, all indicators tend to share the following aspects (LaFond & Brown, 2003):

Validity: It refers to whether the indicator can measure what it had set to measure. The indicators must be closely related to the intervention.

Reliability: Refers to the degree of random measurement error in an indicator. The error may result from sampling. If the answer is objective or subjective.

Well defined: Indicator definitions have to use clear and precise terms so that everyone involved can understand what it is intended to measure.

Sensitivity: It refers to the changes in the elements of the evaluated program.

Another example of indicator development is the SMART (Specific, Measurable, Appropriate, Realistic and Temporal) model adapted by FAO in 2007 as seen below: (Werf, 2007):

Specific: The indicator must specify clearly, unambiguously, what it will measure, and the set of indicators must be concise.

Measurable: The indicator must be measurable through quantitative or qualitative mechanisms. Assessment scales should be based on agreed intervention criteria and expectations and should be accompanied by viable methodologies and resources for measurement. The definitions of indicators and scales should support unbiased ratings.

Appropriate (or relevant): The indicator should be related to the project objectives and objectives. It must be based on an agreed and adequate identification of what is to be measured / evaluated. It must be based on a solid and demonstrated relationship with the result. Furthermore, the set of indicators must be comprehensive to cover all relevant questions.

Realistic (or achievable): The resources involved in the project must be real and sufficient, from a human and economic point of view, to measure the indicator.

Temporal (or time-based): The indicator must be measurable / evaluable within the project term.

In the field of capacity measurement in health and other sectors, LaFond and Brown (2003) extract the following "lessons" on the development of indicators:

I. Lesson 1: Indicators should reflect an understanding of the change strategy for training development. The process of choosing training indicators should feed the general strategy for change, designed to develop capacities, and improve performance. Indicators should be developed in conjunction with capacity mapping when designing a training plan intervention. Furthermore, evaluators have an active role in trying to understand how to use the information to ensure that indicators become incentives for change rather than barriers.
II. Lesson 2: Indicators should capture organizational and behavioral change, as well as material and technical changes. The most challenging training demand to measure is human and organizational behavior change. Especially in the health sector, there is a tendency to advance explanations of what are likely to be organizational or human behavior problems. For example, it is often assumed that training health providers alone will address gaps in service delivery, yet the root of the poor performance problem may be due to unreliable sources of supplies for people with problems. of health. Evaluators must have an idea of how people and organizations change, what causes lasting change, and why changing certain values and practices makes a difference. Training indicators must capture the essence of these changes in human and organizational behavior.
III. Lesson 3: In planning the training evaluation plan, it is important to monitor not only the training, but also key aspects of the intervention and the context.

Evaluators should review changes in the intervention along with the ability to examine relationships between different variables of training and performance. Additionally, evaluators need to track contextual changes. Environmental factors often help explain changes (or lack of change). Indicators that monitor external conditions serve as a warning that training and performance may have risks.

IV. Lesson 4: Indicators should foster ownership of the training process. Evaluators should work with stakeholders in capacity development to define indicators that reflect locally accepted notions of change. Evaluators should also keep in mind that measurability can also be an issue. Organizations and individuals do not enjoy documenting their "weaknesses." The quality of the data collected to build capacity indicators could be distorted and / or obstructed unless the purpose of monitoring and evaluation is not clear to all stakeholders.

V. Lesson 5: The results of the indicators must be interpreted with caution. The evaluators will have to consider the following aspects:

a. Capacity development is context specific. Training development is context specific. This reflects qualitative as well as quantitative changes in the availability of resources. Given the wide range of possible scenarios and training objectives, it is often not possible to establish objective standards that allow local or regional comparisons of training between similar entities. Internal benchmarks can be set but may not be valid for other entities or contexts.

b. The selection of training indicators is often very subjective. To foster relevance, evaluators often rely on perceptions of capacity and change among participants in the training development process as a basis for measuring progress. Therefore, it is necessary to balance subjective measures with a range of indicator objectives and data collection strategies.

c. Training is influenced by many variables. Therefore, there is a tendency to evaluate several indicators at the same time. It is advisable to promote the use of multiple indicators for each level within the training map because they provide greater understanding and can serve to validate recommendations. The use of multiple indicators is often recommended to explain what an imprecise situation or occurrence may be. However, at the same time, the evaluators must prioritize indicators based on the objectives of the program, thus fostering the development of a viable set.

d. Evaluators are experimenting with complex indicators that combine a short list of essential indicators into a single training measure.

e. Determining the cause and effect of training is not easy to assess, although a training map could clearly indicate assumptions about relationships between variables. Some evaluators have found linear evaluation frameworks and the strict use of inflexible and mechanical indicators is not effective in monitoring and evaluating training.

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TEC-MED Model:

Capacity Building Plan in Egypt

EGYPT

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Start Data of Project: Duration:	September 26, 2019 36 months
Total Budget: Contribution received:	EUR 3.331.225, 33
Design and Produced by:	Tec-med Egyptian Team
Abstract	The aim of this document is to show a clear pathway of the creation and the proposed implementation methodology of the capacity building plan in Egypt Through different steps aimed at assessing the needs, Design of the training programs and finally implementation and monitoring. This process was validated through series of online workshops with key agents from different sectors (socio-health administration, researchers, policy makers as well as civil society).

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Keywords:	Elderly, TEC-MED, social care, social model, Key agent's, capacity building plan, Egypt, Mediterranean basin, dependent

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Table of Contents

Introduction:

Capacity-building is defined as the "process of developing and strengthening the skills, instincts, abilities, processes and resources that organizations and communities need to survive, adapt, and thrive in a fast-changing world." An essential ingredient in capacity-building is transformation that is generated and sustained over time from within; transformation of this kind goes beyond performing tasks to changing mindsets and attitudes. Therefore, Training is very important aspect to provide the elderly, their households, health-and social care workers, local authorities and community group guidance and advice for health promotion, prevention and caring to elderly people. a number of actions are planned by the project Egyptian planning committee to Develop a partnership platform for sharing knowledge and good practices, as well as enhancing the visibility of the model; Formulating and applying a capacity building plan to strengthen skills of key agents involved in the implementation of the model (training agents, caregivers-formal and family-, final beneficiaries and other stakeholders focus in the quadruple helix and the three levels of management-macro, meso, microlevel);Responding to specific Egyptian national or local capacity needs; and later on to promote the sharing of experiences and the dissemination of best practices between partner countries of TEC-MED project.

The Implementation Process

Step 1: Capacity Assessment	• Identify/define the target level based on strategy, policies, mandates, etc. • Assess the current capacity of target group. • Identify training needs.
Step 2: Design of Training Programme	• Draft the framework of training programme. • Employ a facilitator to conduct the training. • Conduct a pilot study for a detailed design of the training. • Set up a detailed schedule and content of training. • Notify the details of the training to the participants.

Step 3: Implementation and Monitoring	• Arrange the venue and needed equipment. • Prepare an attendance sheet, feedback sheet. • Implement the training. • Monitoring the training participants and facilitator(s). • Participants fill in the feedback sheet. • Analyze the process of the training and the results of feedback.

STEP 1: Training Needs Analysis and Capacity Assessment

Framework

The Project identifies:

(1) the capacity development needs of the target groups and
(2) the level of existing capacity of target group through pre-survey and capacity assessment.
(3) the available resources (financial, physical, and human resources)

the methodology of training "needs analysis" and capacity assessment is explained.

Capacity Assessment Workshops

Three Capacity Assessment workshops were conducted (by PP8&9) to collect data to better design the Capacity Building program.

The Capacity Assessment workshops had three objectives:

1. to help the participants understand their role.
2. to assess the participants knowledge, skill, and attitude towards the training scope to identify the important capacities.
3. to identify the main stakeholder groups who will support the implementation process.

During the workshops, the facilitators asked the participants to name stakeholders they feel are relevant and/or have a direct impact on the implementation. The facilitator asked the participants to categorize the stakeholders they named, and themselves, to fit into one (or more) of the following categories.

Our key stakeholders were classified into four sectors according to the Quadruple Helix model (6) (figure 1).

• **Public administrations:** It is not a matter of imposing participatory models according to the government in charge, but of being part of the team and collaborating with the same conditions as the rest of the agents.

• **Research and Education/Academy:** All knowledge and teaching centers at all levels are part of it such as public and private research entities, universities, education and training, science and technology parks, technology transfer offices, etc.

• **Business:** Includes organizations, which have a great opportunity to innovate and participate in a business with more competitive strength in open markets such as big firms, SMEs, young entrepreneurs, students with business ideas, and business organizations.

• **Society:** These are the individuals, who are a key element that functions as a link between the other actors, especially in improving cooperation between companies and universities such as NGOs, citizens...etc.

Afterwards, the facilitators of each workshop requested the participants to list the skills and capacities they need to perform their role as identified in the previous exercise.

Workshops results were variable, we considered the following target beneficiaries list after analysis of all responses in the three workshops held

Group A: Managers and policy makers

Group B: Health professionals

Group C: Social care professionals

Group D: Non-Professional (family) Caregivers

Group E: Final Beneficiaries

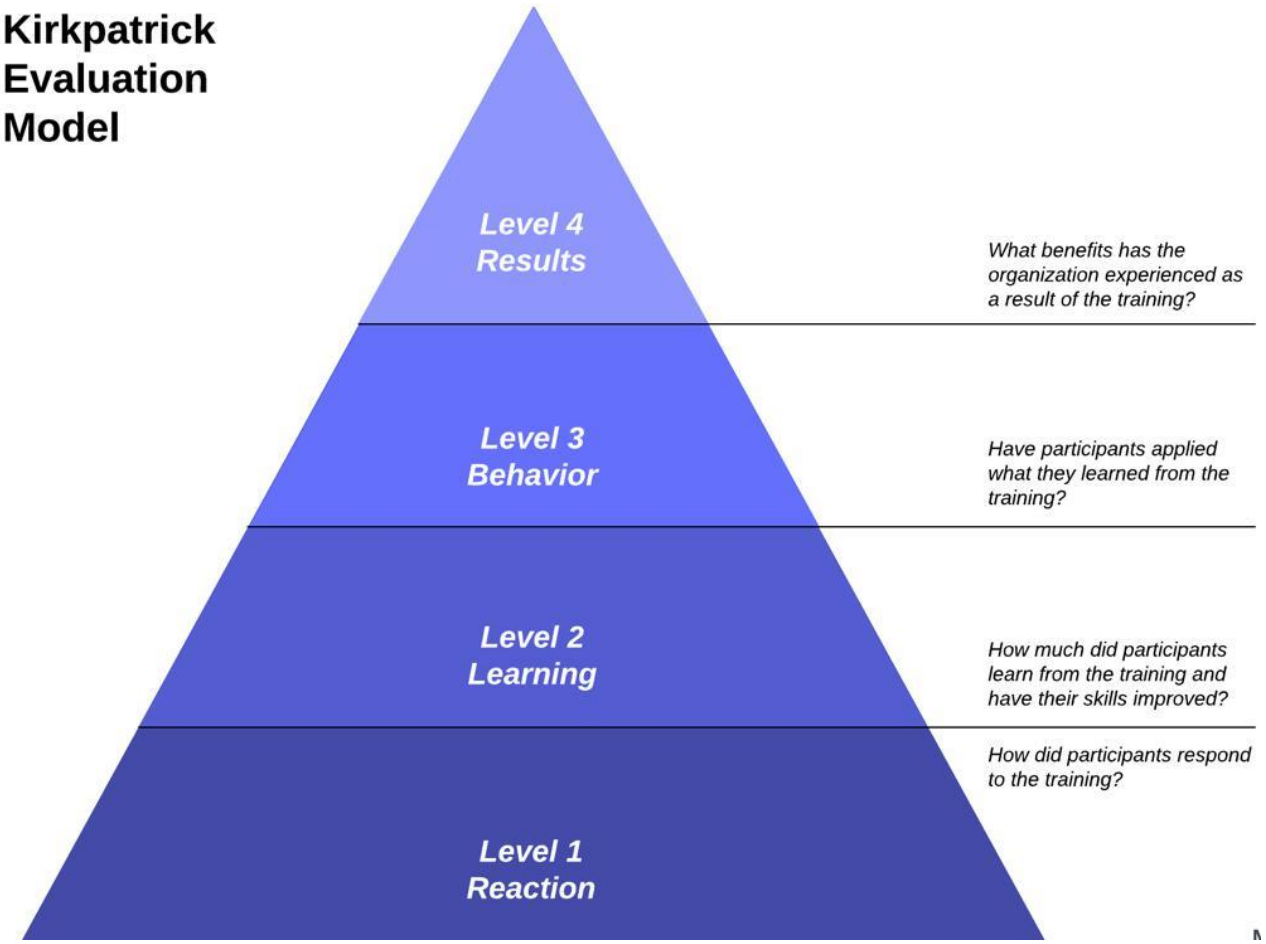
The following Table specifies the main priorities that were identified during the workshops by the stakeholders.

Group	**Identified Needs**	**Suggested Strategies/actions of training.**
Managers and policy makers	- Strategic planning - Communication skills - Auditing	Workshops Mentoring and one on one training Educational resources
Health professionals	- Training on different technological practices in diagnosis - Training in ICT - Training of the medical staff such as nurses, caregivers...etc on the right methodologies in elders health care. - Identification of sanitary and hygiene risks and increase the awareness to prevent them - Facilitate the process of diagnosis, assessment, follow up and medicine	- Training on listening to the patients needs. - Different workshops and info sessions on the use of technological methodologies. - Training on dealing with different social and cultural differences and different environments - Training on dealing with emergencies and risks such as pandemics - Training on use of

	delivery especially in the rural areas - Increase the number of the medical staff especially in geriatric medicine - Encourage the collaboration between the caregivers at the elders homes and medical staff to guarantee the quality of the care for elders.	virtual diagnosis systems (TELEMEDICINE)
Social care wokers	- Database of the cases in every area - Sharing the knowledge and the database with other concerned networks - Training in the medical and social care - Psychological assessment training - Research methodology.	Field training Workshops and meetings Educational resources and materials
Non-Professionals (family) caregivers.	- Training on the right methodologies of care to maintain quality. - Collaboration with health professionals to follow up the status of elders especially at their homes - Training on the use of simple technological tools that will facilitate the follow up of the elders statuses	- Workshops and training for the non professional caregivers in the concerned entities such as NGOs. - Training on the simple technological devices to follow up on the statuses of elders. - Integration of use of ICT - Training on the

		importance of listening to the needs of elders and follow up on their mental and psychological health.
Final Beneficiaries	- Self care training - Training on reporting - Training on engaging with the community in different programs - Training on ICT	- Workshops and training on the use of ICT and simple technological tools. - Formal meetings and gatherings to share the elders Knowledge and expertise. - Programs to integrate the elders' knowledge with different generations and prevent their marginalization. - Booklets on maintaining a healthy lifestyle: diet, exercises and emotional and psychological health. - Booklets on enhancing self esteem and expressions of emotions. - Training on the use of assistive products

Using the Kirkpatrick Model[1] as the evaluation of capacity development, the facilitator will ask each participant to score themselves on a level of 1 to 4 for each of the identified capacities



STEP 2: Design of Training Themes

Establishment of Training Framework (for specific details of each planned capacity building activity, please refer to the appendix)

(1) Decide on the purpose and outcome of each workshop.
(2) What outputs are you looking to have by the end of each workshop.
(3) Divide the trainees into groups based on a common criterion.
(4) Make sure there is enough budget to cover all your needs.

[1] https://www.lucidchart.com/blog/how-to-use-the-kirkpatrick-evaluation-model

(5) Decide on the location and venue. It should be closer and accessible to most of the participants / Webinars can always be an option, depending on the situation.
(6) Decide of the number of days to complete each workshop.

Selection of a facilitator

Select the appropriate facilitator using the following criteria:

(1) Educational background
(2) Experiences as a facilitator
(3) Expertise of training theme
(4) Reputation
(5) Speaking language

Design of a Training Course

Some important decisions to consider here are:

- Will you have different levels of advancement based on the assessment you've done in step 1
- The language of the training. Do you need a translator or translating the training hand books
- The length of the workshop.
- The priority of the training and if it needs a prerequisite certificate or basic level of understanding.
- Assessments to ensure the transfer of knowledge.

STEP 3: Implementation and Monitoring (for specific steps please refer to the appendix)

Preparation

Considerations before starting the Capacity Building activities

(1) Venue

- Confirm the venue is appropriate for the size of attendees and has the available facilities.
- Confirm the availability of the room and make a reservation.

(2) Schedule and agenda

Introduction to the TEC-MED model and the desired capacity building dimension

Invited Lecture (s): Guest speakers with validated experience in the relevant fields will be invited to present (both face to face and online) e.g. Global Brain Health Institute, Social Research center (SRC), Survey of aging in EU (SHARE)

Interactive workshop: The workshops will depend on interaction and contributions by attendees (involves small projects and tasks)

Open Discussion and feedbacks: Each session should end up by a summary, conclusions and a survey to get feedbacks by attendees to estimate the benefits

NB: According to the interviews, we had some recommendations to try to organize the events as face to face as much as possible and to be continuous over a period of time (eg three days) as the interaction between attendance will motivate them to practice and do activities better

(3) Notification to Participants

- Inviting participants using an efficient tool.
- Collecting confirmation (accept/decline.
- Adjust schedule/agenda is needed.

(4) Handouts

- Ask the facilitator to prepare any necessary handouts.
- Collect the handouts from the facilitators before the trainings and print in the appropriate numbers.

(5) Equipment

- Make sure all needed equipment are available and functional (visual aids, markers, flipcharts, Post Its, notebooks, tape, scissors, staplers, etc…)

Implementation

Opening Session

Opening remarks is necessary to introduce the purpose of the training, the appropriate use of the venue, the agenda of the day and follow-up. You then introduce the facilitator(s)

Supervision

Observe the lecture and monitor the progress. Make sure the facilitator is going in a pace suitable to the participants and using relevant examples.

Time management is also very important so that the objectives of each activity is achieved.

Recording could be helpful for referencing and feedback after the workshop.

Closing

At the end you request the trainees to fill-in a feedback sheet and to submit it back. The result will be entered into a database for analysis and reporting.

Reporting

At the end of each workshop a report is expected that covers:

- Why the workshops were conducted.
- Overview of workshops.
- Framework.
- Facilitator(s) and the reason why he/she/they was/were chosen.
- Curriculum and timetable.

- Results of feedback.
- Lessons learnt.

Appendix 1 : Capacity Building plan

Based on the several responses received during the different workshops, we put this plan for different training actions targeting the previously identified target audiences:

1. Family caregivers:

Topic	Specific Objectives	Outcome	Target stakeholders	Methods to be used	Timetable
First aid skills	To have a good knowledge in providing first aid for emergencies	Improved first aid knowledge and experience of caregivers	Caregivers	1 Training workshops (small groups) 2 site visits 3 videos provided by experts to be disseminated	July 2021, Cairo , Sharkia , if possible
Psychological background assesment	To have an understanding of psychological needs for elderly groups	Building a knowledge that help them appreciate the psychological aspects of aging	Caregivers	1 Focus groups 2 small group meetings	July 2021, Cairo , Sharkia , if possible
Communications skills	To master the best ways / specific needs of communications and of elderly	Better communication skills/ improved communication with care recipients	Caregivers	1 workshop 2 online training course	July 2021, Cairo , Sharkia , if possible

Specific Key indicators for this group:

Improved skills for first aid and health interventions as indicated by decline in number of health adverse events reported to the local elderly care hospitals or centers

Family care providers shows better communication skills when attending different organized meetings or visits

Percentage/ persistence of participation in the workshops

2. Social workers

Topic	**Specific Objectives**	**Target stakeholders**	**Methods to be used**	**Outcome**	**Timetable**
Communications skills	To master the best ways / specific needs of communications and of elderly	Social workers	1 workshop 2 online training course 3 Onsite training	Better communication skills/ improved communication with care recipients	May, 2021, Cairo & Sharkia if possible physical meetings
Psychological assessment	To have an understanding of psychological techniques of assesment for elderly groups	Social workers	1 training practical courses 2 supervised practice 3 manuals dissemination	To have an ability to do an initial scientifically sound psychological assessment of the studied /served groups	May, 2021, Cairo & Sharkia if possible physical meetings
Data Collection and analysis	To build competencies in data collections (surveying) and analysis	Social workers	1 training workshops 2 courses	Social workers will be able to be engaged in research and data collection	May, 2021, Cairo & Sharkia if possible physical meetings

Specific Key indicators for this group:
Improved performance through internal and external auditing.
Inputs/contribution to research activities and active engagement with research groups

3. Healthcare workers (this group comprises physicians, pharmacists and nurses)

Topic	Specific Objectives	Target stakeholders	Methods to be used	Outcome	Timetable
Geriatric training	To provide general practitioners with minimum required knowledge in the different aspects/ changes in elderly that can affect health, social life and psychology	Healthcare workers	Online courses Face to face /onsite training Training materials (videos and lectures)	Better understanding and competencies of healthcare providers about aging persons specific medical needs	May, 2021, Cairo & Sharkia if possible physical meetings
Research skills	To improve research abilities in the field of qualitative research	Healthcare workers	Workshops Online courses	Healthcare providers will improve their ability to engage in research related to elderly population	May, 2021, Cairo & Sharkia if possible physical meetings
Communications skills	To master the best ways / specific needs of communications and of elderly	Healthcare workers	1 workshop 2 online training course 3 Onsite training	Better communications tools will be acquired	May, 2021, Cairo & Sharkia if possible physical meetings
Management and quality	Providing clinicians with basics of managerial skills	Healthcare workers	Training workshop lectures	Healthcare providers will be able to coordinate minor/moderate projects	May, 2021, Cairo & Sharkia if possible physical meetings

Specific Key indicators for this group:

Less reported complications or incidents e.g. drug side effects or lack of dosing adjustments
More active research contributions/ number of new research papers
Better performance in internal and external auditing

4. Managers/ policy makers

Topic	Specific Objectives	Target stakeholders	Methods to be used	Outcome	Timetable
Strategic planning	Supporting the ability of managers to plan and formulate strategies	Managers/ policy makers	workshops	Better ability of planning. Making a strategy or elderly care	June 2021 , Cairo & Sharkia if possible
Communication skills	To master the best ways of communications to the public	Managers/ policy makers	Small group training	Communicating society efficiently to seek their support for elderly directed initiatives	June 2021 , Cairo & Sharkia if possible
Auditing	Introduction to auditing and reviewing	Managers/ policy makers	Courses Workshops Onsite training	Managers are able to conduct a professional auditing for their institutions performance	June 2021 , Cairo & Sharkia if possible

Specific Key indicators for this group:
More multidisciplinary projects and initiatives
Better project outputs/success rates

5- Target beneficiary:

Topic	Specific Objectives	Target stakeholders	Methods to be used	Outcome	Timetable
Self-care training	To have knowledge on how to self care, first aid/interventions	Elderly/vulnerable population	Workshops Booklets Educational videos	Less reported incidents. Better overall conditions during visits	June 2021 , Cairo & Sharkia if possible
Reporting	To know precisely how to report incidents, where to report	Elderly/vulnerable population	Small group training Booklets	More active reporting to the responsible	June 2021 , Cairo & Sharkia if possible

	and exact procedures		Educational videos	authorities or centers	
Community engagement	To actively start engagement in community activities (bothe dedicated to elderly and normal community activities)	Elderly/vulnerable population	Courses Workshops Invitation to some activities Promotional materials	Elderly population will start to re-engage with community activities	June 2021 , Cairo & Sharkia if possible

Specific Key indicators for this group:

More participation in the training workshops

Reporting less complications during follow up process in the clinical geriatric centers Increase in reports rate to responsible authorities

General indicators for the whole process of training activities;

1- Attendance rate of the activities
2- Diversity of attendees (geographic and disciplinary)
3- Positive results of the post activity surveys
4- Performance rate in the post activity assessments
5- Successful implementation of acquired skills in new projects
6- A final design roadmap based on different stakeholder's professional input.

ENI CBCMED
Cooperating across borders in the Mediterranean

Project funded by the EUROPEAN UNION

REGIONE AUTÒNOMA DE SARDIGNA
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TEC-MED

TEC-MED Model:

Capacity Building Plan in Greece

GREECE (PP4) – "MERIMNA"

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

CONTENTS

1. INTRODUCTION:

The **TECMED** Project "*Development of a transcultural social-ethical-care model for dependent populations in the Mediterranean Sea basin*" (**A_A.3.2_0376 TECMED ENI CBC MED-Europe**), is an innovative model of intercultural social care aimed at a specific age group.

The program refers to **Elderly 65+** that face threat of social exclusion.

The **principle objective** is the evolution and the upgrade oh the existing social care units in collaboration with public administrations and agencies involved in the protection and support of this age group, in order to achieve a higher quality of social services provided. The countries that participate in this specific project are six (*Spain, Italy, Greece, Lebanon, Egypt and Tunisia*). All the countries participants focus their interest in the central objective of the TECMED project, taking into consideration relevant aspects that may affect the action and the intervention such as ethical codes, gender, cultural habits, accessibility and community status or values.

Reaching the theoretical framework we clearly refer to six (6) state dimensions that are of great importance and defined as follows:

1) **Subject of care**: This aspect refers to the person as individual who is 65+ in a state of dependency of in danger of social exclusion. As "person" is automatically placed in the centre of the system while its needs considered as the starting point for further processes. What is crucial is that the person should not be faced only individually but in major relation to its immediate family or social environment.

2) **Health and social providers**: This aspect mainly includes persons or agencies that consists the key role between the person in need and the good practices and benefits. The caregivers may be formal or informal. Either professionals or not, the support of people offer to the elderly should take into considerations dimensions such as skills, stability over time, training capability, remuneration and reinforce.

3) **Care environment and service delivery:** This aspect as the title reveals is strongly related to the living environment of the person. The term "**environment**" may include home

living conditions, accommodations, physical environment, accessibility, hospitality, daily facilities, family or institutional support and others and the quality of living.

4) **Governance:** This aspect refers to a whole system of social providing in a spectrum of agencies, policy makers, European programs, funding, rules and principles of each country participant and restrictions of acting. In Greece, we face a limited availability of public long-term care and support while Elderly living in the lack of social care and ideal social, psychological and financial level.

5) **Financing:** This aspect refers to the economic support system of a whole country. Being more specific it may be public, private, mixed or non-profit and includes terms such as financial and accounting system, financial sustainability and priorities concerning political and government issues.

6) **Technology:** This aspect concerns terms related to easy use, availability and accessibility as far as technological issues are centered. Training skills on computer use, telemedicine, robotics and sensors are only a few evidences among the fundamental states that technology may offer.

Having a detailed view on the basic dimensions of a theoretical scope concerning the **TECMED** program, is seems crucial to locate the three levels of management as the key intervention between theory and practice.

Macro level: National policies and strategies where decisions about priorities are taken, policies and interventions are designed and resources are allocated for their implementation. It refers to the government, political or legislative level in public administration that provides social care services. (may include policy makers or relevant stakeholders).

Meso level: policies are implemented as specific programmes and are affected by the organizational context, the strength of competing interests at this level, and the ability to forge alliances among multiple institutions to achieve the same goal. Specifically in

the area of the elderly it may consists of hospitals, nursing homes, open care centers for the elderly, NGO's, public agencies or bodies involved with this particular population group.

Micro level: the micro or service delivery level represents the interface of social care systems and users. It refers to the person/individual as recipient of the social services provided. It may also concern professional and no-professional caregivers.

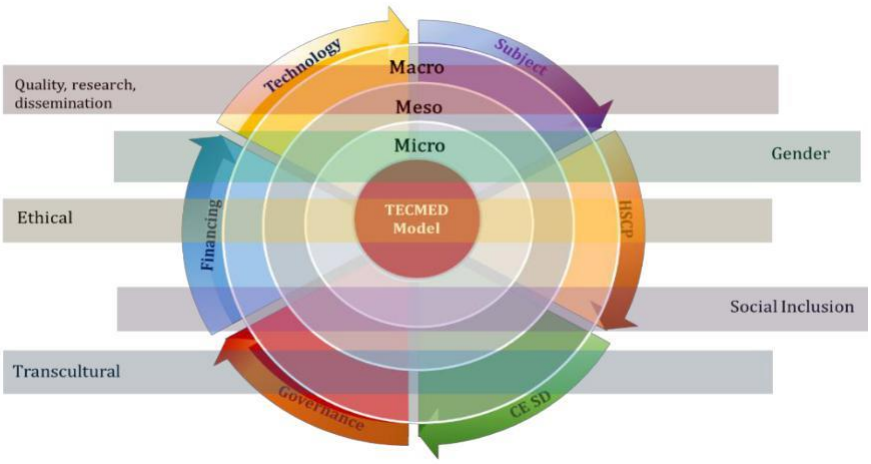

Figure 1: TECMED care model

-**Dimensions (6):** 1. *Subject of care, 2. Health and social providers, 3. Care environment and service delivery, 4. Governance, 5. Financing, 6. Technology*

- **Levels of management (3):** *Macro, Meso, Micro*

2. "COMMUNITY CAPACITY BUILDING" DEFINITIONS:

Community: Highlighting the term "*Community*", we mean a way of strengthening civil society by prioritizing the actions of communities, and their perspectives in the development of social, economic and environmental policy. It seeks the empowerment of local communities, taken to mean both geographical communities, communities of interest or identity and communities organizing around specific themes or policy initiatives. It strengthens the capacity of people as active citizens through their community groups, organizations and networks; and the capacity of institutions and agencies (public, private and non-governmental) to work in dialogue with citizens to shape and determine change in their communities. (*Budapest Declaration on community development*)

Capacity building: mirrors an investment in the effectiveness and future sustainability for nonprofit. It may include many different types of activities that are all designed to improve and enhance a nonprofit's ability to achieve its mission and sustain itself over time. What is essential is that a *capacity building* is not a short-term effort but a continuous improvement strategy.

Community Capacity Building: As a combination of the above reports we could approach the term with the following accurate definition.

"Community capacity building is the **continuous process** required to foster the pride and appropriate **local leadership** that allows communities, through their members, to **take responsibility for their own development** (Human Resources and Skills Development Canada quoted in Verity, 2007, p. 14, emphasis added)".

3. CAPACITY BUILDING OBJECTIVES :

Having analyzed the terms “community”, “capacity building” and “community capacity building” in general we now need to focus and orientate these terms according to the TECMED model and the target population group of the Elderly.

The initial and central objective is for the communities to be empowered.

Apart from that, numerous aside objectives have to be considered in order to achieve an effective community capacity building plan. What is fundamental at this point is to act with safety and be flexible in exploring new needs and ways of intervention as the pandemic situation of Covid-19 in Greece define.

Keeping in mind some major cross-sectional themes such as quality, research and innovation, gender, social inclusion, transcultural and ethic, we may focus on the sub-objectives below.

- Empowering elderly people who are depended or in danger of social exclusion. Self-care techniques, new skills adoption, psychological support, social providing care enhancement are some of the actions required. (***Subject of care, technology****)*
- Empowering families of family caregivers who live with a person 65+ with limited capacity for self-care. Training in detail, remuneration as a means of reward and mental empowerment are considered to act effectively. (***Subject of care, Health care and social providers, Technology***)
- Research and recording of new emerging needs in the midst of the Covid-19 pandemic. Facing all these restrictions and confinement conditions, elderly seem to need more psychological support as well as aimed actions over keeping themselves safe and in a well-being state. (***Subject of care, Technology***)
- Strengthening the family environment in strong relation with the realistic enhancement of living conditions of the elderly is required. Being more specific, effective integrated social and health care responding directly to the person and family needs, their preferences, their habits in an attempt to keep aligned n holistic perspective and a person-centered vision. (***Care environment and service delivery***)
- Promoting multi and interdisciplinary teams that include health and social professional and caregivers. Clear distinction between roles and responsibilities in a common line for

maximum quality effect. (***Health and social care providers, Care environment and service delivery)***

- Promoting active healthy living, prevention and nutrition benefits. (***Subject of care, Technology***)

- Act against exclusion, neglecting and abuse. Extensive information on the rights of older people and active aging actions where they can participate online due to Covid-19 pandemic. Raising awareness through a bottom-up perspective to approach elderly care. Active aging need to be enhanced, taking into consideration aspects such as gender, social determinants of health and system establishment. (***Governance, Technology***)

- Raining awareness over the importance of the funding and financial facilities strongly related to the initial goal. Socio-ethical and trance cultural care should be set as priority in alliance with material and human resources. (***Governance, Financing***)

- Promoting the implementation of technology and digital social intervention as innovative step while facing the Covid-19 pandemic. The use of the platform in strict lines with the TECMED model is considered to be effective, innovative, accurate and promising. (***Technology***)

- Implementing practical strategies and analyzed plan for future and continuous creative change, while promoting inclusion and social justice. (***Governance***)

- Achieve equitable living conditions and active participation in a diverse society for the elderly population portion with disabilities. (***Governance***)

4. METHODOLOGY AND TOOLS:

An accurate and effective capacity building must be defined by particular steps in the light of specific and well structured methodology.

PP4 – **Greece** "*Methodology plan to achieve the final community capacity building*"

- Update the Stakeholder template with new entries that may be helpful in the whole procedure of the long-term enhancement of the social care provided

  As it has been analyzed in previous deliverable documents, the stakeholders that will work in alliance with the countries participants in the TECMED project will represent various profiles.

  Specifically, the aspects that will be covered through the "***Quadruple Helix model***" are the following:

- **Business**: primary sectors, creative industries, students with business ideas, social sectors
- **Research & Education**: public and private research bodies, universities, education
- **Public administration**: Governance intervention, regional development, business advice, local authorities
- **Civil society** / Users: associations, NGO's, final beneficiaries. Elderly and families, citizens, agencies directly involved with the requested group

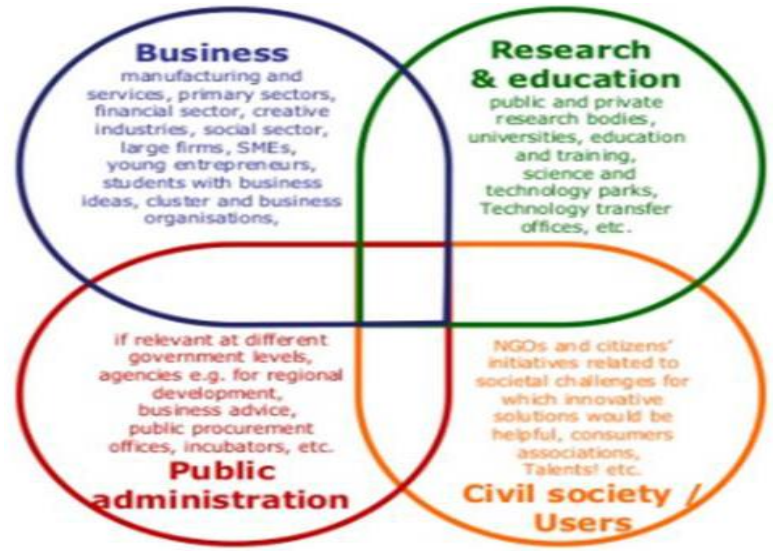

Figure 2. *Quadruple helix of stakeholders source*

- Having clarified the categories that stakeholders may operate, we continue with essential steps planned in order to achieve our community capacity building plan.
- Locating the capacity needs in line with the **TECMED** project desired objectives and setting them in terms with the needs of the stakeholders.
- Having identified the needs it is fundamental to set all the data collected together in an effort to achieve the maximum quality for the elderly facing social exclusion. Data such as objectives, needs, targets, polls, deadlines, resources and indicators must be strictly related to each other.
- Detailed information and presentation of the project and its important goal to agencies and bodies that will participate in the whole procedure through workshops, webinars e.t
- Having informed the interested stakeholders for the project we should set exact roles and responsibilities to each one of them so that the procedure will be accurate, clear and promising.
- Motivation is necessary through the whole implementation. Stakeholders need to feel safe and willing to act. They need to comprehend in depth the benefits of the effort and no to be pressed as is obliged and stressful event.
- Getting back to practice we need to locate ways of connection and communication. The principle action plan was to be mostly face to face. Unfortunately the sudden appearance

and spread of the Covid-19 pandemic has completely affected our plans so we were forced to re-set actions and find solutions that promote and ensure safety. Although the digital and online approach is not so direct, we tried to achieve the maximum.

- Getting an effective result means we need to cooperate with the stakeholders. In Greece as we have already informed the project, the elderly are mostly supported from their own families. As a result the majority of the care provided is from non-formal caregivers. This statement makes the training need of the caregivers extremely necessary. Apart from that, training seems fundamental to formal caregivers as well. Additionally, agencies and bodies involved with this specific target group need to get trained as well in order to achieve an appropriate approach, prevention and intervention to this sensitive population group.
- The duration of the implementation of the model is also crucial as we have to be accurate to the required deadlines.

6. CAPACITY BUILDING PLAN:

	CAPACITY BUILDING PLAN						
	Community Capacity Dimensions	Description of objective	Methodology / Activities	Target group	Indicators	Timeline	Work team responsible
1.	Information and Empowerment	-Detailed information and evolution on aspects concerning welfare issues such as benefits, rights for Elderly, relevant legislation e.t.c) -Act against exclusion, neglect and abuse	-Live sessions with the subject of care or carers -Dedicated platform section to work as a portal connection to help guides and information or relevant services -Online supporting sessions	-Subject of care Final beneficiaries (Elderly, Individual) -Family of the Elderly	-Number of beneficiaries -Number of trainees (including volunteers) -Community empowerment -Better quality of life -Improving living condition	March - June 2021	-Work team of "**Merimna** " participating in "**TECMED**"model -Volunteers (after detailed training)
2.	Technological Education	-Education on the basic use of Computers and its function	-Webinar or personalized online activities for training	-Subject of care Final beneficiaries (Elderly, individual)	-Number of beneficiaries -Number of trainees (including volunteers)	March - June 2021	-Work team of "**Merimna** " participating in "**TECMED**"model (including

		-Familiarization on the network use and search	-Development of guides for use of the platform	-Family of the Elderly -Health and social providers	-Community empowerment -Better quality of life -Increasing self-autonomy -Number of Stakeholders		Computer trainers) -Volunteers (after detailed training)
3.	Health promotion and education	Information programs on appropriate nutrition, fitness and physical condition in order to achieve better quality of life and increase of life expectancy	-Training and consultation sessions with dedicated health professionals (psychiatrists, psychologists, social workers, gymnastic, nutritionists) -Online platform guides and recorded videos with training regimes	Subject of care -Final beneficiaries (Elderly, individual) -Family of the Elderly -Health and social providers -Technology -Governance -Care environment and service delivery	-Number of beneficiaries -Number of trainees (including volunteers) -Better quality of life -Prevention of diseases -Culture for social stigma changing -Covid-19 pandemic consequences	March – June 2021	-Work team of "**Merimna** " participating in "**TECMED**" model (including professionals psychologists, social workers, gymnastic trainers, physiotherapists)
4.	Communication/network on current problems and identification needs	Research over the needs of stakeholders Locating their needs in line with the TECMED	-Continued communication with existing or newly involved stakeholders -Development of questioners for	-Subject of care (elderly) -Care environment and service delivery	-Number of Stakeholders -Improving living conditions -Better quality of life -Better communication	March – June 2021	-Work team of "**Merimna** " participating in "**TECMED**"model including adequate trained stuff

		project desired objectives →Maximum quality for the elderly facing social exclusion	further identification of needs	-Health and social providers	-Prevention of depression -Community empowerment -Community network strengthening -Common needs considering lack on provided care		
5.	Contact point identification	-Funding of programs related to active aging and struggle against social exclusion of this sensitive target group (65+)	-Communication with Regional state offices, public and private agencies	-Governance -Health and social providers -Technology -Care environment and service delivery	-Number of beneficiaries -Number of Stakeholders -Number of volunteers -Better quality of life -Improving Community Network -Improving living conditions -Culture for social stigma changing	March – June 2021	-Work team of "**Merimna** " participating in "**TECMED**"model -Volunteers (after detailed training)
6.	Social and psychological assistance from professionals	-Accurate trained professionals on digital social and psychological assistance and support in order elderly to	-Online scheduled support/sessions with professionals (psychologists and social workers)	-Final beneficiaries (Elderly, individual) -Family of the Elderly -Care environment	-Number of beneficiaries -Number of participating professionals -Covid-19 pandemic consequences -Better quality of life	March – June 2021	Work team of "**Merimna** " participating in "**TECMED**"model including psychologists and social workers

		be considered as active member of society		and service delivery			
7.	-Raising awareness	-Widespread information on local population and leadership -Familiarization of communities with the TECMED program and its goals and innovative -Improve participation	-Development of guides and booklets to be shared with stakeholders and community using printed or online means of dissemination	-Technology -Governance Health and social providers -Care environment and service delivery	Number of volunteers -Better quality of life -Improving Community Network -Improving living conditions -Culture for social stigma changing	March – June 2021	Work team of "**Merimna** " participating in "**TECMED**"model -Volunteers (after detailed training)
8.	Multi and Interdisciplinary teams	Promoting multi and interdisciplinary teams that include professionals and caregivers. -Cooperation to achieve active aging taking into account aspects such as gender, social	-Webinars and arranged short meetings or workshops	-Subject of care Final beneficiaries (Elderly, individual) -Family of the Elderly -Health and social providers -Care environment	Number of beneficiaries -Number of participating professionals -Improving Community Network -Improving living conditions -Culture for social stigma changing	March – June 2021	Work team of "**Merimna** " participating in "**TECMED**"model including adequate trained stuff

		determinants of system establishment		and service delivery			
9.	Practical strategies for fundamental change and social justice	-Implementing practical strategies and analyzed plan for future continuous change while promoting inclusion and social justice -Achieve equitable living conditions and active participation in a diverse society for the Elderly facing additional disabilities	-Development of a plan to be shared with healthy and social providers and care homes concerning elderly with disabilities	-Governance -Subject of care -Technology	-Improving Community Network -Improving living conditions -Culture for social stigma changing -Better quality of life	March – June 2021	Work team of "**Merimna** " participating in "**TECMED**"model -Volunteers (after detailed training)

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TEC-MED

TEC-MED Model: Capacity Building Plan in Italy

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ÍNDICE

1. INTRODUCTION

1.1. Project and TEC-MED Model

The TEC-MED socio-ethical and cultural model is based on comprehensive person-centred care. A foundation of person-centred integrated care is a holistic understanding of the person's health and well-being, abilities, self-management skills, needs, preferences, and direct socio-economic environment. The health of an individual not only includes the entire spectrum of physical, mental, and social well-being, but also the ability to adapt and self-manage. Resilience and ability to cope and restore balance are also part of this broader definition of health (TEC-MED d, 2020). Therefore, the TEC-MED model is an integrated model, person-centred, oriented on 6 dimensions (Subject of care, Health and social care providers, Care environment and Service delivery, Governance, Finance and Technology), on three levels of management (macro, meso and micro) and 5 transversal keys (Quality, research and dissemination, gender, Ethics, Social Inclusion, and Transculturality) (fig.1) (TEC-MED e, 2020).

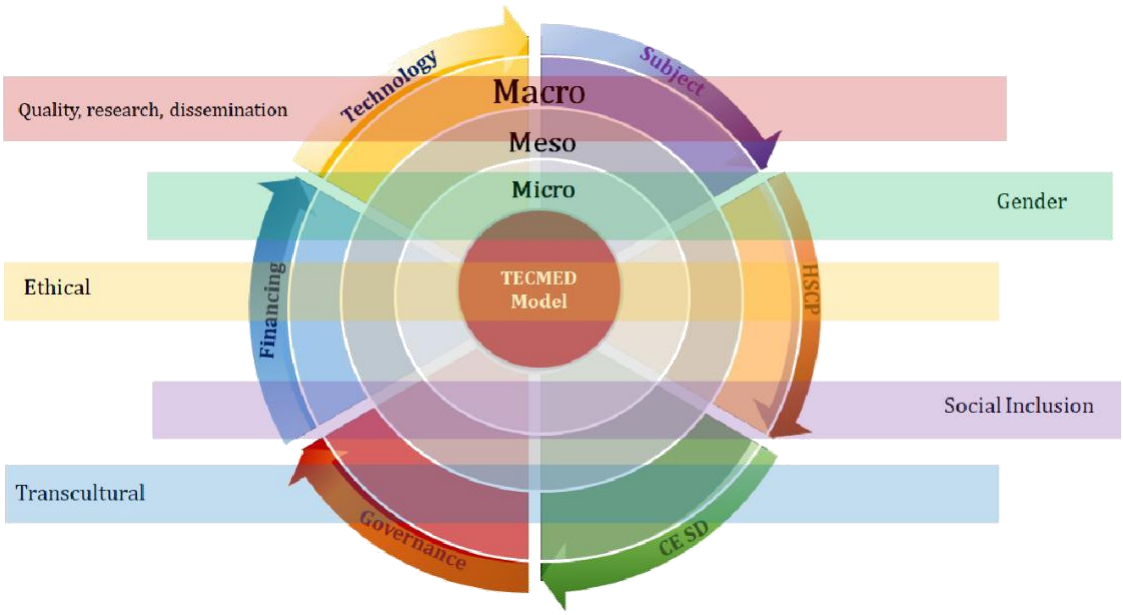

Fig. 1 TEC-MED Model. Theoretical framework.

The dimensions of the frame are described below (TEC-MED d, 2020):

1. *Subject of care*: the subject of care of the TEC-MED model are people over 65 years of age in a situation of dependency or at risk of social exclusion. The person is the subject of assistance and must be placed in the centre of the system. His/her needs should be the starting point of the care process. Furthermore, the person is not (only) a patient or client of health or social care, he/she is a person who lives a life connected with other people in her social environment. In the same way, the family, social resources, and community networks can be considered objects of attention and care.

2. *Health and social care providers*: Health and social care providers are essential for the person to achieve a better state of health and well-being. They must focus on the person with an integrative, multi and interprofessional perspective. For a good and efficient performance focused on quality and user results, it is necessary that sufficient resources are available (number, diversity, skills, good remuneration, balance, and stability over time of workloads). Professionals must have a training approach in the development of capacities from an interprofessional perspective with equality in the treatment of all workers, they must participate in decision-making processes, and they must develop guidelines of attention to guarantee the quality of the Attention.
3. *Care environment and Service delivery*: The context where care is delivered refers not only to the physical environment, which includes accessibility and accommodation (including services, cleanliness, without architectural barriers), but also to the conditions in which care is developed, including the social environment, psychological and human aspects (humanization), hospitality, warmth, affection, response to the needs of the person and, among other topics. Care can take place in their own homes, daily facilities, home care and other community resources, including family needs, should be considered as the context of intervention. On the other hand, the ability to provide quality and effective services is related to having a system centre that serves as an entry point for the care subject.
4. *Governance*: Governance is the process by which social care organizations ensure good service delivery and promote positive outcomes for people who use services. It consists of a wide range of governance and standard-setting functions carried out by government officials. Governance is aimed at developing implementation and change strategies adapted to different care settings and contexts in Europe and the Mediterranean area.
5. *Financing*: Financing is the economic support system of any model. The possibilities are public, private, mixed, or non-profit. This term includes the financial and accounting system, financial sustainability, financial performance, and other matters related to financial matters. This term includes funding priorities at the political and government level.
6. *Technology*: Technology refers to the online support to record information and store it. The roadmap, tools, reports of lessons learned, scientific evidence and good practices can be stored on the technology platform. The technology can be used to train stakeholders or health care providers. In addition, it must be developed under the values of ease of use, availability, and accessibility.

A dignified care for the elderly provides a dignified and positive aging process (PDE), which applies the logic of management procedures to intervention. The principles and criteria constitute the ethical and transversal framework, constituting the basis of the TEC-MED model and are based on universal values that promote the dignity of the elderly, active aging, and long-term care. Therefore, the interrelation between theory and practice

in the intervention is the key to the development of the model, defining the actions at three levels of management, that is, macro, meso and micro (TEC-MED d, 2020):

- *Macromanagement*: Macro refers to the government, political or legislative level in the public administration that provides social care services (may include policy makers and other stakeholders).
- *Meso-management*: It refers to the organizational level such as local government or healthcare management in the hospital, nursing home, etc.
- *Micromanagement*: It refers to the individual level, including people at a professional or non-professional level who provide health and social assistance.

As previously mentioned, the TEC-MED 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 (TEC-MED d, 2020):

- *Quality:* It must be linked to aspects such as respect for human rights and dignity, centred on the person, preventive and rehabilitative, available, accessible, affordable, comprehensive, considering transparency, gender, and culture.
- *Research:* Research support aims to create new knowledge and use existing knowledge good practices in a new and creative way to generate new concepts, methodologies, and understandings, so that they contribute to higher quality.
- *Dissemination:* It refers to sharing research results and good practices with potential users in the field of research, industry, and with commercial and political actors.
- *Gender:* This is about promoting equitable economic independence for women and men, closing the gender pay gap, promoting gender balance in decision-making, ending gender-based violence and promoting gender equality beyond the EU.
- *Ethics:* This concept refers to autonomy as the right of a person to determine their own destiny; charity as a way of doing good (not only for the client, but also for the family and professional social and health care); justice as a way of seeking the distribution of benefits and burdens based on equity and equality. When any of these ethical principles is ignored, a person may risk neglect or abuse. Furthermore, other bioethical principles are related to privacy and confidentiality and empowerment.
- *Social inclusion:* According to the European Committee for Social Cohesion (2004), social inclusion is the ability of a society to guarantee the well-being of all its members, minimizing disparities and avoiding polarization. It's about having access to opportunities, options, and choices in life and having the right resources and support, as well as personal capacity, confidence, and individual resilience. Older people should be treated with fairness and dignity, regardless of their disability or other condition, and should be valued regardless of their financial contribution.
- *Transculturality:* Transculturality consists of a phenomenon of cultural enrichment. The sensitive health care model to explain the link between the provision of patient-centred and culturally sensitive health care is based on a

provision of care that is culturally appropriate, avoiding unnecessary conflict between users and caregivers of diverse cultural backgrounds.

1.2. Protocol of the development of the Capacity Building Plan

The earlier references in the literature about the training plan are from the early 1990s, by the UNCED (United Nations Conference on the Environment), which suggests that the promotion of training "encompasses human capacities, scientific, technological, organizational, institutional and resources of the country "(UNCED, 1992 in TEC-MED c, 2020). Subsequently, capacity building moved to a “more participatory mode” and evolved in the policy discourse towards community capacity building, whereby “Community” we mean a “specific groups and networks of groups that are organized around specific topics, not always delimited in a spatial context” (TEC-MED c, 2020).

The main objective of capacity building is to empower communities (or stakeholder groups representing communities) to define, assess and act on the issues they consider relevant, and to anchor health and social programs in a sustainable way within of the community. This main objective can be achieved through the following specific objectives in line with the theoretical framework and dimensions of the TEC-MED care model and the main transversal axes: quality, research and innovation, gender, social, transversal and ethical inclusion (TEC -MED c, 2020):

- Empowering elderly people and families, and developing elderly education by social, cultural and technological support, including self-care techniques, the learning of new skills and digital competence. (*Dimension 1 - Beneficiary health and social care and Dimension 6: Technology*);
- Training workforce policy and planning with a focus on education and capacity building plans aligned with national health and social care plans. (*Dimension 2 - Health and social care providers*).
- Providing adequate training programs for staff and caregivers with a focus in social care, the basis of the TECMED model; promoting capacity building and training programs to develop skills to working in multi and interdisciplinary teams that includes health and social professionals and caregivers. (*Dimension 2 - Health and social care providers*).
- Strengthening the quality of health and social service delivery on the basis of an integrated social and health care that responds to person and family’s needs and preferences, holistic perspective and person-centred vision. (*Dimension 3 - Care environment and service delivery*).
- Enhancing the proactive health promotion and prevention, fighting with the abuse or neglect in the health and social services as well as a supportive social and physical environment with enough resources, material and human focusing in housing alternatives (*Dimension 3 - Care environment and service delivery*)
- Rising awareness of the importance of the quality of a governance that uses a bottom-up perspective to approach the elderly care from a perspective based on active and positive aging, long-term care and that approaches the gender and

social determinants of health for establishing the systems of care to elderly dependent people and/or at risk of exclusion (*Dimension 4- Governance*).

- Rising awareness of the importance of financing for developing and socio-ethical and transcultural care, also focus on the importance of public and universal funding, the quality and the transparency, and investing in enough material and human resources (*Dimension 5- Financing*).
- Promoting the use of digital social intervention 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 (*Dimension 6- Technology*).

According to a review of literature, several models conceptualized community capacity relative to social and health-determining factors and conditions. The simplest and frequently used model is based on nine domains to build community capacity [3,11,17]. The nine domains of community capacity are: 1. Participation; 2. Leadership; 3. Organizational structures; 4. Problem assessment; 5. Resource mobilization; 6. Enhances critical awareness/reflexivity; 7. Links with others; 8. Role of the outside agents; 9. Program management (Labonte & Laverack 2001; Strobl, Brew-Sam, Curbach, Metz, Tittlbach, Loss, 2020; Goodman, Speers, McLeroy, Fawcett, Kegler, Parker, Smith, Sterling, 1998).

This domain approach can be used within the context of a program to better plan and implement community capacity development. Likewise, according to the Capacity protocol, the training evaluation process focuses on covering the following activities (UNDP, 2008):

- Involve stakeholders.
- Clarify objectives and expectations with primary users.
- Adapt the assessment framework to local needs.
- Determine the approach to analysis and collection of data and information.
- Determine how to conduct the assessment (equipment, location).
- Plan and estimate the cost of the capacity assessment (based on equipment composition, design, and duration).

1.3. Stakeholders, networks, and key agents

The following areas of interest for the community have been evidenced: the public (health administration), social, research, business, and administrative sectors, as well as civil society, known as community helices (Fig. 2) (TEC-MED d, 2020).

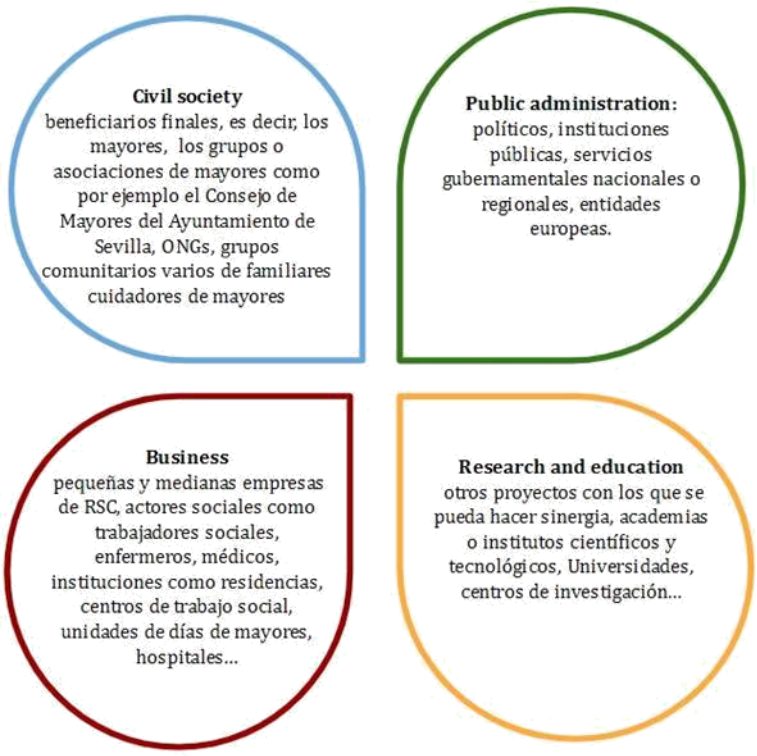

Fig.2 3 Quadruple Helix. Source: Carayannis & Campbell (2009).

Considering this approach, the following stakeholders have been identified:

I. *Final beneficiaries*: People over 65 years of age, dependents and/or at risk of social exclusion who require social and health care.
II. *Caregivers*: Individuals who dedicate themselves individually to the care of the elderly in an unpaid way, dependent and / or at risk of social exclusion (e.g., family members).
III. *Health professionals*: Socio-health personnel who dedicate themselves in a professional and paid manner to the care of dependent elderly people and / or at risk of social exclusion.
IV. *Health services companies*: Private companies dedicated to caring for the elderly.
V. *Community groups*: associations, foundations, dedicated to socio-health care:
VI. *Public administrations*: Public entities that are dedicated to the care of dependent elderly people and / or at risk of social exclusion through the creation of public care services and policies.
VII. Research and education: The centres of knowledge and university education that are dedicated to care, and in particular to care for the elderly.

1.4. Protocol of the Detection of training needs in Stakeholders and Target Groups. Workshop - February 26, 2022.

On February 26th 2022, took place the Workshop: "*TEC-MED Model: Detection of training and capacitation needs in Stakeholders and target groups*" (Annex 1), in which more than 20 people belonging to the target groups participated and in particular:

- Final user: dependent elderly person and/or at risk of exclusion
- Caregiver
- Health Professional
- Public administrators of socio-health services
- Research and education.

To detect training needs when we approach community training in relation to the TEC-MED model, we are faced with the question: what do we expect our community capacity to look like?
The methodological technique chosen to detect training needs by promoting global participation is the ***nominal group***.
The creation of the Nominal Group technique is attributed to A.L. Delbecq and A.H. Van de Ven, and it became particularly well known in 1975. Delbecq and Van de Ven argued that the nominal group process consists of a structured meeting that aims to provide an orderly procedure for obtaining qualitative information from interested groups, who are associated with a specific problem or a specific area (Olaz, 2016). According to Huerta (2005), evaluation expert, the nominal group is a tool to obtain structured information, generating ideas in a stress-free environment, where the participants can express their ideas both orally as written.
The process is widely used in health, social service, and education institutions to maximize group participation in problem solving. The technique guarantees a balanced participation of all the people in the group, thus making the most of the knowledge and experience of each participant. **The nominal group is especially useful for identifying problems, establishing solutions, and setting priorities**, by determining the highest priority problems, deciding strategies to achieve needs, and designing quality community services, where the input of citizens is available. Compared with the focus group, it has the advantage that people of different social status can be recruited, the activity does not lend itself to the more extroverted or higher status members dominating the discussion. The Nominal Group technique makes it possible to reach a consensus, and in a short time, on questions, problems, solutions or projects. It allows us to produce and prioritize many elements. Likewise, being a qualitative technique that encourages debate and participation, it allows avoiding sensations such as "losing" and "winning" among group members (Olaz, 2016). In this way, in the first part the opinion of the group is obtained through a debate among the participants and in the second part, the final result is the assessment of the problem with its priorities (Olaz, 2012).

The nominal groups of the Workshop were 4 and each group made up of 4 participants (in relation to the 4 identified profiles of interested groups) and 2 moderators:

- Final beneficiaries (elderly and/or caregiver)
- Health professionals
- Public administrators of socio-health services
- Research and education

In the four work groups, 2 hours of duration, 2 questions were answered:

I. **What are the training needs of "each profile"?** (In each group the question will be presented with a different profile, for example: group 1- What are the training needs of final beneficiaries and caregivers; group 2- What are the training needs of healt professionals, etc.).

II. **What strategies can be carried out to meet the needs detected, considering the Capacity Building protocol?**

In each one of the four work groups, participants for each profile (4 people per group + 2 moderators) were included, offering different perspectives thanks to different backgrounds, enriching the debate, and providing a complete vision.
The facilitators of the workgroups were members of the research team of the TEC-MED project adjuvated by other staff units made available by the implementing partner. Preferably, in each workshop there were **two facilitators** encouraging the debate. They had to prioritize five answers for each question. The chosen priorities were to lay the foundation for the Capacity Building TEC-MED model.
The Workshop took place online, with some participants and moderators who joined live. During the Workshop, an opening plenary session was organized, followed by four parallel sessions. In the parallel sessions, interesting debates took place, providing important feedback on the community construction of the Capacity Building plan. Finally, in a conclusion plenary session, the facilitators communicated the priorities established in each workshop so that they could be re-voted among all the participants with a multivalued scale from 1 to 10.

2. DETECTED TRAINING NEEDS

The following paragraph specifies the main priorities that were identified in the Workshop developed for each of the workshops, identifying the stakeholders.
These priorities are shown in order according to the results obtained in the survey, including the main statistics for each of them (mean, median, standard deviation, 25th percentile and 75th percentile).

2.1 FINAL BENEFICIARIES

Identified need	Average score obtained	Median	Standard deviation	Percentile 25	Percentile 75

Adequate information on the social assistance path of the final beneficiaries	8,86	9	1,1	8	10
Knowledge of institutional and non-institutional services	8,45	9	1,3	8	9
Ability to do self-care by the final beneficiaries	8,43	9	1,1	8	9

Table 1. Detected needs in Workgroup 1.

2.2 HEALTH PROFESSIONAL

Identified need	Average score obtained	Median	Standard deviation	Percentile 25	Percentile 75
Development of relational skills (empathy, listening, communication) of the socio-health professional	9,27	10	1,1	9	10
Ability to identify and analyze the need (present and previous) of the elderly / caregiver	9.18	10	0.9	8	10
Decision-making autonomy of the socio-health professional	8,45	9	1,3	7	10
Advanced skills in therapy management	7.86	8	1.7	7	9
Use of technological supports for the relationship with the elderly / caregiver and between operators	7.32	7	1.9	6.25	8.75

Table 2. Detected needs in Workgroup 2.

2.3 PUBLIC ADMINISTRATORS OF SOCIO-HEALTH SERVICES

Identified need	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75

Ability to create a network between local services	9,18	10	1,1	9	10
Active involvement of the final beneficiaries in the assistance process	8,77	9	1,3	8	10
Ability to identify the case-management in social and health care for the elderly	8,76	9	1,1	8	10

Table 3. Detected needs in Workgroup 3.

2.4 RESEARCH AND EDUCATION

Identified need	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Develop a case management for social and health services	8,76	9	1,2	8	10
Knowledge of the legislation and procedures of the social and health care protocols	8,64	9	1,4	8	10
Knowledge of the resources of the territory (population)	8,45	9	1,4	7,25	9,75

Table 4. Detected needs in Workgroup 4.

3. TRAINING ACTIONS

Among the objectives of the Workshop, in addition to identifying the training needs of each profile, was the definition of strategies or actions to respond to the training needs identified and which have been collected in the previous chapter.
The most valued strategies / actions for each of the interest groups are shown below, like the previous section.
Both sections will serve as inputs for the Training Plan that will be shown in the following section.

3.1 *Strategies/actions of training.*

The following training actions have been detected to carry out:

3.1.1 FINAL BENEFICIARIES

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Create a social network to support the elderly person	9,14	9	0,9	9	10
Continuous training of operators in a flexible and interactive way	9,09	9	1,0	8,25	10
Education and information in the field of the caregiver and the elderly in a flexible and interactive way	8,68	9	1,1	8	9

Table 8. Proposed strategies in Workgroup 1.

3.1.2 HEALTH PROFESSIONALS

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Strengthening of teamwork strategies at a multidisciplinary level	9,09	10	1,2	8,25	10
Specific training courses for the figures involved in the care process	8,90	9	1,0	8	10
Use of technologies for assistance	8,59	9	1,1	8	9,75
Improved attention in the phase of taking charge of the elderly	8,27	8	1,3	8	9
Develop cross-cultural skills of the caregiver and the final beneficiary	7,91	8	1,3	7	9

Table 9. Proposed strategies in Workgroup 2.

3.1.3 PUBLIC ADMINISTRATORS OF SOCIO-HEALTH SERVICES

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Strengthening of structural and human resources	8,86	9	1,1	8	10
Creation of interdisciplinary work groups with active inclusion of the elderly / caregiver	8,71	9	1,1	8	10
Moments of planned and structured sharing between institutions and local services	8,68	9	1,3	8	10

Finding strategies for sharing and identifying operational tools for the development of a social and health care project	8,45	9	1,0	8	9
Diffusion of support services and implementation of innovative methods	8,45	9	1,2	8	9
Collection and sharing of the experiences from the elderly in the interdisciplinary work group	8,41	8	1,2	8	9
Presence of a figure or service who informs the elderly about his or her rights and acts as a facilitator	8,32	8	1,4	8	9

Table 10. Proposed strategies in Workgroup 3.

3.1.4 RESEARCH AND EDUCATION

Training Strategies	Average score obtained	Median	Typical deviation	Percentile 25	Percentile 75
Characterize the caregiver: role and functions	8,14	9	1,4	7,25	9
Organizational models centered on the elderly that include transversal, inclusive and usable services	8,90	9	0,9	8	10
Collection and analysis of the training needs of operators	8,36	8	1,1	8	9
Data collection and analysis of the territorial context	8,24	8	1,3	7	9
Data collection and analysis of the needs of the elderly and caregivers through family doctors and operators through the administration of questionnaires, including online	7,68	8	1,9	7	9

Table 11. Proposed strategies in Workgroup 4.

3.2 Capacity Building Plan.

After having included in this document the training needs detected within the Workshop carried out for each of the profiles, as well as the training strategies to respond to the identified needs, the Training Plan with which they are pursued is developed below. reduce said training needs identified for each of the profiles that are the object of the TEC-MED Model by applying, whenever possible, the training strategies indicated as a result of the Workshop itself.

Therefore, although the training plan of the TEC-MED Model, taking into account the beneficiary profiles, could be very extensive and diverse, it has been decided to take into account the results of the actions implemented throughout the project, counting as well as what has been defined by the experts who have participated in the process that has been carried out, this being the basis of the Training Plan that is presented below.

3.2.1 FINAL BENEFICIARIES

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to which the capacity building plan belongs
Adequate information on the social assistance path of the final beneficiaries	**Social assistance path**	Meeting with the beneficiaries at the beginning of the service Information of the general public about the assistance path in the local context	Subject of care.	Improved participation
Knowledge of institutional and non-institutional services	**Institutional and non institutional services**	Information of the general public about the assistance path in the local context Public meeting with target population about all the services available in the specific area	Subject of care.	Empowerment Problem solving
Ability to do self-care by the final beneficiaries	**Self-care**	Theoretical and practical training about self caring	Subject of care.	Improved critical awareness Problem evaluation

Table 15. Results of training needs - Final Beneficiaries.

Training Actions	Educational objectives /	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment

	learning outcomes						
Social assistance path	Improve the participation of beneficiaries in their care path. Acquire knowledge about the steps in socio-health assistance he/she will receive.	Meetings with beneficiaries and caregiver	At the beginning of service (starting meeting, 1 hour aprox) and on a quarterly basis during the assistance (follow-up meeting, 30 mins aprox). The meetings could be done at home of the patiens	Rights and duties of the assisted person Rights and duties of the assisting person Basic steps and procedures in home care in different settings The role of each health and socio professional involved	Room equipped for small meetings (either at home) Brochures and documents about the service delivery	Health care professional care giver	Satisfaction survey Report of starting and follow-up meetings
Institutional and non institutional services	Improve the empowerment of beneficiaries in seeking assistance. Acquire knowledge about the available services.	Meetings with beneficiaries and caregiver (online or live) Website of the institutional entity providing the service Dissemination of information material in strategic places (shops, churches,	On a semestral basis, meeting for presentation of all the services available in the area. It could be either online or live, 1 hour aprox. Ongoing distribution of information material	List of social services available and methodologies to activate them List of health services available and methodologies to activate them	Rooms for group meetings Web platform for online meeting Brochure about health and social services available	Health care professional Public administrators of socio and health services	Satisfaction survey Report of meetings

		medical clinics, gym..)					
Self-care	Improve the empowerment of beneficiaries about their health. Acquire knowledge and techniques of care and self-care. Have tools that improve your quality of life and well-being.	Training workshops (either virtual or live) Practical training	Specific workshops (1 hour aprox) about different topics Training sessions at home with health care professionals (aprox 30 mins) on a monthly basis	Healthy lifestyle habits (food, healthy diet, etc). Hotwaves management Most common ailments in the elderly and prevention activities (osteoarthritis, arthritis, prevention of falls, prevention of abuse, etc.). Physical activity (strength exercises, balance, stretching). Pharmacological management. First aid. Sleeping hygiene.	Rooms for group meetings Web platform for online meeting	Health care workers, nurses, fisiotherapists… University researcher/professor	Satisfaction survey

Table 16. Results of training actions - Final Beneficiaries.

3.2.2 HEALTH PROFESSIONALS

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to which the capacity building plan belongs
Development of relational skills (empathy, listening, communication) of the socio-health professional	Relational skills, empathy, listening, communication	Workshops about relational skills	Health and social care provider Subject of care	Empowement
Ability to identify and analyze the need (present and previous) of the elderly / caregiver	Detection and analysis of assistance needs	Workshops and seminaries about the use of tools for detection of assistance needs	Health and social care provider Subject of care	Increase the evaluation of problems.
Decision-making autonomy of the socio-health professional	Decision making	Training about the most common socio-health problems that could occur	Health and social care provider	Improve problem solving abilities
Advanced skills in therapy management	Therapy management	Workshops about therapy management	Health and social care provider	Improve problem solving abilities
Use of technological supports for the relationship with the elderly / caregiver and between operators	Communication technologies	Empowerment of beneficiaries, caregivers and health professionals	Technology Health and social care provider Subject of care	Resources mobilization

Table 17. Results of training needs- Health professionals

* The detection of needs is a step prior to the programming of training plans. The Workshop held and shown in this document is one of the actions carried out to respond to this identified training strategy, having been distributed by peer groups. Subsequently, this strategy will be reinforced again through the evaluations of the training actions that are being developed for the profile.

Training Actions	Educational objectives / learning outcomes	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment
Relational skills, empathy, listening, communication	Empower health care workers to be more empathic and able to early detect the beneficiary's needs	Workshops about relational skills	1 seminar (or webinar) per year (2 hours aprox)	Relational skills: empathy, listening, communication, understanding of others' positioning	Room equipped for group sessions with basic furniture. Tele-formation Platform	Psychologist Communication expert Beneficiary	Post course test
Detection and analysis of assistance needs	Empower health care workers to be more able to detect the needs of the elderly (both at home and in a facility)	Workshops and seminaries about the use of tools for detection of assistance needs (both at home and in a facility)	1 seminar (or webinar) per year about (1 hour aprox)	Scales and methods to assess the assistance needs of elderly people both at home and in a facility	Room equipped for group sessions with basic furniture. Tele-formation Platform	Doctors, nurses, psychologists University researchers/professors	Post course test
Decision making	Empower health care workers to be more able to quickly make decisions and take actions in specific situations	Training about the most common socio-health problems that could occur	2 seminars (or webinar) per year (2 hours each aprox)	The most common socio-health problems that could occur in specific situations that require prompt decision making and action taking (falls, burns, problems at home with infrastructures, suffocations, etc…)	Room equipped for group sessions with basic furniture. Tele-formation Platform	Doctors, nurses, psychologists University researchers/professors	Post course test
Therapy management	Empower health care workers with fundamentals of	Workshops about therapy management	2 seminars (or webinar) per year	Therapies for the most common health probelms in the elderly	Room equipped for group	Doctors, nurses, psychologists	Post course test

	most common therapies of the elderly		(2 hours each aprox)	(hypertension, diabetes, respiratory diseases, urinary tract infections, O2 therapy, etc…)	sessions with basic furniture. Tele-formation Platform	University researchers/professors	
Communication technologies	Reduce the digital divide for caregivers, beneficiaries and health care workers	Empowerment of beneficiaries, caregivers and health professionals	1-hour sessions to increase knowledge and share experiences. Resources and guides on the platform. Group leisure workshops through the platform.	Internet, Instant messaging tools, Video conferencing tools, Social media. Use of tablets and mobiles. Digital home. Telecare and Telemedicine	Room equipped for group sessions with basic furniture and availability of computers and tablets. Tele-training platform. Telecare and telemedicine tools.	Technological consultants. Advertising and public relations. Professionals in the field of communication and marketing.	Satisfaction survey

Table 18. Results of training actions - Health professionals

3.2.3 PUBLIC ADMINISTRATORS OF SOCIO-HEALTH SERVICES

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to which the capacity building plan belongs
Ability to create a network between local services	Creation and articulation of care networks	Workshop with stakeholders	Providers of care Governance	Strengthen ties with other organizations and individuals Control over program management increases
Active involvement of the final beneficiaries in the assistance process	Creation and systematization of practices for the inclusion of the beneficiaries	Planification meetings with health care providers in order to plan proper inclusion of beneficiaries (ex through the organization of meetings with beneficiaries)	Providers of social and health care. Final beneficiaries	Increased participation
Ability to identify the case-management in social and health care for the elderly	Creation of criteria for selection of case-managers	Workshop with stakeholders to define the correct criteria to select case-managers	Providers of social and health care Context and care system	Increase the evaluation of problems. Improve problem solving abilities

Table 19. Results of training needs - PUBLIC ADMINISTRATORS OF SOCIO-HEALTH SERVICES

Training Actions	Educational objectives / learning outcomes	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment
Creation and articulation of care networks	Knowledge about the articulation of services in the area of interest	Workshop with stakeholders Coordination meetings with public	1 workshops (3 hours each) to establish the service network	List of all services available on the field	Room equipped for group sessions with basic furniture.	Public administrator of socio-health services (moderator)	Satisfaction survey

		administrators of socio-health services	Quartely meetings with public administrators of socio-health services		Teleformation Platform.		
Creation and systematization of practices for the inclusion of the beneficiaries	Inclusion strategies and inclusion plan	Planification meetings with health care providers in order to plan proper inclusion of beneficiaries (ex through the organization of meetings with beneficiaries)	Initial meeting with health care providers (2 hours aprox), quarterly meetings for follow up of inclusion of beneficiaries	Inclusion plan for beneficiaries (ex through the organization of meetings with beneficiaries)	Room equipped for group sessions with basic furniture. Teleformation Platform.	Public administrator of socio-health services (moderator)	Creation of an Inclusion Plan
Creation of criteria for selection of case-managers	Empower public administrators of socio and health services to identify proper case managers	Workshop with stakeholders to define the correct criteria to select case-managers	1 workshop (3 hours aprox) to draw the profile of the case manager and possibile criteria of selection	Profile of the case manager Criteria of selection of case managers	Room equipped for group sessions with basic furniture. Teleformation Platform.	Public administrator of socio-health services (moderator)	List of criteria for inclusion of case manager

Table 20. Results of training actions - PUBLIC ADMINISTRATORS OF SOCIO-HEALTH SERVICES

3.2.4 RESEARCH AND EDUCATION

Detected training need	Capacity Actions	Capacity strategies	Model dimension	Dimension to which the capacity building plan belongs
Develop a case management for social and health services	Case management for social and health services	Workshop Systematic review of the literature Drafting of proposal model for case management	Care environment and Service delivery Governance	Increase the evaluation of problems. Control over program management increases
Knowledge of the legislation and procedures of the social and health care protocols	Legislation and procedures of the social and health care protocols	Workshop with researchers in the field Systematic review of the literature	Health and social care providers Care environment and Service delivery Governance	Knowledge about management increases
Knowledge of the resources of the territory	Resources of the territory	Workshop with stakeholders	Care environment and Service delivery Governance	Strengthen ties with other organizations and individuals.

Table 21. Results of training needs - Research and education.

Training Actions	Educational objectives / learning outcomes	Methodology	Temporalization (Duration)	Contents	Resources	Instructor profile	Assessment
Develop a case management for social and health services	Researchers and education are empowered to contributing in the drafting of recommendation for management of social and health services in	Systematic/narr ative review of the literature Workshop Drafting of proposal model for case management	1 review of the literature conducted by researchers in the field 1 workshop with stakeholders (3 hours aprox) 1 document with recommendations from	Management of social and health services in the specific context	Access to scientific literature Room equipped for group sessions with basic furniture. Tele-formation Platform.	Researcher s / professors Public administrat ors of socio and health services	Satisfaction survey Document produced

	the specific context		literature review and workshop			Health care providers	
Knowledge of the legislation and procedures of the social and health care protocols	Researchers and education are empowered about legislation of health and social services in Italy and Europe Procedures of the social and health care protocols	Workshop with researchers in the field Systematic/narrative review of the literature	2 seminaries (either online or live) with researchers expert in the field (aprox 2 hours each) A systematic/narrative review of the literature	Legislation of health and social services in Italy and Europe Procedures of the social and health care protocols	Room equipped for group sessions with basic furniture. Tele-formation Platform. Access to scientific literature		Satisfaction survey Document produced
Knowledge of the resources of the territory	Researchers and education are empowered about all the social and health services present on the specific local context	Workshop with stakeholders	1 workshop with stakeholders (3 hours aprox)	All the social and health services present on the specific local context	Room equipped for group sessions with basic furniture. Tele-formation Platform.	Researchers / professors Public administrators of socio and health services Health care providers	Satisfaction survey

Table 22. Results of training actions - Research and education

4. CAPACITY ASSESMENT

There are different types of evaluation, each with a different purpose. When designing an evaluation strategy, the first thing that is necessary is to identify the questions to which it is intended to answer, and therefore the type of monitoring or evaluation to be carried out (LaFond & Brown, 2003).

Regarding the results of a project and its evaluation, the UNDP (United Nations Development Program) highlights the need to design evaluation tools following some general principles (Werf, 2007):

Clarity of purpose: what, why and for whom?

Nature of information required and choice of data collection method: Specific survey questions reduce information overload).

Overall management of the evaluation process: The tools and indicators are developed for use in combination with information from other sources and good evaluations.

It should be observed that an important distinction in the nature of indicators is the difference between short-term and long-term indicators. In the literature, different terms are used to describe these various types of indicators. In general, the first type would give an idea of the "specific actions and steps" that were taken during certain activities of the training plan. The second type would seek to describe the state of enhanced training (or decreased) (Werf, 2007).

The development of a training plan is a continuous process in which many results of an intervention are not directly visible or measurable, therefore, it is necessary to establish indicators that facilitate the evaluation process. According to Werf (2007), the established indicators may not be entirely correct in measuring

the impact when the period of a project is too short. The challenge in building an adequate assessment tool is to incorporate these elements of uncertainty. In the training plan construction processes, many organizations opt for a more participatory strategy, through which the evaluation process to develop indicators involves different actors. This type of approach contributes to the improvement of the development of indicators both in the impact evaluation process and in the results (Werf, 2007).

In general, all indicators tend to share the following aspects (LaFond & Brown, 2003):

Validity: It refers to whether the indicator can measure what it had set to measure. The indicators must be closely related to the intervention.

Reliability: Refers to the degree of random measurement error in an indicator. The error may result from sampling. If the answer is objective or subjective.

Well defined: Indicator definitions have to use clear and precise terms so that everyone involved can understand what it is intended to measure.

Sensitivity: It refers to the changes in the elements of the evaluated program.

Another example of indicator development is the SMART (Specific, Measurable, Appropriate, Realistic and Temporal) model adapted by FAO in 2007 as seen below: (Werf, 2007):

Specific: The indicator must specify clearly, unambiguously, what it will measure, and the set of indicators must be concise.

Measurable: The indicator must be measurable through quantitative or qualitative mechanisms. Assessment scales should be based on agreed intervention criteria and expectations and should be accompanied by viable methodologies and resources for measurement. The definitions of indicators and scales should support unbiased ratings.

Appropriate (or relevant): The indicator should be related to the project objectives and objectives. It must be based on an agreed and adequate identification of what is to be measured / evaluated. It must be based on a solid and demonstrated relationship with the result. Furthermore, the set of indicators must be comprehensive to cover all relevant questions.

Realistic (or achievable): The resources involved in the project must be real and sufficient, from a human and economic point of view, to measure the indicator.

Temporal (or time-based): The indicator must be measurable / evaluable within the project term.

In the field of capacity measurement in health and other sectors, LaFond and Brown (2003) extract the following "lessons" on the development of indicators:

I. Lesson 1: Indicators should reflect an understanding of the change strategy for training development. The process of choosing training indicators should feed the general strategy for change, designed to develop capacities, and improve performance. Indicators should be developed in conjunction with capacity mapping when designing a training plan intervention. Furthermore, evaluators have an active role in trying to understand how to use the information to ensure that indicators become incentives for change rather than barriers.
II. Lesson 2: Indicators should capture organizational and behavioral change, as well as material and technical changes. The most challenging training demand to measure is human and organizational behavior change. Especially in the health sector, there is a tendency to advance explanations of what are likely to be organizational or human behavior problems. For example, it is often assumed that training health providers alone will address gaps in service delivery, yet the root of the poor performance problem may be due to unreliable sources of supplies for people with problems. of health. Evaluators must have an idea of how people and organizations change, what causes lasting change, and why changing certain values and practices makes a difference. Training indicators must capture the essence of these changes in human and organizational behavior.
III. Lesson 3: In planning the training evaluation plan, it is important to monitor not only the training, but also key aspects of the intervention and the context.

Evaluators should review changes in the intervention along with the ability to examine relationships between different variables of training and performance. Additionally, evaluators need to track contextual changes. Environmental factors often help explain changes (or lack of change). Indicators that monitor external conditions serve as a warning that training and performance may have risks.

IV. Lesson 4: Indicators should foster ownership of the training process. Evaluators should work with stakeholders in capacity development to define indicators that reflect locally accepted notions of change. Evaluators should also keep in mind that measurability can also be an issue. Organizations and individuals do not enjoy documenting their "weaknesses." The quality of the data collected to build capacity indicators could be distorted and / or obstructed unless the purpose of monitoring and evaluation is not clear to all stakeholders.

V. Lesson 5: The results of the indicators must be interpreted with caution. The evaluators will have to consider the following aspects:

a. Capacity development is context specific. Training development is context specific. This reflects qualitative as well as quantitative changes in the availability of resources. Given the wide range of possible scenarios and training objectives, it is often not possible to establish objective standards that allow local or regional comparisons of training between similar entities. Internal benchmarks can be set but may not be valid for other entities or contexts.

b. The selection of training indicators is often very subjective. To foster relevance, evaluators often rely on perceptions of capacity and change among participants in the training development process as a basis for measuring progress. Therefore, it is necessary to balance subjective measures with a range of indicator objectives and data collection strategies.

c. Training is influenced by many variables. Therefore, there is a tendency to evaluate several indicators at the same time. It is advisable to promote the use of multiple indicators for each level within the training map because they provide greater understanding and can serve to validate recommendations. The use of multiple indicators is often recommended to explain what an imprecise situation or occurrence may be. However, at the same time, the evaluators must prioritize indicators based on the objectives of the program, thus fostering the development of a viable set.

d. Evaluators are experimenting with complex indicators that combine a short list of essential indicators into a single training measure.

e. Determining the cause and effect of training is not easy to assess, although a training map could clearly indicate assumptions about relationships between variables. Some evaluators have found linear evaluation frameworks and the strict use of inflexible and mechanical indicators is not effective in monitoring and evaluating training.

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TEC-MED Model:

Capacity Building Plan in Lebanon

IDRAAC, LEBANON (PP7)

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Table of Contents

1. Introduction

The TEC-MED model was developed through a thorough participatory process involving all partner countries which included a literature review and state of the art assessment, structured interviews with stakeholders and a gap analysis through a Delphi panel with experts.

The dimensions of the theoretical framework of the model were defined as follows:

1. Subject of care: person aged 65+ dependent and at risk of social exclusion. (to consider the person and his/her social environment)

2. Health and social care providers: health and social professionals, formal and family caregivers.

3. Care environment and Service delivery: social & healthcare, homecare, and taking into consideration accessibility, accommodation, and prevention.

4. Governance: participation of users and family members, awareness, policies – active aging, management of resources, and needs assessment.

5. Financing: public & private, through initiatives and entrepreneurship.

6. Technology: including mobile technology (training, monitoring, etc…), telemedicine, artificial intelligence, robotics, sensors…

For each of the dimensions, three levels of action were defined: macro, meso and micro:

- Macro management: 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.

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.

They are: quality, research and dissemination; gender perspective, ethics, social inclusion, transcultural. (Figure 1)

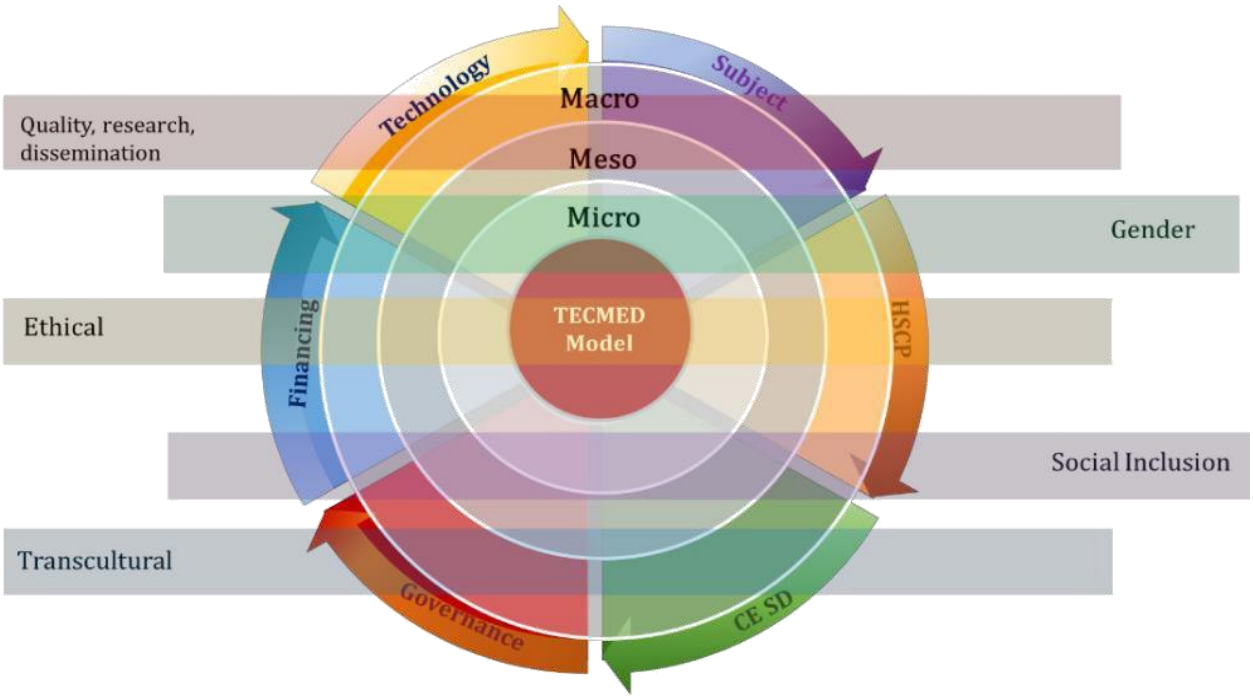

Figure 1: TEC-MED Model care

TEC-MED model care includes

- ***6 dimensions** : 1. Subject of Care, 2. Health and Social Care Providers- HSCP, 3. Care Environment and Service Delivery-CE SD, 4. Governance, 5. Financing, 6. Technology.*
- ***5 key transversal concepts**: Quality, research and dissemination, Gender, Ethical, Social Inclusion, Transcultural ;*
- ***3 levels of managements**: macro, meso, micro level.*

Capacity building is an important aspect with regards to the implementation of the TECMED model in an effort to provide stakeholders such as older people and their caregivers, health- and social care workers and local authorities and community groups guidance for elderly care and the proper implementation of the model/

In support of the implementation of the transcultural social-ethical-care TECMED model developed for dependent and/or at risk of exclusion elderly populations in six countries (Spain, Egypt, Lebanon, Greece, Italy and Tunisia), a number of actions are planned, among them:

- Developing a partnership platform for sharing knowledge and good practices, as well as enhancing the visibility of the model;
- Formulating and applying a capacity building plan to strengthen skills of key agents involved in the implementation of the model (training agents, caregivers-formal and family-, final beneficiaries and other stakeholders focus in the quadruple helix and the three levels of management-macro, meso, microlevel);
- Responding to specific national or local capacity needs;
- Promoting the sharing of experiences and the dissemination of best practices between partner countries.

These actions will be implemented through the capacity building plan established by each country and IDRAAC, PP7, has worked on developing this plan for Lebanon.

The main objective of capacity building is to empower communities (or stakeholder groups representing communities) and this can be achieved via the following specific objectives in line with the theoretical framework of TEC-MED model care and the main cross-sectional themes: quality, research and innovation, gender, social inclusion, transcultural, and ethic.

- Empowering elderly people and families, and developing elderly education by social, cultural and technological support, including self-care techniques, the learning of new skills and digital competence. (***Dimension 1*** - *Beneficiary health and social care and* ***Dimension 6:*** *Technology*);
- Training workforce policy and planning with a focus on education and capacity building plans aligned with national health and social care plans. (***Dimension 2*** - *Health and social care providers*).
- Providing adequate training programs for staff and caregivers with a focus in social care, the basis of the TECMED model; promoting capacity building and training programs to develop skills to working in multi and interdisciplinary teams that includes health and social professionals and caregivers. (***Dimension 2*** - *Health and social care providers*).
- Strengthening the quality of health and social service delivery on the basis of an integrated social and health care that responds to person and family's needs and preferences, holistic perspective and person-centred vision. (***Dimension 3*** - *Care environment and service delivery*).
- Enhancing the proactive health promotion and prevention, fighting the abuse or neglect in the health and social services as well as a supportive social and physical environment with enough resources, material and human focusing in housing alternatives (***Dimension 3*** - *Care environment and service delivery*)
- Raising awareness of the importance of the quality of a governance that uses a bottom-up perspective to approach the elderly care from a perspective based on active and positive aging, long-term care and that approaches the gender and social determinants of health for establishing the systems of care to elderly dependent people and/or at risk of exclusion (***Dimension 4-*** *Governance*).
- Raising awareness of the importance of financing for developing and socio-ethical and transcultural care, also focus on the importance of public and universal funding, the quality and the transparency, and investing in enough material and human resources (***Dimension 5-*** *Financing*).
- Promoting the use of digital social intervention 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 (***Dimension 6-*** *Technology*).

2. Methodology

As part of activity A. 6.1.2. Community Engagement and Enlarging Activities and Network Strengthening and in preparation of the network and key agents capacity building plan, a workshop was planned to discuss two major aspects:

1. The needs for capacity building in relation to the implementation of the TEC-MED model for the care of dependent elderly people and / or at risk of social exclusion
2. The target population for capacity building

In view of the current COVID and renewal of the lockdown situation in Lebanon, we were facing difficulties in gathering stakeholders at the same time to be part of the workshop even online.

Lebanon currently has among the highest rates of spread of the virus at the moment and the death rates have dramatically increased. Hospitals and institutions (particularly those working with the elderly) are very concerned and preoccupied with the current situation.

After agreement with the LB and PP5, we have opted for phone and video interviews with the stakeholders while going through the same agenda and questions we wanted to do in the workshop in order to facilitate the process for our stakeholders and have their feedback at different times. We completed a total of 12 interviews which have guided the development of the stakeholders' capacity building plan report related to Lebanon.

The participants were from different profiles highlighted in the Quadruple Helix model (Civil Society/users, Research and Education, Business and Public Administration) (Carayannis & Campbell, 2009) and from different management levels (Macro, Meso, Micro).

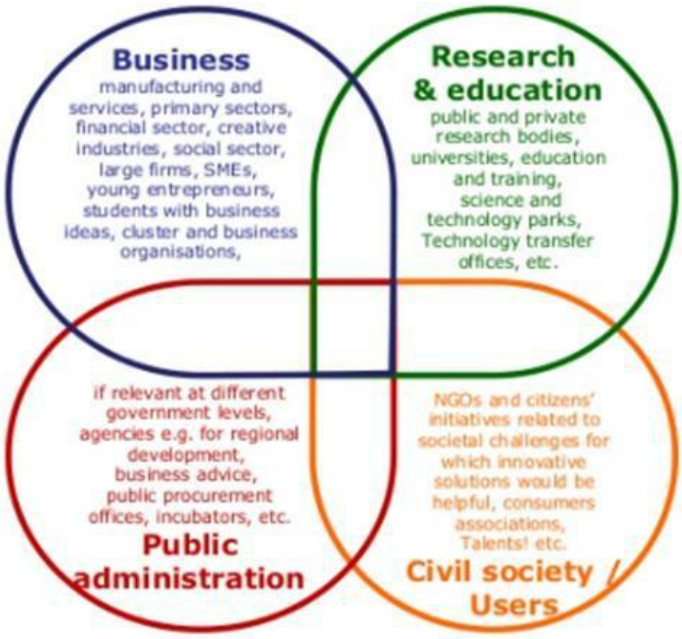

Figure 2. Quadruple helix of stakeholders Source: Carayannis & Campbell (2009).

This meeting has helped in identifying capacity building needs for the different groups in preparation for the implementation of the foreseen project's activities.

Interviews were conducted through online channels (Zoom, Teams, Videocalls) as well as phone calls depending on the preference of each stakeholder.

Each interviewee was updated on the latest advancements of the project and asked to give an overview about his/her work with the target population of the project and elaborate on the following needs:

- capacity building/training of end users/older adults
- capacity building/training of non-professional caregivers
- capacity building/training of professional caregivers, etc.
- capacity building/training of public administrators

The different interviewed stakeholders shared their perspectives on the capacity building needs (summary can be found in Annex 1).

To prepare the capacity building plan, the following steps were followed:

Step 1: Updating the stakeholders' database with new identified stakeholders which are related to the following sectors:

- Public administration (Government and Policy Makers)
- Research and Education / Academics
- Non-governmental bodies and civil society
- Businesses/Private sector
- Society (individuals)

As the Covid-19 situation is already impacting older adults and the institutions working with them, we are working on the inclusion of more entities within our stakeholders' database to ensure the best implementation procedures.

In addition, a mapping of resources and institutions related to older adults in Lebanon is being worked on in parallel in an effort to address community needs and reinforce networking and capacity building efforts among key players.

Step 2: Setting of capacity needs in line with the TEC-MED project objectives and matching the capacity building needs to the stakeholders

Throughout the preparation of the report and the feedback of our stakeholders, we have identified the following groups:

a. End users (referring to older persons)
b. Non-professional caregivers (referring to non-formal caregivers)
c. Professional caregivers (referring to health and social care providers and formal caregivers)
d. Public administrators (referring to governmental entities and supporting bodies in the case of Lebanon)

Step 3: Description of the capacity building plan in terms of topics, objectives, outcomes, targets, methods, timeline, resources and indicators.

3. Identified Needs for Each Group

Following our discussions with stakeholders, the following capacity building needs were identified relating to the target groups and were grouped and summarized below.

Each need was linked to dimensions in the TECMED model of care and domains to enhance community capacity.

Capacity building/training of end users (older adults)	**Model Dimension**	**Domains to enhance Community capacity**
Use of the platform and digital literacy	Subject of Care Technology	Build empowering organizational structures Improve participation
Empowerment and education in old age - activities (cognitive, leisure, social, physical, psychomotor), - self-care, - disease management (chronic conditions, Covid-19, …), - mental health and coping skills - palliative care	Subject of Care	Increase problem assessment and solution Enhance critical awareness/ reflexivity
Elderly rights	Subject of Care Governance	Improve participation

Capacity building/training of non-professional caregivers	**Model Dimension**	**Domains to enhance Community capacity**
Use of the platform and digital literacy	Health and social care providers Technology	Build empowering organizational structures Improve participation

Empowerment and education in old age - activities (cognitive, leisure, physical, psychomotor), - self-care and caregivers' self-care - disease management (chronic conditions, Alzheimer's, Bed Sores, Covid-19, …), - palliative care - mental health and coping skills	Health and social care providers	Increase problem assessment and solution Enhance critical awareness/ reflexivity
Communication with older persons and relational care	Health and social care providers	Create an equitable relationship with others via networks
Preventive measures and enabling environment: First aid, psychological first aid, home safety, …	Health and social care providers Care environment and service delivery	Increase problem assessment and solution Enhance critical awareness/ reflexivity
Available resources and referral to services	Health and social care providers Governance	Develop local leadership & Improve Resource mobilization
Elderly rights and ethical considerations	Health and social care providers Governance	Improve participation

Capacity building/training of professional caregivers	**Model Dimension**	**Domains to enhance Community capacity**
Use of the platform	Health and social care providers Technology	Build empowering organizational structures Improve participation
Training on Interdisciplinary Networking, Interprofessional education, and referral pathways **+ Available resources and referral to services**	Health and social care providers Governance	Develop local leadership & Improve Resource mobilization Strengthen links to other organizations and people

Old age care - active aging (can include empowerment and education in old age: activities (cognitive, leisure, physical, psychomotor), self-care. self-care for caregivers, palliative care, etc… - Psychosocial considerations for old age, mental health and psychological first aid	Health and social care providers	Increase problem assessment and solution Enhance critical awareness/ reflexivity
Communication with older persons and relational care	Health and social care providers	Create an equitable relationship with others via networks
Preventive measures and enabling environment	Health and social care providers Care environment and service delivery	Increase problem assessment and solution Enhance critical awareness/ reflexivity
Elderly rights and ethical considerations	Health and social care providers Governance	Improve participation

Capacity building/training of public administrators	**Model Dimension**	**Domains to enhance Community capacity**
Elderly rights and ethical considerations (+Laws to protect older adults, Improvement of Policies related to old age, Awareness on image of aging, integration of aging concepts in school/professional education,)	Health and social care providers Governance	Improve participation
Networking (+Available resources and referral to services)	Governance Financing	Develop local leadership & Improve Resource mobilization
Governance (+emergency planning and relief for old age)	Governance	Develop local leadership & Improve Resource mobilization
Age friendly activities and services (and giving priorities for older persons in vaccination, decreased waiting time, homecare, etc…) (also addressed to businesses)	Care environment and service delivery	Increase problem assessment and solution Enhance critical awareness/ reflexivity

4. Capacity Building Plan

A capacity building plan was set indicating the topics related to capacity building, objectives and outcomes, methods, target groups, content of the trainings and needed resources as well

Topic	Objectives and Outcomes	Methods	Target(s)	Content	Resources	Responsible	Timeline	Indicators
Use of the TECMED platform and digital capacity	Familiarize the end users of the TECMED platform with the digital tools and services available on the platform.	Formal Training (online or in-person) Video addressing the use and features of the platform.	Older persons. Non-formal caregivers, formal caregivers (after training agents and institutions are trained as well).	Guidance for the use of the TECMED platform for stakeholders.	Manual for Platform Use. Video addressing the use and features of the platform.	IDRAAC	March-June 2021	Training Material Number of training sessions organized Number of persons trained Satisfaction and perceived usefulness Viewership of Recorded Video (if possible, depending on platform)

Elderly rights and ethical considerations	Improve the knowledge of beneficiaries, caregivers and administrators about the rights of the elderly and ethical considerations in elderly care.	Online Training Recorded Webinar to be uploaded on the platform	Older persons. Non-formal caregivers, formal caregivers, public administrators.	Laws and practices related to old age in Lebanon, ethical principles in the care of older adults, legal mechanisms available in Lebanon, protection of older persons.	Trainers (legal and policy) Online Platform for the Webinar. Online section in TECMED Platform to upload the recorded Webinar.	IDRAAC, legal advisor, notary public and associated partner.	March-June 2021	Number of trainings Number of persons trained Satisfaction and perceived usefulness Viewership of Recorded Webinar
Empowerment and care education in old age	Improve the knowledge of beneficiaries and caregivers on the care basis for old age and empower them to address problems related to old age.	Micro-training through videos featuring educational material, role plays, problem-solving and care.	Older persons, non-formal caregivers, formal caregivers.	Content to be included: - activities (cognitive, leisure, social, physical, psychomotor), -self-care, -disease management (chronic conditions, Covid-19, …), -mental health and coping skills - palliative care	Training materials. Trainers (health practitioners) and health promotion specialists. Online section in TECMED Platform to upload the videos.	IDRAAC with health promotion specialists.	March-June 2021	Number of Videos Satisfaction and perceived usefulness Viewership of Recorded Videos (if possible, depending on platform)

Communication with older persons and relational care	Improve communication skills and relational care between older persons and their social network.	Online Training Recorded Webinar to be uploaded on the platform.	Non-formal caregivers, formal caregivers, public administrators, and businesses.	Communication skills and basic communication training adapted to old age.	Training materials. Trainer (communication, health promotion, public health specialist) Online Platform for the Webinar. Online section in TECMED Platform to upload the recorded Webinar.	IDRAAC with health promotion specialists.	March-June 2021	Number of trainings Number of persons trained Satisfaction and perceived usefulness Viewership of Recorded Webinar
Preventive measures and age-friendly environment for old age	Improve the knowledge of caregivers, public administrators and businesses on preventive measures and enabling environment for old age.	Micro-training through videos featuring educational material and role plays.	Older persons. Non-formal caregivers, formal caregivers, public administrators, and businesses.	-Prevention of diseases and old age conditions (falls, frailty, etc…). -First aid and psychological first aid -Safe and age-friendly environment - Age friendly activities and services (and giving	Training materials. Trainer (geriatric nurse/psychiatric nurse) Online section in TECMED Platform to upload the videos.	IDRAAC with health specialists.	March-June 2021	Number of Videos Satisfaction and perceived usefulness Viewership of Recorded Videos (if possible, depending on platform)

				priorities for older persons in vaccination, decreased waiting time, homecare, etc…)				
Interdisciplinary Networking, Interprofessional education, and referral pathways + Available resources and referral to services	Provide stakeholders with resources for interdisciplinary networking, referrals, education and services related to old age.	Resource guide available online on TECMED platform	Older persons. Non-formal caregivers, formal caregivers, public administrators, research and education and businesses.	Available services for old age in Lebanon	Database of resources	IDRAAC	March-June 2021	Developed resource guide Satisfaction and perceived usefulness by users
Governance (+emergency planning and relief for old age)	Offer public administrators and organizations working on emergency planning and relief	Online Training Recorded Webinar to be uploaded on the platform.	Public administrators and organizations working on old age affairs and support.	Best practices for old age during emergencies, pandemics and relief efforts.	Training materials Trainer Online Platform for the Webinar. Online section in TECMED Platform to upload the recorded Webinar.	IDRAAC with organizations working on relief efforts and emergency planning (ex: Helpage)	March-June 2021	Number of trainings Number of persons trained Satisfaction and perceived usefulness Viewership of Recorded Webinar

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Annex 1:

Expressed Capacity Building Needs from 12 stakeholders who were interviewed by PP7

The list below describes some of the expressed needs from our discussions with the different stakeholders we interviewed:

- Capacity building/training of end users
  Training on digital literacy and use of the platform 7/12
  Training on Covid 19 4/12
  Training on activities (cognitive, leisure, physical, psychomotor…) and self-development for old age 4/12
  Training on Mental Health 3/12
  Training on self-care and disease management 3/12
  Training on coping skills (+ dealing with loneliness,…) 2/12
  Training on empowerment of older adults 2/12 Training on palliative care and end of life support 1/12

- Capacity building/training of non-professional caregivers
  Training on digital literacy and use of the platform 5/12
  Training on disease management (Alzheimer's, Hygiene, bed sores, …) 5/12
  Training on Mental Health and awareness 4/12
  Training on communication with older persons and relational care 4/12 Training on disease prevention and early screening 3/12
  Training on first aid, home safety and enabling environment 3/12
  Training on activities (cognitive, leisure, physical, psychomotor…) for old age 3/12
  Training on available resources and referral of older persons to get appropriate care 3/12
  Training on Covid 19 2/12
  Training on self-care 2/12
  Training on psychological first aid 2/12
  Training on elderly care process and specificities 1/12
  Training on ethical considerations for old age 1/12
  Training on autonomy of older person 1/12 Training on empowerment of older adults 1/12 Training on the rights and needs of older persons 1/12 Training on palliative care 1/12

- Capacity building/training of professional caregivers, etc.
  Training on Interdisciplinary Networking, Interprofessional Education, and referral pathways 4/12
  Training on geriatrics and old age care 3/12
  Training on Covid 19 and considerations for old age 3/12

Training on self-care and psychosocial support of caregivers 3/12
Training on psychosocial considerations for old age 2/12
Training on communication with older persons (and listening to their needs) 2/12
Training on first aid and home safety 1/12
Training on psychological first aid 1/12
Training on active aging 1/12
Training on palliative care 1/12
Training on ethical considerations for old age 1/12
Training on the rights and needs of older persons 1/12

- Capacity building/training of public administrators
  Training on the rights and needs of older persons and advocacy 9/12 Training on the image of old age 4/12
  Training on networking 4/12
  Training on governance 4/12
  Training on age friendly activities and services 2/12 Training on ethical considerations for old age 2/12 Training on improvement of policies related to old age 2/12 Training on the integration of aging concepts in school/professional education 1/12

  Training on laws to protect older adults 1/12
  Training on priorities for old age (vaccination, decreased waiting time, …) 1/12
  Training on emergency planning and relief for old age 1/12 Training on the importance of homecare 1/12
  Training on assessment of available resources and communication 1/12

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TEC-MED

TEC-MED Model:

Capacity Building Plan in Tunisia

1. OBJECTIVE

The overall aim of TEC-MED project is to provide transcultural, ethical, social and health model care for dependent elderly persons and/or at risk of exclusion.

2. METHODS

To achieve the TEC-MED global objective, a **"Stakeholder engagement strategy"** should be developed. In fact, the engagement of key stakeholders in the TEC-MED project will improve outcomes, co-define the characteristics of the model care, gain access to final beneficiaries and explore ways of implementation and dissemination of the model care.

To meaningfully and effectively integrate stakeholders into the design and scope of the project, a "**Stakeholder networking strategy"** should be developed.

It is important to note that this document, once approved, will be used as a guideline to ensure that the stakeholder networking strategy works well taking into account the indicated KPIs.

STEP 1: Objectives of the networking strategy

The stakeholder networking strategy aims to facilitate the relationships and connections among target audience, to contribute to the global objective of TEC-MED project, helping to create the anticipated value (that is, to meet the KPIs) and to maximize awareness of the project objectives, means and results.

STEP 2: Identify actions

Four (04) actions for the stakeholder networking are identified in order to achieve the general objective of the TEC-MED project. These actions are:

- ***Incidence***: Direct approaches –generally through face-to-face meetings- with decision makers or high influence people in order to persuade them;
- ***Building Alliances***: Mobilization and coordination with other groups and/ or organizations for a specific solution to a problem or issue. Get input/feedback from target audience;
- ***Awareness*****:** Increase awareness and knowledge of the target audience regarding the project, its opportunities and developments, and the existence of a particular problem or issue;
- ***Campaign*****:** A course of actions organized and designed to publicize the project, its purpose and specific identity, and to achieve a specific response from the target audience.

STEP 3: Identify channels/tools

Every PPs team will identify the **existing communication channels/tools** that they can be used for the engagement of their key stakeholders. Different categories of channels/tools can be used, both traditional or mass media and digital media. Here below we listed most of them in line with the communication plan of the project.

- Face to face meeting/interview
- Mass media

- *Print mass media* (Local or national newspaper, specialized journals/magazines, brochures, Project reports).
- *Radio and Television Media.*

- Digital media
  - *Social media* (Twitter, Facebook, Instagram, Youtube)
- Project Website
- EU channels and Partners Website.
- Online Platform (web-meeting, web-courses, webinars, discussion forum).
- Digital Newsletters and emails.
- Events in real life (workshops, conferences).
- Etc.

STEP 4: Select and establish KPIs

Selected key performance indicators (KPIs) will be used at frequent intervals (every 6 months) to monitor and evaluate the process and impact of the stakeholder networking activities:

Table 1: List of KPIs to measure and the target to achieve

Key Performance Indicator (KPI)	Target
Number of stakeholders included for each country in the network	At least 8 stakeholders/country
Number of stakeholders participating in cross-border exchanges or activities	At least 8 stakeholders/country
Number of online/offline events via the network	At least 2 events/year
Number of documents shared via the network	1 document/ month
Number of real life events organized between stakeholders	2 real life events/year

STEP 5: Classify key stakeholders

In each partner country, the selected key stakeholders will be firstly classified into four sectors according the Quadruple Helix model[1].

- **Research and Education / Academy:** all knowledge and teaching centers are part of it, e.g., public and private research bodies, universities, education and training, science and technology parks, technology transfer offices, etc.
- **Public administration:** if relevant at different government levels, agencies for national and regional development, public procurement offices, etc.
- **Business:** includes organizations, which have a great opportunity to innovate and participate in a business environment with more competitive strength in open markets, e.g., manufacturing and services, primary sectors, financial sector, creative

[1] Carayannis E.G., Campbell D.F.J. Mode 3' and 'Quadruple Helix': Toward a 21st Century Fractal Innovation Ecosystem. International Journal of Technology Management, 46 (3/4) (2009), pp. 201-234.

industries, social sector, large firms, SMEs, young entrepreneurs, students with business ideas, cluster and business organizations.

- **Civil society/users:** they are the individual people, which are a key element that works as a link between the other actors, especially in improving cooperation between companies and universities, e.g., NGOs, citizens, consumers associations,

Then in each helix sector, stakeholders will be classified according the management level:

- **Macro-management:** leadership position in public administration that provides social care services (may include policy makers and other stakeholders).
- **Meso-management:** leadership position of the social enterprise and NGOs that provide social care services, leading academic figure who studies or works in social care services.
- **Micro-management:** health and social care professionals who care for elderly dependents and dependents at risk of social exclusion (in a social company, NGO, etc.).

Finally Key stakeholders were classified based on their location in the matrix:

- *Low interest/low influence* stakeholders: need to be **informed**, ideally with minimum effort;
- *High interest/low influence* stakeholders: need to be **consulted**, so they are reassured their views are taken into account;
- *High influence/low interest* stakeholders: need to be **involved** so they remain on-side during the project;
- *High interest/high influence* stakeholders: need to **collaborate** with you to make the plans a reality.

The following table (*table 1*) will be filled by each PPs team to present the different communication tools selected according to each stakeholder group (*see example of Public administration/macro*).

STEP 6: Carry out the activities identified

In this last step, a table summarizing the list of involved stakeholder groups, their networking objectives, communication channels used with them, the action in which they are implied and the KPIs used to evaluated the process and results.

Each partner must carry out at least one network action for quadruple Helix per year (1 for Government/public administration, 1 for Business, 1 for Research and Education/ Academy and 1 for Civil society/users).

Each partner must develop 3 of the 4 actions identified (incidence, building alliances, awareness, and campaign) during the life of the project.

TUNISIA (PP5 and Associated Partner)

Table 4: Actions carried out or planned and communication channels/tools used for networking stakeholders in TUNISIA

NETWORKING STAKEHOLDERS STRATEGY (LB and PP1)								
N°	**Classification of key stakeholders**			**Networking Objective**	**Action**	**Channel/tool**	**KPI/Evaluation** (documentation)	**Month** (referred to the months of the project)
	Helix sector	Management level	Matrix location					
ACTIONS CARRIED OUT BY PP5 and Associated Partner IN THE NETWORKING STRATEGY								
1	All sectors	Macro, Meso, Micro, final beneficiaries and general audience	Informed	To present the project and the results among the general audience.	Campaign	Social media (Facebook) Tunisian partner Websites	**General audience** of INNTA and INSP websites **Followers** of the INNTA and INSP Facebook TEC-MED Brochure in French and Arabic	Month 3
2	Public administration	Macro	Collaborate	To analyse the current elderly social care practices	Incidence	E-mail Face-to-face interviews	**5 Semi-structured interview** with key stakeholder **1** summary interview **report**	Months 4-6
	Research and Education/Academy; Civil society/users	Meso, Micro and Representative of the final beneficiaries	Consulted					Months 4-6
3	All sectors	Macro, Meso and Micro	Collaborate or Involved	To explore key stakeholder viewpoints on the current situation	Building alliances	E-mail Mailing	**31 stakeholders** were interviewed in a 1st round of Delphi survey	Months 7-10

			or Consulted	regarding elderly social and health care, desired state, priorities and gaps		Online Survey	**24 stakeholders** included in the 2nd round of Delphi survey **24 stakeholders** included in the 3rd round of Delphi survey **1** PP5**-**Delphi survey **report**	
4	Public administration Business; Civil society/users	Macro Meso and Micro	Collaborate Consulted	To engage stakeholders to: • give their opinion on the local social care practices; • critic the draft TEC-MED model; • review the activities that have been done in the project so far	Building alliances	Networking online event on the 29th June 2020	6 stakeholders involved in a networking online event TEC MED Model Agenda_29June20	On the 29th June 2020 (Month 9)
ACTIONS PLANNED TO BE CARRIED OUT BY PP5 and Associated Partner IN THE NETWORKING STRATEGY (following 6 months)								
5	Civil society/ users	Representative of the final beneficiaries	Consulted	Increase / become aware about the importance of care and dignified attention to elderly	Awareness	Publication of a real elderly story via a video	**Hundreds** of people thanks to dissemination action “the elderly count” that will take place at the European Night Researchers. **1 video**	On 27th November 2020 (Month 14)