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An Evaluation of Service Centres for Older Persons in the Western Cape.

Commissioned by the Western Cape Department of Social Development.

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EXECUTIVE SUMMARY

INTRODUCTION

Population projections show that the Western Cape will experience significant ageing of its population in the coming decades, mirroring global, regional, and national trends. Although there is a considerable dearth of comprehensive and representative research on older persons in the Western Cape, published literature highlights the vulnerable position of older persons in society. The impact of changing age structures, HIV/AIDS, poverty, migration, abuse, changing household structure and family support, poor health, and the gendered nature of ageing in the Western Cape, contribute to the challenges facing older persons and concomitant demand for services that meet their needs.

The introduction of the Older Persons Act (No.13 of 2006; OPA) presented a shift in policy focus from institutional care to community-based care and support for older persons in South Africa. Community-based care exists on a continuum of care for older persons ranging from home-based care services to residential facilities and institutionalised frail care. This is reflective of a broader international shift to integrated, multidisciplinary care, providing access to health and social welfare services for older persons in order to support active and independent ageing.

In line with legislation and global trends, the Western Cape Department of Social Development (WC DSD) currently supports a large number of service centres for older persons in the province, through funding the non-profit organisations that manage the service centres. Services such as service centres are a key component in the field of care for older persons who are living independently in their own homes and communities. However, while the WC DSD's Older Persons Programme has been providing community based care and support services through service centres in the province for a number of years, the effectiveness and relevance of the service centres in meeting the needs of older persons has not yet been determined. The effectiveness of existing management models and service delivery approaches of service centres has also not been explored.

Population ageing has various social and economic implications. It is predicted to place a significant burden on the social service and healthcare systems, including intergenerational support systems, social welfare, health care, and recreational resources. Taking into consideration the projected ageing population, the concomitant increased need for social development services and strain on existing service structures, it is important to explore alternative, sustainable models of community-based care to accommodate the future needs of a growing older population and to comply with the requirements of the OPA. Simultaneously, it is necessary to explore the role that service centres can play within these models of community-based care.

Thus, the WC DSD appointed Creative Consulting and Development Works (CC&DW) to undertake an evaluation of service centres for older persons in the province.

EVALUATION DESIGN AND METHODOLOGY

A formative evaluation approach was adopted for this evaluation. Stemming from the formative and exploratory nature of this evaluation, the evaluation utilised a mixed methods data collection approach drawing on predominantly qualitative, but also quantitative data, to achieve breadth and depth of understanding of service centres in the Western Cape. The WC DSD selected 20 service centres across the Western Cape, geographically situated in the (a) Cape Winelands and Overberg and (b) Metro South areas of the province.

The evaluation was informed through multiple streams of information and data. Data was collected through (a) structured interviews with service centre management, (b) focus group discussions with service centre staff and/or volunteers, (c) semi-structured interviews with beneficiaries, and (d) semi-structured interviews with WC DSD and external key informants. Half-day site visits took place at all 20 service centres by two fieldwork teams. The resulting data was captured and analysed using largely qualitative methods of data analysis. Quantitative data was analysed using simple descriptive statistics.

EVALUATION FINDINGS

The findings from the interviews and focus groups at the 20 service centres varied due to wide disparities in the settings, facilities, services, and organisational capacity and structure of service centres. However, a number of key findings emerged:

1) There is little consistency between centres with regards to management and staffing, capacity, funding, and infrastructure. Centres range from highly structured and well-resourced to unstructured and poorly resourced.
2) Services and activities offered to members also varied widely between centres. This ranged from structured daily programmes to informal and ad hoc activities, with the only consistent service being the provision of a daily meal.
3) The majority of beneficiaries included in the evaluation were women, spanning the age range from <60 years to >85 years. Beneficiaries generally reported low levels of education. The living circumstances of beneficiaries varied, although a large proportion reported living with children, grandchildren, and other extended family members. A large number were dependent on the old age grant. Beneficiaries reported good mobility but high levels of chronic illness.
4) Most service centres could not speak to a significant change in membership figures although they acknowledge a number of barriers that prevented access, including transport, cost, poor physical health, and the other responsibilities of older persons, such as childcare.
5) Older persons face a number of challenges, including poverty, acting as caregivers for grandchildren, crime, abuse, social isolation, loneliness, and a marginalised position within the communities in which they live.
6) Beneficiaries identified a number of services that would be helpful to them; most frequently cited were healthcare, transport, community awareness, and exercise.
7) Service centres appear to be playing three key roles in the lives of older persons, meeting both lower-order and higher-order needs. These are (a)

meeting basic physiological needs through the provision of a regular meal, (b) providing safety and social support, and (c) providing a sense of family and belonging. To varying degrees, service centres are also providing beneficiaries with a sense of purpose through participation in activities, programmes and decision-making.

8) Overall, beneficiaries reported to be satisfied with the services they received at the service centres. However, a number of recommendations were put forward to align services to the needs of older persons and the service gaps that currently exist.
9) Service delivery is hindered by capacity- and infrastructure-related challenges facing service centres. In particular, these include infrastructure (transport and venues) and lack of consistency in capacity (funding, skill, and operational structure).
10) A number of best practices were identified across all service centres, including well-established and small independent centres. These provide promising examples of service delivery, management, funding, and infrastructure amongst existing service centres.

RECOMMENDATIONS

Broadly, the report concludes that there is no one-size-fits-all model for service centre best practice or community-based care. Developing a model of best practice for service centres or community-based care needs to carefully consider the needs of the specific communities and be tailored appropriately to those needs (goodness of fit for the community). Strategic partnerships between stakeholders are vital to the realisation and sustainability of an integrated model of care. Collaboration between service centres, other service providers, and between government departments is essential to facilitate knowledge exchange and service delivery.

Based on the evaluation findings, various recommendations are made for improvement to current service centres, alternative models of community-based care and support for older persons, and for further research:

1) **Recommendations for improving access** include (a) a transport route for service centres, (b) extending the transport subsidy to all service centres, and (c) addressing the lack of awareness of service centres through awareness-raising activities.
2) **Recommendations for improved service delivery** include providing (a) standardised service guidelines, (b) the use of a bulk food procurement system, (c) the provision of social work services, and (d) interdepartmental collaboration. In addition, a key recommendation is a focus on integrating service delivery by developing processes to facilitate referral and collaboration, such as through the development of central referral resource, the use of a case management approach, and developing partnerships.
3) **Recommendations for improved organisational capacity** include (a) first and foremost addressing funding challenges through concentrated efforts to increase the income-generating activities of service centres; (b) applying the minimum requirements for management and staff or providing training and mentorship where these are lacking; and (c) incorporating small independent service centres under umbrella organisations.

4) Three suggestions were made regarding broad **alternative models of community-based care and support.**
    a. **Model 1 ('the decentralised model)** is based on two key factors: (1) decentralising services to combat the problem of transport and (2) beneficiary-led services. This model offers an innovative way of overcoming infrastructure issues, particularly concerning transport. It also speaks to the value of the support an overarching mother body organisation can provide while keeping agency and decision-making power in the hands of older persons.
    b. **Model 2 ('basket of services for older persons')** builds on the existing service centre model but expands the services provided and focuses on interdepartmental collaboration in the provision of integrated housing and health services to older persons. As a model, this offers older persons a 'one stop shop' where multiple services that meet multiple needs are offered in one place.
    c. **Model 3 ('the community hub')** sees the service centre as a multipurpose community hub providing services to not only older persons but also the broader community, particularly other vulnerable groups. Those services offered to older persons, including meals, social services and healthcare, are extended to the broader community, which facilitates integration and inter-generational activities. Services can include community feeding programmes and programmes for children.
5) Lastly, it is recommended that the WC DSD undertake **further research** to (a) explore the region- or area-specific service needs of older persons in the province and develop a policy framework or guidelines, (b) the financial feasibility and sustainability of the above-described recommendations, and (c) address the lack of data regarding older persons and community-based care in the Western Cape.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
AU	African Union
CC&DW	Creative Consulting and Development Works
CHC	Community Health Centre
CPOA	Cape Peninsula Organisation for the Aged
ECD	Early childhood development
GAPA	Grandmothers Against Poverty and AIDS
GIS	Geographic Information System
HSFA	Helderberg Society for the Aged
HIV	Human immunodeficiency virus
IAA	Institute for Ageing in Africa
MIPAA	Madrid International Plan of Action of Action on Ageing
NOAH	Neighbourhood Old Age Homes
NCOA	National Council on Ageing
NGO	Non-governmental organisation
NPO	Non-profit organisation
OPA	Older Persons Act (No.13 of 2006)
SAOPF	South African Older Persons Forum
SASSA	South African Social Security Agency
SES	Socio-economic status
STTOP	Sector Task Team for Older Persons
TPA	Transfer Payment Agreement
UCT	University of Cape Town
UN	United Nations
WC DSD	Western Cape Department of Social Development
WHO	World Health Organisation

1. INTRODUCTION

While the Western Cape Department of Social Development's Older Persons Programme has been providing community based care and support services through service centres in the province for a number of years, the effectiveness and relevance of the service centres in meeting the needs of older persons has not yet been determined. The effectiveness of existing management models and service delivery approaches of service centres has also not been explored. Importantly, the role of service centres in broader community-based care models aimed at keeping older persons living in their communities for as long as possible is not well understood.

Population ageing has various social and economic implications. It is predicted to place a significant burden on the social service and healthcare systems, including intergenerational support systems, social welfare, health care and recreational resources (Joubert & Bradshaw, 2006). Taking into consideration the projected ageing population, the concomitant increased need for health and social support services, and strain on existing service structures, it is important to explore alternative, sustainable models of community-based care to accommodate the future needs of a growing older population and to comply with the requirements of the Older Persons Act (No. 13 of 2006) (OPA). Simultaneously, it is necessary to explore the role that service centres can play within these models of community-based care.

Thus, the Western Cape Department of Social Development (WC DSD) appointed Creative Consulting and Development Works (CC&DW) to undertake an evaluation of service centres for older persons in the province. The current document reports on the evaluation in the following sections:

1) Introduction
2) Literature review: This section of the report reviews relevant local and international literature on population ageing, changing family structure and other challenges facing older persons in the Western Cape. In addition, it reviews both local and international models of community based care and support for older persons.
3) Legislative and policy framework: Key international and national legislation and policy governing the rights, care, and protection of older persons are discussed.
4) Evaluation design and methodology: The evaluation objectives, questions, and design, as well as the sampling methodology, data collection, and data analysis procedures that were followed are outlined. This section of the report also highlights the methodological limitations of the evaluation.
5) Findings and discussion: This section of the report describes the findings from the data collection process. The findings are organised broadly according to the key themes and evaluation objectives and are presented as follows: (a) the trends in and description of service centres, beneficiaries, membership and attendance; (b) the needs of older persons; (c) the effectiveness, accessibility, relevance and appropriateness of the services offered; (d) service delivery gaps and barriers; and (e) emerging best practices.
6) Recommendations: The first part of this section makes recommendations for the improvement of the current service centre model, including key crosscutting recommendations regarding the sustainability of service centres.

The second part of the recommendations section draws on international and local organisations and identifies three broad models of community-based care and support for older persons that can be applied to the local context. Lastly, recommendations for further research are made.

2. LITERATURE REVIEW

"*Population aging will become perhaps the most important demographic dynamic affecting families and societies throughout the world in the coming decades*"(Velkoff & Kowal, 2006, p. 55)

This section outlines the context of older persons in South Africa with reference to international and national literature, examining the demographic trends with regards to ageing and the legislative context applicable to older persons, with a specific focus on the Western Cape.

2.1 DEFINING AN 'OLDER PERSON'

The Older Persons Act (No. 13 of 2006; OPA), the key piece of legislation providing the regulatory framework governing the empowerment, care, and protection of older persons in South Africa, defines an older person as "a person who, in the case of a male, is 65 years of age or older and, in the case of a female, is 60 years of age or older". Although not formally amended, it is generally accepted that individuals 60 years and older are considered older persons, indicated by the fact that the qualifying age for the old age grant was amended in 2010 by the Social Assistance Amendment Act (No.6 of 2008) to 60 years and older for both males and females. This is consistent with the definition of older persons adopted by the United Nations (UN) and World Health Organisation (WHO).

2.2 POPULATION AGEING

2.2.1 GLOBAL AND REGIONAL TRENDS

Population ageing is the process by which the proportion of older persons in the total population grows. Although comprising a smaller percentage of the total population in developing countries than in developed countries, the number of older persons is growing rapidly in developing countries, such as South Africa. Regionally, the annual growth rate of the population group 60 years and older in sub-Saharan Africa is expected to increase from just over 2% to nearly 4% over the next several decades, whereas the growth rate of this population group in developed countries is expected to decline to less than 1% (Velkoff & Kowal, 2006). The number of older persons in sub-Saharan Africa is expected to nearly double to over 67 million by 2030 (Velkoff & Kowal, 2006).

Worldwide, the age group 80 years and older (the 'oldest-old' age group) is growing particularly fast (Mirkin & Weinberger, 2001). Although accounting for less than 1% of the total population, the number of oldest older persons in sub-Saharan Africa is expected to increase nearly 3 times over by 2030 and comprise an increasing proportion of the age group 60 years and older (Velkoff & Kowal, 2006).

2.2.2 NATIONAL AND PROVINCIAL TRENDS

The proportion of persons 60 years and older in South Africa has increased from 7.1% in the 1996 Census to 8% in the 2011 Census and is projected to almost double between 2000 and 2030 (Makiwane, 2011; Statistics South Africa, 2014). Population

projections show that the Western Cape will also experience significant ageing of its population in the coming decades. The proportion of the population 65 years and older is expected to increase from 5.88% in 2011 to 11.57% in 2040 (PricewaterhouseCoopers, 2014). Table 1 (below) displays the projected percentage of the province's population aged 65 years and older.

Table 1. Projected percentage of the Western Cape population aged 65 years and older

Year	% of population 65 +
2011	5.88%
2020	7.19%
2030	9.40%
2040	11.57%

Source. PricewaterhouseCoopers (2014)

2.2.3 PROCESSES UNDERLYING POPULATION AGEING

Fertility, mortality, and migration are the key processes responsible for reshaping the age distribution of the population. In the Western Cape, the total fertility rate is projected to decline from 2.18% in 2011 to 1.89% in 2040 (PricewaterhouseCoopers, 2014). This trend (i.e., a continuous decline in fertility and the size of successive birth cohorts) means that the proportion of older persons will grow.

Life expectancy is increasing as people live longer due to improved medicine and lifestyles (Lee, 2003). For example, the mortality rates for a 35-year old in the Western Cape are projected to decrease from 2011 to 2040 from 0.72% to 0.62% for females and from 0.88% to 0.76% for males (PricewaterhouseCoopers, 2014). The decrease in mortality rate means that there will be a larger number of persons surviving into old age. The HIV/AIDS epidemic also has a significant impact on shaping the population structure of South Africa. However, the ageing of South Africa's population will occur despite the increased HIV-related mortality as the country is experiencing a decreased fertility rate and an increased mortality rate amongst young and middle adult age groups, which contributes to the increased proportion of older persons in the total population (Makiwane, 2011; Statistics South Africa, 2014).

The expected ageing of the Western Cape's population is impacted, in part, by considerable migration into the Province. Annual net in-migration figures stand at just over 19 000 (PricewaterhouseCoopers, 2014). The 20 – 30 year old age group comprises a significant proportion of the in-migration figures and, as this group ages in the coming decades, they will add to the growing number of older persons in the province. As evident in Figure 1 below, the impact of migration on the age structure of the population is compounded by an influx of older age groups who move to the Province for retirement (PricewaterhouseCoopers, 2014). Noting the smaller difference in the median age[1] between men and women and the higher sex ratio[2] in

[1] Median age refers to the age that divides the population into two equal parts (i.e., that half the population are younger than the median age and half the population are older than the median age).

[2] Sex ratio is defined as the proportion of males to females in the total population, with a higher ratio indicating more equal sex composition.

the Western Cape compared to other provinces, Statistics South Africa (2014) point to the migration of adult and older-aged men into the province in particular.

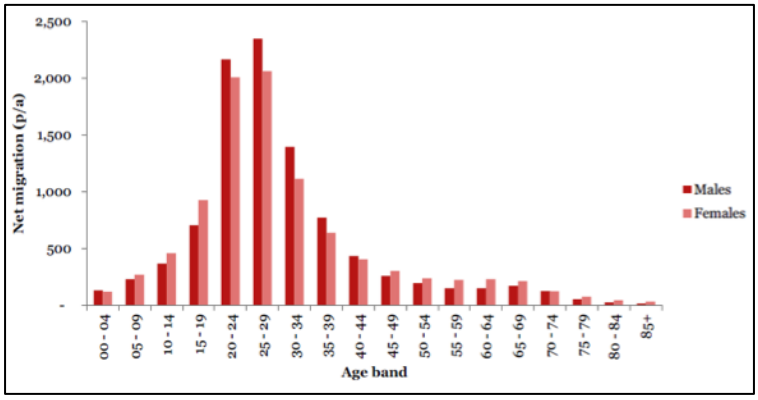


Figure 1. Annual net migration into the Western Cape by age group and sex (PricewaterhouseCoopers, 2014).

2.3 THE CONTEXT OF OLDER PERSONS IN THE WESTERN CAPE

"These growing numbers of older people will age in countries that are ill equipped to deal with the challenges that aging populations pose" (Velkoff & Kowal, 2006, p. 89).

Although some authors have highlighted the need for further research (Cohen & Menken, 2006; Ferreira, 2005b), there is a considerable dearth of information on the health, well-being and needs of older persons in South Africa more broadly and in the Western Cape in particular. A small number of studies have investigated the daily lives and experiences of older persons (Bohman, Vasuthevan, Van Wyk, & Ekman, 2007; Makiwane & Kwizera, 2006), the impact of HIV/AIDS (Hosegood & Timaeus, 2006; Munthree & Maharaj, 2010) and the old age grant (Barrientos, 2003; Burns, Keswell, & Leibbrandt, 2005), the needs of older caregivers (Kuo, Reddy, Operario, Cluver, & Stein, 2013; Petros, 2012), and the issue of elder abuse (Keikelame & Ferreira, 2000; Marais, 2006). While there appears to be increased awareness of the problem of elder abuse due to increased activities of programmes and exposure of cases, both reliable evidence and national and provincial prevalence rates are lacking (Ferreira & Lindgren, 2008).

Nonetheless, older persons are widely recognized as a vulnerable group in need of special care and attention. Social exclusion, poor living conditions, and poor health are among the global concerns facing older persons. In South Africa, older persons may be particularly vulnerable due to the intersecting factors of HIV/AIDS, poverty, and abuse. The HIV/AIDS epidemic, poverty, and migration means that older persons are facing new burdens and declining traditional care and support mechanisms as they age (Kay, 2011).

2.3.1 THE DEMOGRAPHIC PROFILE OF OLDER PERSONS IN THE PROVINCE

2.3.1.1 The number and age of older persons in the Western Cape

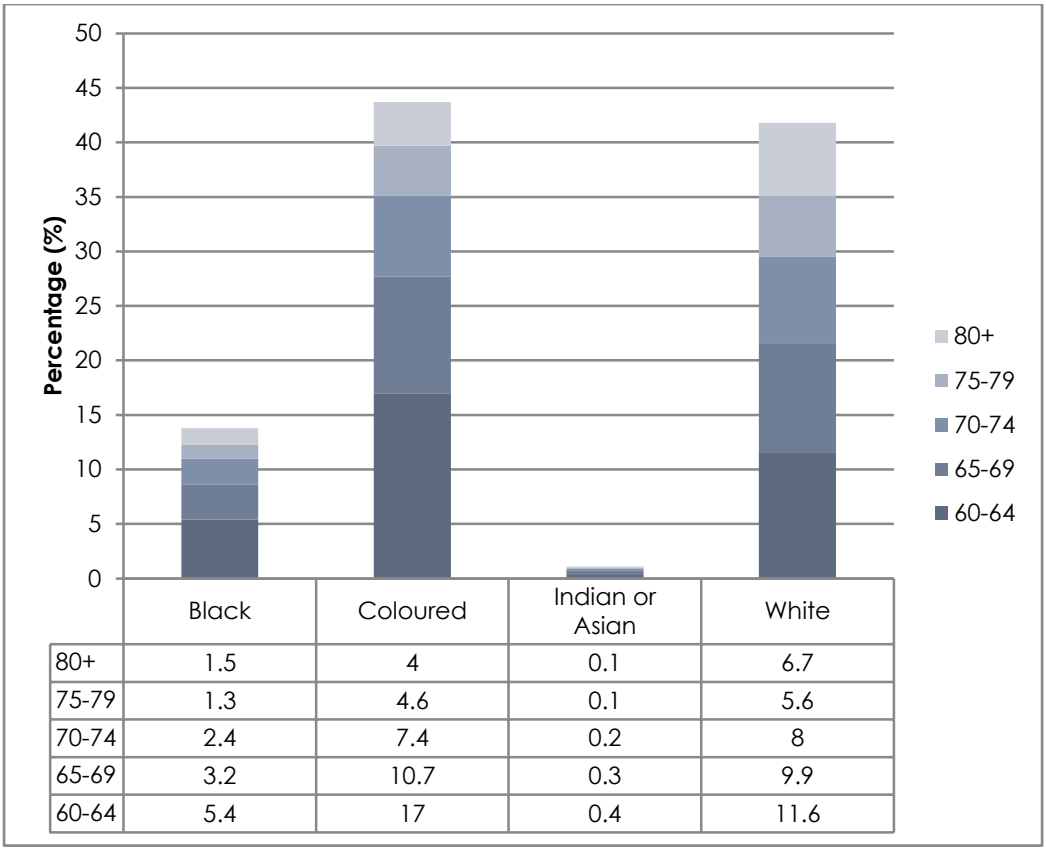
The growing number of older persons in the Western Cape is clearly depicted in the Census figures displayed in Table 1 (see p.13). Illustrating the demographic profile of

this growing age group in the province is important for understanding the context of older persons in the province and for determining service needs. Table 2 (below) prevents figures on the number of older persons in the province according to age and gender and Figure 2 (p.20) describes the estimated population by age and population group. As the WC DSD (2015) notes, Coloured and White older persons comprise the largest proportion of older persons in the Western Cape. However, the proportion of White older persons, particularly in the oldest age brackets, has been decreasing through the 1996 to 2011 Censuses, while all other population groups have seen an increase across all age brackets (WC DSD, 2015).

Table 2. Western Cape mid-year population estimates by age and sex, 2014

Age Group (years)	Male	Female	Total
60 - 64	96 816	110 137	206 953
65 - 69	69 674	88 394	158 068
70 - 74	47 236	62 430	109 666
75 - 79	29 215	34 588	63 803
80 +	19 504	26 836	46 340
Total	**262 445**	**322 385**	**584 830**

Source. Statistics South Africa (2014)



	Black	Coloured	Indian or Asian	White
80+	1.5	4	0.1	6.7
75-79	1.3	4.6	0.1	5.6
70-74	2.4	7.4	0.2	8
65-69	3.2	10.7	0.3	9.9
60-64	5.4	17	0.4	11.6

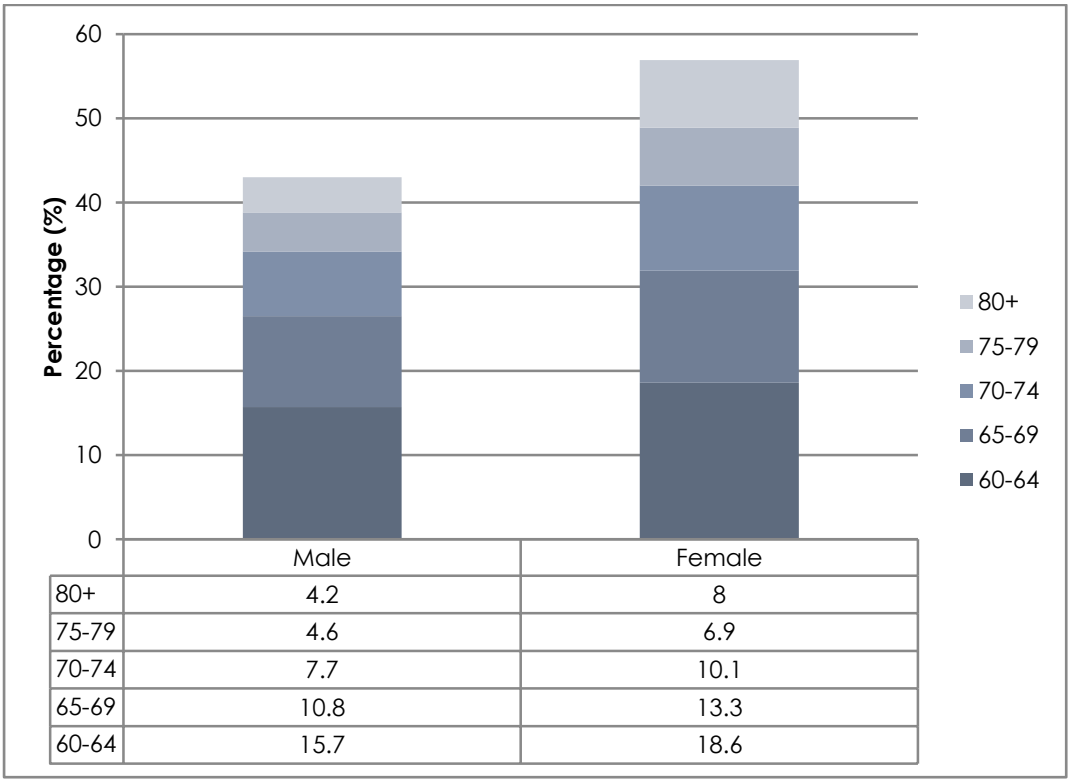
Figure 2. Distribution of older persons in the Western Cape by age group and population group (Statistics South Africa, 2011, as cited in WC DSD, 2015).

2.3.1.2 The gendered nature of ageing in the Western Cape

The life expectancy for females is higher than for males. It is clear from the statistics presented thus far that this will remain the case. The disproportionate gender distribution of this group reflects global (Mirkin & Weinberger, 2001) and national (Makiwane, Ndinda, & Botsis, 2012; Statistics South Africa, 2014) patterns of ageing due to higher male mortality across the lifespan, particularly amongst the oldest old. Figure 3 (p.21) depicts the breakdown of older persons in the province according to age group and gender, with females comprising a larger proportion of each age group.

The disproportionate gender distribution of this group increases their vulnerability both in terms of age but also because of the burden of care placed on them. As more women survive into older age than men, there are more female-headed households in older age groups. Census statistics show that of the 70 years and older age group, 54.7% of households are female-headed, compared to the 37.5% of households that are female-headed across all age groups in the population (Statistics South Africa, 2012). More female-headed households are skip-generation households, where older persons are caregivers for their grandchildren, than male-headed households (7% vs. 6%; Statistics South Africa, 2012). Such households are also more likely to be poorer and located in rural areas (Møller & Devey, 2003). A larger proportion of older women are consistently shown to have poorer socio-economic status (SES), lower levels of education and severe functional difficulties (Statistics South Africa, 2014). The intersection of gender and socio-economic status (SES) in this population group

means that many older persons, particularly women, are unable to meet their basic needs (Makiwane et al., 2012).



	Male	Female
80+	4.2	8
75-79	4.6	6.9
70-74	7.7	10.1
65-69	10.8	13.3
60-64	15.7	18.6

Figure 3. Distribution of older persons in the Western Cape by age group and gender (Statistics South Africa, 2011, as cited in WC DSD, 2015).

2.3.1.3 Distribution of older persons across district municipalities

Table 3 on the following page displays detailed population projections and % growth for the Western Cape's six districts. Two things are evident in the table: (a) the proportion of older persons is expected to grow across all district municipalities within the province and (b) the proportion of female older persons is expected to grow quicker than the proportion of male older persons across all district municipalities within the province. Noting these broad trends, it is also important to identify: (a) the largest number of older persons are located in the City of Cape Town, followed by the Cape Winelands and Eden districts and (b) the Eden and Overberg districts are expected to experience the largest growth in the number of older persons in the coming decades, followed by the West Coast. That the largest number of older persons are residing in the Cape Town Metro is not surprising considering it has the highest population in the province; however, the large percentage growth in older persons expected in the Eden, Overberg, and West Coast are important for planning purposes.

Table 3. Population projections and % population growth for the 65+ age group per district for the period 2011 - 2040

	2011		2020		2030		2040	
District	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
West Coast								
Population projection	194 541	197 232	219 685	224 818	242 128	250 396	259 947	271 198
% of population	2.63%	3.38%	3.30%	4.31%	4.19%	5.79%	5.10%	7.16%
Cape Winelands								
Population projection	388 207	399 278	435 132	449 429	476 371	494 768	506 806	529 265
% of population	2.15%	2.98%	2.67%	3.80%	3.52%	5.28%	4.40%	6.61%
Overberg								
Population projection	129 372	128 806	144 705	146 445	158 518	162 711	170 018	176 348
% of population	3.73%	4.61%	4.21%	5.62%	4.79%	6.76%	5.57%	7.83%
Eden								
Population projection	280 919	293 347	306 877	324 128	330 316	351 882	348 462	372 905
% of population	3.48%	4.33%	3.96%	5.51%	4.60%	6.85%	5.40%	8.11%
Central Karoo								
Population projection	34 765	36 238	37 650	39 370	40 822	42 784	43 333	45 428
% of population	2.70%	3.46%	3.32%	4.57%	4.17%	5.91%	4.77%	6.96%
City of Cape Town								
Population projection	1 830 701	1 909 335	2 019 568	2 112 152	2 154 732	2 265 413	2 252 676	2 381 526
% of population	2.24%	3.30%	2.67%	4.09%	3.49%	5.49%	4.44%	6.74%
Total	2.45%	3.43%	2.92%	4.28%	3.72%	5.68%	4.63%	6.94%

Source. PricewaterhouseCoopers (2014)

2.3.2 CHANGING LIVING ARRANGEMENTS AND FAMILY SUPPORT

The ageing population means that there is an increasing number of older persons in need of care and support in relation to the number of persons of working-age who are able to contribute towards this care, particularly within the traditional family-based care model (HelpAge International, 2015). 2011 Census statistics show that the Western Cape had one of the highest proportions of older persons relative to adults <60 years and children (8.9%; Statistics South Africa, 2014). This was slightly lower than the Eastern Cape, which had the highest proportion of older persons relative to adults and children (9.7%) but was higher than the national figure (8%).

The effect of population ageing on household structure in South Africa is compounded by the impact of HIV/AIDS, poverty, and migration (Statistics South Africa, 2014; WC DSD, 2015). The impact of HIV/AIDS and poverty means that traditional social support mechanisms, whereby children and extended family care for the ageing, are weakening. Older persons are now playing an important role living with and caring for children with and grandchildren orphaned by the illness (Clark, 2006; Merli & Palloni, 2006; Munthree & Maharaj, 2010). As Table 4 (below) shows, there are a growing number of households headed by older persons in the Western Cape.

Table 4. Number and proportion of elderly-headed households in the Western Cape by age group, 2001 and 2011

	2001		2011	
Age Group (years)	***n***	**%**	***n***	**%**
60 - 64	105 590	6,0%	72 232	6,5%
65 - 69	770 041	4,5%	54 719	4,7%
70 - 74	58 174	3,4%	41 095	3,6%
75 - 79	37 362	2,2%	26 385	2,3%
80 +	33 405	1,8%	21 733	2,0%
Total	**311 571**	17,9%	**216 164**	19,1%

Source. Statistics South Africa (2001; 2011) as cited in WC DSD (2014a)

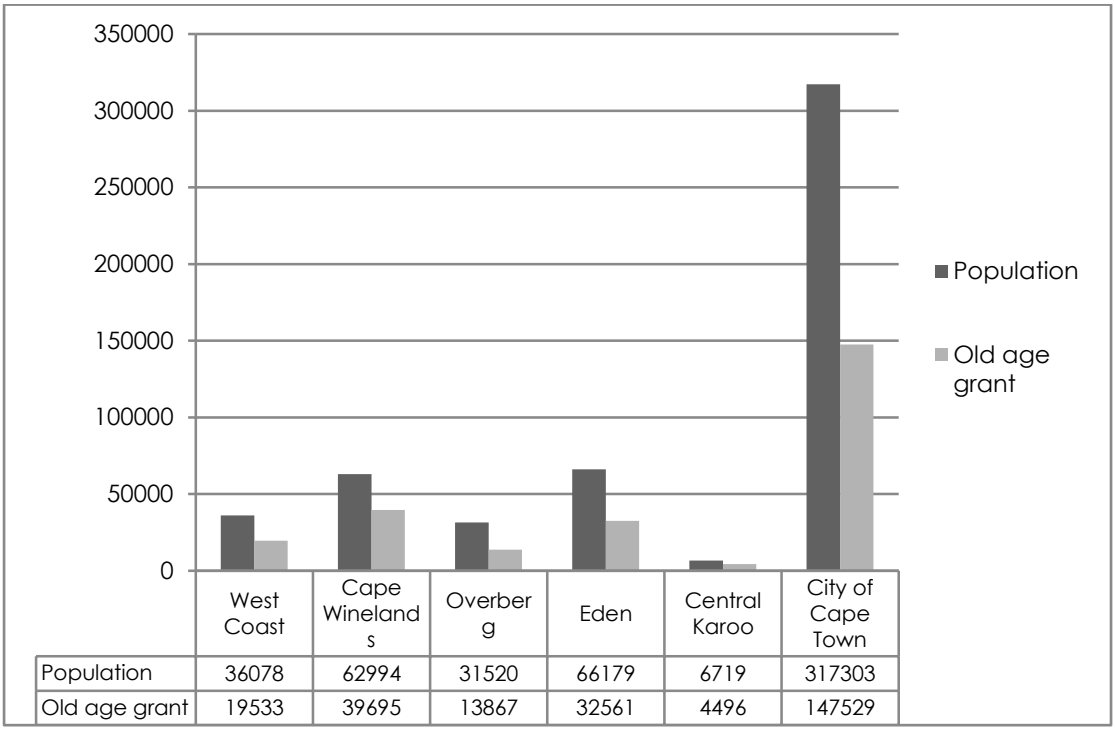
In fact, younger-adult death or inability to work or find employment means that the old-age grant is often the household's main or only source of income, and pensioners are likely to face the pressure of supporting the needs of their extended family by sharing their grants (Statistics South Africa, 2012). There is little research in the Western Cape; however, in Mpumalanga, Makiwane and Kwizera (2006) found that older persons were the breadwinners or main source of income in most households. This was despite their own declining health and the associated challenges that ageing brings. In a qualitative study in Western Cape townships, found that grandmothers caring for a child with HIV/AIDS reported poorer socio-economic circumstances and health as a results of the economic and physical demands of caregiving (Ferreira et al., 2001, as cited in Hosegood & Timaeus, 2006). Living arrangements have a key influence on an older person's ability to access services, including health care, and social support to ensure their needs are met as they age.

2.3.3 POVERTY

Thus, it is not surprising that, while poverty is pervasive across South Africa, older persons are disproportionately affected by poverty. Although 40% of South African

older persons are classified as 'poor[3]' according to the 2011 Census, the proportion of older persons classified as 'poor' is somewhat lower in urban provinces such as the Western Cape compared to more rural provinces, such as Limpopo. In the Western Cape 4% of older persons are classified as such, with 38.5% classified as 'average' and 57.5% classified as 'rich' (Statistics South Africa, 2014).

As mentioned, old age grants are often the only source of income for households due to widespread unemployment. Old age grants therefore play an important role as a source of income for many households; in 2014, 257 678 (197 556 aged 60 – 74 years and 60122 aged 75 years or older) older persons received the old grant in the Western Cape (WC DSD, 2015). Figure 4 (below) displays the number of older persons in each district compared to the number of older persons receiving the old age grant in 2014.



	West Coast	Cape Winelands	Overberg	Eden	Central Karoo	City of Cape Town
Population	36078	62994	31520	66179	6719	317303
Old age grant	19533	39695	13867	32561	4496	147529

Figure 4. Number of older persons receiving the older age grant per district compared to number of persons aged 60 years and older (WC DSD, 2015).

Such statistics may not reflect the daily hardships of many older persons in the Western Cape. For instance, 12.9% of elderly-headed households experience hunger compared to 11.1% of households headed by younger adults 18 – 59 years old (Statistics South Africa, 2012). Research with elderly South Africans shows that some of their daily concerns include a lack of basic resources, such as heating, toilets, and water (Bohman et al., 2007; Makiwane & Kwizera, 2006). A study with a group of older persons in a Cape Town township revealed that older persons receiving pensions struggled to meet their basic needs and many were reliant on their children or grandchildren for additional support (Chigali, Marais, & Mpofu, 2002). Changing household structures and a lack of family support, as well as historical disadvantages

[3] Socio-economic status was determined using measures of dwelling type, access to services, and household assets.

in education and employment are said to increase older persons vulnerability to long-term poverty, as well as pose significant challenges to their independence and their human rights (Gorman & Heslop, 2002; Lombard & Kruger, 2009).

2.3.4 ELDER ABUSE

In this context, the vulnerability of older persons' to abuse is increased. There is little literature on elder abuse in the Western Cape but the gender distribution of this group, with women consistently comprising a larger proportion of the older population (PricewaterhouseCoopers, 2014; Statistics South Africa, 2012), heightens their risk. "Older women are at particular risk of abuse or violence through physical weakness, and a lack of economic capacity to care for and protect themselves, and thus to resist violence" (Ferreira, 2005a, p. 20). In addition, although the old age grant has been shown to have a measurable impact on poverty reduction and protection among households with older persons (Barrientos, 2003), the receipt of a state pension may also increase their vulnerability to violence (Bohman et al., 2007). Over and above the pervasive levels of violence in South Africa, particularly physical and sexual abuse against women, elderly women may be at a particular risk of financial abuse (Keikelame & Ferreira, 2000; Makiwane & Kwizera, 2006).

2.3.5 HEALTH AND PHYSICAL FUNCTIONING OF OLDER PERSONS IN THE WESTERN CAPE

Ageing is often characterised by poor health. Disability and other chronic diseases are a major public health concern for older persons in the Western Cape. Statistics South Africa (2014) reports that a large number of older persons have difficulty with hearing, seeing, walking, communicating, climbing stairs, remembering, and self-care (Statistics South Africa, 2014). As expected, these proportions are small in the younger old age group (60 – 64 years) but functional difficulties become more common with increasing age. Whilst a smaller proportion rely on the use of a wheelchair, the use of a wheelchair or frame increases dramatically with age, from 5.4% in the 60 – 64 age group up to 29.8% in the 85+ age group (Statistics South Africa, 2014).

Loneliness, depression, and anxiety have also been shown to contribute to poor emotional well-being amongst older persons (Makiwane & Kwizera, 2006). Recent research shows that roughly one third of South African older persons report symptoms of depression (Tomita & Burns, 2013). Depression is also thought to have a substantial impact on physical functioning. Depression has been shown to be significantly associated with functional challenges in activities of daily living in older South Africans (Tomita & Burns, 2013).

Poverty and poor physical functioning are compounded by high numbers of older persons with little or no formal education. The Western Cape, however, has the lowest proportion of older persons with no formal education; 7.5% of older persons in the province have no schooling compared to 28.0% of older persons nationally (Statistics South Africa, 2014). Although, it must be noted that a large proportion of those older persons in the Western Cape with no schooling are functionally illiterate, meaning that they are unable to write their name (53.4%), read (58.9%), calculate change (53.8%), or fill in a form (63.3%; Statistics South Africa, 2014). This can affect their productivity, independence, and ability to access services.

Reduced physical function in old age can lead to a loss of independence, requiring either hospitalisation or placement in an old age home or assisted-living facility. Evidence shows, however, that when older persons are able to remain in their homes and communities for as long as possible, stay active and engage socially, their health and general well-being is heightened and there are savings in health care expenditure (Chen & Thompson, 2010; Ferris, Glicksman, & Kleban, 2014; Grabowski, 2006; Sands et al., 2006).

Home and community-based services for older persons are an essential component of allowing older persons to remain living independently in their homes and communities for as long as possible. Meeting the needs of older persons in terms of home and community-based care may reduce older persons subsequent reliance on health services and assisted living facilities (Ferris et al., 2014). Randomised controlled trials of community-based multifactorial interventions in older persons have shown a reduction in admissions to nursing-homes and falls, as well as higher physical functioning (Beswick et al., 2008).

2.4 COMMUNITY-BASED CARE AND SUPPORT FOR OLDER PERSONS

2.4.1 COMMUNITY-BASED CARE AND SUPPORT FOR OLDER PERSONS IN THE WESTERN CAPE: THE ROLE OF THE WESTERN CAPE DEPARTMENT OF SOCIAL DEVELOPMENT

In accordance with the policy framework outlined in the following section (see p.39), the WC DSD's Programme for Older Persons ("the Programme") has taken a developmental approach to ageing. In keeping with international and national policy and legislation (see Section 3), the Programme aims to keep older persons in their families and communities for as long as possible (WC DSD, 2014b). The Programme aims to maintain and support existing social welfare services for older persons in the Western Cape, including Day Care Centres, Service Centres, and Senior Clubs. These types of services and models of care align with the objective of the OPA and the Programme to support older persons to live in their communities. Residential and frail care services are seen as a final resort, when other community-based care services have been exhausted (WC DSD, 2014b). Independent and Assisted Living and community-based care initiatives are not mutually exclusive, and older persons who reside in independent or assisted living facilities are still able to access services through the latter (WC DSD, 2014a)

Where the WC DSD is unable to provide certain social welfare services due to resource constraints, it contributes towards funding the provision of such services by various registered non-profit organisations (NPOs). The WC DSD currently supports a large number of service centres in the province, through funding the non-profit organisations (NPOs) that manage the service centres. Table 5 displays the services funded by the WC DSD per district in the province (see Appendix A for a map of service centres in the Western Cape funded by the WC DSD).

Table 5. Service facilities funded by the WC DSD according to district

	Service centres		Other services	
District	**Number of service centres**	**Number of older persons reached**	**Residential Facility**	**Private Facility**
West Coast	29	1704	11	7
Cape Winelands	32	2649	22	12
Overberg	22	1684	11	14
Eden	40	3791	16	28
Central Karoo	8	492	5	0
City of Cape Town	68	5191	53	122
Western Cape	199	15511	118	183

Source. WC DSD (2015)

According to the 2013/2014 Annual Report, the Programme reached 13 303 older persons through community based care and support services in the 2013/2014 financial year (WC DSD, 2014b). However, participation in service centres has been lower than expected, and dropped from 16 867 in the 2012/2013 financial year. These figures reflect a significant (21.1%) decrease in participation from 2012/2013 to 2013/2014.

At these centres, older persons who are still living in their communities (whether independently or in assisted living facilities) have the opportunity to participate in various programmes and activities that promote active ageing, social engagement, improved well-being, and/or quality of life. The opportunities for engagement and service offerings differ from centre to centre but some examples include social support, physical exercise, hairdressing, and educational activities, among others. Some service centres provide social services to older person's families or provide home-based care programmes where caregivers care for frail, sick, and vulnerable elderly persons at their homes.

The current WC DSD criteria for service centre funding consist of three levels of service, in accordance with the OPA (see Table 6). Specifically, the primary services offered by the service centres include:

1) Nutritionally balanced meals;
2) Information awareness campaigns;
3) Educational and skills development programmes;
4) Coordinating spiritual, cultural, health, civic, and social services;
5) Recreational opportunities; and/or
6) Accessibility to professional services, counselling services, including care and rehabilitation

Table 6. Criteria and level of service according to transfer payment agreements between WC DSD and service centre NPOs

Operational level	Details	Services	Duration	Minimum membership
Level A	Basic services	2 primary services of which meals are compulsory	3 days/week, 18 hours/week	20
Level B	Intermediate services	3 primary services of which meals are compulsory	5 days/week, 30 hours/week	50
Level C	Tertiary services	All six primary care services and as many secondary services as possible as may be determined by the level of care required[a]	5-7 days/week, 40 or 168 hours/week	75

[a]i.e., assisted living, respite care or home based care. Three meals have to be provided if respite care services and/or assisted living services are provided.

2.4.2 COMMUNITY-BASED CARE AND SUPPORT FOR OLDER PERSONS: LESSONS FROM INTERNATIONAL MODELS

The change in focus from institutional care to community-based care and support for older persons in South Africa and in the Western Cape is reflective of a broader international shift. Community-based care exists on a continuum of care for older persons ranging from home-based care services to residential facilities and institutionalised frail care. Community-based care exists as the first line of care on this continuum, where services are provided to help older persons to live independently in their communities for as long as possible (HelpAge International, 2015; World Health Organization, 2004). There is significantly more literature on community-based care in developed countries, much of which cites an ageing population, cost considerations and beneficiary preferences as the driving force behind a growth in community-based care approaches (Low, Yap, & Brodaty, 2011).

Services such as service centres are a key component in the field of care for older persons who are living independently in their own homes and communities. In order to achieve quality of life, life satisfaction, and integration of older persons, it is advised that service centres should maintain a standard of guidelines or norms to operate (Ferreira & Charlton, 1996). There are no standards or norms guiding the activities of service centres in South African legislation or policy[4]. In the absence of accreditation guidelines for centres in South Africa, it is not impossible that centres may be offering services that have little or no relevance to the needs of older persons in the community. Noting the dearth of local published literature and guidelines, it is important to explore international findings.

[4] See section 3 on the legislative and policy context governing older persons and community-based care for an outline of relevant policy guidelines for community-based care in South Africa.

2.4.2.1 Integrated models of care

Typical approaches to support and care for older persons have been criticised for being fragmented, where older persons need to go to different providers to access the multiple services they need. For example, in a comparison of care for older persons in the United States, Canada, and Israel, it was noted that despite historical, social and demographic differences between the countries, all three displayed significant discontinuity between and within social and medical care for older persons (Clarfield, Bergman, & Kane, 2001).

Thus, a number of international models of care have focused on the provision of integrated care (Béland et al., 2006; Bernabei et al., 1998). Integrated care is defined as "a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors" (Kodner & Spreeuwenberg, 2002, p. 3). According to Leutz (1999), integrated care can occur at three levels:

1) Linkage: Health and social service providers still work within their respective silos and separate funding but they work together more closely, and have the knowledge to refer people to other services. For example, non-medical service providers can notice when clients are not taking medication and contact the medical service provider with this information.
2) Coordination: Particular structures and mechanisms are in place to coordinate service provision across the different systems. This helps to deal with poor communication between service providers, share information, and avoid friction or discontinuity for persons requiring multiple services.
3) Full integration: New interdisciplinary programmes are created. Rather than having to share information across systems or for clients to access services separately, everything happens through a central body.

These integrated models typically focus on the provision of health and social care, and there is a growing body of research on the efficacy of these models on health outcomes, cost savings, and client satisfaction (see e.g., McAdam, 2008). Although the research shows an association between integrated care and greater use of hospital and community services, there is mixed evidence for the efficacy of these models in reducing clinic outcomes (Low et al., 2011).

Research has attempted to identify the elements of successful integrated models of care. Successful integrated programmes in North America have been found to use multidisciplinary care in addition to access to a range of health and social services. Kodner (2006) identified the key elements to the success of three[5] well-known integrated models in North America:

1) Umbrella organizational structures to guide integration of strategic, managerial and service delivery levels; encourage and support effective joint/collaborative working; ensure efficient operations; and maintain overall accountability for service, quality and cost outcomes

[5] The Program of All-inclusive Care for Elderly People (PACE) in the United States, Système de Soins Intégrés pour Personnes Âgées (SIPA) in Canada, and the Programme of Research to Integrate Services for the Maintenance of Autonomy (PRISMA), also in Canada.

2) Multidisciplinary case management for effective evaluation and planning of client needs, providing a single entry point into the health care system, and packaging and coordinating services
3) Organized provider networks joined together by standardized procedures, service agreements, joint training, shared information systems and even common ownership of resources to enhance access to services, provide seamless care and maintain quality
4) Financial incentives to promote prevention, rehabilitation, and the downward substitution of services, as well as to enable service integration and efficiency.

2.4.2.2 Service centre models from developed countries

Community-based care services such as service centres are a key component in the field of care for older persons who are living independently in their own homes and communities. With regards to service centre models in particular, the literature identifies breath of innovation, stakeholder involvement, the impact of participation, the potential for replication, and long-term feasibility for the service centre as the most important considerations for service centres in terms of providing an innovative and effective service (Lawler, 2011). Several innovative community-based care models exist internationally. A national study of emerging service centre models in the United States (Pardasani, Sporre, & Thompson, 2009; Pardasani & Thompson, 2010) identified the following:

1) Wellness Centre: Having a focus on the healthy and mobile older persons, this model focuses on improving the health/well-being of its members by providing a range of recreational programmes, professionally developed health and fitness programmes, and a state of the art fitness facility. These facilities primarily operate from one site with extensive resources and space but have linkages, collaborations, and coordinated programmes with other community organisations and service providers.
2) Lifelong Learning/Arts Centres: The Lifelong Learning/Arts model provides a range of programmes, including classes, workshops, and travel, aimed at providing intellectual stimulation and creative pursuits. This model is generally not connected to one site given the nature of the programming, often needing multiple sites to fulfil programme requirements.
3) Entrepreneurial Centre: The Entrepreneurial Centre model focuses on civic engagement, volunteerism, and resource generation by mobilizing the skills and expertise of older persons. Primarily operating from one site with extensive resources and space, this model offers a range of recreational programmes, structured volunteer programmes, and entrepreneurial (income-generating) opportunities. These centres have a number of community linkages, collaborations, and coordinated programmes. The Entrepreneurial Centre model generally attracts more men, newly retired and active adults who are interested in civic engagement, volunteering, and vocational opportunities, and relies on public funding.
4) Café Programme: The Café Programme model offers a restaurant-style experience for all members of the community, and opportunities for intellectual stimulation and creative pursuits for older persons. Café Programmes offer a meal service; a few recreational and educational programmes focused on intellectual stimulation, exercise, performing arts, health, and literacy, and generally operate around meal times. The Café

Programme model is generally privately funded, through sponsors and charging for meals and programmes, and attracts those who live nearby and are interested in community dining.

2.4.2.2.1 Applicability to the local context

Cross-national differences in population ageing, policy, funding and infrastructure, as well as the socio-economic conditions and health of older persons are important considerations when assessing the applicability of international models to the local context (Kodner, 2006). Thus, the suitability of models from developed settings for the South African context is challenging. Many of these models are costly and require significant infrastructure and resources (e.g., multiple or large sites, state of the art equipment, travel) that limit their applicability to the developing world context. Low levels of educational attainment, high rates of poverty, poor access to basic services and already strained resources, limit the relevance of each of these models individually to South Africa. However, there are a number of individual practices/service offerings within these models, which may be pertinent to the local context.

For example, the Wellness Centre model involves extensive collaboration and coordination between community organisations and service providers. It is suggested that if South African service centres were to be valuable, auxiliary services such as health check-ups, dispensing of medications, and pay-out of pensions should be offered through stakeholder involvement (Ferreira & Charlton, 1996). Stakeholder involvement or strategic partnerships are vital to facilitate the development of a diverse range of programmes. This is particularly true in South Africa, where there have been calls for the integrated service delivery between the Department of Health and the Department of Social Development. Such partnerships could lead to collaboration between basic health services in service centres for older persons[6].

The Entrepreneurial Centre model focuses on mobilising older persons to become active in either income-generating or volunteer activities. This is similar to the model of AgeWell, who use a peer-to-peer approach based on the mothers2mothers model that has been used to address mother to child transmission of HIV (see e.g., Zikusooka et al., 2014). AgeWell trains and employs older persons who themselves carry out the programme activities of visiting older persons in their homes. Through providing companionship, collecting and monitoring health information, and making referrals to other service providers, it is thought that the programme will improve well-being and independence and reduce healthcare costs and institutionalisation. The programme has been piloted in Cape Town, although there is no published evidence of its effectiveness.

2.4.2.3 Models of Community-Based Care from East and Southeast Asia

East and Southeast Asia is experiencing a similar rapidly ageing population and declining family care and support to that being witnessed in Sub-Saharan Africa. HelpAge International (2015) refers to third party community-based care provided by civil society organisations, the public sector, the private sector, and community

[6] Although no evidence of implementation was found in this evaluation, a partnership of this nature has been entered into (DSD/ DoH)

volunteers. This includes (a) China's 'Golden Sunshine Action' programme which matches teenagers and other young people to care for older persons; (b) Singapore's 'Neighbourhood Links' provides activities and other social well-being focused services for older persons within the neighbourhood by linking them with other residents and service providers as well as providing inter-generational activities; (c) the HelpAge Korea-initiated volunteer-based home care programme trains volunteers and matches them with older persons in mostly poor rural settings; and (d) the Indonesian PUSAKA. The latter is discussed in more detail below.

The Indonesian PUSAKA (meaning 'home-based care centre') is often pointed to as a successful and sustainable model of care. As described by Do-Le and Raharjo (2002), PUSAKA emerged from a 'Meals on Wheels[7]' concept in response to a perceived lack of facilities and community concern for older persons in Indonesia in the 1970s. PUSAKA centres provide care to poor older persons in a community through volunteers from the same community. After a two-year trial period, centres can be evaluated and accredited by a central coordinating body. After accreditation, they receive a small subsidy, management training, and supervision in return for the submission of quarterly and annual progress reports but are otherwise independent in terms of the running of activities and programmes. Criteria for membership include age, a disadvantaged background, and living within walking distance of the home of the caregiver.

Services are free and include (a) meals provided 3 – 7 times a week, which members collect from the home of a coordinator; (b) home visits for frail elderly; (c) monthly medical check-ups and distribution of medication; (d) weekly spiritual guidance; (e) physical fitness programmes; (f) crafts, baking, or cooking courses; (g) clothing provided on special occasions, such as Ramadhan; (h) recreational activities once or twice a year; (i) help with improvements to members houses; (j) provision of capital for small businesses; and (k) assistance to family members. PUSAKA may also work with community health clinics to establish 'Health Posts for the Elderly' whereby basic health care is provided.

No formal training is provided but PUSAKAs are predominantly run by volunteers, including the health services. The economic crisis saw a reduction in donations, funding, and volunteers, and, while around 40% of the cost of meals is subsidised by the government through the coordinating body, PUSAKAs are otherwise reliant on private sources of funding. This is identified as a significant challenge.

2.4.2.4 Best practice for service centres: Evidence from developed countries

Although comprehensive best practice research on service centres is lacking in South Africa, there are a number of examples of key characteristics or standards that have been identified in developed countries (see e.g., New York City Department for the Aging, 2011; Pardasani et al., 2009; Zena Simces & Associates & CS/RESORS Consulting Ltd, 2003). It is important to note that these best practices emanate from a developed world setting. However, observing (a) the lack of published best practice

[7] 'Meals on Wheels' generically refers to a meal home-delivery programme which the delivers meals to older or otherwise vulnerable persons who cannot cook or purchase food for themselves.

guidelines in South Africa or other developing world setting; (b) the broad challenges regarding care and support for older persons that are said to cross-cut countries and settings, such as fragmented services, high costs, and poor service quality (Kodner, 2006); and (c) the overarching similarities in the goals of service centres globally to provide community-based care and support for older persons living in their communities; these guidelines may have relevant applicability to service centres in other contexts. To contextualise the findings of this report in international and available best practice, two are discussed in more detail below[8].

In an attempt to effectively standardize best practice among service centres in the United States, the National Council on Aging (NCOA) in that country developed an accreditation program for service centres. As part of this process, the NCOA (2012) developed nine standards, which are:

1) Purpose: Written statement of its mission consistent with the service centre philosophy, its goals and objectives based on its mission and on the needs and interests of older persons in its community, and action plans that describe how its program will achieve goals and objectives.
2) Community: Participate in cooperative community planning, establish service delivery arrangements with other community agencies and organisations, and serve as a focal point in the community. Be a source of public information, community education, advocacy, and opportunities for older persons.
3) Governance: Be organized to create effective relationships among participants, staff, governing structure, and the community in order to achieve its mission and goals.
4) Administration and human resources: Have clear administrative and human resources policies and procedures that contribute to the effective management of its operation. Staffed by qualified personnel--paid and volunteer--capable of implementing its program
5) Programme planning: Provide a broad range of group and individual activities and services that respond to the needs and interests of older persons, families, and caregivers in its community.
6) Evaluation: Have appropriate and adequate arrangements to evaluate and report on its operation and program.
7) Fiscal management: Practise sound fiscal planning and management, financial record keeping, and reporting
8) Records and reports: Keep complete records required to operate, plan, and review its programmes. Regularly prepare and circulate reports to inform its governing structure, its participants, staff, funders, public officials, and the general public about all aspects of its operation and programme

[8] These guidelines were chosen as they were identified as containing broadly applicable principles and standards. These best practices speak to the key broad areas of service delivery, management, funding and infrastructure that are applicable to service centres aimed at keeping older persons living in their communities. Most importantly, these best practice guidelines acknowledge that programmes and services need to be sensitive to the needs and circumstances of the specific community within which the centre is located.

9) Facility: Make use of facilities that promote effective programme operation and that provide for the health, safety, and comfort of participants, staff, and community

Much like the NCOA, MacRae-Krisa and Paetsch (2013) identified five best practices in a comprehensive review of best practice in multipurpose senior centres for the Kerby Centre in Calgary[9], Canada. These are:

1) Promotion of health and well-being of older persons by offering a diversity of programme and services options while still engaging in their communities to avoid isolation;
2) To be aware of the characteristics and service needs of older persons and perception of the centre;
3) The centres should provide spaces that are accessible, age-friendly, safe, and comfortable and offer opportunities for social engagement;
4) The centres offer a range of programmes and services that are sensitive to the demographic diversities and interest in the communities served; and
5) The development of strategic partnerships is a key best practice as this helps to maximize available resources, minimize duplication of services, and promote participation.

Both the NCOA and Kerby Centre guidelines acknowledge the importance of awareness of the needs of the specific community in which the service centre is located in developing a best practice model. MacRae-Krisa and Paetsch (2013) conclude that there is no one-size-fits-all model. They argue that "developing a best practice model involves balancing facility space, resources, and participant needs and desires" (MacRae-Krisa & Paetsch, 2013, p. vi). This requires rigorous and on-going evaluation of programmes and services. To establish local best practice, the authors argue that service centres should conduct (where possible) a comprehensive assessment in the community of both users and/or non-users of the service centre to determine what is required.

2.4.3 LOCAL MODELS OF COMMUNITY-BASED CARE

While local best practice guidelines or published literature on models of models of community-based for older persons are lacking, a number of South African NPOs working with older persons have developed innovative and noteworthy service models. These models, whereby a basket of services are provided[10], are congruent with the notion of integrated service provision and multipurpose service centres noted in the discussions of international models. In addition, they correspond with standard 5 in the NCOA best practice guidelines and notion of providing a variety of services noted by MacRae-Krisa and Paetsch (2013). A number of these are discussed below.

[9] The Kerby Centre in Calgary, Canada, is a flagship NGO operating since 1973 offering a variety of services to support older persons living in the community, including food, housing, a shelter, education and recreation, wellness clinic, personal decision-making assistance, information and advice

[10] The information contained in this section was obtained through a combination of secondary data (from websites and annual reports) and primary data obtained from key informant interviews with the identified organisations.

2.4.3.5.1 Grandmothers Against Poverty and AIDS

Grandmothers Against Poverty and AIDS (GAPA) offer a two-pronged approach, including education and psychosocial support for older persons. Key to their model is that the grandmothers themselves take initiative in co-constructing and facilitating the programmes and activities. Their activities include:

1) A health club: Weekly exercise and health promotion.
2) A mobile clinic: Partnership with the local CHC in the provision of a monthly clinic where screenings are provided by a registered nurse to older persons and other community members.
3) Support groups: Groups of 10 – 20 members meet at homes once a week where they provide peer psychosocial support and participate in income generating activities. Each support group has a communal bank account ('stokvel'), committee, and buy their own materials or supplies. Technical support is provided by a coordinator at the head office.
4) Income generation: Income generating activities take place at the level of the support group with support and workshops/training provided by GAPA. Supported by a coordinator with some crafts sold on the premises, with 10% going to GAPA.
5) Workshops: Predominantly held on the radio focusing on health promotion and other issues relevant to older persons.
6) Aftercare: For children aged 5 – 13 years, supervised by grandmothers, who are paid a stipend, and co-constructed with international volunteers. The volunteers buy crafts produced by the support groups.
7) Indabas: Monthly meetings for all members

Meals do not form a fundamental component of GAPA's activities but are provided when members are at the head office (e.g., for the health club or workshop). The centre has a vegetable garden.

2.4.3.5.2 Helderberg Society for the Aged

The Helderberg Society for the Aged (HSFA) offers integrated 'pillars of service':

1) Independent living facilities,
2) Assisted living facilities,
3) Frail care,
4) Home-based care, and
5) Service centres.

The independent-living facilities offer varied types of accommodation from bachelor flats and shared houses to one- and two-bedroom flats to cottages, with size determining cost. The HSFA offers a variety of services and activities to these residents through service centres. Additional services include meals, a coffee shop, library, hair salon, kiosk, access to a laundrette, and an emergency medical call button service. Social activities include games, exercise, church services, and outings. Medical care is available through the HSFA's dedicated clinic sister who services the different facilities on a rotational basis.

As older persons' require additional support with daily activities, home-based care services are available to both independent and assisted-living residents and older persons living in the wider community. These services are aimed at promoting

continued independence and active ageing through providing direct assistance and referral to relevant services. The services are person-centred in that individual care plans are developed to meet individual needs and include care by a registered nurse, clinic sister, carers, housekeepers, and a social worker.

Whereas in independent living, residents are encouraged to remain in independent flats and cottages for as long as possible, assisted-living and frail-care accommodation are available as residents' physical and mental capacity decreases their ability to live independently.

2.4.3.5.3 Neighbourhood Old Age Homes

The Neighbourhood Old Age Homes (NOAH) model takes a human-rights based approach to help older persons take control of their lives and meet their needs through empowerment and facilitating community integration. NOAH provides three key services:

1) Home: Shared/communal independent-living homes for healthy older persons and assisted living facilities for those who are more frail but do not yet require placement in a frail care institution.
2) Health: A primary health care clinic provides essential primary health care by two contracted general practitioners to residents and other social pensioners in surrounding communities for a small monthly payment fee.
3) Happiness: NOAH provides opportunities for social engagement and development through a service centre model that provides (a) support through the implementation of social enterprise development (e.g., candle making, soap making, The Clothing Bank[11]), a second hand shop, a bulk food buying scheme, a savings scheme ('stokvel[12]'); (b) social activities, including talks, outings, games, cultural exchanges between centres, and simply the coming together of residents and members; (c) spiritual engagement; (d) access to information through an referral pathway based on knowledge and partnership; (e) exercise and talks about health issues; and (f) meals.

[11] The Clothing Bank is a registered enterprise development NPO, which assists unemployed mothers to develop their own businesses, selling garments donated to the Clothing Bank from the organisation's major retail partners in South Africa.

[12] A stokvel refers to a savings club whereby members contribute regular amounts of money and receive payment from these pooled savings.

3 LEGISLATIVE AND POLICY FRAMEWORK

The interests of older persons are often marginalised, or at least not prioritised in policies, programmes, funding and research (Ferreira, 2005b). This is despite their rights being violated in numerous spheres (Ferreira & Lindgren, 2008). Researchers have highlighted the need for research on the situation of older persons on the African continent to address the challenges associated with an ageing population and to inform policy development and implementation (Ferreira, 2005b). The key international and national policies and acts of legislation regulating the rights, care, and protection of older persons are highlighted below.

3.1 INTERNATIONAL FRAMEWORKS

There are a number of international frameworks promoting the rights of older persons and the development of research and policy addressing the ageing agenda. Two key frameworks to which South Africa is a signatory are (1) the Madrid International Plan of Action on Ageing (MIPAA) and (2) the African Union Policy Framework and Plan of Action on Ageing.

3.1.1 The Madrid International Plan of Action on Ageing

The MIPAA was signed and adopted by South Africa in 2002, although it is not legally binding. Whilst acknowledging the differential impact of ageing in developing countries, the MIPAA aims "to ensure that persons everywhere are able to age with security and dignity and to continue to participate in their societies as citizens with full rights" (United Nations, 2002). The key areas of the plan relate to older persons and development, advancing health and well-being of older persons, and ensuring enabling and supportive environments. The plan recognises the importance of providing a continuum of care and support for older persons, including (a) improving the quality and access to community-based care and (b) promoting quality of life to allow for older persons to continue living independently in their communities as opposed to hospitalization and placement in a nursing home.

3.1.2 The AU Policy Framework and Plan of Action on Ageing

The African Union (AU) Policy Framework and Plan of Action on Ageing, drafted in 2002 with HelpAge International, provides guidance to member states on designing and implementing policy on older persons (African Union, 2003). The policy emphasises the economic and social difficulties older persons face and the need for health care. With regards to social welfare, the plan recommends that Member States "design, develop, and implement practical, realistic and appropriate social welfare strategies that include the concerns of older people" (African Union, 2003). Specifically, states are encouraged to take action to sustain the independence of older persons and reduce the placement of older persons in institutions. The Plan emphasizes traditional community care and support mechanisms and the decentralization of health, welfare, and social services. In addition, it supports the voluntary contributions of older persons to community-based initiatives and access to adequate recreational and leisure facilities.

Both the AU Policy Framework and Plan of Action on Ageing and the MIPAA acknowledge the impact of HIV/AIDS on older persons and the need to support older

persons affected by the epidemic (e.g., those who have lost children to HIV/AIDS or are the caregivers to grandchildren orphaned by HIV/AIDS), including community-based care (e.g., psychosocial support and counselling). In addition, they encourage policy and actions that allow older persons to play an active role in society and contribute to their communities for as long as possible or desired.

3.2 NATIONAL POLICY AND LEGISLATION

3.2.1 Older Persons Act (No. 13 of 2006)

Older persons are entitled to the rights enshrined in the Bill of Rights in the Constitution of the Republic of South Africa (1996). Such rights include (a) Section 9, which prohibits unfair discrimination on the basis of, inter alia, age, (b) the right to dignity contained in Section 10, and (c) the right to freedom from violence contained in Section 12. The rights enshrined in the Constitution and Bill of Rights supplement the rights that older persons have in terms of the OPA.

The government responded to public outcry over the neglect and abuse of older persons in South Africa stemming from the screening of footage on Carte Blanche in March 2000, commissioning the Ministerial Committee on Abuse, Neglect and Ill-treatment of Older Persons to investigate the issue. Following public hearings across South Africa's nine provinces, a two-volume report 'Mothers and Fathers of the Nation, the Forgotten People' was published in 2003. This process eventually led to the overhaul of legislation governing the care and protection of older persons in South Africa when the OPA was signed into power in 2010.

The OPA, which takes a rights-based approach, states that older persons may not be unfairly denied the right to:

a) participate in community life in any position appropriate to his or her interests and
b) capabilities;
c) participate in inter-generational programmes;
d) establish and participate in structures and associations for older persons;
e) participate in activities that enhance his or her income-generating capacity;
f) live in an environment catering for his or her changing capacities; and
g) access opportunities that promote his or her optimal level of social, physical, mental
and emotional well-being.

Reflecting the commitments of the MIPAA and AU Policy Framework and Plan of Action on Ageing, the objects of the OPA are to:

a) maintain and promote the status, well-being, safety and security of older persons;
b) maintain and protect the rights of older persons;
c) shift the emphasis from institutional care to community-based care in order to ensure that an older person remains in his or her home within the community for as long as possible;
d) regulate the registration, establishment and management of services and the establishment and management of residential facilities for older persons; and

combat the abuse of older persons.

In particular, object (c) of the OPA represents a significant policy change in terms of the focus of service delivery to older persons. This is further reiterated in Chapter 3 of the OPA. Chapter 3 signifies a significant departure from previous legislation, which focused on residential facilities. The Chapter supports the rights of older persons receiving community-based care and support to remain in their homes within the community for as long as possible. Chapter 3 regulates community-based care and support services, requiring services to be registered with the Department of Social Development. According to the OPA, these services can include prevention and promotion programmes, which help to keep older persons living independently in their community for as long as possible or home-based care services, which are provided to frailer older persons to allow them to receive maximum care within the community. The latter includes (a) provision of hygienic and physical care of older persons; (b) provision of professional and lay support for the care of older persons within the home; (c) rehabilitation programmes that include provision of assisted devices; (d) provision of respite care; (e) Information, education and counselling for family members; (f) caregivers and the community regarding ageing and associated conditions; and (g) provision of free health care to frail older persons.

Annexure B of the OPA sets out the national norms and standards regarding acceptable service standards for community-based care and support services, including level A, B and C services and home-based care. These include guidance on statutory requirements, service requirements and specifications, management services, operational management, asset and human resource management, the rights and responsibilities of older persons, and data information systems. The activities and connected standards for community based care and support programmes are highlighted in Table 7 on the following page.

Table 7. Community-based care and support programmes outlined in the Older Persons Act (No.13 of 2006) and national norms and standards.

Community-based programmes	
Service	**Standard**
Economic empowerment of older persons	• Income generating activities • Food and gardening projects • Arts and craft projects • Poverty relief projects • Employment and economic empowerment projects and programmes
Establishment of recreational opportunities for older persons	• Cultural and/or social activities • Indoor and outdoor games • Library services • Sport activities and/or physical exercise activities
Information awareness, education and skills development campaigns	• Adult Basic Education Training (ABET) • Life skills programmes (e.g. budgeting, grand parenting skills etc.) • Computer training • Skills training as identified in a community • Awareness campaigns on the rights of older persons, on abuse, health and lifestyle aspects e.g. Dementia, Alzheimers, HIV and AIDS • Information on basic and other professional services, how and where to access services
Counselling services	• Bereavement, trauma and/or pre and post retirement counseling • Support groups • Telephone helpline • Counseling based on verbalized personal needs
Spiritual, cultural, medical, civic and social services	• Religious activities • Primary Health Care (PHC) services (e.g. immunisation, basic podiatry services, monitoring of Health status, community and these etc) • Cultural/traditional activities (e.g. indigenous games) • Pension pay points/access social grants

	• Advice and referral in order to access basic services • Preventative and promotive health care programmes
Provision of nutritionally balanced meals to needy older persons	• Meals on wheels (Provision of meals to older persons in the community on a regular basis) • Food on foot (When members from the service centre deliver meals to other members of the community who due to ill health are unable to collect meals) • Provision of a balanced meal to older persons at a designated facility
Professional services, including care and rehabilitation to ensure independent living of older persons	• Sessional social work services • Primary Health Care services by a primary health care nurse • Community Based Rehabilitation workers (CBR workers)-Assistant physiotherapist & Assistant occupational therapist and other professional categories • Support services • Programmes to enable and support families and spouses/partners to provide care and support
Appropriate services contained in the indigent policy for vulnerable and qualifying older persons	• Awareness on the content of the indigent policy of local government and rebates or rates concession for qualifying older persons (e.g. subsidised transport, rates and taxes) • Referral systems in place to access services contained in the indigent policy
The utilisation and management of existing facilities for older persons as multi-purpose community centres	• Outreach programmes (taking services to the community and making the facility available for the community) • Cooperation agreement with other stakeholders
Integrated community care and development systems for older persons	• Directory of community care and support services available to all older persons • Utilisation of skills of older persons in the community projects (e.g. skills of retired professionals)
Intergenerational programmes.	• Reality orientation programmes available, accessible or developed and made accessible • After school classes run by older persons • Cultural story telling encouraged • Operation dignity programmes developed and implimented • Cultural games organised • Grand parenting programmes • Moral regeneration activities (preservation of values, adopt a school, adopt a granny)

Although all national, provincial, and local spheres of government rendering services to older persons must implement the prescriptions of the OPA, some analysts are critical of the OPA's lack of enforcement mechanisms (Malherbe, 2007). In addition, while norms and standards regarding the acceptable levels of service to older persons and service standards for community-based care and support services have been developed, norms and standards guiding the activities of community-based programmes, and service centres specifically, still need to be developed.

3.2.2 The South African Social Security Agency Act (No.9 of 2004) and the Social Assistance Act (No. 13 of 2004)

The South African Social Security Agency Act (No.9 of 2004) provides for the establishment of the South African Social Security Agency (SASSA), the body responsible for the administration and payment of grants. A key piece of related legislation that impacts the lives of many older persons in South Africa is the Social Assistance Act (No.13 of 2004), which dictates the eligibility criteria for the older person's grant and the procedures to be followed in the application and payment of social assistance. As with other social assistance grants, the income and assets of older persons applying for the older person's grant are considered, as are their age (persons 60 years and older are eligible) and whether they are in receipt of other grants. The current older person's grant is R1350/month plus an additional R20 for persons over 75 years of age.

3.2.3 South African Older Persons Charter

The Older Persons Charter was developed in partnership with the National Department of Social Development and the South African Older Persons Forum (SAOPF), thus including the contribution of older persons themselves. The Charter echoes the rights of all older persons to equality, respect and freedom, as outlined in the Constitution. The Charter also speaks to the rights of older persons living in the community to basic services (shelter, healthcare, water and electricity), social security, as well as affordable and accessible transport, wheelchair access, and the right to receive home-based care. It also encourages the rights of older persons to participate in community life as active citizens.

4 EVALUATION DESIGN AND METHODOLOGY

This section outlines the evaluation objectives and the approach CC&DW took in conducting this evaluation, including the sampling, data collection, and data analysis. CC&DW team members consulted with WC DSD particularly during the design and initial planning stages of the research. This engagement ensured that all the relevant variables, issues, and stakeholders were identified.

4.1 EVALUATION OBJECTIVES

The specific aims of the evaluation are detailed in Table 8 according to the key themes.

Table 8. Evaluation objectives

Theme	Evaluation Objectives
Trends	To explore trends in terms of the number of beneficiaries of service centres and factors contributing to these trends. To explore trends in terms of the number of service centres in the province and factors contributing to these trends.
Needs	To assess the need for service centres in the Western Cape and the needs of older persons who could make use of these services.
Nature of services offered	To describe the nature of services offered by service centres in the province.
Best practises	To identify best practises in service centres in the province, specifically in terms of management structures, funding models, infrastructure and the nature of services provided.
Gaps	To identify gaps in service delivery and make recommendations for the improvement thereof.
Effectiveness, relevance, accessibility, and appropriateness	To evaluate the effectiveness, relevance, accessibility, and appropriateness of service centres in addressing the needs of older persons.
Models of care	To propose alternative models of community based care and support that could be considered by the Older Persons Programme in the expansion of its services. To inform the development of a sustainable model for service centres in the Western Cape that addresses the needs of older persons in the province.

4.2 EVALUATION QUESTIONS

In order to reach the above set out objectives, the evaluation attempted to answer a number of questions (see Table 9). All the evaluation questions speak to objective 9, to ultimately inform the development of a sustainable future model for service centres in the province that is responsive to older persons' needs.

Table 9. Key evaluation questions

Theme	Evaluation Questions
Trends	How many service centres are there in total currently in the Western Cape? How many of each type of service centres are there? What factors are contributing to trends seen in the number of service centres? How many older persons are currently benefiting from the service centres? What factors are contributing to trends in usage in terms of the number of older persons benefiting from the service centres?
Needs	What are the service needs of older persons in the province? What is the difference between the service needs of older persons and the services currently provided by service centres?
Nature of services provided	What services do the service centres provide to older persons in terms of number, type, frequency, and content?
Effectiveness, relevance, accessibility, and appropriateness	How do beneficiaries of the service centres experience the delivery of services? Are the services currently offered by service centres accessible to as many older persons as possible? What factors are hindering or facilitating the ability of older persons to access the services? Are the services appropriate in relation to the needs of older persons? What is the relationship between service centres and independent and assisted living services for older persons? Are the services perceived to be effective in addressing the needs or issues faced by older persons? What is the evidence for the effectiveness of these services?
Best practices	What are the management structures, funding models and infrastructure of the service centres? What are examples of best practises from service centres which are functioning effectively in terms of management, funding, infrastructure and service delivery?
Gaps	What are the perceived gaps in services offered to older persons? What factors hinder the delivery of services to older persons? What steps can be taken to improve service delivery at service centres?
Models of care	What are alternative models of community-based care and support? Which model(s) is best suited to the expansion of the WC DSD's Programme for Older Persons? What role can service centres play in the suggested alternative models of community-based care and support?

4.3 EVALUATION DESIGN

A formative evaluation approach was adopted for this evaluation. As described by Rossi, Lipsey and Freeman (2004), a formative evaluation is usually conducted to gain insight into how an intervention is working and how it can be improved. The formative nature of this evaluation guided the evaluation team in gathering evidence of the current status and functioning of the service centres sampled; the relevance, accessibility, effectiveness, and efficiency of the services offered in achieving their outcomes, and the general relevance of their services in relation to the needs of their intended beneficiaries. Importantly, a formative evaluation approach assisted in determining why the current model of community-based care and support does or does not work and informed the recommendations for the improvement of the programme design and implementation.

Stemming from the formative and exploratory nature of this evaluation, the evaluation utilised a mixed methods data collection approach drawing on predominantly qualitative, but also quantitative data, to achieve breadth and depth of understanding of service centres in the Province. The most fundamental part of mixed methods research is that its eclectic nature provides the best chance to produce useful answers. The approach CC&DW took with this evaluation allowed for engagement in multiple ways with key stakeholders, service providers and beneficiaries in order to elicit multiple standpoints on the needs, nature, gaps and best practices with regards to the services offered at service centres for older persons in the Western Cape.

4.4 SAMPLING

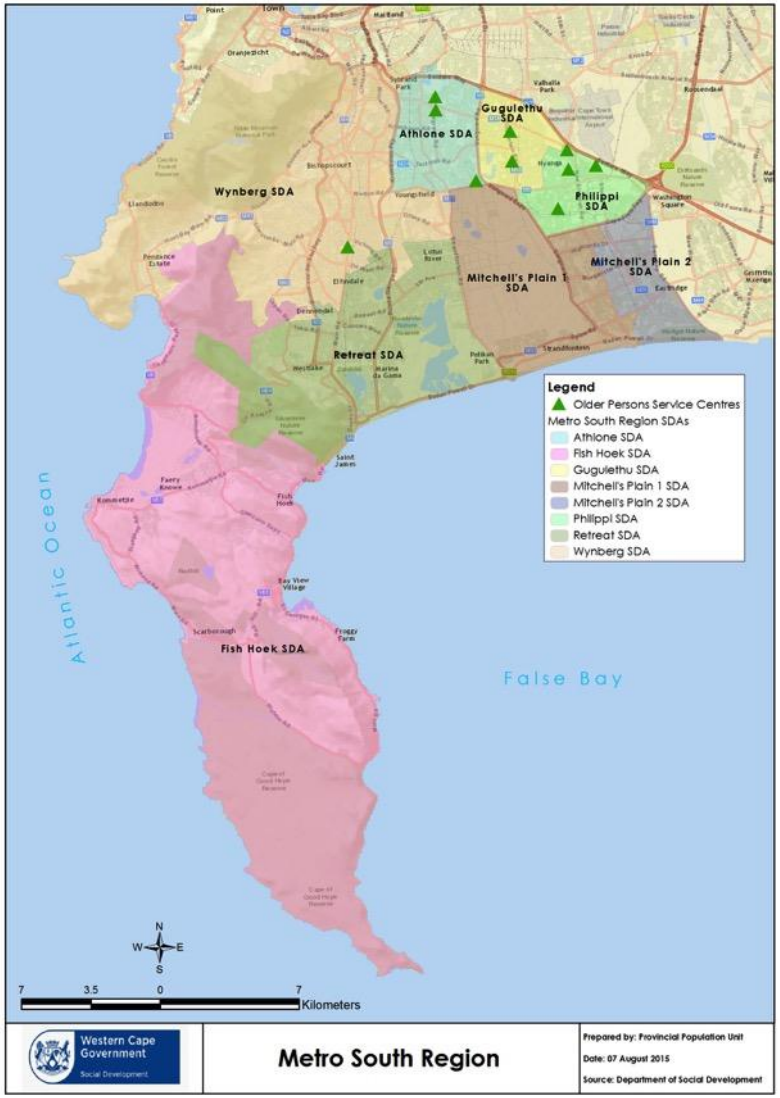
4.4.1 SAMPLING OF SERVICE CENTRES

The service centres for this evaluation were purposively sampled. *Purposive sampling* is a sampling technique used when it is not possible to select participants randomly. In purposive sampling, the sample is chosen or selected on the basis of particular characteristics, the aims of the research or the researcher's knowledge of the population (Babbie & Mouton, 2006). The WC DSD selected 20 service centres across the Western Cape. Geographically, the centres were situated in the (a) Cape Winelands and Overberg and (b) Metro South areas of the province (see Figure 5 on p.48). The sampling strategy was chosen to provide a diverse sample of both rural and urban service centres, with the former corresponding with the Cape Winelands and Overberg and the latter corresponding with the Metro South, as well as service centres serving diverse socio-economic groups. Although time and resource constraints prevented all service delivery regions in the province being sampled, these two regions and the service centres sampled are thought to be broadly characteristic of other regions in the Western Cape.

However, it must be noted that the non-probability based nature of the sampling may introduce bias into the evaluation sample and limit the generalisability of the findings to the provincial level (Babbie & Mouton, 2006). A more in-depth discussion on the limitations of this evaluation sampling strategy follows in section 4.8.

4.4.2 SAMPLING OF PARTICIPANTS

The evaluation was informed through multiple streams of information and data. Data was collected through interviews and focus groups with (a) service centre management, (b) service centre staff and/or volunteers, (c) service centre beneficiaries, (d) WC DSD key informants, and (e) external key informants. As with the sampling of service centres, participants were purposively sampled. Table 10 and Table 11 (p.49) outline the final sampling framework for participants from each of the service centres and key informants respectively.



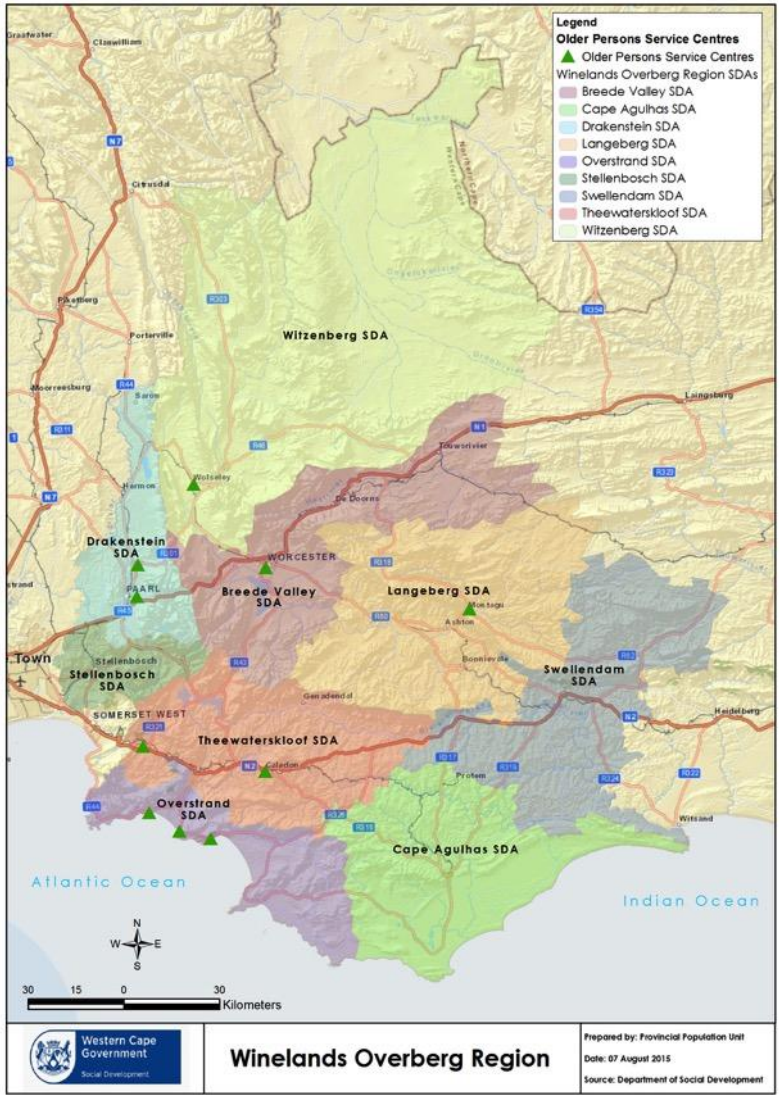


Figure 5. Maps depicting service centres sampled in the Metro South (left) and service centres sampled in the Winelands/Overberg region (right) Source: Maps Developed by WC DSD 2015

Table 10. Details of final sampling framework for participants from service centres

Participant Group	Description	Type of Interview	Data Type
Management	One interview with the service centre manager and/or coordinator	Structured interview	Qualitative and quantitative
Staff and volunteers	One focus group per service centre with staff and/or volunteers at the centre, with a maximum of five participants per focus group	Focus group	Qualitative
Beneficiaries	Five members of each service centre selected based on availability and to include both male and female participants as well as younger old (60 - 79 years) and older old (80+ years) participants	Semi-structured interview	Qualitative and quantitative

Table 11. Details of final sampling framework for key informants

Key Informant Group	Description	Type of Interview	Data Type
WC DSD regional office	One representative from each of the two service delivery regions sampled	Semi-structured interview	Qualitative
WC DSD Special Programmes Directorate	One interview with two representatives from the WC DSD Special Programmes Directorate	Semi-structured interview	Qualitative
External key informants	The manager or director of six organisations or coordinating bodies	Five semi-structured interviews and one panel discussion session	Qualitative

CC&DW used a mixed-method design for this evaluation, combining both qualitative and quantitative data collection techniques. The above-mentioned evaluation objectives were achieved using a methodological framework that incorporated a comprehensive literature review, collection and analysis of secondary data, semi-structured and structured interviews, semi-structured focus group discussions, and a panel discussion session.

4.5.1 PROCEDURE

A fieldwork team comprising CC&DW researchers and English-, Afrikaans- and isiXhosa-speaking fieldworkers underwent training before the roll out of the evaluation. Fieldworkers were familiarised with the evaluation protocol and tools and trained on the key considerations when interviewing older persons.

Half-day site visits took place at all 20 service centres in the Metro South and Winelands Overberg regions by two fieldwork teams consisting of either a researcher and a fieldworker or two fieldworkers. During each site visit, one team member was responsible for the (a) interview with service centre management, (b) focus group with service centre staff and/or volunteers, and (c) site description while the other team member conducted the beneficiary interviews. The lead researcher conducted all the key informant interviews for the evaluation.

Before each interview or focus group was conducted, consent was obtained from the participant(s). During the interview or focus group, information was gathered through note-taking and recorded on a dictaphone for back-up purposes. At the conclusion of the interview or focus group, the participant(s) was given the opportunity to ask any questions or raise any concerns that had surfaced during the interview process.

4.5.2 DATA COLLECTION TOOLS

Structured and semi-structured interview guides and a focus-group discussion guide were developed based on the evaluation questions, literature review, and technical expertise. Specifically, the tools included a (a) consent form (see Appendix B), (b) service centre manager interview guide (see Appendix C), (c) focus group discussion guide (see Appendix D), (d) beneficiary interview guide (see Appendix E), (e), site observation tool (see Appendix F), and (f) key informant interview guide (see Appendix G). These tools were translated from English into Afrikaans as more than half of the service centre sample indicated that Afrikaans was the first language of staff and beneficiaries.

4.5.3 PILOT SITES

The evaluation procedure and tools were piloted at two service centres, one in the Metro South (Centre 1) and one in the Winelands Overberg (Centre 11). Any necessary revisions were made before the evaluation was rolled out to the entire sample.

4.5.4 TIMEFRAME

The timeline of the evaluation, according to the key evaluation stages, is depicted in Figure 6 below.

Figure 6. Overview of evaluation timeline.

4.5.5 FINAL SAMPLE

The final samples for the key informants and service centres are displayed in Table 12 (below) and Table 13 (see p.53) respectively.

Table 12. Final evaluation sample for key informants

Key informant group	Interviews held	Number of participants
DSD regional offices	2	2
DSD Special Programmes Directorate	1	2
External key informants	6	9
Total	**9**	**13**

As evident in Table 13, at four service centres, more than one person took part in the management interview. These interviews included a higher-level programme manager or coordinator, usually from the mother body organisation, as well as the centre manager or coordinator in charge at the level of the service centre. A combination of these participants facilitated the answering of all the interview questions, particularly when individuals were new in their position.

Focus groups were not conducted at eight service centres due to the lack of availability or suitability of additional staff or volunteers. Three sites did not have additional staff or volunteers besides the service centre manager or coordinator. At five sites, the only staff member(s) or volunteer(s) in addition to the service centre manager or coordinator was a part-time cook, gardener, or driver. This was not conducive to a focus group discussion as (a) such staff members had little direct interaction with beneficiaries or involvement in service delivery as thus could not answer the questions, and (b) such a staff member or volunteer was the only additional staff member. In addition, numbers participating in the focus groups fluctuated slightly between centres based on the staff and volunteer complement and availability. As evident in Table 13, focus group sizes ranged from two participants to seven participants. However, where possible, the fieldwork team attempted to keep the focus groups small in order to facilitate the discussion and ensure all voices were heard.

At 12 of the service centres, the target number of five beneficiaries was interviewed. However, at seven service centres, fewer than five beneficiaries were available or willing to be interviewed. The reasons included that (a) attendance at the centres

was sometimes poor on the day of the fieldwork visit due to inclement weather, and (b) service centre beneficiaries were hesitant to participate, as they were busy with activities.

The above points on the final sampling relates to the significant variation between service centres, which means the same evaluation methodology and procedure was not applicable across all service centres

Table 13. Final evaluation sample for service centres

	Participant group			
Service Centre	**Interview with manager**	**Focus group with staff/ volunteers**	**Interview with beneficiary**	**Total number of participants**
Centre 1	1	1 (2)	6	9
Centre 2	1	1 (4)	5	10
Centre 3	1	1 (3)	5	9
Centre 4	1	-	5	6
Centre 5	1	-	3	4
Centre 6	1 (2)	-	5	7
Centre 7	1	1 (4)	5	10
Centre 8	1	-	5	6
Centre 9	1	-	5	6
Centre 10	1	1 (4)	4	9
Centre 11	1	1 (7)	4	12
Centre 12	1	1 (3)	4	8
Centre 13	1	-	4	5
Centre 14	1 (2)	1 (2)	5	9
Centre 15	1	1 (7)	4	13
Centre 16	1	1 (6)	5	12
Centre 17	1 (2)	-	4	7
Centre 18	1	1 (4)	5	10
Centre 19	1 (2)	-	5	7
Centre 20	1	1 (6)	5	12
Total interviews	**20**	**12**	**93**	**125 (171)**

Note. Figures present the number of interviews conducted, with the number of participants in brackets when this number was great than one.

4.6 DATA ANALYSIS

As formative evaluations lend themselves to qualitative methods of enquiry, the predominant method of data analysis was qualitative. The qualitative data collected was analysed using thematic analysis principles, identifying, recording, and reporting on key themes. For this purpose, interviews and focus groups were transcribed in Microsoft Word into short reports that captured key salient points. Data was organised around the evaluation objectives and main indicators addressed in the research tools.

The quantitative data was captured and analysed using Microsoft Excel. Analysis was in the form of descriptive statistics and frequencies. During data analysis

'triangulation' between various sources (e.g., interviews and focus groups) and kinds of data (i.e., quantitative and qualitative) was performed.

4.7 ETHICAL CONSIDERATIONS

A number of methods were used to ensure certain ethical considerations were adhered to:

1) Ethical approval for the research was obtained from the WC DSD Research Ethics Committee.
2) Participants' anonymity was protected in that no names or other identifying information was used in the analysis and write-up. All service centres were assigned a study number.
3) All participants were required to sign a consent form before the interview was conducted. The consent form informed participants of what the information provided would be used for and how it would be used. It also asked their permission for the interview to be recorded and provided the contact details of key stakeholders, should they have any questions or require further help.
4) All participants were encouraged to participate on a voluntary basis. They were free to not participate or to not answer any questions without any negative consequences.
5) Data (completed interview schedules) were stored securely in a locked room on CC&DW's premises. Collected data, including electronic copies of the transcripts and interview recordings, is available only to the CC&DW research team.

4.8 LIMITATIONS

A key limitation of this evaluation was the lack of a representative sample of service centres. As the sample was not randomly selected to be representative of the province and included service centres in only two of the province's six service delivery regions, results cannot be generalised to the Western Cape more broadly. Little is known about the nature of the service provided by and the circumstances facing service centres in the West Coast, Eden Karoo, Metro East, and Metro North regions and in what ways these may be similar to or different from the situation observed in the Metro South and Winelands Overberg regions.

While the evaluation identified service gaps and service needs of older persons and service centres in the two regions, the evaluation does not replace a comprehensive needs assessment. As outlined in more detail in section four, a full needs assessment is a key recommendation emerging from the evaluation. Furthermore, the narrow scope and the limited secondary data available, particularly lack of access to the most up-to-date TPAs[13] and quarterly reports, contributed to the evaluation not being able to comment comprehensively on trends in terms of the numbers of beneficiaries and service centres in the province.

In addition, due to scope of work and budget available, the evaluation methodology followed meant that only older persons who were already accessing

[13] Access to the most recent TPAs was requested but deemed unfeasible due to an internal audit.

care and support provided by service centres were sampled. Thus, the report does not comment on the needs and experiences of older persons living in their homes in the community or in independent- or assisted-living facilities who are not attending service centres. It is suggested that future research includes these groups in order to explore their lived experiences, service needs, and barriers to access.

As discussed in section 4.5.5 above, there is significant variation between service centres, which means the same evaluation methodology was not applicable across all sites. Thus, the fieldwork procedures and sampling had to be adapted to the realities 'on the ground'. For example, that focus groups were held at only 12 of the 20 service centres is a limitation of the evaluation and means that richer qualitative data is available for some service centres than others; however, this relates to the reality that some service centres operate with a limited staff and volunteer complement.

The need to adapt the fieldwork and sampling procedures also resulted in the sampling of beneficiaries not being standardised across the service centres. While the fieldwork team endeavoured to select beneficiaries independently from the service centre management based on characteristics (age and gender) and willingness to participate, in some cases service centre management facilitated the selection of members to participate. For example at one service centre, beneficiaries received a meal delivery service and did not attend a central venue; the manager therefore provided the contact details of 5 beneficiaries according to criteria requested by the research team. In this instance, the volunteers who delivered the meals made initial contact, asking beneficiaries permission for a researcher to contact them. This was followed by a phone call and home visit during which the interview was conducted. At another site, after two previous visits to the venue when no beneficiaries were present[14], the research team liaised with the manager and chairperson to ensure that at least five beneficiaries were present at the third scheduled visit. It must be noted that this could introduce an element of bias into the sample as managers may have selected beneficiaries who they thought would give a favourable view of the centre. At a third service centre, the only centre catering for older persons in the early stages of dementia or having suffered from a stroke, the manager assisted in identifying beneficiaries who would be capable of participating and answering the interview questions.

[14] According to the manager, the beneficiaries were participating in exercise at an external venue.

5 EVALUATION FINDINGS AND DISCUSSION

This section of the report describes the findings from the interviews and focus groups conducted at the 20 service centres sampled. The findings are organised broadly according to the key themes and evaluation objectives and are presented as follows: (a) the trends in and description of service centres, beneficiaries, membership and attendance; (b) the needs of older persons; (c) the effectiveness, accessibility, relevance and appropriateness of the services offered; (d) service delivery gaps and barriers; and (e) emerging best practices.

5.1 TRENDS AND DESCRIPTION OF SERVICE CENTRES

5.1.1 SITE DESCRIPTIONS

Table 14 on the following page below depicts the number of service centres operating in rural and urban settings, the types of facilities from which service centres operated, and the number of centres having office space, kitchen and bathroom facilities, and wheelchair access. The 20 sites varied widely, including rural and urban locations. The former included two centres located on farms, while others were located within or on the outskirts of small towns and the latter included centres in residential areas and peri-urban township settings. Service centres were run from dedicated NPO facilities, churches, rented buildings, community halls, and sports clubs, with one being run from a home due to lack of an alternative venue. Some were multipurpose community centres, from which other services and activities were run, while others were dedicated spaces used only the service centre.

While all sites had kitchen facilities, these varied from small, poorly equipped kitchens to large kitchens well equipped to cater for large numbers of persons. In addition, due to the wide variation in venues and the finding that activities were often run from spaces in church halls, rented buildings, and other community facilities, meant that a number of centres did not have dedicated office space from which staff could run the administrative and management tasks of the centre, although this is identified as a requirement in the minimum norms and standards in the OPA. This meant that some managers reported using their personal homes and computers to complete these duties.

Buildings were also assessed according to wheelchair accessibility. 6 of the 20 service centres did not appear to be wheelchair accessible. Even those centres that had ramps or wide doorways to allow older persons in wheelchairs to access the buildings, often the facilities inside, particularly the bathrooms, were not wheelchair-friendly.

Some buildings were in a good state or repair, but many were seen to be in need of repair and maintenance. As fieldwork took place during winter, it was also assessed whether service centres were able to provide heating to keep beneficiaries comfortable. Evident in the table, few centres were able to provide heating during winter and venues were often described as cold. Due to the wide variation in service centre settings and facilities, Table 29 and Table 30 in Appendix H provide a more detailed description of the 20 service centres in the sample according to these variables.

Table 14. Characteristics of the service centres according to setting and facility characteristics (*n* = 20)

Characteristic	Number of service centres
Setting	
Urban	10[a]
Rural	10[b]
Service level	
A	8
B	12
C	0
Facility	
NPO facility	8
Church	5
Rented building	3
Community hall	1
Residential facility	1
Home	1
Office	13
Kitchen	20
Bathroom	20
Wheelchair access	14
Heating	7

[a]Five of the urban sites can also be classified as peri-urban township settings. [b]Two of the rural sites were located on farms.

5.1.2 NATURE OF SERVICES PROVIDED

The description of the services provided was based on the information obtained by management but triangulated against staff/volunteer focus groups and beneficiary interviews. The services offered varied between centres from daily structured programmes to the provision of a meal-delivery service. A number of centres do not have a structured programme running continuously although they offer outings, exercise, workshops, and other activities as and when they are available. Descriptions of the key services are presented below.

5.1.2.1 Meals

Although the provision of a meal was the only consistent service across centres, the nature and content of the meals differed. A number of centres do not only provide meals to members who come to the centre, but also to those who are absent due to illness or otherwise unable to attend. Members and staff may drop off these meals or family members may come to pick them up from the centre. Service centres differed according to what meals were provided - some only provided one lunchtime meal while other centres provided both breakfast and lunch.

5.1.2.2 Spiritual services

Spiritual activities appear to form a significant part of the centres' activities. Only one of the centres in the Winelands Overberg region did not speak about some form of spiritual activities held regularly. These included (a) the local minister or pastor coming

to lead the seniors in reading scriptures, (b) a weekly bible study or prayer meeting, and (c) a daily bible study or prayer session to start off each morning at the centre. At Centre 19, as members live on farms in the surrounding area, the manager and members explained how they visit the different farms on a weekly basis and hold prayer meetings in members' homes.

5.1.2.3 Exercise

Some form of physical activity or exercise was widely offered. This ranged from daily to once- or twice-weekly sessions, offered by an external person or a member or staff member. For example, a member at Centre 17 spoke about how she leads the exercises for the group. She used to be part of an aerobics group in Gauteng where the instructor sometimes allowed her to lead the members and she therefore takes on that responsibility at the centre.

5.1.2.4 Foot care

Chiropody, also referred to as a "foot clinic" or "foot care", was a very common service offered at the service centres. In some centres this was charged for and provided by an external chiropodist and at other centres, members or staff provided this service themselves.

5.1.2.5 Crafts

Craft activities, such as knitting and needlework, were also prevalent. These activities often took place in dedicated timeslots and for specific projects. The manager at Centre 17 spoke about how they work towards a specific project, such as knitting blankets for the old age home for Mandela Day. At some centres, this was less formal and members worked on knitting and needlework throughout the day or as they pleased to keep them busy. The 'Pretty Things for Little Things[15]' project was mentioned a number of times as a project the centres were working towards (3 of the 20 centres).

The popularity of craftwork service varied between centres. At Centre 15, the manager identified needlework, held once a week, as the best attended activity. At Centre 18, the manager spoke about how the female members would do needlework or knitting for an upcoming bazaar but that this "is not a very popular activity amongst seniors".

A small number of centres attempted to offer a woodwork project for men (2 of the 20 centres), however these were in the minority and hindered by external factors. For example, Centre 17 spoke about how the woodwork equipment had been stolen and this activity had to be shutdown, although the manager indicated that the centre was planning on starting up these activities again.

[15] Pretty Thing for Little Things is an intiative by Age in Action and Shoprite Checkers open to older and other persons to make clothes and other items for vulnerable and needy children to wear and play with. Older persons stand a chance to win vouchers, competing at the provincial and national level.

5.1.2.6 Outings

Outings appeared to play a big part in centres' activities, for those that provided this service. These took place as frequently as once a month or as infrequent as once a year but more commonly every 2 – 3 months. These outings include trips in the local area, such as to the local shopping mall or the theatre, or weekends away, as depicted in the two narratives below:

> **Narrative 1**: *Twice a year seniors go on a tour to a place like Mossel Bay. Members pay their own way and pay off the cost of the tour over the course of the year. The outstanding part of this activity is that other members of the community (not just seniors) are invited along on these tours. This is how the centre makes some profit from the tour. The tours are very popular amongst other community members and the centre has had very positive feedback in this regard.* (Centre 14)

> **Narrative 2**: *The funds raised through efforts also go towards the yearly outing (stay over) of the seniors to a resort, such as Goudini Spa, Montagu. The seniors look forward to this outing tremendously. They are treated during these outings to restaurant meals, such as at the Spur or Wimpy. The seniors are not used to such restaurant meals and for them it is a great treat. This probably contributes to the seniors' motivation to work hard during the year to raise funds. The manager said that although it is only June now, the seniors had already raised 50% of the funds needed for their trip.* (Centre 18)

5.1.2.7 Health

Centres had tried to incorporate health services into their programmes. For the most part this was in the form of a nurse visiting the centre on monthly or weekly basis to do a basic blood pressure and sugar screening. Although in some instances, this role was performed by members who also happen to be retired nurses and perform this basic screening for other members. At Centre 16 the clinic nurse brings members their chronic medication and advises on their clinic appointments.

5.1.2.8 Awareness-raising

Activities focusing on education and awareness-raising seemed inconsistent. Talks were generally given by guest speakers from external organisations focusing on topics such as (a) older persons rights, (b) health, (c) social issues such as grants and wills, and (d) spiritual issues.

5.1.2.9 Reading and writing

Only three centres spoke about literacy classes for members. At Centre 14, ex-teachers, who were also members, held regular lessons with illiterate members. While for the most part, these appeared to be based on need, facilitated by the managers and to help seniors to be able to sign their name. Only one centre spoke about a library service where the library bought books for the members once every two weeks (Centre 18).

5.1.2.10 Cultural activities

Cultural activities, such as singing, dancing, art, and poetry, were also inconsistent. However, a number of centres had choirs. Centre 13 reported holding regular concerts or being invited to perform at events in the community or for other service centres.

5.1.2.11 Social activities

The social aspect of the service centre appears important:

> "*[*The members*] come to the activities and then sit and enjoy each other*". "*Dit is 'n sociale klub [this is a social club]"* (Manager, Centre 18).

Games were a regular feature of centres weekly programmes. At some centres smaller groups of 6 – 8 members played card games whereas others played darts or dominoes to keep themselves busy during the day. Other special events include special celebratory days, such as Mother's day and birthday teas, which were commemorated by the centres.

5.1.2.12 Support groups

Two centres mentioned support groups held at the service centre for dementia and depression, run by external professionals.

5.1.2.13 Special events

Besides the above activities, centres were also involved in certain 'special events' that took place during the year. For example, Centre 20 is invited by the local football club to their yearly cross-country event, which is followed by a breakfast for the members. A number of the centres, particularly in the Winelands Overberg region, were involved with the events held by Age-in-Action. However, this was less frequently mentioned in the Metro South. For example, the Manager from Centre 5 spoke about how they used to pay the monthly membership fee to take part in the Age-in-Action activities but no longer do this as they felt that Age-in-Action "don't [sic] do anything". Managers spoke about the march against elder abuse that was taking place. Specific sporting and associated activities that form part of the active ageing programme[16] (such as the Golden Games[17] and City of Cape Town games) were also mentioned by centre managers, staff and beneficiaries. Managers and staff in particular spoke of the centres participating in the Golden Games, noting that, in addition to the benefits of physical exercise, beneficiaries seemed to particularly enjoy taking part and competing against each other. It was also mentioned that there was additional support

[16] The Active Ageing Programme of the DSD is in line with the mandate of the OPA and the MIPAA.

[17] The Golden Games was a national programme for older persons providing a platform for older persons to compete in sports and games at the local, provincial, and national level. While initially there was cooperation between the Department of Social Development and Department of Sports and Recreation, this has since dissipated.

5.1.3 ORGANISATIONAL STRUCTURE

5.1.3.1 Management and staffing structure

In an attempt to explore the organisational structure of the service centres, management were asked to provide information regarding various indicators of management and staffing structure. The number of service centres belonging to a mother body organisation, utilising a Board of Directors, employing full time and part time staff ('staff complement'), utilising criteria for staff and volunteers, and providing training to these employees or volunteers are depicted in Table 15 (see Table 31 in Appendix H for a detailed description of these variables broken down per service centre).

Table 15. Number of service centres employing various management and staffing structures

Management / staffing indicator	Number of service centres
Mother body organisation	11
Board or Governing Body	18
Full-time staff[a]	17
Part-time staff[a]	6
Volunteers[a]	13
Criteria for employment	6
Training	10

[a]Where service centres fall under larger mother body organisations, only the staff and volunteers who work directly in the older persons programme of the organisation are included in the numbers quoted.

The management and staffing structures of the 20 service centres varied. Roughly half of the sample belonged to a mother body organisation, which generally provided administrative, funding, and/or training support. These centres generally had a more formal organisational structure, with criteria and training processes in place. However, others were smaller independent centres with few staff and a more informal organisational structure.

Most organisations had some form of Board of Directors, Trustees, or Governing Body. Permanent staff ranged from 1 to 6 in number, and usually included a manager or coordinator and/or individuals in administrative, cook and other support positions (such as drivers). Few centres reported employing part-time staff, although a larger number (13 of the 20 centres) reported relying on volunteers. Volunteer numbers and roles varied widely. One centre reported having one volunteer who directly with the beneficiaries day-to-day, while another reported up to 40 volunteers who work in driving and delivering meals to beneficiaries at home as part of the centre's meal-delivery service. Centres predominantly reported that volunteers helped with cooking, cleaning, and general administrative tasks.

Few centres had requirements for staff and volunteers to be able to work at the centre. Although the national norms and standards for acceptable levels of services to older persons states that organisations must have a recruitment programme and selection and appointment criteria for staff and volunteers, where centres spoke of

requirements for staff and volunteers these were often informal, relating to attitude or passion:

> "*They need an understanding of older persons.*" (Manager, Centre 6)

> "*The volunteer must help because they love to work with seniors and have a passion for the job.*" (Manager, Centre 17)

However, the general sentiment expressed a shortage of staff and volunteers that meant service centres did not apply strict criteria:

> "*If somebody is prepared to help or work here, their services are used immediately.*" (Manager, Centre 12)

Instead, organisations preferred to fill positions from within the organisation:

> "*We try to empower our staff here and look at the inside first before looking outside.*" (Manager, Centre 1)

In addition, few centres required or provided any form of training to staff and volunteers. For the most part, training that was provided was inconsistent and sporadic. A number of centres were still 'finding their feet' with regards to training and staff, and the remainder provided training as and when available but otherwise staff and volunteers learnt via experience:

> "*Their experience is their training*" (Manager, Centre 12)

Only 4 of the 20 centres spoke about some form of consistent or regular training for staff. This training included basic governance and financial training provided or facilitated by the mother body organisation.

5.1.3.2 Decision-making and the role of beneficiaries at service centres

Service centre managers were also asked about the decision-making process at the service centre, particularly around funding and expenditure, as well as the role played by beneficiaries at the centre. Most commonly, day-to-day decisions were made by the centre manager or coordinator with larger decisions having to go through the mother body organisation or respective Board or management committee.

Beneficiaries played a larger, more significant role at some centres than at others. Most often, the centres had either a separate committee compiled of members and/or members formed at least part of the management committee or Board. Beneficiaries also took on the role of volunteers, taking on specific responsibilities, such as cooking, cleaning, and running activities. Beneficiaries were not always involved in the day-to-day decision-making of the centre but were, in the least, able to make suggestions to the centre management. While at some centres, beneficiaries play a more informal role or subsidiary role as recipients of services, rather than active participants, centre managers at a number of centres spoke of the importance of always referring decisions back to or through members.

The varying role of beneficiaries is highlighted in the contrasting narratives below:

> **Narrative 1:** The manager at Centre 18, a centre that broke away from the mother body organisation to which it used to belong and been independent for

the past 3 years, spoke of one of the outstanding features of this centre being that the members are given many responsibilities. The members are, for example, responsible for the running of certain of the activities (such as braai days) or involved in taking a leading role in some activities (like presenting the exercise class or taking blood pressure or sugar levels). Some decisions are left to the members to make, but they report to the manager about these responsibilities. The manager was adamant about informing the seniors about every aspect of every activity. She spoke of how she, for example, tells the members exactly how much money was made at fundraising events. The manager spoke about how it is important that the seniors are empowered and this is the way that she ensures that.

Narrative 2: At Centre 12, members are welcome to make suggestions to management regarding particular requests or complaints; however, the members are not involved in decision making at the centre at all. The board makes all decisions. Day-to-day decisions may be made by the manager and implemented, but this is subject to the ratification by the Board.

Narrative 3: At Centre 8 and Centre 9, run by the same mother body organisation, there is only a 'club assistant' who plays a coordinating role at each centre but centres are otherwise run largely by the members and members committee. The mother body organisation supports and empowers members them through providing the members committee with governance training. The 'club assistant' helps with day-to-day planning, with overall administrative and funding support from the mother body organisation. For example, the mother body organisation provides a menu that is followed or direction and support on new income generation or other programmes to be offered. However, all other decisions are made by the members' committee with support or advice provided by the 'club assistant' where necessary. Members are further empowered through a monthly meeting of all the clubs belonging to the mother body organisation, governed by an overarching members committee.

5.1.4 FUNDING AND EXPENSES

An understanding of the funding and financial management of the centres, particularly how centres procure funding and what it is spent on, is key to understanding the circumstances under which centres operate as well as identifying examples of best practice. Financial records and statements were not examined, but management responded to a number of interview questions regarding sources, successes, challenges, decision-making, and expenditure

5.1.4.1 Estimated proportion of costs covered by WC DSD funding

Table 16 (p.67) presents a description of the fee structure and funding practices of the 20 service centres, including information on the estimated proportion of each service centre's costs covered by the WC DSD funding. As financial reports were not scrutinised it must be emphasised that these figures are an estimation rather than accurate representation of centres' annual costs covered by this funding. In addition, 5 of the 20 service centres were unable to provide an estimation for various reasons (see Table 16 for an explanation).

At two service centres (two independent centres), WC DSD funding covered 100% of the centre's costs. The two independent centres (Centre 4 and Centre 5) reported struggling to keep the centres running efficiently. At Centre 4, the centre manager was not paid a salary and worked a second full-time job. The manager reported that the centre had been forced to stop providing most of the services they used to provide to members, besides a meal and transport, and had seen a considerable drop in attendance as a result. Centre 5 faced a similar struggle. Although it charged the lowest membership fees of all the centres, the manager reported that almost none of the members paid this fee. The centre was unable to afford a venue and was only able to provide meals and a exercise, via the City of Cape Town games, as a result. A third centre (Centre 17) reported 100% of the centres costs were covered by WC DSD funding and membership fees, but were unable to disaggregate this percentage. However, the centre reported consistently overspending (i.e. operating at a loss) and was planning on attempting to address the lack of additional funding.

Excluding those centres for which WC DSD funding covered 100% of the centre's cost, figures given ranged from 10% to 75%. A number of centre managers that the funding they received either barely or did not cover the food costs. Therefore, centres were compelled to ensure their sustainability and ability to offer a full range of services through other methods of raising funds or mobilising resources.

5.1.4.2 Funding practices

It is clear that it is vital that service centres explore additional avenues of income and funding in addition to the subsidy they receive from WC DSD, as this does not cover all operational costs. Three key ways in which centres appear to be mobilising additional funds and resources is through (a) fundraising activities, (b) donations, and (c) membership fees.

5.1.4.2.1 Fundraising activities

It appears that centre-specific fundraising activities were an important source of income for many centres, with 15 of the 20 centres citing this as a way they mobilise additional resources and 7 of the 20 centres citing this as something that worked particularly well. These activities ranged from members baking and selling food; bazaars; raffles; book sales; and events, such as concerts, braais, tours, gold days, potjie days, and outings. Centres hold such events, often organised by members, with members selling tickets to the community. Centre 11 has recently started a contract with a catering organisation that cooks the meals for the centre; in addition, community members are able to order frozen meals, which are prepared in the centre's kitchen along with the meals for service centre members. The sale of these meals to the community brings in extra funds for the centre.

5.1.4.2.2 Funders and donors

A large number (11 of the 20 centres) also reported relying on donations, both private and from corporate sponsors or funders. These varied from small private donations or bequests to larger funders such as Community Chest and National Lottery.

Only a small number received some form of financial support from the mother body organisation to which they belonged (6 of the 20 centres); however, this appeared to be particularly valuable. For example, two service centres belonging to a central mother body organisation were supported by a local and overseas-based funding department which allocated funding from both large and smaller funders and donors to 19 service centres that fell under its umbrella, based on membership numbers. Others noted that the funding obtained through the mother body organisation was able to be split between the organisations various projects based on need. One organisation reported being paid by the mother body organisation per meal delivered.

5.1.4.2.3 Membership fees

A key way in which centres help to cover the costs of the centre is to charge a membership fee. The way centres charged fees differed, but included (a) monthly fees, (b) once-off joining fees, (c) yearly fees, and (d) fees per meal or activity. Some centres utilise a sliding scale or variable fee structure based on a member's income to accommodate older persons who rely on the old age grant and those with additional sources of income.

As can be seen in Table 16, only 1 out of the 20 service centres sampled did not charge members some form of a fee. Most of the centres used this fee towards covering general costs not covered by the funding they received, with food mentioned a number of times.

Table 16. Fee structure and funding practices of service centres

Centre	Membership fee charged	Amount	Use of membership fee	Estimated proportion of costs covered by DSD funding	Additional funding practices[a]	Challenges	Successes
1	✓	R110/month all inclusive	Cover expenses not covered by funding	±10 – 15%	Fundraising activities; Donations; Large funders; Sponsorship for specific needs; Funding through mother body	None	None
2	✓	R100/month for meal and transport; R70/month for meal; No charge for members from affiliated old age home	Transport and meal costs	DK[b]	Funding through mother body; Fundraising activities	None	Raffles and outings
3	✓	R10/month	Decided by the members	DK[c]	The centre is currently getting an outside consultant in to revise their strategy, costs, and fundraising.	None	None
4	✗	NA	NA	±100%	None. Manager reported covering shortfall personally	Lack of fundraising capacity	None
5	✓	Once off joining fee of R35; Monthly fee of R20	Not paid by many members	±100%	None	Lack of fundraising capacity	None
6	✓	R10 joining fee/year; R35 for meals/months; R5/quarter fundraising contribution	Cover expenses not covered by funding; The fundraising fee goes towards quarterly outings	±50%	Large funders; Donations; Funding through mother body	Lack of fundraising capacity	None
7	✓	R235/month for transport and meals	Cover food costs	DK[d]	Fundraising activities; Donations	Lack of up to date financial statements	None

8	✓	R40/month for meals; R90/month for meals and transport	Cover expenses not covered by mother body (particularly food)	±25%	Funding through mother body; Donations; Fundraising activities	None	Overseas and local funding department of mother body organisation; Fundraising activities
9	✓	R40/month fee plus additional R40/month for volunteers	Pay gardener and cook; Cover food costs	±25%	Funding through mother body; Donations; Fundraising activities	None	Overseas and local funding department of mother body organisation
10	✓	Fees are charged on a sliding scale based on income from R9/meal to R15/meal; Membership fee of R25/month	Cover administrative and food costs	< 33%	Donations and bequests; Money through mother body per meal delivered; Fundraising activities	None	Private donations and bequeaths
11	✓	R23 – R300/year charged on sliding scale; R13 – R25/ meal. Homecare costs between R20 – R350	Cover expenses not covered by funding; The fee of those who can afford it is used to subsidise the cost of others, who can't afford it	±10%	Donations; Large funders; Fundraising activities	None	None
12	✓	R120/year; Social pensioners pay R90/year (and can pay monthly); R15 – R47/meal	Cover food, salaries and transport	±20%	Fundraising activities	Local business community cannot support the NPOs in the community	Fundraising activities such as the winter market
13	✓	R30/month; R20 once-off joining fee	Cover food costs and outings	DK[e]	Donations; Fundraising activities	None	None
14	✓	R10 once-off joining fee; R90/month	Cover expenses not covered by funding	±75%	Fundraising activities	None	Events such as concerts and tours[f]
15	✓	R100/year R25/meal R15/meal	Cover general expenses	±25%	Donations; Fundraising activities	None	Fundraising activities such as a bazaar, tea garden and potjie events that are held

							once a year, and the selling of baked goods to the community
16	✓	R60/month	Cover food costs	±70%	Fundraising activities	Not able to secure funding due to issue with registration of financial office	Fundraising activities such as the yearly 'Debutante Ball'
17	✓	R50/month for meals at the centre; R30/month for meals at home	Cover expenses not covered by funding (particularly food)	100% (covered by WC DSD funding and membership fees)	None	Centre consistently overspends	The centre does not have to pay rent or electricity costs
18	✓	R60/month	Cover food, staff, petrol and overhead costs (water, electricity)	±50%	Fundraising activities	None	Fundraising events such as community braais are well supported
19	✓	R20/month	Supporting members families when they pass away	DK	Fundraising activities; Donations	Private donations are not consistent	None
20	✓	R30/month; additional R30/month for transport	Cover expenses not covered by funding	±40%	Fundraising activities; Donations	None	Fundraising activities such as selling food

Note. DK = Do not know. NA = Not applicable. [a]Excluding funding from the WC DSD. [b]No money has recently been cut and she does not know. [c]The manager was not able to say as the DSD funding is the only funding for the service centre programme, all other costs are billed to the mother body and they currently do no allocate separate costs to the different projects. [d]The centre is not up to date with their annual financial statements so the manager is unsure if they are still receiving DSD funding. [e]The centre has recently become independent from the mother body organisation and is registering its own NPO number. [f]Twice a year seniors go on a tour. Members pay their own way and pay off the cost of the tour over the course of the year. The outstanding part of this activity is that other members of the community (not just seniors) are invited along on these tours. This is how the centre makes some profit from the tour. The tours are very popular amongst other community members and the centre has had very positive feedback in this regard.

5.1.4.2 Cost drivers

While based on anecdotal evidence, 12 of the 20 centres noted food as the biggest cost for the centre (see Table 17). Transport also appeared as a significant cost, particularly for those centres in the Winelands Overberg region. All 4 of the centres that noted transport as their biggest expense, were located in this region. Staff salaries also appeared as a significant expenditure for a large number of centres, with overhead costs, such as venue rental, water, and electricity, also identified as some of the biggest cost drivers.

Table 17. Biggest cost drivers identified by service centre management (*n* = 19)

	Identified as the biggest expense (*n*)	Identified as one of the biggest expenses (*n*)
Food	12	4
Transport	4	7
Staff	3	7
Venue	-	4
Water and electricity	-	3
Equipment	-	2

Note. One centre was not able to answer this question.

5.1.5 DESCRIPTION OF BENEFICIARIES

5.1.5.1 Socio-demographic characteristics

A number of socio-demographic characteristics of beneficiaries were collected through structured interview questions. Table 18 depicts the profile of the beneficiaries according to sex, population group, age, level of education, marital status, dwelling type, household structure, and income.

There were more than three times as many women than men in the beneficiary sample. This is not surprising considering the gendered nature of ageing in South Africa and the fact that more women are reaching old age in the Western Cape than men (PricewaterhouseCoopers, 2014). Although more women than men were included in the sample, it appears that beneficiaries of all ages are accessing service centres. The beneficiaries sampled ranged in age from less than 60 years to over 85 years. A similar number fell into the young-old (60 – 69 years; 35 beneficiaries), middle-old (70 – 79; 28 beneficiaries), and old-old (≥ 80; 25 beneficiaries) age brackets, with 5 of the beneficiaries aged < 60 years.

Beneficiaries generally reported low levels of education, with a large number (32 of the 93) not progressing further than the primary school level and four beneficiaries reporting having received no formal education. Only a small number (12 of the 93) reported having received some form of tertiary education.

Table 18. Sociodemographic characteristics of beneficiaries (n = 93)

Characteristic	Number of beneficiaries
Sex	
Male	21
Female	72
Population group	
Black	23
Coloured	56
White	14
Age	
<60	5
60 – 64	20
65 – 69	15
70 – 74	15
75 – 79	13
80 – 84	19
≥85	6
Education	
None	4
Some primary school	24
Primary school completed	8
Some secondary school	41
Secondary school completed	4
Tertiary education	12
Marital status	
Married	19
Widowed	51
Divorced/separated	14
Never married	7
Cohabiting	2
Dwelling type	
House flat or apartment (own)	53
House, flat or apartment (rent)	11
Residential facility	11
Other	17
Informal housing or backyard dwelling	1
Household structure	
Alone	6
Spouse/partner	9
Children and/or grandchildren	52
Spouse and children and/or grandchildren	11
Other	15
Income[a]	
Old age grant	77
Disability or child support grant	13
Private pension, savings or investments	10
Support from family	18
Other	10

[a]Total is >93 as beneficiaries could indicate multiple sources of income.

As evident in Table 18, beneficiaries home circumstances varied. Very few of the beneficiaries reported living alone but a large number reported living with their children, grandchildren and/or other extended family members. Those included in the 'other' category with regards to household structure comprised predominantly those beneficiaries living with extended family members and those sharing rooms with other older persons in independent- or assisted-living facilities. Many of the beneficiaries owned their own homes, while some lived in rented accommodation or in residential facilities. Those included in the 'other' category with regards to dwelling type comprised predominantly those beneficiaries living in farm workers cottages in rural farming communities, in the home of a family member, or in an RDP house. Only one beneficiary reported living in an informal settlement or backyard dwelling.

A large proportion of the beneficiaries (77 of the 93) indicated that they received the old age grant. For many (50 of the 93), this was their only source of income while others relied on additional support, such as from children or grandchildren. Only a small number (10 of the 93) were supported, at least in part, from a private pension, savings, or investments. Beneficiaries' income was broken down further to examine whether they relied on single or multiple sources of income (see Table 19 below). Just over one third of beneficiaries reported that they relied on only one source of income. Of those relying on only one source of income, 50 beneficiaries reported relying solely on the old age grant.

Table 19. Number of beneficiaries relying on single or multiple sources of income (*n* = 93)

	Number of sources of income		
	1	**2**	**3 or more**
Number of beneficiaries	61	29	3

5.1.5.2 Health and mobility

In addition to the above socio demographic variables, beneficiaries were also asked whether they had been told by a health professional that they have a health condition, such as high blood pressure, diabetes, arthritis, or depression or had suffered a stroke (see Table 20 on the following page). Only 12 beneficiaries indicated they were not currently dealing with any health conditions. A large number of beneficiaries indicated that they were suffering from hypertension (high blood pressure), arthritis, or diabetes, with a smaller number indicating that they had been diagnosed with depression or had suffered a stroke. It was clear that beneficiaries suffered from multiple health issues; 65 identified two or more conditions, which they were aware of at the time.

Most of the beneficiaries indicated that they were able to get around freely and independently both inside and outside the home; only a small number relied on the use of a cane or the help of other persons to get around. More beneficiaries appeared to be freely mobile within the home than outside the home.

Table 20. Self-reported health and mobility of beneficiaries (n = 93)

Characteristic	Number of beneficiaries
Health conditions	
None	12
High blood pressure	65
Diabetes	26
Arthritis	37
Stroke	13
Depression	10
Other	53
Multiple health conditions	65
Mobility inside the home	
Get around freely	79
Get around but with difficulty	5
Needs to use a cane	7
Cannot get around without the help of another person(s)	2
Mobility outside the home	
Get around freely	70
Get around but with difficulty	6
Needs to use a cane	12
Cannot get around without the help of another person(s)	5

5.1.6 TRENDS IN MEMBERSHIP AND ATTENDANCE

Managers were asked to report on changes in membership and attendance over the past 12 months. Responses included an increase in numbers (7 of the 20 service centres), a decrease in numbers (3 of the 20 service centres), and no change in numbers (10 of the 20 service centres). Reasons for the decrease in numbers referred predominantly to economic reasons and that older persons were not able to afford the services. Only one centre attributed the drop in membership to the nature of the services provided. Only one centre acknowledged that they are no longer able to provide the services they used to provide, predominantly due to funding challenges:

"The drop is due to the poor service that we are providing." (Manager, Centre 4)

On the other hand, financial pressures were also given as a reason for the increase in membership witnessed by some service centres, as members could no longer afford to buy groceries. As the manager at Centre 3 said, "as the economic conditions get worse, more and more of them are coming, primarily for the meal". Others attributed the increase in membership to the centre's activities appealing to community members. Centre 13 had experienced declining numbers but had recently split from the mother body organisation under which they had been operating and had seen an increase of five members in a space of two months. The manager felt this was due to the poor services members had experienced under the previous management and that many more activities were offered now.

However, the largest proportion of centres did not speak to a significant change in membership. For the most part, as members left due to illness, death or moving away, new members joined to fill their place and numbers stayed constant.

Management, staff, and beneficiaries spoke to the challenges faced by and concurrent needs of older persons in their communities.

5.2.1 MASLOW'S HEIRARCHY OF NEEDS

This section is analysed according to Maslow's hierarchy of needs (Maslow, 1943, 1970). Although receiving some criticism in the literature (Wahba & Bridwell, 1976), this is a valuable model that is still widely used in assessing and measuring need and motivation (Stehling-Ariza, 2013), including with older persons (Nydén, Petersson, & Nyström, 2003; Thielke et al., 2012). Maslow's hierarchy of needs is a practical framework that can be applied to community-based care and support for older persons.

Figure 7 on the page that follows present the five sets or levels of Maslow's hierarchy of needs that range from lower-order needs at the bottom of the pyramid to higher-order needs at the top. The first level of needs are basic, physiological needs, which are the starting point of an individual's aspiration to become self-actualising. These lower-order needs need to be satisfied first; as the needs on each level are relatively well gratified, a new, higher-level set of needs emerge. The last level of needs, self-actualisation, is elusive and less frequently realised, and said to overlap with esteem and love needs (Wahba & Bridwell, 1976).

Figure 7. Figure depicting Maslow's hierarchy of needs.

Each of these levels is discussed below in relation to the role the service plays in meeting these needs. These include physiological needs (i.e., meals), safety needs

(i.e., feelings of safety and health services), needs related to love and belonging (i.e., creating a sense of belonging), and needs related to esteem (i.e., a sense of purpose).

5.2.2 CHALLENGES FACING OLDER PERSONS

All the evaluation participants (managers, staff, and beneficiaries) spoke to the *perceived* challenges facing older persons in the respective community. Although challenges may differ per community, a number of key themes or difficulties emerged.

5.2.2.1 Poverty

Economic hardships were frequently mentioned. Participants particularly commented on the inadequacy of the old age grant and the reality that many older persons were supporting not only themselves, but also their unemployed children and grandchildren on the R1350 they received monthly:

> *"Their children aren't working and they have to look after their children with the pension…[*and] *raise these grandchildren and make sure they are going to school with the little money that they get from the pension."* (Manager, Centre 9)

> *"They get their pension like today and a day or two days later, there is nothing left."* (Manager, Centre 6)

The financial burdens placed on older persons, high cost of living and lack of affordable accommodation in relation to their meagre monthly income was reiterated numerous times. Managers and staff raised concern that this resulted in older persons having to rely on the meals provided at service centres to provide food for dependents at home:

> *"Most of them are spending it* [grant] *not on themselves but on the unemployed people in the house…that's the sad part…they take it [the meal] home to their unemployed children"*. (Focus group, Centre 3)

- Level of need challenged: Physiological and safety

5.2.2.2 Crime and abuse

Participants noted the high levels of crime, gangsterism, and drug use in their communities and the concern that older persons were particularly vulnerable to such violence when walking on the streets and collecting grant money. However, high levels of neglect and abuse within families appeared as a significant concern for participants, creating a perception that older persons were neither safe in their homes or outside their homes:

> *"The children don't make time for their parents…here in this community, they neglect their parents."* (Focus group, Centre 7)

> "[They] are always looking over their shoulder…" (Manager, Centre 9)

> *"We are too scared of the gangsters and we cannot walk alone on the streets, I don't trust anyone in the community and I have to stay indoors."*(Beneficiary, Centre 3)

Participants were concerned that older persons were financially abused by their children and grandchildren, who steal from them. It was frequently perceived that this was to buy drugs and alcohol:

"*My son drinks a lot, and sometimes when he is drunk he becomes obstinate. This scares me.*" (Beneficiary, Centre 16)

- Level of need challenged: Safety

5.2.2.3 Loneliness

That older persons are isolated and lonely was perceived as a significant challenge facing older persons in the communities that the centres served. Participants noted that older persons were often ignored by their family, particularly for those living alone in their homes, and had little opportunity for engagement with others or participation in the community.

"*A lot of them are very lonely.*" (Manager, Centre 10)

There was also concern that sick older persons were bound to their homes, with little social interaction with other people.

- Level of need challenged: Love and belonging

5.2.2.4 Position of older persons in society

Participants spoke about a general lack of respect for older persons in the community.

"*There is no respect for older persons…it is very tough for older persons in the community*". (Focus group, Centre 7)

"*There is a lack of respect from the youth in our community.*" *Beneficiary, Centre 5*

"*Seniors are supposed to be retired and looked after but they are the ones who must work the most*" *(*Manager, Centre 4)

This was related to poor service delivery to older persons, particularly with regards to access to grants and healthcare. Participants noted long queues at primary healthcare facilities in particular, and the fact that older persons received no preferential treatment, having to wait in the same queues as younger as persons that are more able:

"*If older persons can all go to the centre and their money gets given to them there…or the machines are there for the older persons to draw... Now they have to stand in long queues at the bank or at Shoprite…do you think it's nice for a wheelchair person or a lady who can't even stand to queue for 3 to 4 hours…I think it's disgusting.*" (Focus group, Centre 7)

- Level of need challenged: Esteem

Although based on perception, the above challenges concur with the limited literature on the circumstances faced by older persons in South Africa including poverty (StatsSA, 2014); elder abuse and neglect (Bohman et al., 2007; Makiwane & Kwizera, 2006); loneliness, depression and isolation (Makiwane & Kwizera, 2006), as

well as increased dependence and changing family structure (Chen & Thompson, 2010). The vulnerability of older persons increases their risk to victimisation. Delport (2005) notes risk factors that increase the vulnerability of older people include isolation, diminished physical strength, pension pay-out days, dependence on public transport, and that they often live in inner-city areas where crime rates tend to be high. Roger at al. (2007) highlight that as older persons are likely to have little (or no) access to transport, shopping becomes an additional worry and they remain dependent and less in control of their lives (Roger et al., 2007).

5.2.3 SELF-REPORTED NEEDS

As already noted in this report, this evaluation does not replace a comprehensive needs assessment. However, in an attempt to identify the service needs of older persons, beneficiaries were asked to identify additional services or support that they felt they needed or would be helpful for them. Overall, the fieldwork team noted that beneficiaries struggled to identify such needs; 8 of the 93 beneficiaries were unable to elucidate any needs or services that would be helpful to them. The remaining beneficiaries identified various services that they felt they needed or would be helpful to them. The key themes that emerged are displayed in Table 21.

Table 21. Service needs identified by beneficiaries

Self-identified needs	Number of beneficiaries
Accessible primary healthcare services	62
Transport	48
Community awareness to reduce stereotyping of the elderly and service centres	41
Exercises specific for older persons and their specific illnesses to increase mobility and decrease dependence	25
Support groups and information regarding depression, dealing with death, and health issues	19
Materials for activities (such as craft materials, sports equipment)	15
Affordable housing	15
Home-based care	13
None	8
Skills development, such as crafting and administrative skills	7

Note. The number of beneficiaries is > 93 as this was an open-ended question and some beneficiaries identified multiple service needs.

Access to health services and medical care was found to be the most common need identified by beneficiaries. Beneficiaries voiced the need for their medication to be delivered to them and noted the poor service they received at primary healthcare facilities. In addition, needs such as community awareness and reduced stereotyping of the elderly, age-appropriate and age-specific activities, and the provision of quality services offered at senior service centres (particularly craftwork and the provision of adequate materials) were observed as their most pressing needs of older persons.

Respondents in Levenson et al's (2005) study depicted similar self-identified needs. Levenson et al. (2005) noted these needs to include (a) quality services that enable older persons to maximise and retain their independence; (b) older persons' need to be valued as individuals and not stereotyped because of their age; (c) the need to stay socially and intellectually active; (d) 24-hour, on-call medical services; and (e) access to tutors, students or teachers for skills development activities.

5.3 EFFECTIVENESS, ACCESSIBILITY, RELEVANCE AND APPROPRIATENESS OF SERVICES

5.3.1 THE ROLE OF THE SERVICE CENTRE IN THE LIVES OF OLDER PERSONS

Considering the above-mentioned challenges facing older persons and their potential service needs, the following section discusses the role of the service centre in the lives of beneficiaries in an attempt to understand what needs the service centres fulfil.

Estimating the efficacy or impact of an intervention requires measurement of the change on the social conditions or programme beneficiaries that can be attributed to the intervention, usually requiring a baseline or 'pre' measure, followed by a 'post' measure (Rossi et al., 2004). Lacking this data, and due to the largely qualitative nature of the current evaluation, participants were asked to respond two questions on (a) the role of the service centre in the lives of beneficiaries[18], and (b) the manner in which the service centre had helped beneficiaries in their life (i.e., to identify changes)[19]. However, it must be noted that this measure of effectiveness is purely anecdotal and subjective, and not based on any objective measures.

Managers and staff perceived the service centres to play a significant role in the lives of beneficiaries (see Table 22 below).

Table 22. Role of the service centre in the lives of older persons according to managers and staff/volunteers

Role	Number of service centres
A sense of belonging and family	19
A sense of purpose and dignity	16
Nutrition and exercise	10
Safety	5

Note. The number of service centres is >20 as this was an open-ended question asked to both managers and staff/volunteers, who could give multiple explanations.

5.3.1.1 Meeting basic physiological needs

It appears, that at the most basic level, service centres are meeting the nutritional needs of beneficiaries in providing a regular meal. It is clear the provision of a meal is central to the role of the service centre in the lives of beneficiaries. It was noted that for some older persons this was the only meal they received and was a central reason for their attendance at the centre:

[18] This question was asked to management and staff/volunteers.

[19] This question was asked to beneficiaries.

"Some of them just come for the food, they are not motivated…don't feel they are useful and are just waiting to die". (Manager, Centre 7)

"They come here and become active…they are not just sitting at home, depressed, waiting to die. They come here and do these activities and socialise and be active. And get these 2 balanced meals a day…it helps the poverty. They are earning something here too… getting an income during the month besides their grant." (Manager, Centre 9)

For some centres, this was acknowledged as the central need the centre was currently fulfilling:

"They come for the food…they sit and wait for their lunch…they take their lunch and they leave. That culture of just coming for the food is very difficult to change. Come for the support. Come for the skills that we can maybe teach you that you can use at home to occupy yourself. Come for that. It's a struggle... to get them to do the things." (Manager, Centre 3)

"People are poor, they come here to eat because they are hungry…they depend on us to eat." (Manager, Centre 4)

5.3.1.2 Providing safety

Service centres take older persons out of abusive situations at home and/or unsafe communities. Service centres provide a place where older persons are able to leave behind stressful or problematic situations at their homes, at least for the time that they are at the centre:

"To provide support to the elderly when they have problems at home…they come to relax for these few hours, engage in recreational activities that them out of their stressful environment." (Manager, Centre 3)

However, the centres also directly assist members in dealing with the problematic situations:

"It's not just here as a club but for problems with personal affairs…children, fighting about houses and grants…" (Manager, Centre 5)

5.3.1.3 A sense of love and belonging

Service centres give older persons a sense of family, friendship, and community, meeting their need for love and belonging. Beyond the provision of services that meet older persons lower-order needs in terms of nutrition and safety, service centres appear to play a significant role in providing members with a sense of belonging. A sense of friendship and family was identified as a role the centre played in the lives of beneficiaries by all but 2 of the 20 service centres. Staff described how the centres provide a space where beneficiaries open up and become part of a 'community' or 'family', interacting and socialising with other older persons. While meals, activities, and other services were noted, emphasis was frequently placed on members simply enjoying each other's company and feeling part of the centre:

"The members come to feel at home at the centre." (Manager, Centre 15)

"[It is a place where they are] not just sitting without any attention, without anybody chatting to them, without a meal… [It's a place to come] to feel loved, to feel that they are also part of life still…they are still alive, they don't have to be sitting at home just becoming so depressed because the community is in such a negative space. It is here they find that peace and that negativity goes away…here they will find that joy and that peace." (Focus group, Centre 7)

"I would love to see them happy. When they walk out with a new friend, we are successful." (Manager, Centre 11)

*"There is trust… they are not scared to open up and say whatever they want to say. …friendship… they advise one another. They learn how to share…It's like a family. If a member dies at home, we all go for prayers." (*Manager, Centre 6)

5.3.1.4 A sense of purpose

Participation and learning gives older persons a renewed sense of purpose, meeting their need for self-esteem and value. Centres appear to allow beneficiaries to maintain their dignity and find a sense of purpose through empowering them to become active participants as opposed to simply recipients of services. This includes participation in decision-making for members who are part of the members or management committees. Participation in crafts, exercise, reading, and storytelling was seen to empower older persons, give them confidence, and demonstrate their ability to still be active contributors in the community:

"Dit hef hulle op, hulle bly nie armsalig nie" (Manager, Centre 18)

"The centre affords seniors with a second life…they dress up to come to the centre and feel that they are still important." (Manager, Centre 13)

5.3.2 STORIES OF CHANGE

In attempting to explore the effectiveness of the services in the lives of beneficiaries, beneficiaries were asked to respond to an open-ended question regarding whether they had seen any changes in their life since they started attending the service centre. It was found that beneficiaries reported a number of changes in their lives and ways in which they felt the services had helped them. The responses were coded and the most common themes are highlighted in Table 23 below with the number of beneficiaries who spoke to each theme. Examples of these changes included (a) from being stressed, anxious and depressed to being happy and able to cope; (b) from being shy and withdrawn to being able and willing to engage and socialise with other people; (c) from having no family members or close friends to having met people they consider family; and (d) from physical injuries or health issues to feeling more fit, active, and healthier.

Table 23. Have the services helped you in your life? Changes reported by beneficiaries

Change or impact	Number of beneficiaries
Reduced stress and feelings of depression, increased happiness and coping ability	37
Increased ability and willingness to engage and socialise with other people	33
Social support: Gained 'family' at the service centre	24
Physical changes: More flexibility, mobility, and reduced pain	22
Improved health through healthy eating and exercise	21

Note. The number of beneficiaries is >93 as this was an open-ended question and some beneficiaries gave multiple examples.

Although the beneficiary interview was not constructed to gain in-depth case study material, a number of beneficiaries provided detailed narratives of the influence the service centre had had on their lives:

Narrative 1: *"We come despondent but go home overjoyed". The beneficiary and her husband used to live in their own house (it was their parents and they had a granny flat built on the property) but there was controversy over the property when the parents died. According to the beneficiary, the sister-in-law and family took over the property and kicked the beneficiary and her husband out. They rented a flat for a number of years, and their own children helped to pay the rent. However, when the rent was increased they could no longer afford it and had to move into the daughter's house. It is a two-bedroomed house and the daughter and two grandsons stay in the house. The beneficiary, her husband, and their son, who suffers from bipolar, are therefore living in a dilapidated wendy house in the backyard. There is not a proper ceiling and they get cold in the winter. There is also no toilet and they use a portable toilet in the garden. Because of the conditions that they live in, the beneficiary said that she used to sit at home and worry about the situation, especially after her husband was diagnosed with cancer. They considered trying to go to a pensioner's cottage but because she looks after their 40+ year old son, they cannot do this. She struggles with their living conditions as they have always lived in a house and their current situation is not how she imagined she would live when they retired. "That was not our wishes to end up there". According to the beneficiary, since coming to the centre, it has drawn her and her husband closer. They have something "more fun to talk about". They can talk about their day at the centre and "forget about all that" [referring to the situation at home]. "It's everything" to the beneficiary. When she is at the centre, she socialises, learns from other elderly, learns of others hardships, and has developed new friendships. "We enjoy ourselves to the utmost everyday". (*Beneficiary, Centre 2)

Narrative 2: *"The centre has given me strength to go through a lot of things that have happened in my life that is why I am happy and satisfied." The beneficiary spoke about how she has been accessing the services at the centre on a daily basis for the past eight years. She suffers from high blood pressure, arthritis and psoriasis. She lives with her daughter, who assists her financially, and help her to*

move around when she has difficulty. She started coming to the service centre as she was alone at home when her daughter went to work. She decided to make use of her time to meet other elders rather than isolate herself. She began to engage in numerous activities at the centre, including having meals, doing exercises, singing in the choir and doing beadwork and knitting. She felt that it helped with her recovery the year she lost her two sons. The one son was stabbed in the community and a few months later, 3 months, she lost her second son. He went to work one day and he stopped breathing, they took him to hospital and he passed on when he was at the hospital. By the time they picked her to go see him he was no longer alive. While she said that it hurt her to speak about it, she acknowledged that speaking about it helps to heal it too. The beneficiary described the support she received from the centre as "amazing". The social worker worked with her regularly and had more visits than usual to cater to her situation. The other members were very supportive as well. (Beneficiary, Centre 14)

5.3.3 ACCESSIBILITY OF SERVICE CENTRES

When asked if there were times when they wanted to come to the centre but could not come, 58 out of 93 beneficiaries answered this was the case. While 9 of the 58 beneficiaries did not provide a reason for why they sometimes could not come to the centre, the responses were coded and the most common reasons beneficiaries gave for not being able to attend are highlighted in Table 24 below with the number of beneficiaries who spoke to each theme.

Having to attend clinic appointments or pick up chronic medication from the clinic appeared as the most frequent reason. Beneficiaries mentioned the responsibilities they had at home, looking after ill children or grandchildren:

"When I have to take care of my grandchildren at home… if I don't take care of them then my son has to take an off day at work. I use most of my pension in paying for things for my grand-children and no one is giving me any money for this" (Beneficiary, Centre 16)

A number of 'other responsibilities' were mentioned, such as attending other activities, cleaning, shopping, and other household duties, which highlight the demands placed on older persons. Beneficiaries also cited that they did not come due to illness, if the weather was poor, or due to difficulties with transport.

Table 24. Reasons given by beneficiaries for non-attendance

Reason	Number of beneficiaries
Clinic appointments	19
Other responsibilities	14
Feeling unwell	12
No reason given	9
Looking after children and grandchildren	8
Collecting grant money	6
Lack of transport	6
Inclement weather	4

Note. This question was asked only to those beneficiaries (*n* = 58) who indicated that there were times when they could not come to the centre. The number of beneficiaries given in the table is > 58 as this was an open-ended question and some beneficiaries gave multiple reasons for non-attendance.

In addition to asking beneficiaries the reasons they were sometimes unable to attend the service centre, beneficiaries were also asked to identify reasons why other older persons may not come to the centre, or have stopped coming. A large number of beneficiaries indicated that they were aware of other older persons in the community who did not come to the service centre or used to come, but no longer came (84 of the 93 beneficiaries answered in the affirmative). Those beneficiaries who indicated they knew of other older persons who did not come to the service centres, were asked why they thought this was the case. The responses were coded and the most common themes are highlighted in Table 25 below with the number of beneficiaries who spoke to each theme. The reasons given corresponded with the findings above, with transport, financial, health, and safety cited most frequently.

Table 25. Perceived barriers that prevent other older persons from attending the service centre

Barrier to access	Number of beneficiaries
Transport	48
Cost	36
Physical health, mobility and illness	33
Other (Vulnerability to crime and violence in coming to the centre, other responsibilities at home)	25

Note. This question was asked only to those beneficiaries (*n* = 84) who indicated that they knew of other older persons who do not attend the centre. The number of beneficiaries given in the table is > 84 as this was an open-ended question and some beneficiaries gave multiple responses.

These perceived barriers to access were supported by findings in international literature. For example, Pardasani's (2004) survey of users found that the biggest obstacles identified include lack of transportation (31.1%), lack of interest (25.6%), lack of access (7.3%), and fear of stigma (7.3%). The management interviews and staff focus groups provided further support with regards to transport, cost, health issues, and responsibilities at home, acting as barriers to access. However, many also spoke to the reality that some older persons simply do not want to come to the service centre:

"*I think some seniors have just accepted being alone.*" (Manager, Centre 6)

"*They don't want charity or a hand-out.*" (Manager, Centre 10)

"*Many think they are not old.*" (Manager, Centre 18)

Managers and staff also voiced the belief that older persons in the community do now know about the service centre:

"*People don't know what's happening inside.*" (Manager, Centre 8)

"*Nothing prevents them but they have a mind-set that it's [the centre] is an old age home…they don't know that they will be active here and do activities. Some people also don't know it's here…*" (Manager, Centre 9)

"*They don't know what services are being offered…we need to encourage them to join.*" *(Manager, Centre 5)*

In addition, there was a concern that older persons in the community have the incorrect perception about what happens at the centres. There is a perception that the centres are only for *old people*, and many people who are 60 years or older do not perceive themselves as such:

"*Those seniors do not want to be amongst old persons.*" (Focus group, Centre 15)

5.3.4 RELEVANCE AND APPROPRIATENESS OF SERVICES

Service centre managers were asked to explain the process by which centres decided what activities were offered and how they would be offered. Responding to the needs and wishes of older persons has a direct influence on relevance and appropriateness. Most frequently, centre activities developed organically, according to what seniors were perceived to need and enjoy (9 of the 20 centres; i.e., activities were offered by centres only if they were requested or attended by members). 4 of the 20 centres were unsure as to why the services were offered, and cited this as being in place by previous management:

"*It was in place when I came here.*" (Manager, Centre 10)

6 of the 20 centres spoke of how their activities were guided by the criteria of their TPAs and they offered services in keeping with those requirements. Those centre falling under mother body organisations reported receiving guidance from them, with some direct input from members (4 of the 20 centres):

"*You must plan with the seniors because they won't do anything if they don't want to.*" (Manager, Centre 8)

Few centres (2 of the 20 centres) acknowledged that they looked at what other centres were offering in order to guide their activities. Only 1 of the 20 centres spoke about services coming into being based on research (a community needs assessment).

When asked if they were happy about the services they received at the centre, 83 out of 93 beneficiaries answered in the affirmative. Beneficiaries were also asked which services or activities they felt were the most helpful. Responses were coded

and the services identified most frequently as valued or helpful are highlighted in Table 26 below. It appears that beneficiaries value the social aspect of the service centre - simply coming together and spending time with other older persons, rather than a specific service, was identified most frequently as a helpful or important aspect of the service centre. Beneficiaries also frequently identified the exercise they participated in at the centre as being important to them. This was followed by the meals, transport and access to other amenities, as well as the psychosocial support provided through speaking about and sharing problems they may be experiencing.

Table 26. Most valued services identified by beneficiaries

Service	**Number of beneficiaries**
Togetherness, socialisation, interaction with others and making friends	44
Exercise and physical activity	40
Daily meals	26
Transport to the centre and other services and activities in the community	20
Psychosocial support: Counselling, sharing problems and group support	19
Games (such as bingo)	16
Religious activities (such as prayer groups)	10
Medical care (such as blood pressure testing)	7
Outings (such as theatre shows)	7

Note. The number of beneficiaries given in the table is > 93 as this was an open-ended question and some beneficiaries identified more than one service as being most helpful.

These findings seem to indicate that services offered are generally accepted by beneficiaries and support the findings from the management interviews. However, when asked to identify how services could be improved to better serve the needs of older persons in the community, beneficiaries spoke about a number of potential improvements. Their responses were coded and the key themes that emerged are highlighted in Table 27, with the number of beneficiaries who spoke to each theme. These responses suggest that, although service centres are consistent with the priorities and needs of beneficiaries, who are generally satisfied with the services offered, there are a number of ways in which the relevance and appropriateness of service centres can be improved.

Table 27. How service centres can be improved to better serve the needs of older persons

Suggestion	Number of beneficiaries
Transport to access the centre and other community-based services	35
Medical and health care at the centres (e.g., permanent nurses and chronic medication is delivered at the centres) so beneficiaries can attend the centre more frequently and do not have to wait at primary health care facilities	32
More involvement of 'younger-older' persons, students and volunteers	26
Safety and security for older persons in the community, particularly coming to and from the centre	24
Awareness and education to other older persons about the nature of the centre and services provided	17
Focus on or expand home-based care/visits to look after older persons who are unable to come to the centre	10

Note. The number of beneficiaries given in the table is > 93 as this was an open-ended question and some beneficiaries noted more than one area of improvement.

5.4 SERVICE DELIVERY GAPS AND BARRIERS

Service centre managers were asked a number of questions regarding additional service needs of older persons that they currently were not able to meet. Only 4 of the 20 managers indicated that they felt there were no further services that older persons in the community needed, which the centre was not currently providing. However, the service needs noted most frequently by the 16 managers who answered in the affirmative to this question included (a) transport, (b) health, (b) home-visitation services, (c) social services, and (d) awareness-raising. These are discussed in more detail below. However, it is difficult to identify broad service delivery gaps due to the considerable variation between centres in terms of service delivery.

5.4.1 SERVICE GAPS

5.4.1.1 Health services

A large number of the beneficiaries reported suffering from various and multiple health issues, particularly diabetes, hypertension, and arthritis. In addition, long queues at primary health care facilities and lack of transport were noted as some of the key difficulties older persons faced. Furthermore, poor health was identified as one of the primary factors contributing to poor attendance and membership.

However, few centres provided some form of health service to members. It is thus not surprising that managers (5 of the 20) frequently identified this as a service gap. These broadly fell into two categories, namely screenings and distribution of chronic medication. This need is illustrated in the quote below:

"We have a blood pressure machine and a sugar tester…but there is no dedicated health professional that…comes around to do a general check up on what the condition of the older persons are…The service centre should have that formal link to the health facility in the area. We have a clinic but the clinic currently…their focus isn't on older persons…women and children is the clinic's focus. Where there may be a day hospitals that services the general community, which includes servicing older persons [but] instead of the older person having to go to the day hospital, the day hospital must come to the older persons. They have to go for chronic medicines to the day hospital but they cannot get to the day hospital, they don't have money to go to the day hospital. Then, when they get to the day hospital, the conditions there is so chaotic… they get there at 7 o'clock in the morning…at 4 o'clock some of them are sent home because there is no more time in the day or the files are lost. We have spoken about this, about bringing the chronic meds to the site…so they don't have to go to the day hospital… The government is trying to do that but the administration of the system is still not satisfactory." (Manager, Centre 3)

5.4.1.2 Social services

Older persons are facing numerous social difficulties; however, few centres have access to qualified social workers who are able to address these issues effectively. Service centres generally reported using informal referral networks, based on personal knowledge and experience of staff, where this was present. 5 of the 20 centres expressed a desire to have a social worker at the centre to address issues of abuse, trauma, grants, conflict between members, and referrals. Although staff and management try to keep up to date with issues such as grants, they struggle to do so and feel a social worker should be available to help with these issues:

The manager expressed a desire to have a social worker at the centre, but it would be too expensive to employ such a person. Although they used to have an auxiliary social worker at the centre, they no longer have funding for this position. The manager suggested the idea of sharing a social worker between multiple centres, where the person can come to centre once a week to deal with conflict between people, cases of abuse and pension problems. (Manager, Centre 7)

5.4.1.3 Home-care and home-visitation

Reasons behind fluctuating attendance and access, is that older persons are often isolated within their homes, unable to access services due to lack of awareness or ability/mobility. The need to provide services and support to older persons in their homes was noted by managers at 6 of the 20 centres. This acknowledged that some older persons cannot come to the centre and there is a need to provide meals, home-based care and/or to identify needy older persons living in the community:

"We would like to take the meals to those who can't come in, but the home-carers are busy and there is gang violence in the area. How would we get it to them?" (Manager, Centre 3)

One mother body organisation has initiated a novel programme using community development worker approach. An individual is trained to assess and screen older persons in heir homes in a given community. Based on their need, the older person is referred to the service centre or to other appropriate services. This is based on an

initial pilot project by AgeWell, where older persons themselves were trained to perform this role.

5.4.1.4 Skills development

Beneficiaries frequently undertake craft activities. However, managers and staff noted that the quality of the items produced often hinders these being sold to contribute towards fundraising or generate an income for members. In addition, a lack of materials or knowledge means that some services are unable to offer such activities. At 5 of the 20 centres, management expressed the need for more activities that developed members' skills. Computer skills training, crafts, baking, sewing, and painting were cited as activities that would empower members to learn new skills and create more opportunities for socialisation and income.

5.4.1.5 Other

The role of older persons as caregivers for grandchildren and the finding that this acts as a barrier to access, stands in contrast to the number of centres linked to early childhood development (ECD) or aftercare facilities. In fact, 2 of the 20 service centre managers noted ECD/aftercare as a key service gap. One manager had the following to say in speaking about how beneficiaries need to be supported to raise their children through the provision of aftercare:

> *"You cannot solve the problems of the seniors without solving the problems of the youth." (*Manager, Centre 4.)

A further noticeable gap in services offered by centres is dementia care. Few centres are providing support to older persons with dementia; only one centre reported that older persons with early dementia attended the service centre while some were a venue for Alzheimer's support groups provided by external organisations. Dementia day-care services enable the adult children of older persons with dementia to work during the day while still having their parents reside at home. While such services are traditionally funded by the DSD, dementia is both a social and health issue that needs to be addressed by additional stakeholders, such as the Department of Health.

5.4.2 INFRASTRUCTURE CHALLENGES

Noting the above-mentioned gaps in service delivery, it is important to consider the key challenges facing service centres that hinder the delivery of effective and efficient services.

5.4.2.1 Venues

The site descriptions detailed earlier in the findings section, paint a picture of infrastructure-related challenges, which were also identified by 9 of the service centre managers as hindering service delivery. These challenges included cold venues, poor maintenance, vandalism, and venues that were too small to accommodate existing or additional members. A lack of venue ownership (i.e., venues that are not used by the service centre alone) appeared to be a significant concern for some centres in that the venues did not lend themselves to the activities of the centres. Two narratives below reflect the challenges centres may experience:

Narrative 1: *The Chairlady and members' committee of the service centre decided to break away from the mother body organization to which they had belonged for a number of years. This took place at the beginning of 2015, due to unhappiness with how the members were treated and their finances managed. The centre had existed for over 10 years, yet when they broke away from the mother body, they had to leave with none of their own equipment. The members, their families, and friends donated various items and they are slowly building up a collection of their own equipment. However, the centre had to find a new venue where they could gather. They have applied to the municipality for land to build their own facility, but in the meantime, they have been allowed to use the clubhouse of a local sports facility on a temporary basis. The venue is atop a steep hill, which makes access difficult. In addition, as the venue is utilised by others, the centre sometimes has to end their activities early and they cannot leave their equipment. The centre's hands are tied as they are still dependent on the mother body, with which they have a strained relationship for their funding, as they await the outcome of their submission for their own NPO number.* (Centre 13)

Narrative 2: *The centre has had various venues since breaking away from the mother body organization, which they first joined many years ago. The centre was forced to leave one venue, a church, due to other activities being held there. Another venue burnt down and a further venue was vandalised. This disrupted the activities for roughly two years until the centre began operating from the home of the committee Chairperson. However, the home is not spacious enough for large numbers of people to gather and the small home kitchen and bathroom not appropriate for the centre's needs. A lack of storage means that although they try to buy food in bulk in order to cut costs, the food spoils and goes to waste.* (Centre 4)

5.4.2.2 Transport

Transport can be viewed as both a service gap and a capacity-related challenge that affects the provision of other services. It is clear from the above discussion of the findings that transport appears as a barrier to access and challenge facing older persons and service centres. 9 of the 20 managers identified transport as a key challenge facing their centre. This was closely linked to funding and attendance, as transport was costly to provide and the lack of daily transport or transport to outings and events limited the ability of members to attend.

"We can't pay for the transport to bring them here everyday…we wouldn't be able to afford the taxis." (Manager, Centre 3)

"If you took that [transport cost] away, my goodness, what we could do…" (Manager, Centre 17)

Managers voiced the need to be able to provide transport to members on a day-to-day basis in order to bring them to and from the centre:

"This would be especially helpful to pick members up when it is cold and raining…it does not even have to be door to door, even nearby…in a group" (Manager, Centre 6)

"We need assistance with transport…perhaps we could combine clubs and meet in one place. This transport could also be provided to take them to the hospital." (Manager, Centre 5)

This was particularly a problem for the more rural or isolated sites. In the farming communities in the Winelands Overberg region, where poor roads and large distances prohibit access to centres, centres are attempting to overcome this problem through providing satellite services on the different farms on which seniors live:

Narrative 3: The members live far apart from each other on various farms in the area. The farm roads are poor and often inaccessible to the transport service that picks them up and drops them off. The taxi is often not able to access a farm and then the members have to walk long distances to the main road to catch the taxi. Because of the problems in attending the centre for some older persons in the community, the centre started a project where a person on a farm cooks soup and provides the seniors, children, sick, and frail in their immediate area with the soup, with the centre providing the ingredients for the soup. In this way, the centre reaches out to those older persons who are unable to attend the centre too. (Manager, Centre 20)

5.4.3 CAPACITY CHALLENGES

5.4.3.1 Funding

Funding-related challenges were mentioned most frequently by service centre management as a challenge facing their centre, with this identified by 17 of the 20 service centres. A scarcity of funding was seen to limit the activities centres wanted to provide and had resulted in centres being unable to offer activities that they had previously offered. This ranged from smaller changes in activities, such as having to stop giving the seniors pudding with their meal and not being able to go on outings, to extensive changes in the services offered. Centre 4, for example, had to stop virtually all the centre's activities, besides the provision of meals and transport. In addition, a lack of funding was seen to influence centres' ability to advertise and take on additional members.

Regular funding appeared to be a specific concern for centres. While some had received funding from large funders, such as Community Chest, they had failed to secure that funding in later years. Centres reported receiving donations or promises of donations from community members but that these were not always followed through on or where what was need by the centre. Even centres that received support through free building rentals, disclosed concern for the future:

"It's too little. We get the building for free and don't pay electricity but it won't be for long as the place is going to close and we will need to pay rent and electricity... I am worried about what will happen." Manager, Centre 17

Three managers from centres in the Winelands Overberg region expressed difficulties associated with living in small communities, where local businesses were unable to support all the organisations operating in the area:

*"We are a small community and everybody wants a piece of the cake and it's [*funding*] getting more difficult. Now we need to look outside for funding."* (Manager, Centre 17)

5.4.3.2 Difficulties with WC DSD funding criteria

Related to funding challenges, five centres specifically noted difficulties associated with the WC DSD funding criteria. This seemed to revolve predominantly around a lack of understanding of the criteria contained in the transfer payment agreements (TPA). Some centres do not understand what the centre is able to do with their funding:

"*[*Speaking about the TPA*] It says 'recreational activities' but we are not sure what this is…what is recreation? Can we take them to Greenpoint Park…is that recreation? They don't give you more information…*" (Manager, Centre 3)

There also appeared to be some misunderstandings between management and members regarding the allocation of funding from the WC DSD and a perception by members that this should go directly to members, towards items for members, and events, such as outings:

"*I'm hesitant to do these things because I don't have clear guidelines…can we do this?* (Manager, Centre 3)

Managers also expressed feeling restricted by the target outlined in their TPA. They spoke about how they were hesitant to advertise or talk more to persons in the community as a result:

"*If more and more persons came to the centre, we will not be able to accommodate them.*" (Manager, Centre 6)

Difficulties in getting members to sign their names and give their identity numbers due to concerns about privacy and illiteracy, was also mentioned.

5.4.3.2 Staffing and skills deficits

A further implication of funding-related challenges for centres was an inability to retain or employ skilled personnel. Managers from five of the centres identified capacity as an issue the centre was dealing with. This included too few staff and a large turnover of staff, as well as a lack of skills.

"*We need volunteers that can actually do things.*" (Manager, Centre 11)

"*They make, for example, hats, but then you find that they keep them here in the club. If they can have someone who tells them what to make and where to make them to sell them…They are doing it but they don't know how to sell it.*" (Manager, Centre 9)

15 of the 20 service centre managers interviewed expressed a need for training and staff capacity development. Interestingly, all five of the centres that did not express a need for training, were situated in the Winelands Overberg region. Particular training needs included (a) management, administrative, governance, and funding training for staff and members committees; (b) training to help staff to interact and deal with older persons (conflict and anger management, understanding older persons,

dealing with dementia, basic counselling skills;); (c) training on health screenings (including identifying early symptoms of dementia and other health issues) and home-based care; and (d) training on what types of activities and exercise are appropriate for older persons and how to do them.

The importance of point *b* in the above paragraph, 'training to help staff to interact and deal with older persons', is further highlighted by the difficulties cited by 5 of the 20 managers in dealing with members. For example, one manager who had been in the position less than one year, expressed concern that members seemed to complain about various services at the centre and felt that they did not realise how fortunate they were to have the centre. However, while noting challenges, some managers took a different perspective:

> *"The seniors can be difficult but…[you] just have to understand them…[you] can't push them to do things."* (Manager, Centre 9)

> *"You must be patient and understand the seniors and talk to them."* (Manager, Centre 8)

Although some form of exercise was reported to be provided by centres, staff or members themselves who had little training or experience often led this. Older persons, particularly those dealing with multiple health issues, may have specific constraints in terms of what exercises are needed and appropriate, which requires a level of knowledge and expertise.

5.5 EMERGING BEST PRACTICES

Promising practices, relating to management, funding, infrastructure, and service delivery, emerged from a number of the service centres sampled (see Table 28 on the following page). These individual and collective practices exemplify strategies that community-based care programmes and the WC DSD can draw upon in the expansion of services for older persons in the province. A number of new and innovative methods of service delivery emerged; some were well established, others were still in the initial or planning phases.

Table 28. Example of promising practices from service centres

Category	Indicator	Best Practice
Service delivery	Structured programme	• A structured daily programme offers members a diversity of services which they can choose to attend
	Income generating activities	• Members are trained to produce craftwork of a saleable standard. This is used to generate income for members and for the centre
	Exercise	• Regular exercise is provided by trained personnel • Older persons have the opportunity to participate in collaborative events, where they are able to meet with and engage with older persons from their own and other communities
	Meals	• Older persons are actively involved in the cooking of meals according to a roster agree upon by members. Members are paid for this • Meals are outsourced to an external catering organisation • Menus are decided upon in collaboration with members and management based on key nutritional criteria
	Outings	• Outings provide members with an opportunity for new experiences and learning and are used to raise funds through the selling of tickets to community members. Members fundraise towards these activities and are jointly planned between members and management
	Childcare	• ECD or aftercare services are provided on the premises to allow members who have childcare responsibilities to attend services
	Health	• Members' chronic medication is delivered to the centre • Members or staff provide basic health screenings and referrals to primary healthcare facilities • Centre works with other NPOs who provide delivery of chronic medication and screenings
	Activities for men	• Centre offer activities specifically aimed to appeal to men, such as woodwork and games
	Home visits	• Members and staff visit ill or homebound members and deliver meals when they are unable to attend
	Referrals	• Service centre managers and staff 'keep an eye' on seniors and have an open-door policy. Members are able to approach management for help with problems in all areas of their lives. • Referrals are made based on reliable and broad knowledge of policy and legislation and service availability and appropriateness. • Innovative recruitment: Door-to-door community worker identifies at-risk older persons in their homes, referring to service centre or other available services based on accurate assessment of need. • Records or folders are kept on each member. Referrals are followed up on to see if members have been assisted.
Infrastructure	Venue	• Ownership of venue: Service centre has a dedicated venue and exclusive use of the space • Venue is situated within the community or town providing facilitating access and involvement of older persons in the broader community • Services are delivered in multiple locations (i.e., the service centre is taken to the beneficiaries rather)

	Transport	• Dedicated vehicle picks up and drops off members daily.
Capacity	Leadership	• Manager has previous experience in social work • Passion and understanding of older persons
	Role of management and staff	• The role of management is to advise and support older persons, but centres are beneficiary-driven
	Role of older persons	• Members are active participants rather than passive recipients of services; they take charge and are actively involved in decision-making, service provision, and fundraising. Centres are run by older persons, for older persons • Members sit on both the members' committee and management committee or Board • Skills and expertise of members is mobilised. Members are able to apply the skills from previous jobs or experience, such as retired nurses or teachers, and take on responsibilities in delivering these services to other members
	Organisational structure	• Strong mother body organisation provides a strong service infrastructure, administrative support, training, and assistance with funding • A multipurpose centre/organisation provides service centre members with linkages to other services within the same organisation including health care, social services, housing, and frail care
	Partnerships	• Working closely with other organisations providing care and support services to older persons
	Awareness	• Members act as centre ambassadors, informing other older persons in the community via word-of-mouth
Funding		• Dedicated funding officer or department • Fundraising events organised and led by members, involving the broader community • Members are trained on craftwork, which is sold to generate income for the centre and/or members • Meals provided to members are also sold to the community • Membership fees are charged and used to subsidise the activities of the centre • Membership fees are charged on a sliding scale to accommodate older persons dependent on old grant and those with other sources of income. The fees of those who can afford it are used to subsidise the fees of those who cannot

1) There is little consistency between centres with regards to management and staffing, capacity, funding, and infrastructure. Centres range from highly structured and well-resourced to very unstructured and poorly resourced.
2) Services and activities offered to members also varied widely between centres. This ranged from structured daily programmes to informal and ad hoc activities, with the only consistent service being the provision of a daily meal.
3) The majority of beneficiaries included in the evaluation were women, spanning the age range from <60 years to >85 years. Beneficiaries generally reported low levels of education. The living circumstances of beneficiaries varied, although a large proportion reported living with children, grandchildren, and other extended family members. A large number were dependent on the old age grant. Beneficiaries reported good mobility but high levels of chronic illness.
4) Most service centres could not speak to a significant change in membership figures although they acknowledge a number of barriers that prevented access including transport, cost, poor physical health, and the other responsibilities of older persons, such as childcare.
5) Older persons face a number of challenges, including poverty, acting as caregivers for grandchildren, crime, abuse, social isolation, loneliness, and a marginalised position within the communities in which they live.
6) Beneficiaries identified a number of services that would be helpful to them; most frequently cited were healthcare, transport, community awareness, and exercise.
7) Service centres appear to be playing three key roles in the lives of older persons, meeting both lower-order and higher-order needs. These are (a) meeting basic physiological needs through the provision of a regular meal, (b) providing safety and social support, and (c) providing a sense of family and belonging. To varying degrees, service centres are also providing beneficiaries with a sense of purpose through participation in activities, programmes and decision-making.
8) Overall, beneficiaries reported to be satisfied with the services they received at the service centres. However, a number of recommendations were put forward to align services to the needs of older persons and the service gaps that currently exist.
9) Service delivery is hindered by capacity- and infrastructure-related challenges facing service centres. In particular, these include infrastructure (transport and venues) and lack of consistency in capacity (funding, skill, operational structure).
10) A number of best practices were identified across all service centres, including well-established and small independent centres. These provide promising examples of service delivery, management, funding, and infrastructure amongst existing service centres.

6 RECOMMENDATIONS

This section of the report consists of three key parts. This evaluation has looked into existing practices at 20 centres in the Western Cape. The evaluation of the 20 service centres revealed a number of challenges, service gaps, needs, and best practice elements. In addition, a number of the service centres showed strong evidence of goodness of fit for the specific communities they served. In light of these findings, as discussed above, the first part of this section makes concomitant recommendations, including key crosscutting recommendations regarding the sustainability of service centres for older persons. The second part of the recommendations section draws on international and local organisations and identifies three broad models of community-based care and support for older persons that can be applied to the local context. Lastly, recommendations for further research are made.

6.1 CURRENT SERVICE CENTRE LEVEL RECOMMENDATIONS

In light of the above findings and interviews with key informants, certain broad recommendations are made regarding a sustainable future model for service centres in the province:

1) There is no one-size-fits-all model for service centre best practice or community-based care.
2) Developing a model of best practice for service centres or community-based care needs to carefully consider the needs of the specific communities and be tailored appropriately to those needs (goodness of fit for the community).
3) Strategic partnerships between stakeholders are vital to the realisation and sustainability of an integrated model of care. Collaboration between service centres, other service providers, and between government departments is essential to facilitate knowledge exchange and service delivery.

However, there are also a number of more specific recommendations regarding the areas of service delivery, accessibility, management, funding, and infrastructure. In realising any models of care and support, sustainability is key. There are a number of broad, crosscutting recommendations regarding the sustainability of services, which can be applied to current or future models of care. A number of these recommendations speak to 'economies of scale' in terms of a reduction of cost seen in increasing the scale of operations. These are discussed below.

6.1.1 RECOMMENDATIONS FOR IMPROVING ACCESS

Improving access to service centres is the foundation of any future sustainable model of care. Regardless of enhanced service delivery, management, funding, and awareness of service centres or adaption of service centres to a new model of care, if older persons are not able to reach the service centre, these become redundant. One of the most important targets of resource allocation and investment in service provision to older persons needs to be in addressing the infrastructure challenge with regards to transport. This recommendation corresponds with the finding that a lack of available and affordable transport is one of the key reasons older persons do not attend service centres. This contributes to fluctuating numbers seen at service centres, which reflects differences between the numbers of registered members

versus the attendance figures and has an impact on funding. It is therefore recommended that the WC DSD revises its current funding strategy regarding the transport subsidy.

6.1.1.1 Recommendation: Transport route for service centres

This is seen as a transport service, servicing a number of centres or organisations, utilising a preferred or approved service provider (i.e. a transport service that could serve all service centres in a broad area, picking up and dropping off older persons from their homes and or central collection areas). Such a service (a) speaks to economies of scale and (b) protects service centres from being at the mercy of expensive private taxi operators who can escalate costs and are not sensitive to the vulnerable position of older persons. Whilst the dial-a-ride service is provided by the City of Cape Town, it is widely acknowledged that this service is over-subscribed and not available to centres outside the Metro.

6.1.1.2 Recommendation: Extend transport subsidy to all centres

The current funding criteria for service centres allows only rural sites receive a transport subsidy. However, centres in the Metro South are experiencing significant constraints due to the lack of transport or cost of providing transport to members, and transport was frequently noted as a significant challenge impacting on the quality of life of older persons in both rural and urban sites. The lack of affordable transport is acting as a significant obstacle to attendance and service delivery. The extension of a transport subsidy, which acknowledges that transport is an essential service across all centres, would assist in increasing access and improving service delivery.

6.1.1.3 Recommendations: Awareness-raising activities

In order to reach more older persons and increase membership figures the general lack of awareness of service centres needs to be addressed. A lack of awareness was seen as a key barrier to access; creating awareness amongst older persons of the services available is therefore important as the foundation of a sustainable future for service centres. However, in alerting people to the availability of services, it is important to acknowledge that (a) not all older people will choose to attend the service centre and (b) centres need to be equipped and prepared to service a larger number of people that increased awareness campaigns may attract.

A number of recommendations regarding awareness-raising include:

1) Radio awareness campaigns
2) Advertising at SASSA pay points, churches and other important resources that older persons use
3) A government road show
4) Active beneficiaries act as ambassadors for the service centres to which they belong
5) Recruitment drive using a 'bring-a-friend' initiative
6) Awareness raising via a dedicated community development worker[20]

[20] This is based on the activities of one of the mother body organisations participating in the evaluation and a pilot project by AgeWell. The mother body organiation are currently instituting a programme whereby a trained 'Umelwane' visits older persons in their homes in a

6.1.2 RECOMMENDATIONS FOR IMPROVED SERVICE DELIVERY

Overall, it appears that service centres are providing effective and relevant services that meet older person's basic physiological needs for food and higher level needs for a sense of love and belonging. However, some centres struggle to understand what services are most appropriate and compliant with their TPAs. In addition, certain services (i.e., meals) are particularly costly to provide.

6.1.2.1 Recommendation: Standardised service guidelines

Detailed guidelines developed by WC DSD in consultation with key stakeholders and based on best practice explain what the service categories mean and provide examples and suggestions to service centres of the form those activities could take. Particularly, such guidelines should recommend the provision of activities for men, which are currently provided by only a small number of centres.

6.1.2.2 Recommendation: Bulk food procurement system

The application of a bulk food procurement system to service centres can assist centres to meet the basic physiological needs of beneficiaries through providing a nutritious meal while maintaining economies of scale. This could draw on similar models, such as the Department of Basic Education's National School Nutrition Programme. A bulk food procurement system could include the provision of key bulk ingredients and prescribed menus that meet three requirements in terms of being culturally appropriate and accepted by beneficiaries as well as nutritious and more economical than service centres' current methods of food procurement. The use of a bulk food procurement system could allow beneficiaries to purchase, at cost price, food to take home, which recognises that older persons are often the providers to other family members at home, particularly children.

A bulk food procurement system may introduce administrative challenges in handing over the food to the centres (noting the significant transport challenges in particular). To offset these challenges, it is suggested that the WC DSD explores the feasibility of (a) linking service centres to the kitchens of old age homes, (b) linking service centres with external catering service providers, and/or (c) incorporating smaller independent service centres under the umbrella of larger mother body organisations[21]. This could facilitate the provision of food in bulk to one location, from where it is distributed by the managing organisation. As a first step in exploring this recommendation, the WC DSD should refer to geographic information system (GIS) maps to identify the proximity of old age homes to service centres and explore the alternative suggestions for service centres not in close proximity. A number of service centres are already implementing suggestion (b) above, outsourcing catering to an external provider, which is proving cost effective and providing an additional source of income through the selling of meals to the broader community.

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given community or district, assessing them and referring them to either the service centre or additional services as required.

[21] This recommendation is explore in more detail in recommendation 6.1.3.6 (p. 109).

Although, the administrative challenges and possible resistance from beneficiaries and staff must be noted, a focus on education on nutrition and emphasis on cost reduction could increase acceptability.

6.1.2.3 Recommendation: Integrated service delivery

A key element of integrated service delivery is the development of processes to facilitate referral and collaboration (Hébert, Durand, Dubuc, & Tourigny, 2003). While this is happening informally in many service centres, in line with the national norms and standards regarding information on accessibility to additional support services, many lack the infrastructure and information to do this (e.g., knowledge of where to refer people within and outside the community).

6.1.2.3.1 Recommendation: Referral resource

A referral resource for service centres and other service providers could take the form of a centrally compiled and regularly updated database[22], list/handbook, or an 'advice bureau'. This falls within the second level of integration (coordination)[23] whereby management and staff at a particular organisation, who may be lacking in a social development or social work background, may therefore still have access to an 'umbrella' system which it can adapt to its own requirements and processes (Leutz, 1999).

6.1.2.3.2 Recommendation: A case management approach

Based on best practice identified in service centres, it is recommended that service centres are encouraged to adopt a case management approach whereby centres keep complete records on members. All referrals and follow-ups are documented. This ensures that when older persons enter the service model, their needs are first thoroughly evaluated. The literature notes this as an important process in integrated services, and is most effective when performed by an individual who "is not just a service broker but is also actively and directly involved in delivering the services to the client" (Leutz, 1999).

6.1.2.3.3 Recommendation: Developing partnerships

Developing mutually beneficial partnerships with key stakeholders will facilitate knowledge exchange and service delivery. Key stakeholders include provincial and local government departments, civil society, and the private sector. Developing partnerships between key stakeholders, including between service centres and between different providers of services relevant to older persons, will increase the likelihood that older persons will have access to services that meet their multiple needs.

As part of the focus on developing partnerships, partnerships with the religious sector should also be strengthened. While a number of service centres are run from churches and spiritual activities appear to form a significant part of the centres' activities, the direct contribution or relationship of the religious sector is unclear.

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[22] Such a handbook has been developed by the Cape Peninsula Organisation for the Aged (CPOA) although when this was last updated and its availability is unclear.

[23] Leutz (1999) identifies three levels of integration of social and medical services, (a) linkages, (b) coordination, and (c) full integration (see p.29).

6.1.2.4 Recommendation: Provision of social work services

In light of the significant challenges facing older persons, and concomitant needs, it appears that service centres would benefit from the services of a registered social worker or socially auxiliary worker. Service centres seem to be the first point of call for many older persons and are already informally acting as social support and referral mechanisms; however, the input from regional WC DSD offices is unclear.

The provision of social work services would not have to be on a full-time basis and could take the form of a government-paid or subsidised rotational position, with one dedicated older persons' social worker or social auxiliary worker servicing a large number of centres in a given district or region. This would be of particular benefit to smaller, rural, and less structured services that lack the capacity to identify and address the social needs of members. In addition, the provision of a social worker or auxiliary social worker on a sessional basis is congruent with the national norms and standards regarding acceptable levels of services to older persons for level B (intermediate) and level C (tertiary) service centres.

6.1.2.5 Recommendation: Interdepartmental collaboration

It is clear that the Western Cape DSD cannot carry this mandate alone and that there are limits to what can be achieved without buy-in from other provincial departments. Quality research, innovative ideas, and a strong NGO sector can support a collective interdepartmental understanding and response to the challenges of an ageing population. The WC DSD should engage with stakeholders including City of Cape Town, other municipal government departments, Department of Health (DoH), Department of Transport, Department of Cultural Affairs and Sport, and Department of Human Settlements regarding integrated service delivery to older persons.

In line with the need for health services identified in the evaluation and in the OPA, the involvement on the DoH is particularly important in bringing primary health care services to older persons at the level of community-based care (i.e. the service centre). Few centres are currently able to fulfil this role.

6.1.3 RECOMMENDATIONS FOR IMPROVED ORGANISATIONAL CAPACITY

6.1.3.1 Recommendation: Address funding challenges

Funding remains the fundamental challenge facing centres. Given the limited allocation of resources and funds to older persons programmes despite the growing needs of older persons and service providers, it is difficult to begin to reimagine substantial and costly changes in facilities and programmes (Pardasani & Thompson, 2010). It is therefore important that service centres consider innovative and viable mechanisms to diversify their funding base, increase revenue, and decrease costs. This is in keeping with best practice identified in high-income countries (MacRae-Krisa & Paetsch, 2013); however, will need to be tailored to the local environment. A number of examples of such mechanisms have already been identified in the exploration of the fundraising activities and best practices of existing service centres.

In reality, the subsidy provided by the WC DSD does not cover the real costs of providing the services offered by the centres, including costs of staff and other operational expenses. The organisations therefore need to spend a considerable amount of time and effort raising additional funds. However, this need for additional fundraising efforts is often not supported by the necessary capacity, knowledge, and skill. Whilst the scarcity of funding in the NPO sector in South Africa is widely acknowledged, the number of funders who provide funding to services for older persons is particularly limited.

6.1.3.1.1 Recommendation: Income generation as a key function of service centres

It is clear that any model of care requires a committed income. Government subsidies and private sector donations and funding are an important source of income for centres but these are unpredictable and fluctuate with global economic trends. Income-generating activities are not only in agreement with the stipulations of the OPA and nationals norms and standards[24] can assist centres in become self-sustaining, raising money to fund the centre's activities and/or also providing an income for members. In addition, there are many older people who are still active and although retired are still able to contribute important skills, such as retired teachers and nurses.

The provision of ECD or aftercare services may help to enhance the income of service centres through employing members to provide supervision or through venue rental. This is congruent with the WC DSD's focus on the risks for unsupervised children and will contribute to the protection of children. It may also help to increase attendance, as older persons do not have to be home to look after grandchildren during the day or after school.

[24] The OPA confirms the right of older persons to participate in activities that enhance his or her income-generating capacity and the importance of economic empowerment programmes as a service provided by community-based care programmes.

6.1.3.2 Recommendation: Revisiting the sporting and associated activities of the Active Ageing Programme

It is recommended that the WC DSD compare the cost overall and per beneficiary that was spent by the previous administration under the banner of the Active Ageing Programme (including the Golden Games specifically), looking at how that could be replicated. Questions that need to be addressed include (a) whether this initiative and allocated funding still exists, where it exists and for whom; (b) what is the substitute or alternative provided; (c) can this funding, infrastructure, personnel and participation by other key partner government departments continue to be linked to the Older Person's Programme and available to service centres? The excitement surrounding the activities and additional support provided as part of this programme (including transport, sports training, and additional resources, such as apparel and equipment) appears to be instrumental in increasing membership of service centres.

6.1.3.3 Recommendation: Minimum requirements for management and staff

While the national norms and standards dictate numerous staffing and management prescripts, it is clear that there was little consistency across centres with regards to management capacity. Many of the organisations visited have formal management structures in place. Other service centres, however, due to funding and other capacity- and scale-related challenges, have adopted an informal approach to management and have few trained and experienced staff. This means that there may be skill deficits that hinder centres' service provision, as well as the ability to meet administrative and financial requirements.

A number of criteria emerged through the data collection and literature review that could inform the minimum requirements for service centre management and staff, these include (a) experience in working with older persons, (b) understanding of the needs of older persons, and (c) administrative and financial skills, particularly with regards to fundraising. However, key minimum requirements for personnel in management positions at service centres need to be explored further by the WC DSD.

6.1.3.4 Recommendation: Training and mentorship

Where the above-mentioned minimum skills are currently lacking, the WC DSD should explore training opportunities to support the capacity building of existing managers and staff. This will help to ensure some level of consistency across service centres, provision of services, and competencies. Alternatively, or in combination, the WC DSD can explore mentorship opportunities for smaller independent service centres, where management and staff are lacking key skills. These could include, for example, links to same-sector NPOs or mentorship by private sector companies.

6.1.3.5 Recommendation: Incorporation of small independent service centres under umbrella organisations

This recommendation builds upon the above recommendation regarding training and mentorship. There are currently a larger number of smaller independent and larger organisations attempting to access the same number of funders and small amount of funding from provincial government, which fragments already strained

resources. Bringing small independent organisations together under larger well-established mother body organisations that have the necessary infrastructure, knowledge, staffing and skills is one way of achieving economies of scale[25]. The mother body organisation also aids in the provision of the necessary fundraising capacity. This is consistent with (a) international best practice regarding integrated service provision to older persons through an umbrella organisational structure that provides strategic and managerial guidance, encourages collaboration, and maintains accountability (Kodner, 2006) and (b) local best practice identified in the current evaluation.

6.1.3.5.1 Recommendation: Map and identify organisations working in the same geographical areas.

As a first step in facilitating partnerships and collaboration, organisations working in the provision of community-based services in the same geographical areas need to be identified according to affiliation (independent vs. belonging to a mother body).

6.1.3.6 Recommendation: Active participants versus passive recipients: A beneficiary-driven approach

In keeping within the rights enshrined in the OPA, international best practice regarding capacity building of older persons (Zena Simces & Associates & CS/RESORS Consulting Ltd, 2003), and best practice identified in the current evaluation, it is recommended that service centres adopt a beneficiary-driven approach. This approach views service centre members as active participants rather than passive recipients of services and supports policy in terms of the importance of increased recognition and participation of older persons in society as part of active ageing. As a first step in such an approach, is the establishment of older persons committees at all service centres to increase the participation of older persons in the planning and management of services[26] and guidelines highlighting how older persons can play a greater decision-making role at centres. The latter could be based on best practice identified in existing local organisations.

6.2 MODELS OF COMMUNITY-BASED CARE AND SUPPORT FOR OLDER PERSONS

Three broad models of service provision are discussed below. These models emerged based on the literature review, evaluation findings, particularly through the key informant interviews, and were interrogated during the panel discussion session. Current health and social services for older persons are delivered in varied locations by a myriad of service providers. The models below focus on how current services can be reengineered to reach more older people and better meet their needs, while remaining financially viable.

Although depicted as three distinct models, these models, particularly Model 2 and Model 3, are not mutually exclusive. Rather, these models are overlapping and complementary and can be seen as existing on a continuum; the placement of a

[25] This is a sensitive issue that would need to be handled carefully in terms of avoiding smaller independent organisations from a feeling of being 'colonised' by larger well-established organisations

[26] In line with the National Norms and Standards Regarding the Acceptable Levels of Services to Older Persons and Servce Standards or Community-Based Care and Support Services.

service centre on this continuum should be carefully tailored to both the context and needs of the area the centre serves. This way of understanding the below models acknowledges that there are general themes that are applicable across regions but that a 'one-size-fits-all' is wholly unsuitable. Aspects of these models may be beneficial to all service centres.

6.2.1 MODEL 1: THE DECENTRALISED MODEL

This model is based on two key factors: (1) decentralising services to combat the problem of transport and (2) beneficiary-led services. This model offers an innovative way of overcoming infrastructure issues, particularly concerning transport. It also speaks to the value of the support an overarching mother body organisation can provide while keeping agency and decision-making power in the hands of older persons.

This model is based on the current service model of Grandmothers Against Poverty and AIDS (GAPA). Services are coordinated from a central mother body organisation, which handles key administrative tasks and provides technical support and training; however, service delivery takes place in members' homes. Members form smaller subsidiary groups based on location and meet in members' homes in the community on a regular basis. Members/groups only come to the service centre to access key services such as a monthly health clinic and a monthly meeting for all members. These subsidiary groups operate independently with their own elected committee and bank account. Decisions around expenditure and day-to-day activities are made at the level of the group.

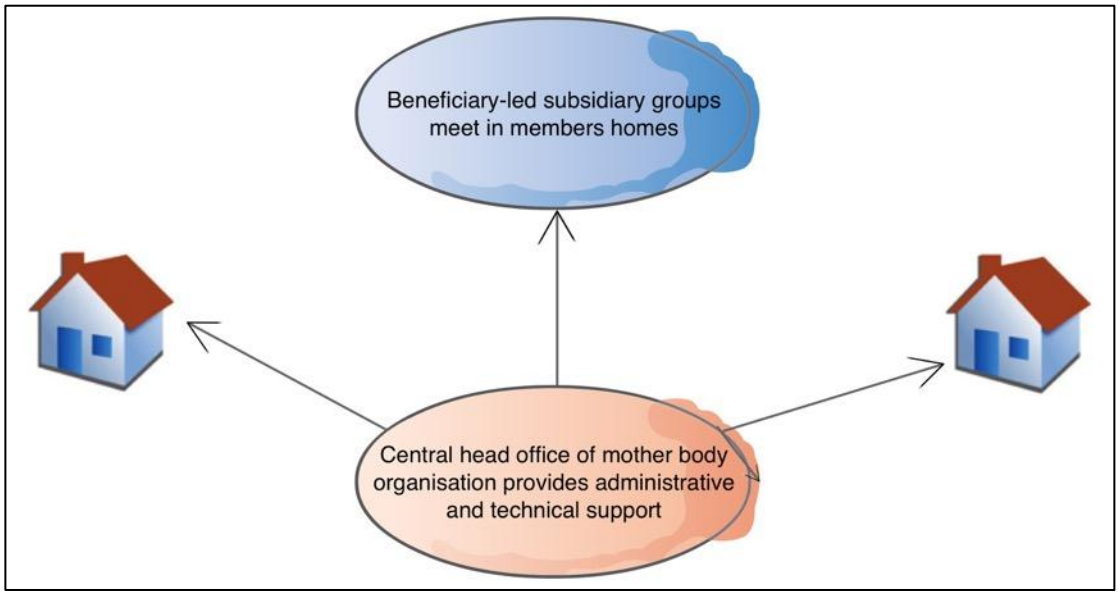

Figure 8. Diagram illustrating model 1

6.2.2 MODEL 2: BASKET OF SERVICES FOR OLDER PERSONS

This model builds on the existing service centre model but expands the services provided and focuses on interdepartmental collaboration in the provision of housing and health services to older persons. As a model, this offers older persons a 'one stop shop' where multiple services that meet multiple needs are offered in one place. This reduces older person's reliance on transport and increases their accessibility to

necessary services in a safe and secure environment[27]. This model draws heavily on the services offered by the HSFA and NOAH. It can be seen as offering 'home', 'nutrition', 'activities', and 'health' under one roof.

While providing a basket of services, this model also acknowledges that service centres cannot meet all older persons' service needs and thus the service centre becomes a single point of contact with older persons from which they are referred to additional services as required. In other words, it is a social hub that also addresses key basic needs and is a place where older persons requiring additional care and support are referred to the relevant services.

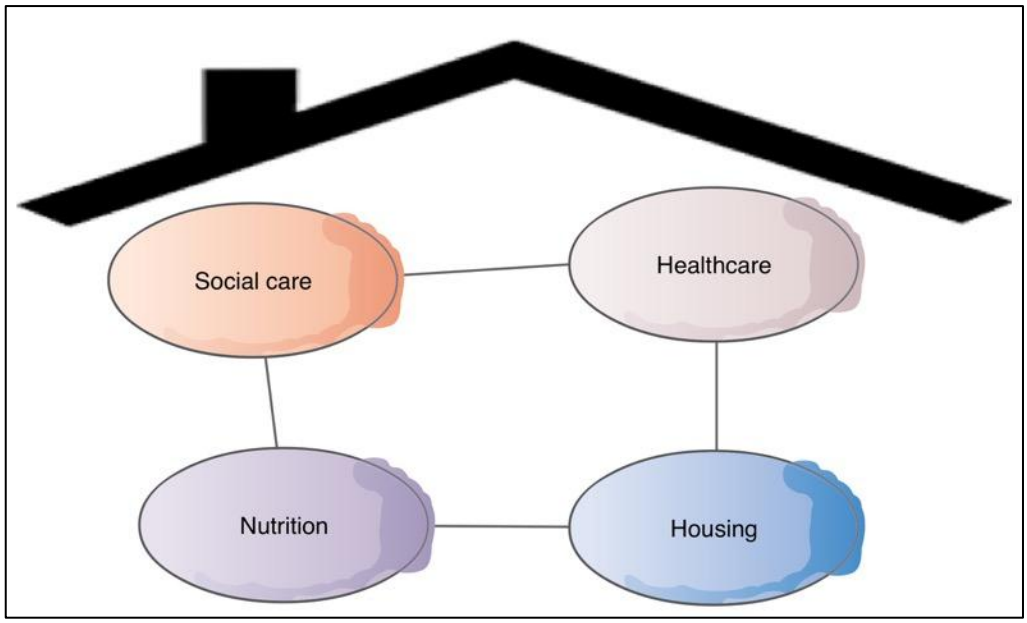

Figure 9. Diagram illustrating model 2.

6.2.2.1 Health services

A strong recommendation emerging from the discussion session and key informant interviews was for the incorporation of primary health care into a service centre model. This is congruent with international literature regarding integrated services. "Because older people's needs are interrelated, there are clear benefits to the close collaboration of social care and health care providers and the development of integrated services and policies" (Meads, Ashcroft, Barr, Scott, & Wild, 2005 as cited in HelpAge International, 2015, p.4).

In other words, in this model, health services are extended beyond the primary health care facility and can be accessed by older persons directly through the service centre. This improves the quality of care for older persons, as they do not have to wait in the long queues symptomatic of primary health care facilities. While the DoH currently provides home-based care for those that are already frail and immobile, it

[27] While a suggestion could be made for access to SASSA pension pay outs at service centres, concerns were raised during the discussion session that this might make service centres a target of crime.

was noted that health services are reactive rather than preventative. In order to meet the objectives of the OPA and the Western Cape DSD Older Person's Programme in terms of enabling active ageing, older persons need access to health services 'that come to them' before they get to the level of frailty where they require home-based care.

Services provided should include:

1) Distribution of chronic medication[28],
2) Counselling and re-education about adherence to medication,
3) Basic screening, including blood pressure and sugar testing,
4) Early identification of dementia,
5) Booked appointments with a registered nurse or medical officer linked to the CHC for a more comprehensive medical check-up, and/or
6) Referral to additional care at a primary, secondary, or tertiary facility.

Services could be provided on a rotational basis at each venue, with a mobile clinic team serving a number of centres in a health district.

The efficacy of such a service requires a responsive public health system. If older persons are referred to healthcare services for further medical care, the referral pathway needs to be appropriate and there needs to be relevant follow-up at primary, secondary, or tertiary health facilities. It is recommended that the Western Cape DSD refers to the DoH Task Team on Health who are developing packages of care for older persons, detailing the essential health services older persons can reasonably expect at primary, secondary or tertiary facilities.

Certain NGOs are already providing a primary healthcare service to older persons that takes the pressure off the public health system. For example, NOAH has employed their own general practitioner where both members and older persons residing in the community can book appointments. However, concern was raised during the panel discussion session that such services are not universally applicable and many NGOs would not be able to afford to put such a service in place.

6.2.2.2 Safe and Affordable Housing

The services discussed above are vital; however, these do not meet the needs of those older persons who are homeless or living in very compromised conditions. For such older persons, these services cannot compensate for a lack of safe and affordable housing. A fundamental foundation in keeping older persons active and living independently in their community as long as possible is access to safe and affordable housing. In addition, this is congruent with those basic human rights guaranteed in the Constitution of the Republic of South Africa.

In this model, a service centre is directly linked to low-cost housing for older persons. Such a model offers older persons an independent-living facility, meal(s), home-based care, and other services seen in the more traditional service centre setting, such as exercise, games, and spiritual services. However, the services provided by this model can be accessible not only to those older persons living within the facility but also to older persons living in the broader community. As older persons require

[28] It is recommended that the Department refers to the DoH Chronic Distribution Unit.

greater care, they can draw more heavily on the services offered, particularly the home-based care.

A number of NGOs (e.g., Abbeyfield, NOAH, and HSFA) have realised economies of scale with regards to the need for safe and affordable housing for older persons in a non-institutional setting through communal housing. Communal housing offers people an opportunity to live on a limited income (i.e., the old age grant) while still be able to access a matrix of services including meals, activities, and healthcare.

6.2.3 MODEL 3: THE COMMUNITY HUB

The third broad model sees the service centre as a multipurpose community hub providing services to not only older persons but also the broader community, particularly other vulnerable groups. Those services offered to older persons, including meals, social services and healthcare, are extended to the broader community, which facilitates integration and inter-generational activities. Services can include community feeding programmes and programmes for children.

This model draws heavily on a new pilot development by Abbeyfield as well as a number of the service centres sampled. This integrated development brings together housing for older persons, ECD/aftercare for children, and a community-feeding scheme, which services older persons and other vulnerable community members. A joint executive committee represents these three branches as well as community members and local government. The aftercare facility may have a dual purpose as a service centre for older persons.

A key concern is that when facilities that are made available to the broader community, there is a risk that older persons will be marginalized and their needs side-lined in favour of other groups. It is therefore important to ensure that the service remains first and foremost older-persons focused. This may require that services for older-persons be first well established before additional services to the broader community are added to the model. In addition or alternatively, the venues can be utilised for different services at different times. Typically, service centres for older persons run activities till just after lunchtime in the early afternoon, after which the venues are left unused. For example, the venue can act as a service centre for older persons during the morning while it is utilised by children in the afternoon after school, through the provision of after-care and other recreational services.

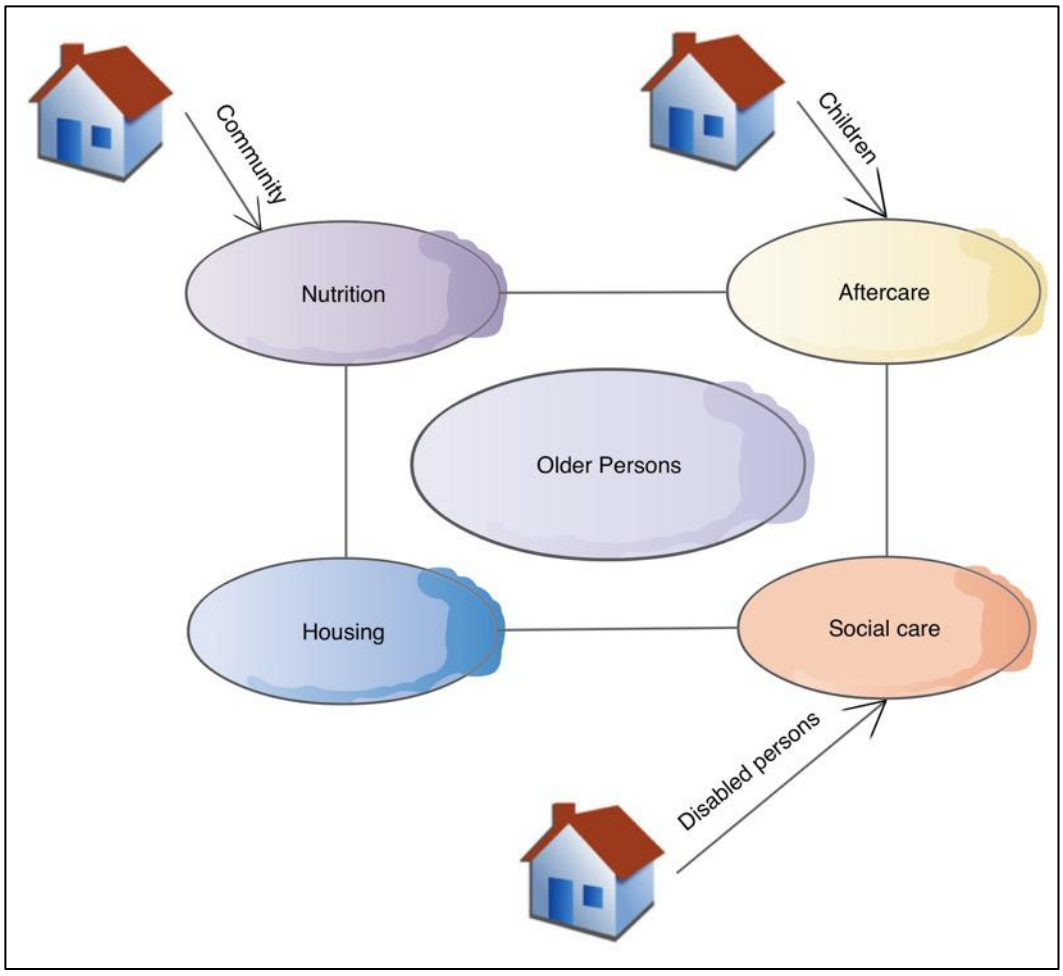

Figure 10. Diagram illustrating model 3.

6.3 RECOMMENDATIONS FOR FURTHER RESEARCH

6.3.1 NEEDS ASSESSMENT AND POLICY FRAMEWORK

Firstly, the allocation of scarce resources needs to be based on a thorough needs assessment. In order to assess how needs differ between regions, it is important that the needs of male and female, young-old and old-old, poor and middle-class older persons in urban, peri-urban and rural areas are well understood through a representative snapshot of the province. The identified needs can then be compared against available services to see where and how the service footprint needs to be expanded. For example, in historically underserved areas where there are few or no residential facilities, the building of independent and assisted living (e.g., community-based communal housing facilities) or frail care might need to take priority over the expansion of service centres, within the confines that needs are prioritised within available resources (WC DSD, 2014a). In addition, the needs assessment will access those older persons who are not attending service centres and were thus not included in the current sample, to find out what their service needs are and the barriers that have prevented them from utilising the services already available. The needs assessment can include measures of (a) mobility (to inform transport services), (b) income and dependence on the old age grant, (c) activities of daily living, and

(d) instrumental activities of daily living. This needs assessment could also explore the organisational developmental needs of service centres and staff.

The findings of the current evaluation and the needs assessment may form the basis for the development of a policy framework or guidelines governing service implementation in areas according to context and level of need.

6.3.2 FINANCIAL FEASIBILITY

Secondly, the financial feasibility and sustainability of the above-described models needs to be carefully researched and interrogated by the Western Cape DSD and other key stakeholders.

6.3.3 ONGOING DATA COLLECTION

Thirdly, there appears to be a significant lack of data regarding the effectiveness and impact of the services offered by service centres and other community-based care providers. This mirrors international research gaps and limits the ability to comment on service impact and relevance (Pardasani & Thompson, 2010). While centres funded by the WC DSD keep track and submit records of attendance figures and adherence to financial and governance record keeping, the only data on impact of participation is anecdotal. The collection of such data requires the use of longitudinal research and ultimately the development of standardised, easily implemented processes.

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APPENDICES

APPENDIX A: MAP OF SERVICE CENTRES IN THE WESTERN CAPE

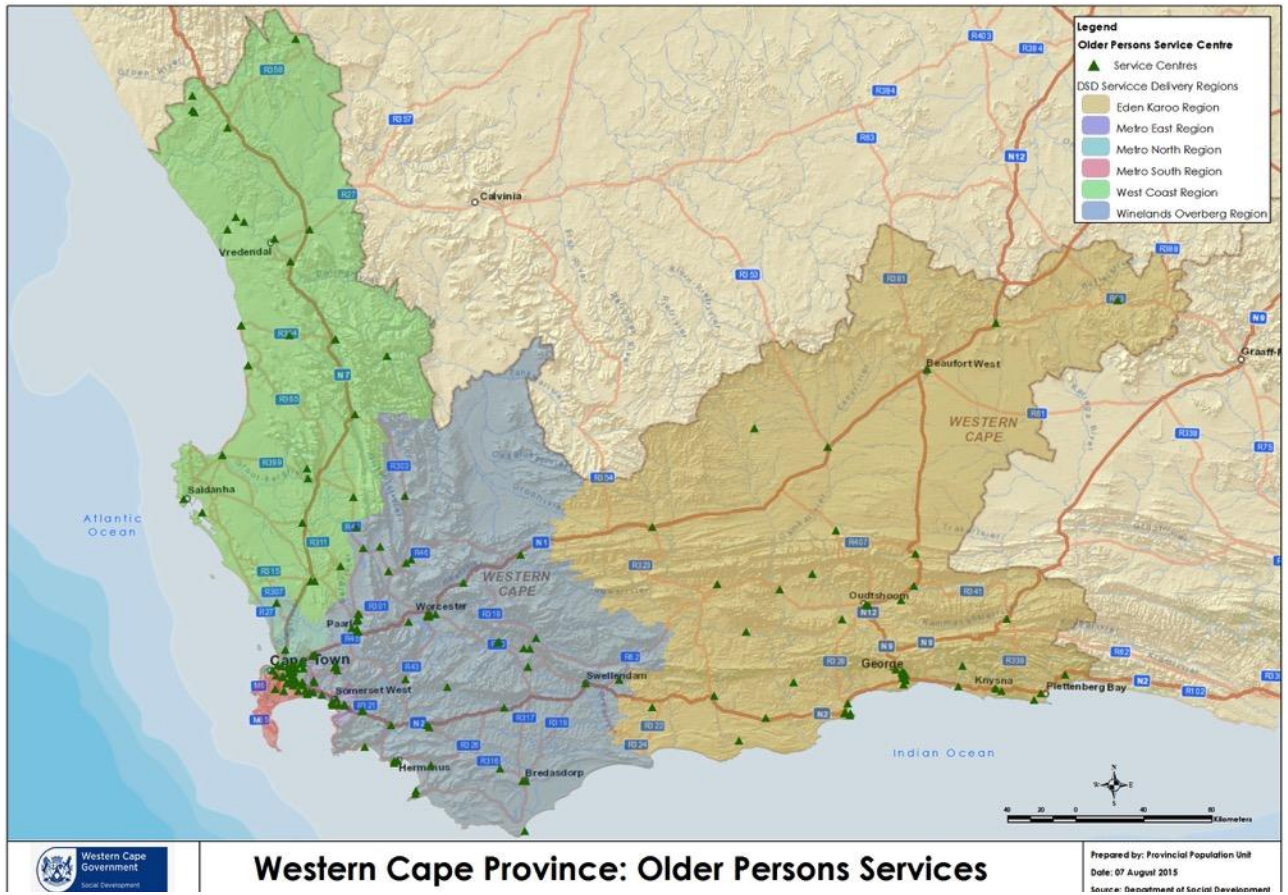

Figure 11. Map of service centres in the Western Cape
Source: Maps Developed by WC DSD 2015

CONSENT FORM TO PARTICIPATE IN EVALUATION

Evaluation of Service Centres for Older Persons in the Western Cape

1. Why is this research being done?

An evaluation is a way to learn more about something. You are being asked to participate in an evaluation of service centres for older persons in the Western Cape. The Department of Social Development of the Western Cape Government has asked a team of researchers from a company called Creative Consulting and Development Works (CC&DW) to conduct this evaluation. You have been selected as a participant because you have knowledge and information about the service centres, and your experience and opinions may provide valuable information.

The main purpose of this evaluation is to learn more about the need for services amongst older persons in the Western Cape and the services that are offered by service centres in order to assist the Department of Social Development to provide sustainable community based care and support services to older persons in the Western Cape.

2. What will happen to you if you agree to take part?

If you volunteer to participate in this evaluation, we will ask you to write and sign your name at the bottom of this form. The researcher will then ask you a series of questions about your knowledge, opinions, and experiences of the service centres. The researcher will ask your permission to record the interview with you on a voice recorder. The interview will last between 30 and 60 minutes. Please tell the interviewer if you are concerned about the time or if you need to leave at any point during the interview.

3. Do you have to take part in this research?

You can choose whether to participate in this evaluation or not. If you volunteer to be in this evaluation, you may ask the researcher to stop at any time. You may also refuse to answer any questions you do not want to answer. If you choose to not participate in this evaluation or you do not want to answer any of the questions, nothing will happen to you. Your participation in the centre or any other activity will not be affected.

4. Are there any risks in taking part?

There are no immediate risks in taking part in this evaluation. However, if at any time you feel uncomfortable or do not want to answer a question, please tell the researcher. You are free to decide that you do not want to answer any questions.

If you feel that you need further help about any issue spoken about during the interview please contact your local DSD office or the Action on Elder Abuse SA toll-free hotline to report abuse, neglect or maltreatment:

- Action on Elder Abuse SA toll-free number: 0800 003 081
- Department of Social Development Metro South Regional Office: (021) 763 6200

- Department of Social Development Cape Winelands Overberg Regional Office: (023) 348 5300

5. Do you have to pay to take part?

No, you don't have to pay anything to take part. You will also not receive any payment for participating in this evaluation.

6. What will happen to the information you give us?

Any information that is obtained from this interview is confidential. This means that all the information you give us will not be identified with you and your name will never be used or linked to your responses. It will be disclosed only with your permission or as required by law. The collected data will be made available only to the researchers.

If you agree to having the interview recorded, the researcher will be record it by means of a voice recorder. The recorded interview will only be available to the researchers to refer to after the interview so that they can ensure they understand and write-down your answers correctly.

7. What if you have any questions?

If you have any questions or concerns about the evaluation, please feel free to contact Susannah Clark from Creative Consulting and Development Works telephonically on (021) 448 2058 or via email: Susannah@developmentworks.co.za or Victoria Tully from the Western Cape Department of Social Development on (021) 483 0562 or via email: Victoria.Tully@westerncape.gov.za.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____

Name of Participant

_____ _____

Signature of Participant Date

An Evaluation of Service Centres for Older Persons in the Western Cape: Interview with Service Centre Manager								
Interviewer: "My name is …… I am part of a research team from a company called Creative Consulting and Development Works. We are conducting an evaluation of service centres for older persons in the Western Cape for the Western Cape Department of Social Development. As you are aware, *[name of service centre]* was chosen to be included in this evaluation. \ This interview will take a maximum of 1hour." **Note to interviewer:** Review the informed consent form with the participant, ask the participant to sign the form and return it to you before the interview begins.								
For interviewer to complete before beginning section 1								
Interviewer name								
Date	D	D	M	M	Y	Y	Y	Y
Name of service centre								
Name of mother body/organisation (if applicable)								
Gender of participant	F				M			
Role at service centre [**Note to interviewer:** If not manager / director / similar please suspend interview]								

SECTION 1: BACKGROUND AND CONTEXT **Interviewer:** "I would like to start by asking you a few background questions about how you came to be the manager at this centre".
1.1. How long have you been the manager at the service centre?
1.2. Can you tell me briefly about your background and how you came to be the manager of this service centre?
1.3. What do you understand as the role of the service centre in the lives of older persons?

SECTION 2: NATURE AND USE OF SERVICES **Interviewer:** "I would like to talk more about the types of services this centre offers."		
2.1. Which of the following services do you offer?	Nutritionally balanced meals	1
	Information awareness campaigns	2
	Educational and skills development programmes	3
	Recreational opportunities	4
	Accessibility to professional services, counselling services, including care and rehabilitation	5
	Coordinating spiritual, cultural, health, civic and social services	6
	Other, specify	7
2.2. Please can you tell me more about each of these services? What do these activities involve and how often do they take place?		
2.3. How many members on average come to these different activities?		
2.4. Do you provide home-based care?	Yes	1
	No	2
2.5. If yes, please explain the home-based services you provide.		
2.6. Do you have on site visits by a clinic sister/nurse/doctor?	Yes	1

	No	2
2.7. If yes, please explain.		
2.8. Do you provide transport to members?	Yes	1
	No	2
2.9. If yes, please explain.		
2.10. Is this service centre linked to a residential, independent or assisted-living facility?	Yes	1
	No	2
2.11. If yes, please describe the nature of this relationship / link.		
2.12. Do you keep a list of members registered with this service centre?	Yes	1
	No	2
2.13. How do you keep record of this? *[Prompt: Do you use and update a register or keep copies of members IDs?]*		
2.14. Have you seen a change or pattern in terms of the number of members using the service centre in the past 12 months?	Yes	1
	No	2
2.15. Please describe what changes or patterns you have witnessed in terms of the number of older persons using the service centre?		
2.16. What do you think has contributed to this change?		
2.17. Other than these routine services, is this service centre involved in any additional activities or special events for older persons in the community?	Yes	1
	No	2
2.18. If yes, please give some examples from the past 12 months.		
3.9. Do you work with other NGOs, organisations, clubs or other service providers?	Yes	1
	No	2
3.10. If yes, please describe the organisations and relationship. If no, why not?		
SECTION 3: NEED AND GAPS IN SERVICE DELIVERY **Interviewer:** "Now I would like to ask you some questions about the need for services amongst older persons in the community."		
3.1. What is the name of the community/s this service centre serves?		
3.2. What do you see as the main issues/difficulties/challenges facing older persons in this community? *[Prompt: What is life like for older people in this community?]*		
3.3. Do you think that this service centre is able to meet the need/s in terms of the number of older persons requiring services in this community?	Yes	1
	No	2
3.4. Please explain what affects your ability to meet or not meet the need in the community?		
3.5. Considering the services currently provided at the service centre, are there any additional services that you believe older persons in this community need that you are currently not able to provide?	Yes	1
	No	2
3.6. Please describe these services and why you feel they are important. If no, why?		

3.7. Do you know of other older people in the community who do not come to the service centre?	Yes	1
	No	2

3.8. Why do you think some older people in the community do not come to the service centre?

3.11. What other services are available in this community that may be relevant to older persons? [Prompt: *Please speak about clinics, ECD/child care, other NGOs etc*]

SECTION 4: EFFECTIVENESS, RELEVANCE, ACCESSIBILITY AND APPROPRIATENESS OF SERVICES

Interviewer: "Part of this evaluation is to find out whether services are relevant and accessible to older persons, and what some of the challenges and successes are in this regard."

4.1. Please briefly explain the process by which older persons become members of this service centre? [*Prompt: How do older persons hear about this centre? Are there admission or exclusion criteria or a referral process?]*

4.2. How did the service centre decide what services to offer and how to deliver them?

4.3. Are your activities guided by any policies, legislation or guidelines?	Yes	1
	No	2

4.4. If yes, please list and explain how your activities are guided by these documents?

4.5. What changes do you expect to see in the lives of older persons that use this service centre? *[Prompt: What effect does the service centre have on the lives of older persons who come here?]*

4.6. What challenges, if any, do you experience in the delivery of these services? *[Prompt: Please provide some examples.]*

4.7. What would you point to as the key successes this service centre has had in the delivery of services to older persons? *[Prompt: Are there any things that you feel work particularly well at this service centre?]*

4.8. Do you have a referral process for older persons requiring further support or care, whether this is medical, psychological or social (such as needing assisted living facilities)?	Yes	1
	No	2

If so, please describe this process/es.

SECTION 5: GOVERNANCE, MANAGEMENT AND STAFFING

Interviewer: "This evaluation is also interested in finding out how the different service centres in the Western Cape operate in terms of management, staff and funding."

5.1. Please describe the management structure at this service centre? *[Prompt: Is there a mother/umbrella organisation? Is there a governing body/board of directors/trustees/steering committee?*	Mother/umbrella organisation	Yes	1
		No	2
	Governing body/board of directors	Yes	1
		No	2

5.2. What is the size, composition and responsibilities of this structure(s)?

5.3. How many staff work or volunteer at this service centre? *[Prompt: How many staff or volunteers work here in total, not just those on duty today?]*

5.4. How many of those are part-time, full-time or volunteers?	Part-time	
	Full-time	
	Volunteers	

5.5. How many of those, if any, are members / beneficiaries themselves?

5.6. **What are their roles at the service centre?** [*Prompt: What are the roles of part-time/full-time/volunteers/members who are staff?]*		
5.7. **Are there any requirements /criteria for volunteers or staff to be able to work here?**	Yes	1
	No	2
5.8. **If yes, what are they? If no, why not?**		
5.9. **Do staff or volunteers undergo any training?**	Yes	1
	No	2
5.10. **If yes, what does this involve and how often does it take place?**		
5.11. **Is there a need for training?**	Yes	1
	No	2
5.12. **What type/s of training would be helpful?**		
5.13. **What role do older persons play at this service centre?** *[Prompt: Are older persons involved in the decision-making process and delivery of services?]*		
SECTION 6: FUNDING AND FINANCIAL MANAGEMENT		
6.1. Does the service centre charge members a fee?	Yes	1
	No	2
6.2. If yes, under what circumstances are fees charged and what is the amount charged? If no, why not?		
6.3. If yes, what is this fee used for?		
6.4. Is this service registered with the Department of Social Development?	Yes	1
	No	2
6.5. Does this service centre receive any funding from the Western Cape Department of Social Development?	Yes	1
	No	2
6.6. Do you have an idea of the proportion of your annual operational costs that are covered by this funding and what proportion you raise yourselves?	Yes	1
	No	2
6.7. If yes, are you able to approximate what percentage of your annual operational costs and/or income are covered by this funding from the Western Cape Department of Social Development?		
6.8. How (else) do you raise funds or mobilise resources to fund the provision of services at this service centre? Can you please provide some examples from the past 12 months? *[Prompt: Do you rely on a few major grants/funders, government, members fees or fundraising activities/events?]*		
6.9. What are some of the successes and challenges you have had in regard to funding the activities of the service centre? *[Probe: Please provide an example.]*		
6.10. How are decisions around funding and expenditure made and recorded?		
6.11. How often does it come in and where does it go? *[Prompt: What are the biggest cost drivers/expenditures of the centre?*		
6.12. Are you able to give an idea / estimate the proportion of funding spent on each of the services offered by this service centre? [Prompt: *Which are most costly and which are less costly to provide?*]		
SECTION 7: CLOSING QUESTIONS **Interviewer:** "The purpose of community based care is to support older persons to remain living in their communities for as long as possible. There are a number of models of care, of which service centres are one, including day care centres, seniors clubs and independent and assisted living."		
7.1. **What do you see as the value service centres add to community based care for older persons?**		

7.2. **What could be done to improve service centres in terms of supporting older persons to remain living in their communities for as long as possible?**
7.3. **To close this interview, I would like to know if you have any last comments or suggestions regarding community based care for older persons which you feel are important but have not been covered in this interview?**

An Evaluation of Service Centres for Older Persons in the Western Cape
Focus Group with Service Centre Staff/Volunteers

SECTION 1: INTRODUCTION

Facilitator: "My name is ..... and this is my colleague ..... We are part of a research team from a company called Creative Consulting and Development Works. We are conducting an evaluation of service centres for older persons in the Western Cape for the Western Cape Department of Social Development. *[Name of service centre]* was chosen to be included in this evaluation.

Thank you for making the time to speak to us today. As staff/volunteers at *[name of service centre],* your input will be very helpful. I am going to be guiding the discussion by asking you a series of questions about *[name of service centre],* what you think works well and what you think does not work well. My colleague will be listening and taking notes. We will be having discussions like this at a number of different service centres in the Western Cape.

There are no right or wrong answers and some points of view may differ. You don't need to agree with each other but I will ask that one person speaks at a time and we listen and respect others points of view. This discussion will take a maximum of 1hour.

[Interviewer to review the informed consent form with the participants, ask the participants to sign the form and return it to the facilitators before the focus group discussion begins.]

Before we start this discussion I would like to do a round of introductions. Please can each person introduce themselves by giving their name, where they are from, their role at *[name of service centre],* and how long they have worked here."

For assistant facilitator to complete during introduction								
Facilitator name								
Assistant facilitator name								
Date	D	D	M	M	Y	Y	Y	Y
Name of service centre								
Participant 1								
Name								
Gender of respondent	F				M			
Role at service centre & date started								
Participant 2								
Name								
Gender of respondent	F				M			
Role at service centre & date started								
Participant 3								
Name								
Gender of respondent	F				M			
Role at service centre & date started								
Participant 4								
Name								
Gender of respondent	F				M			
Role at service centre & date started								
Participant 5								
Name								
Gender of respondent	F				M			
Role at service centre & date started								

SECTION 2: FOCUS GROUP DISCUSSION QUESTIONS

TOPIC 1: NATURE AND USE OF SERVICES

1. I would like to start by discussing what services this centre offers. Please can you describe what services for older persons are offered here? *[Prompt: What do those activities involve? Please give some examples.]*
2. Who comes to these different services? *[Prompt: How would you describe the people who come here? How many members come on average to those different services/activities?]*
3. Which are the most popular services? Which are the least popular services?
TOPIC 2: IMPACT OF SERVICES
4. What do you understand as the role of the service centre in the lives of older persons?
5. In what ways do you think the service centre is helpful to older persons? *[Prompt: What changes do you see in the lives of older persons who come to the service centre? Please give some examples.]*
6. In what ways do you think the service centre could be doing more to help older persons? *[Prompt: In what ways do you feel the services fall short in helping older persons? Please give some examples.]*
7. Do you know of older people in the community who do not come to the service centre? Why do you think they do not come? *[Prompt: What are some of the things that prevent older persons from coming to the service centre or make them not want to come? Please give some examples.]*
8. What about older persons who used to come to the service centre but do not come anymore – why do you think some older persons have stopped coming?
TOPIC 3: MANAGEMENT
9. Now I would like you to think about the running of this service centre. If you could change anything about how the service centre is run, what would you change?
10. What role do older people play at this service centre? *[Prompt: What is the involvement of older persons themselves in the running/decision-making of this service centre? Please give some examples.]*
11. While you have been at this service centre, have you received any training? If yes, what training have you had and who provided it? Have you had any other training that has helped you to perform this job? Is there any training you feel you need / would be helpful to you?
TOPIC 4: NEED AND RELEVANCE
12. What do you feel are the key issues/challenges/difficulties facing older persons in this community? [*Prompt: What is it like to be an older persons living in this area/community? Please provide some examples]*
13. What do you think are the most important services older persons in this community need? [*Prompt: Please think about medical/health services, physical activities, social, food/meals, and anything else you feel they need]*
14. If you could make any suggestions for how the service centre can be improved to better help older persons in the community, what would you suggest? *[Prompt: Is there anything else you wish this service centre could do for older persons in the community? Keep in mind that the role of service centres is improve the quality of life and help older persons living in the community]*
SECTION 3: ENDING QUESTIONS
15. *[Facilitator reviews the purpose of the study and provides a brief summary of what has been discussed during the focus group.]* Is this an adequate summary of what we have discussed today?
16. Is there anything else we haven't discussed today that you think is important for someone to know about the needs of older persons in this community or about designing services to improve functionality and quality of life and help older persons 'age-in-place', living in your familiar community for as long as possible?
Facilitator: "Thank you very much for taking the time to talk to us today and for sharing your views and experiences."

An Evaluation of Service Centres for Older Persons in the Western Cape: Interview with Beneficiary		
Interviewer: "My name is ..... I am part of a research team from a company called Creative Consulting and Development Works. We are conducting an evaluation of service centres for older persons in the Western Cape for the Western Cape Department of Social Development. *[Name of service centre]* was chosen to be included in this evaluation. As a member of this service centre, I am interested in talking to you about your experiences here. Thank you for making the time to speak to me today, your input will be very helpful. The content of this interview will be used to assess the services [*name of service centre*] but your views will remain anonymous. This interview will take a maximum of 1 hour." **Note to interviewer:** Review the informed consent form individually and ask participant to sign the form and return it to the facilitators before the interview begins		
For interviewer to complete before beginning with section 1		
Interviewer name		
Respondent name		
Date	D D M M Y Y Y Y	
Name of service centre		
Gender of respondent	F	M
DOB [**Note to interviewer:** This can be obtained from a copy of the participant's ID if available in cases where the participant is unsure of their age.]	D D M M Y Y Y Y	
Population group	Black	1
	Coloured	2
	Indian/Asian	3
	White	4
	Other, specify	5
SECTION 1: PERSONAL PROFILE **Interviewer:** "I would like to start by asking you a few questions about yourself."		
1.1. What is your age?	< 60 years	1
	60 – 64 years	2
	65 – 69 years	3
	70 – 74 years	4
	75 – 79 years	5
	80 – 84 years	6
	85+ years	7
1.2. What is the highest level of education you have completed?	None, cannot read and/or write	1
	None, but can read and write	2
	Some primary school completed	3
	Primary school / grade 7 completed	4
	Some secondary school	5
	Secondary school / grade 12 completed	6
	Some tertiary education	8
	Tertiary education completed	9
1.3. What is your marital status?	Married	1
	Widowed	2
	Divorced / separated	3
	Never married	4
	Cohabiting	5
	Other, specify	6
1.4. What type of home do you live in?	House, flat or apartment (own)	1

	House, flat or apartment (rent)	2
	Independent living / residential facility	3
	Assisted living facility / frail care	4
	Informal housing or backyard dwelling	5
	Other, specify	6
1.5. Who do you live with? *Select all that apply to beneficiary.*	Live alone	1
	With spouse or partner	2
	With child(ren)	3
	With grandchild(ren)	4
	Other family member(s)	5
	Other, specify	6
1.6. **What is your source of income? [Note to interviewer:** This question can be asked by saying, *If you don't mind me asking, what is your source of income? Do you get a pension? Do you have any other source of income?] Select ALL that apply to beneficiary.*	Private pension	1
	Old age grant (state old age pension)	2
	Disability grant	3
	Child support grant	4
	Salary	5
	Savings	6
	Support from spouse/children/other family members	7
	Other, specify	8

1.7. How easily are you able to get around these days inside your home and outside in the community?		Inside the home	Outside the home
	Get around freely and independently	1	1
	Get around but with difficulty	2	2
	Can get around but only with a cane	3	3
	Can get around but only with a walking frame	4	4
	Cannot get around without the help of another person(s)	5	5

1.8. Now I want to ask you about health conditions you may have. Have you ever been told by a doctor/nurse/traditional healer or other health professional that you have a health condition? *[Prompt: If the person does not say anything, mention the conditions listed below and ask them if they have been told they have any of them?]*

	No	Yes
High blood pressure (hypertension)		
Stroke		
Parkinson's disease		
Diabetes		
Loss of memory		
Depression		
Arthritis		
Other, specify		

SECTION 2: NATURE AND USE OF SERVICES

Interviewer: "Now I would like to ask you some questions about what you do at *[name of service centre]* and your experiences here."

2.1. Can you tell me about when you first start coming to this service centre. Why did you decide to start coming here?

2.2. What services does this service centre offer to older persons in the community?

2.3. Which of those activities do you come to? Can you tell me a bit more about what those involve? *[Prompt: Please give me some examples of what you do when you come here?]*

2.4. How often do you come to each of these services and why?

2.5. How else are you involved at the centre? *[Prompt: Are you or other members involved in making decisions, running activities or otherwise volunteering/working at the centre?]*		
2.6. Do you have to pay to use the services at this service centre?	Yes	1
	No	2
2.7. If yes, how much do you pay? [Prompt: *Do you pay for each service or a monthly fee or are any services free?*] **If no, would you be happy to pay something towards the services / in order to use the services?**		
2.8. If yes, how do you feel about this amount? [Prompt: *Is it too much, too little or are you satisfied with the amount that you pay? Why?*]		
2.9. You have spoken about what you do at this service centre. Are you involved in any other activities in the community? [*Prompt: What else do you do when you are not at this service centre or at home? Are you involved in any support group, club, library or church group?]*		
SECTION 3: EXPERIENCE OF SERVICES		
3.1. Are you happy or satisfied with the services offered by this service centre?	Yes	1
	No	2
3.2. If no, why are you not happy?		
3.3. Have the services helped you in your life? *[Prompt: Have you seen any changes in your life since you started coming to the service centre? Can you give me some examples of changes you have seen?]*		
3.4. I understand that the service centre provides a number of services or activities. Which services do you think are the most helpful? [**Note to interviewer:** Here, you can list or mention the services the beneficiary has told you they come to]		
3.5. Are there any services that you feel are not important or helpful?		
3.6. Are there any time when you want to come to the service centre but cannot?	Yes	1
	No	2
3.7. If yes, what stops you from being able to come even though you would like to? Do you have any difficulties in coming to this service centre?		
SECTION 4: NEED AND GAPS IN SERVICE DELIVERY		
4.1. I would like to talk about what it is like to be an older person in this community. What are some of the issues or difficulties or challenges older people in this community are facing?		
4.3. What about other older people in the community who perhaps would like to come to the service centre but do not come – do you know any of these people?	Yes	1
	No	2
4.5. Why do you think some older people in the community do not come to the service centre?		
4.2. Do you know of older people who used to come to this service centre but do not come anymore?	Yes	1
	No	2
5.3. If yes, do you know why they stopped coming to the service centre?		
4.6. Besides this service centre, where else do you go to receive help, support or other services?		
***4.7.* What types of services or help or support do you need?** [Prompt*: What would be of help to you? Are there any services that you need that you are not able to get at this service centre? Is there anything you wish this service centre could do that it doesn't do currently?] [**Note to interviewer:** You can mention specific issues e.g. medical issues, talking to someone about any problems you may be having in your life; help with shopping or cleaning or cooking; exercise; or any other types of support or services]		
4.8. If you could make any suggestions for what can be done to make more older people in the community come here/use this service centre, what would you suggest? *[Prompt: This could be the types of services, how the services are provided, the types of people working here, how access to the centre be can be improved?]*		

4.9. If you could make any other suggestions for how the older people living in the community can be helped, what would you suggest?

Thank you very much for taking the time to talk to us today and for sharing your views and experiences

An Evaluation of Service Centres for Older Persons in the Western Cape: Site Description									
Fieldworker name									
Date	D	D	M	M	Y	Y	Y	Y	
Name of service centre									
Source of information									
External									
Description of community setting including additional facilities nearby. *Make a note of clinic(s), ECD (creche, daycare etc)facilities and other NGOs nearby.*									
What is your impression of the facility - is it in a good state of repair or is it in a state of neglect/in need of repair? *Describe / write down specific examples.*									
What are the safety/security features of the facility? *Describe / write down specific examples.*									
Structural facility within which service provided?	Residential facility								1
	Church								2
	Community hall								3
	NPO/NGO								4
	Other, specify								5
Is the service centre near transport links? *Describe / write down specific examples.*									
Does the service centre have a designated transport vehicle? *Describe.*									
Is there a ramp / wheelchair access to the facility?	Yes				No				
Internal									
Is there a kitchen / space for meal-preparation? *Describe.*	Yes				No				
Is there adequate space for management to run the service/activities? *Describe.*	Yes				No				
Is there a bathroom / toilet?	Yes				No				
Does the toilet have wheelchair access?	Yes				No				
Does the toilet have grab bars?	Yes				No				
Comfort	Is the facility cool in summer?								1
	Is there heating in winter?								2
	Is the facility sheltered from the rain?								3
Is there a place/room for beneficiaries to rest if tired / unwell?	Yes				No				

An Evaluation of Service Centres for Older Persons in the Western Cape: Interview with Key Informants
Interviewer: "My name is …… I am part of a research team from a company called Creative Consulting and Development Works. We are conducting an evaluation of service centres for older persons in the Western Cape for the Western Cape Department of Social Development. Thank you for making the time to speak to me today, your input will be very helpful. I am going to ask you a series of questions about community-based care and support and the role of service centres in the Western Cape. This information will help to inform the development of a sustainable model for service centres in the Western Cape that addresses the needs of older persons in the province. This interview will take a maximum of 1hour." **Note to interviewer:** Review the informed consent form with the participant, ask the participant to sign the form and return it to you before the interview begins.

For interviewer to complete before beginning with section 1								
Interviewer name								
Date	D	D	M	M	Y	Y	Y	Y
Name of participant								
Gender of participant	F				M			
Description of stakeholder / organisation / affiliation								
Role in the organisation								

SECTION 1: NATURE AND USE OF SERVICES

Interviewer: "I would like to start by discussing the role of service centres in the Western Cape and any trends or changes in the use of these services."

1.1. What do you understand as the role of service centres in the lives of older persons?

1.2. Does this differ from the role service centres are actually playing? What role do you think service centres are currently playing?

1.3. The number of service centres in the Province has declined. In your opinion, what are the reasons for the decline in the number of service centres operating in the province / region?

1.4. What trends or changes have you seen in terms of the number of beneficiaries using these services?

1.5. What factors do you think may have accounted for these changes?

SECTION 2: NEED, GAPS AND SUGGESTIONS FOR IMPROVEMENT

Interviewer: "I would also like to get an understanding of the needs of older persons in the Province, and whether service centres are meeting this need."

2.1. What do you see as the most important concerns and issues facing older persons in the Western Cape?

2.2. What do you see as the most pressing service needs of older persons in the Western Cape? [Prompt: *Please think about service needs specifically in relation to community based care and assisted living?*]

2.3. Do you think that service centres in the province / communities that you serve are able to meet the need in terms of the number of older persons requiring services in this community?	Yes	1
	No	2

2.4. Please explain what affects their ability to meet or not meet this need?

2.5. Based on your knowledge of the services currently provided at service centres, are there any additional services that you believe older persons in the province / communities that you serve need that service centres are currently not able to provide?	Yes	1
	No	2
2.6. Please describe these services and why they are important. If no, why?		
2.7. In line with the Older Persons Act No.13 of 2006, the focus of the Western Cape Department of Social Development Older Persons Programme is to keep older persons living in their homes and communities for as long as possible through the provision of community-based support services, such as day care centres, seniors clubs, independent and assisted living and service centres. In this regard, which services provided by service centres do you think are the most helpful? [Prompt: *Please provide examples.*]		
2.8. Which services do you think are least helpful? [Prompt: *Where do service centres fall short?]*		
2.9. What do you think can be done to improve the ability of service centres to enable older persons to continue living independently for as long as possible? [Prompt: *Please provide examples*.]		
2.10. What do you think can be done to improve service delivery by service centres? [Prompt: *Please provide examples*.]		
SECTION 3: BEST PRACTISE AND MODELS OF COMMUNITY-BASED CARE AND SUPPORT **Interviewer:** "I am interested in finding out more about what you think are examples of best practise in terms of community-based care and support for older persons."		
3.1. Please tell me briefly about your organisation [DSD regional office] and the nature of your involvement with service centres in the Province?		
3.2. What communities / districts / regions do you serve?		
3.3. How many service centres does your organisation run / manage / serve? [How many service centres are there in the region?]		
3.4. In your opinion, what are the most significant challenges facing service centres in the province?		
3.5. Can you provide any examples of how your or other organisations have responded to these challenges? [Prompt: What worked and what did not work? Please provide examples.]		
3.6. What would you point to as the key successes this organisation has had in the delivery of community-based care and support services to older persons? [Prompt: What works well? Please provide examples.]		
3.7. Are you aware of other organisations who you feel are really providing excellent community-based care and support to older persons? If yes, please describe. [Prompt: Please provide examples. These can be local, national or international examples.]		
3.8. In closing, do you have any other suggestions regarding how service centres and the provision of community-based care and support to older persons in the Western Cape can be improved? [Prompt: *Please speak specifically with regards to the relationship between service centres and other models of care, such as independent and assisted living.*]		

Table 29. Site descriptions of service centres sampled

Centre	Description
1	**Centre 1** is a large multipurpose centre located next to residential flats but not far from a nearby stadium and busy road, with a hub of retailers and food outlets nearby.
2	**Centre 2** is run from a converted house in a residential neighbourhood, with office space upstairs and recreational space downstairs. While situated amongst other houses, the centre is not far from the main hub of the area, with shops, transport, and food outlets.
3	**Centre 3** is a large multipurpose community centre run by an NPO. The building is situated slightly away from a busy road, sandwiched between blocks of residential flats in an area that is frequently the scene of gang violence.
4	**Centre 4** is a large community venue with a large kitchen, office space, and small hall attached. While surrounded by a fence and burglar bars, the building is not secure and has been vandalised by the community, stripped of all fittings and fixtures. The lights do not work as the switches and fittings have been stolen. There is a fireplace but the centres cannot always afford to buy wood. The building is in dire need of repair and reappointment.
5	**Centre 5** does not have a permanent venue and activities are currently run from the house of the Chairperson in a residential peri-urban township setting. The bathroom and kitchen facilities are therefore not suitable for a large number of people and the there is not enough space or seating.
6	**Centre 6** lies on expansive grounds in a peri-urban township setting, located on a fairly busy road. The grounds have a number of buildings and houses from which various activities are run. The building has many rooms and outdoor spaces but a number are unused and in need of maintenance.
7	The activities of **Centre 7** take place in a large hall with attached kitchen that is linked to an independent- and assisted-living facility. The centre is located in a residential area well known for gang violence.
8	**Centre 8** is a stand-alone facility situated next door to a crèche and close to the day hospital. It consists of a small hall with adjoining bathroom, kitchen, office, first aid room, and crafts room. It in a good state of repair, with a vegetable garden outside and is surrounded by a high fence.
9	**Centre 9** is run from a small building that is in a good state of repair with areas for storage, office space, a small kitchen and outside space with vegetable garden. It is situated near a busy road frequented by taxis.
10	**Centre 10** is directly linked to a church hall but as members do not meet at the centre, the facilities used by the centre consist simply of a large, well-equipped kitchen with garage for storage. The manager uses a small section of the kitchen from which she runs the administrative tasks of the centre.
11	**Centre 11** uses a permanent space attached to a large church hall. It is located in the centre of a busy holiday town close to shops and other amenities, and is walking distance from the sea.
12	The services of **Centre 12** are run from a church hall. Although the building is

in need of some maintenance, it is generally in a good state of repair.

13 The temporary home of the **Centre 13** is the local sport clubhouse, situated atop a very steep hill slightly outside the small town. A well-maintained brick building, it is along a dirt road near the local high school but there are no other facilities nearby. When beneficiaries miss the bus that fetches them in the morning, they have been known to walk up the steep hill.

14 **Centre 14** is in the middle of a well-established residential area where the library, clinic, and schools are nearby. The building is in a very good state of repair, belonging to the Methodist church. There is no dedicated office space for management to use but there is a large well-appointed kitchen.

15 **Centre 15** is located in the middle of the town near the shops, library, clinic, and members homes. The rented building is old but in a good state of repair.

16 **Centre 16** is situated in an area where the roads are poorly maintained. The centre is close to the library, community hall, day hospital, and clinic. While it is an old building that was originally designated as a clinic, it is well maintained, neat, and clean.

17 **Centre 17** is located far outside the town and away from any transport links or other services, which means that beneficiaries need to be transported there by bus. The building is in good condition, belonging to a private business that rents the space to the centre free of charge. While there is a bathroom inside for female beneficiaries, male beneficiaries have to use a portable toilet located outside.

18 **Centre 18** is situated on the outskirts of the community next to the secondary school and college campus but far away from other amenities. While neat and tidy, the building is in need of maintenance. The kitchen is basic but adequate.

19 The hall where **Centre 19** runs its activities is situated on a farm and services older persons from 4 farms in the surrounding area. The building is quite run down and in need of maintenance and repair.

20 The activities of **Centre 20** are held in a church hall situated outside the town, servicing older persons who live on the surrounding farms. Although not in the centre of town, the church is located near the clinic and school. As there is no office, the manager runs the centre from her home. The centre is cold in the winter and gets very hot in the summer.

Table 30. Description of service centres according to setting, service level, and facilities

Centre	Setting[a]	Service level	Facility	Office	Kitchen	Bathroom	Wheelchair access	Heating
1	Urban	B	NPO facility	✓	✓	✓	✓	×
2	Urban	B	NPO facility	✓	✓	✓	×	×
3	Urban	A	NPO facility	✓	✓	✓	✓	×
4	Urban	A	NPO facility	×	✓	✓	✓	×
5	Urban	A	House	×	✓	✓	×	✓
6	Urban	A	NPO facility	✓	✓	✓	✓	×
7	Urban	B	Residential facility	✓	✓	✓	✓	×
8	Urban	B	NPO facility	✓	✓	✓	✓	×
9	Urban	B	NPO facility	✓	✓	✓	✓	×
10	Urban	A	Church	×	✓	×	×	×
11	Rural	B	Church	✓	✓	✓	✓	✓
12	Rural	B	Church	✓	✓	✓	✓	✓
13	Rural	A	Sport clubhouse	×	✓	✓	×	×
14	Rural	B	Church	×	✓	✓	×	✓
15	Rural	B	Rented building	✓	✓	✓	✓	×
16	Rural	B	Rented building	×	✓	✓	✓	✓
17	Rural	B	Rented building	✓	✓	✓	×	×
18	Rural	B	NPO facility	✓	✓	✓	✓	✓
19	Rural	A	Community hall	✓	✓	✓	✓	✓
20	Rural	A	Church	×	✓	✓	✓	×

Note. Urban corresponds with the Metro South and rural corresponds with the Cape Winelands and Overberg regions respectively.

Table 31. Description of service centres according to management and staffing structure

Centre	Mother body	Board or Governing Body	Full-time staff[a]	Part-time staff	Volunteers	Role of beneficiaries	Criteria for staff or volunteers	Training provided for staff and volunteers
1	✓	✓	3 including manager, one responsible for cooking and interacting with members	-	-	One of the members helps informally.	✗	✗
2	✓	✓	3 including manager, cook, and administrator	-	6 help when needed, such as cleaning	All the volunteers are members and there is a Committee	✗	✗ (except manager)
3	✗	✓	2 including manager and cook	-	1	Committee		✓ (If available)
4	✗	✓	-	1 (manager has a full-time job and is not paid)	2 volunteers paid by external organisation to cook and clean	Committee	✗	✗
5	✗	No details provided	-	1 (manager has other responsibilities and is not paid)	-	Committee; Seniors also do the cooking	✗	✗
6	✓	✓	2 including programme manager responsible for oversight and coordinator for day-to-day running	-	-	Committee assists One of the seniors is a board member (additional member) and assists with tea and coffee.	✓	✓
7	✗	✗	3 geriatric carers	-	4 volunteers in kitchen and interacting with	Committee; One member runs the exercises	✓	✓

					older persons			
8	✓	✓	1 club assistant	3 who work in garden, cleaning and security	-	2 seniors do the cooking each day; Committee	✗	✓
9	✓	✓	1 club assistant	-	-	2 seniors do the cooking each day; Committee	✗	✓
10	✓	✓	4 including manager, supervisor, cook and general worker	-	25 help with cooking, driving and dropping off meals to members	One member is also a volunteer	✗	✗
11	✓	✓	6	40 home carers	50 help with front desk and fundraising	Most of the volunteers are members	✓	✗
12	✓	✓	5 including manager, admin, cook and kitchen assistants	-	7 help with food prep, delivery, reception and admin	They make suggestions to management	✗	✓
13	✗	✓	3 including chairperson, coordinator and cook	-	-	5 members are part of the management committee	✗	✗
14	✗	✓	1 coordinator	3 work in kitchen	2 help in kitchen	Members committee	✗	✗
15	✓	✓	2 including manager and cleaner who also does chiropody	-	40 help with delivering meals	Most of the volunteers and members of the management committee are members	✗	✓
16	✗	✓	2 including bus driver and manager	-	30 help with cooking, cleaning, gardening, and activities	All members of the management committee are members	✓	✗
17	✓	✓	1 manager	-	1 helps in the kitchen	Members committee; one member also volunteers in kitchen	✓	✗
18	✗	✓	5 including 3 who	-	10	Members are part of the	✗	✓

			work in kitchen, driver and manager			governing body and volunteer at the centre, organising events and running activities		
19	✓	✓	1 manager	1 cook	-	Committee	✗	✓
20	✗	✓	1 manager	-	11 help with cooking, cleaning	Members form part of the management committee	✓	✓

[a]Where service centres fall under larger mother body organisations, only the staff who work directly in the older persons programme of the organisation are included in the numbers quoted.