บทเรียนการประเมินผลระหว่างการดำเนินโครงการ: กรณีศึกษาโครงการการป้องกันการดูแลสุขภาพผู้สูงอายุในประเทศญี่ปุ่น

Lessons Learned from The Formative Evaluation: A Case Study of The Care Prevention Program in Japan

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Abstract

The objective of this research was to study the lessons learned from the formative evaluation of the Care Prevention Program in Japan. The sample was 8 staff members from two municipalities (Tokyo and Kanagawa Prefectures) in urban areas in Japan. All participants were representatives at the policy and practitioner level of the program. An interview with questions concerning program policy was used as a research instrument. The qualitative data were analyzed using thematic content analysis. The study revealed that this program was implemented through five steps 1) conducting a survey 2) network mobilization 3) activity planning 4) promoting the program and 5) evaluation. The strength of the program was the variety of the activities in various dimensions: physical, psychological and social. Most of the activities were designed to match with the characteristics

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of the older adults to encourage them to be active. A weakness of the program was in a lack of public places to organize the activities, as well as the high cost of renting venues for activities. However, factors that make the program effective include selecting community appropriate venues, creating a mechanism for public civil society and providing an operation manual. In summary, it can be concluded that, apart from health activities, other activities within the multi-dimensional range could help improve the program. In addition, understanding the situation and the context of each community could strengthen the program and aid in selecting appropriate venues for organizing activities.

Keywords: Formative evaluation, Care prevention program, Active aging

Introduction

In 2025, Japan will become a Super Aged Society, and one-third of the population will be older adults, giving it the highest percent (35.1%) in the world (Ministry of Health, Labour and Welfare of Japan, 2014). Alwin (2011) stated that the demographic realities of population aging will substantially increase in the number of older adults with disability and long-term care need over the next several decades. According to Settersten and Angel (2011), while there is an unprecedented number of people living longer, there are also more people living with disability and chronic disease. Therefore, health life

expectancy[2] should be focused upon more than life expectancy. In fact, health life expectancy, which means that the older adults spend their life independently or actively, is the main point of this research.

In addition to the term "health life expectancy", "aging challenge" from the study of Timonen (2016) is another term that inspired the researcher to conduct this study. Furthermore, a number of books and previous studies explained that not only older adults' lives in 21th century will be challenging, but will also be one of the most important issues in society. The book entitled "Beyond Successful and Active Aging" defines the meaning of "active" as remaining an active contributor to society and maintaining independence (Timonen, 2016). In this current research "active" refers to active life, which means that older adults cannot maintain their independence without support from family or community. "Active" is thus related to the older adults' lives and social structures.

In response to the health life expectancy, a new Japanese system called *"Community-Based Integrated Care Systems"* was promoted by the Japanese Government in 2012. This system not only organizes service delivery but also initiates a community-based social movement (Curry, Clarke and Hemmings, 2018). This system has been

[2] Health Life Expectancy in Japanese word is **健康寿命**. The Ministry of Health, Labour and Welfare of Japan defines this word as "a number of years that a person can spend their daily life in full health with no health limitations or without chronic diseases."

created to prevent the deterioration of older adults in Japan. The Japanese government has encouraged persons over-65 without care needs (active aging group)[3] to engage in community activities to reduce isolation and deterioration. According to Ministry of Health, Labour and Welfare of Japan (2016), those older adults who are over-65 without care needs are called the "Not certified group"[4].

However, in 2014, the Japanese health law was amended, and health care services were provided for all types of older adults no matter how old they were or what kind of condition they were in. The service program focused on activities among them. The aim of the program was not for curing disease or treating illness in older adults but in lengthening one's lifespan, delaying illness, helping improve their quality of life and developing the community (Ministry of Health, Labour and Welfare of Japan, 2017). The program was called the Care Prevention Program and the purposes were as follows: 1) to increase numbers of health care centers 2) to organize the system of long-term health care continually 3) to inspire key persons in promoting health care service and 4) to solve the problems and create the development in the community. In addition, this program was to organize the system of the older adults' health care at the community level and to encourage older adults to go outside and mingle with others, especially those over 65 years.

[3] 26.33 million who are not eligible for care and services" (Ministry of Health, Labor and Welfare of Japan, 2016)

[4] Those likely to come to need long-term care and support in the future" (Ministry of Health, Labor and Welfare of Japan, 2016)

Like Japan, a Health Promotion Program and Treatment Program in Thailand has also been created with the concept of a community-based approach. Nevertheless, the program has faced many obstacles among the growing needs of the older population which is increasing rapidly in Thailand. Studies indicate that many elderly programs have been established in Thailand and run by municipalities. Most of them provided health promotion rather than health prevention and some were promoted as model programs. According to Knodel, Teerawichitchainan, Prachuabmoh and Pothisiri (2015), there were 290 existing Multi-Purpose Centers established to promote social participation. Some of these centers were developed and changed their names to “Older Persons Quality of Life Development Centers” or “Community Centers” depending on the concept of the lifestyles of the older adults in each area. However, some centers experienced problems in organizing activities. Some centers were closed and others had only the committee structure without any activities or action (Yodphet, Sombat, Sarobol and Sakdaporn, 2015). From the pilot study of service-learning programs by the researcher, it was found that the objectives of those programs were not clear. There were no documents which identified program planning, implementation and evaluation. Most of the elderly programs in Thailand had also encountered problems in program management.

In order to solve the problem, previous studies have suggested that formative evaluation could help adapt and enhance implementation of a large-scale intervention which aims to increase physical activity and social connectedness amongst older adults (Sims-Gould, Franke, Lusina-Furst and McKay, 2019). According to Knodel et al (2015), it was revealed that almost 30% of older adults in Thailand live alone and have difficulties with self -care, so effective programs in the community are necessary for maintaining dignity and independence in their daily life. The lack of an effective program in the community not only brings about personal health risks, but can create a household economic crisis and place a burden on the community. Consequently, this study concerns what an effective program for active aging should consist of. In order to determine the best way to develop such a program in Thailand, the formative evaluation and Care Prevention Program in Japan is study in this current research.

Background of the Study

This article is one part of the full PHD research entitled *"The Development of an Effective Program for Promoting the Model of Active Aging in Thailand Utilizing a Care Prevention Program from Japan"*. The full research contains three steps with different paradigms. However, only the result from the first step of the full research is presented in this article.

Objective of the Study

The primary objective of this research is to study the lessons learned from the formative evaluation of the Care Prevention Program in Japan. Also, the researcher wishes to determine the process, strength and weakness of the program including the factors that make it effective.

Significance of the Study

The significance of the study is for providing a rich and contextualized understanding of several aspects of the program such as policy, staff, activities, and program management including factors that help make the program effective. The stakeholder in this field, especially the health care service for the older adults in Thailand can make use of this knowledge for improving the Health Promotion Program and Treatment Program in Thailand. In addition, the findings of the research will benefit the older adults in Thailand directly.

Review of the Related Literature

In the study by Timonen (2016), the idea of “aging challenge” was mentioned. The aging challenge occurs when the life expectancy increases throughout the world. The question becomes, how can older persons prevent themselves from physical disabilities and extend their active life? Other researchers provide different aspects of

the term “active aging.” For example, “active aging is believed to reduce premature deaths in the productive age: reduce disabilities linked to non-communicable diseases (NCDs) in older age and enable more people to enjoy a positive quality of life, as they grow older” (World Economic Forum, as cited in Yudo, 2016, p.59). Furthermore, it promotes “continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labor force. Older persons who retire from work and those who are ill or live with disabilities can remain active contributors to their families, peers, communities and nations” (WHO, 2002, p.12). This concept is similar to the idea of Timonen (2016) which stated that older adults are expected to remain active contributors to society and maintain their independence. Active aging also aims to “extend healthy life expectancy and quality of life for all people as they age, including those who are frail, disabled and in need of care” (WHO, 2002, p. 12).

It is concluded that the concept of active aging provides support for a variety of issues affecting older adults. Older people cannot maintain their independence without social support, so active aging should involve relative parties - friends, work associates, neighbors and family members (WHO, 2002). Moreover, active aging is also related to the social structure based on the assumption that patterns of health and well- being are affected by a dynamic interplay among biology, behavioral, and environmental factors - an interplay

that unfolds throughout the life of individuals, families, and communities (Smedly & Syme, 2000). Also, most experts in the field agree that “active aging is a multidisciplinary concept (also called successful, productive, or optimal aging), and cannot simply be reduced to “healthy aging” needing rather, to take into account protective behavioral determinations (protective lifestyles and the prevention of risk factors)” (Caprara, Molina, Schettini, Santacreu, Orosa, Mendoza-Nunez, Rojas & Fernandez-Ballesteros, 2012, p. 2). In addition, it was found from prior research that social connection, cultivation and contribution were factors under the umbrella of meaningful activities which could motivate older adults to participate in social activities and games (Schutter & Vandenabeele, 2008).

To conclude, active aging in this study refers to a concept related to social structure which supports older adults and promotes their well-being and quality of life in a multidimensional way by focusing on health promotion and prevention programs in the community.

With regards to promoting active aging, health promotion, disease prevention and equitable access to quality primary health care and long-term care should be focused upon (WHO, 2002). In support of this idea, prior research showed the impact of the health promotion program in four dimensions of active aging: physical, nutritional, cognitive functions and quality of life (Ruvalcana & Arias-Merino, 2015). In addition, from a study by Fernandez-Ballesteros, Molina and Santacreu (2012), a four-domain model of aging well was

tested by Structural Equation Modeling (SEM) and presented as presented in the following aspects: 1) health and independence 2) physical and cognitive functioning 3) positive affect and control and 4) social engagement. Similar dimensions of active aging were also found in the study of Caprara et al., (2012), which reported that a four-domain model of aging included 1) behavioral lifestyles 2) cognitive activity and training 3) positive effect, coping and control and 4) social functioning and participation.

According to Fertman & Allensworth (2010, p. 4), “A health promotion program can improve physical, psychological, educational, and work outcomes for individuals and help control or reduce overall health care costs by emphasizing prevention of health problems, promoting healthy lifestyles, improving patient compliance, and facilitating access to health services and care. The health promotion program plays a role in creating healthier individuals, families, communities, workplaces, and organizations”. It was also mentioned in their study that a health promotion program that takes action prior to the onset of health problems to intercept its causation or to modify its course before people become involved. This level of health promotion is called primary prevention. However, a health promotion program, which can interrupt problematic behaviors among those who are engaged in unhealthy decision making and perhaps show early signs of disease or disability, is called secondary prevention” (Fertman & Allensworth, 2010).

The focus of the basic study of the Care Prevention Program in Japan was both primary and secondary prevention. “Over the years, the Japanese government has reformed its policies to respond to the need of the ageing population and to prevent long-term care. In 2006, the government implemented measures aimed to identify frail or semi-frail older adults (65 years or older) and provide early preventive care program for functional decline, to delay dependence on long-term care” (Saito, Haseda, Amemiya, Takagi, Kondo, Kondo, 2019. p. 571).

To summarize, the purpose of the Care Prevention Program is to prevent illness in older adults, improve quality of life, and to promote an active life in multi-dimensions.

Regarding the idea to make the health promotion program effective, there are two aspects to consider. The first aspect is theories relating to the health promotion program. Rimer & Glanz (2005, p.54) stated that “theories provide a roadmap and step-by-step summary of what factors to consider when designing, implementing and evaluating a health promotion program. It is vital to have a theoretical understanding of why people and communities make health-related choices and offer a systematic way of understanding situation, examining relationships and predicting outcomes” (as cited in Rainguber, 2017). In addition, theories about the health promotion program also include behavioral change theories, ecological theories and models, planning models, communication theories and evaluation models.

The second aspect is a formative evaluation. The main purpose of the formative evaluation is to find information in order to improve the program. Formative evaluation can be general knowledge which any researcher can use as a tool to test whether a program is designed on the basis of theory, workable and effective (Rossi, Lipsey and Henry, 2004). According to Odendall, Atkins and Lewin, (2016, p. 1-2), "the formative program evaluations assess intervention implementation processes, and are seen widely as a way of unlocking the black box of any program in order to explore and understand why a program function as it does. This evaluation aims to identify the key components of a program as implemented and to explore the factors affecting its implementation, in relation to the implementation context."

In the study of Sarah & Heath (2015), the six-step model for evaluation includes engaging stakeholders, describing the program, focusing the evaluation design, gathering credible evidence, justifying conclusions and ensuring use and sharing the lesson. Also, from the study of Sims-Gould, Frank, Lusina and Mckay (2019, p. 4-5), it was revealed that the framework for successful implementation includes three specific systems which are essential for effective implementation. "There is the delivery system (which implements innovations in the world of practice), prevention support system (which provides training, technical assistance or other support to users in the field), and knowledge synthesis and translation system (which distills information about innovations and translates it into user-

friendly formats). It can be concluded that three key systems drive successful implementation- delivery, support and research system."

Context of the study

In 2015, an urgent policy was announced by the Japanese Government to promote the Care Prevention Program. The Care Prevention Program focuses on the integrated care system in the community. In Japan, although people who are over 65 are certified as older adults, the purpose of the Care Prevention Program is not focused on only older adults but also healthy people before they reach 65 and people between 70 and 74 who are at risk of deterioration. The government planned to encourage older adults not to stay at home but to go outside and participate in activities. Therefore, "Health Centers" in each community were established. These centers are run by a professional staff including nurses, care managers, social workers and general officers. Activities are provided in the centers and their objective is to prevent illness and disease in older adults.

Research Methodology

Research design

The design of this research is a descriptive, qualitative study. An in-depth interview was used to collect the data about the Care Prevention Program in Japan.

Participants

Participants (N=8) who were approved from two municipalities in urban areas in Japan participated in this research. All participants from the policy and practitioner level were representatives of the Care Prevention Program. All of them were asked about their willingness to participate in this study in advance. From each municipality, two participants were policy makers responsible in the policy division and other two participants were service providers managing the program in the community.

Areas of the study

As shown in Table 1, two municipalities in Japan were selected by purposing sampling.

Table 1

Areas of the study in Japan and the participants' level of their position

Area of the Study	Level	Number of Participants
Municipality A (Tokyo)	Policy	2
	Practitioner	2
Municipality B (Kanagawa)	Policy	2
	Practitioner	2
Total		8

Procedure

After the document of ethics approval (19-0304) from the Japan College of Social Work was approved, the researcher sent a request form via email to two municipalities and invited the participants to participate in this study. After the researcher had received the confirmation letter to participate in this research, the researcher made an appointment with the participants for an interview. The policy officers who are in charge of the Care Prevention Program in Japan were interviewed using broad questions. Then, the program staff members were interviewed with the structure questions for completing a formative evaluation of the program.

Statistical analysis

After the data collection, the analysis was not based on the attributes and properties of a thing and phenomenon, but the inductive approach[5] was used as the process of the data analysis. The first step was to transcribe an interview from recording to paper and then read over the written transcripts. Second, the thematic content analysis was applied. Next, the data were arranged systematically by converting the data into a text format and then the data were organized based on the questions. Then, the codes were set and

[5] It involves analyzing data with little or no predetermined theory, structure or framework and uses the actual data itself to derive the structure of analysis (Burnard et al., 2008).

grouped into categories as to the ideas and concepts. After that, the researcher picked up the words and expressions used frequently by the interviewees including “rich point”[6].

Result

In this section, the data from an in-depth interview from 8 participants from two municipalities are organized into three aspects as follows: process or step of the Care Prevention Program, strength and weakness, and factors that make the program effective.

1. Process of the Care Prevention Program

It was found that the process includes five steps: 1) conducting a survey 2) network mobilization 3) activity planning 4) promoting the program and 5) evaluation.

STEP 1: Conducting a survey

Before the project’s implementation, a survey was conducted in accordance with Japanese health law, which requires municipalities to survey public needs every three years. Municipality A stated that most of the older residents in its area were over 75 years old, so the survey primarily focused on pre-dependent groups, including healthy older adults between 70 and 74 years old, whereas Municipality B

[6] New things or things we didn’t expect to hear. It seems to be going in a new or unexpected direction (Asar, 1998, as cited in Gibson, 2003)

conducted a survey with older adults mostly staying at home, over 75 years old, who had not been registered in the long-term care system.

Both municipalities explained that the initial health promotion program is aimed at exercise and health care, and its target group was healthy older adults who enjoyed exercising. However, after the survey, the findings suggested other problems besides health-related issues. Therefore, the survey led to focusing on a larger group from D1-D5, that is, the dependent older adults who were not certified with a long-term care system (D1), the introverted older adults (D2), the healthy older adults (D3), the male older adults (D4), and the older adults who neglected self-care (D5). In addition, as to the fingings of the survey, the activites in the program were created considering various aspects including health promotion activities, rehabilitation activities, life skills activities, consulting activities, and social activities.

STEP 2: Network mobilization

After the older adults' needs were identified from the survey, each municipality had to mobilize networks from different institutes as well as professional e.g. medical doctor, dentist, physical therapist, and nutritionist. Those networks were invited to work as the committee to set the program policy. From data collection, it was found that the two municipalities had different concepts in setting the policy.

Municipality A set its town policy as "Care Town Structure[7]". In addition, "Silver Human Resources Center" were established in every sub-district as a corporate organization to guarantee elderly employment security. The center also recruited third parties to organize learning/classroom activities with local elderly volunteers.

Regarding Municipality B, its policy is focused on "Sharing Community," in which its healthcare facilities were accessible for everyone, not limited only to the older adults. Thus, its network covered a wider group of people such as children, the disabled, and the older adults' networks. It is worth noting that this municipality had a sound strategy of keeping consistent records of organizations and its networks in a list.

In this step, the data shows that both municipalities mobilized their network under the Life Support Center to assist older adults' living in the community. In this center, the key person who plays a crucial role was in a position of a supporter who helps the older adults for their living.

STEP 3: Planning Activity

Results from the survey in Step 1 led to activity planning in this step. For example, the findings from the survey indicated that most of the older adults had difficulties in chewing and swallowing; thus, the lesson regarding "oral health" was offered as one of the

[7] Care Town Structure is a community system to support kids, the disabled, and the older adults by focusing on appointing key persons under each administrative zone to encourage community-based participatory actions within the local administration.

activities. Moreover, the institutions and the networks mentioned in Step 2 had an important role in planning the activity. According to the survey, health promotion activities did not include only exercising, but also other activities that helped promote preventive healthcare behaviors:

1) Health promotion activities included activities that promoted positive healthcare behaviors such as health-related seminars, a health promotion curriculum, oral health classes and mouth movement, muscle training, dementia prevention activities, and locally-initiated activities.

2) Rehabilitation activities included physical rehabilitation, physical therapy, and home visit activities.

3) Life skills activities included driving activities for the older adults, seminars on safe driving for the older adults, conversation enhancement activities (for the older adults who often stay home), listening skill improvement activities, and shared dining activities.

4) Consultant activities included a mobile consulting unit provided at the local grocery store area.

5) Social activities included community-based service volunteering, elderly dependency caretaker volunteering, and public social services.

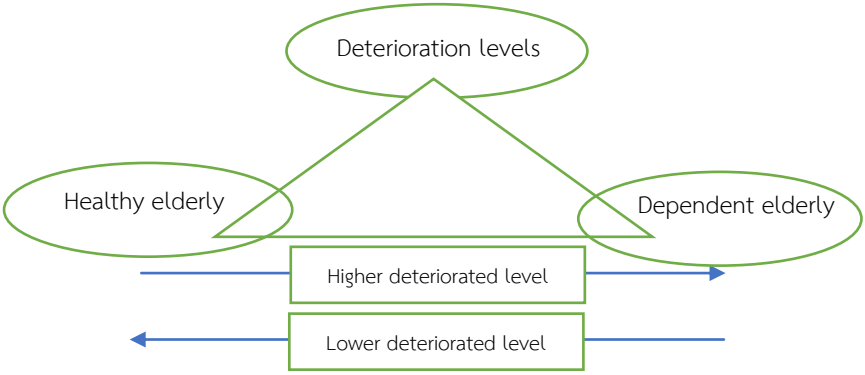
In this step, Municipality A scheduled activities and set some requirements for the participants. For example, for an activity for older adults in general without any health restrictions, the activity

required a large venue which could accommodate up to 60 attendees. An activity for specific groups of the older adults such as an oral health class could accommodate up to 20 people. Furthermore, there was an activity focusing on health problem of the older adults such as physical therapy.

Regarding Municipality B, target groups were set using a triangle (figure 1) Considering this figure roughly as a spectrum, the further to the left a program is, the more that program benefits the older adults. The further right, the more the older adults deteriorate and enter a dependency state. As a result, several measures were taken to slow down this condition.

Figure 1

Tendency of Healthcare Programs Offered to the Older Adults



In addition, Municipality B mentioned that the municipality scheduled 5 activities per month and if the community could hold the activities in accordance with the schedule that they had set, they could get financial support in the amount of 15,000 yen per month for one year. In addition, in case of the exercising activity, a minimum of 15 minutes of body movement was required.

With regards to the title of the activity, it was found that if the title of the activity was named negatively, it will affect the number of older adults' attending. For example, Municipality A set an activity titled "Dementia Prevention", which saw the lowest enrollment.

STEP 4: Promoting the Program

This step is to advertise the program. Advertising was undertaken in order to stimulate older adults' participation. Municipality A stated that they never said "You must ....." or "Would you please.....?" to the **prospective** activity attendees. Instead, they focused on using media to promote the program including:

1) Posters which illustrate activities from other areas to increase awareness

2) News articles in a local newspaper to introduce available centers where the older adults could join the program

3) Video presentations to encourage the communities to organize activities

4) Manuals to introduce activities.

However, the means of promotion undertaken by Municipality B was different from Municipality A in that Municipality B emphasized providing support funds through the municipal website. In this step, it was also found that, in terms of promoting the program, activities in the program of both municipalities included physical fitness tests for the older adults. This was advertised. This was done in order to group them according to physical capability so that appropriate activities could be scheduled for them. Furthermore, there was an announcement informing the public that the municipalities also supported the establishment of a support center to improve the older adults' living. This center was established to help and give advice to people in the community.

STEP 5: Evaluation

In this step, the evaluation of the program was done. According to the Ministry of Public Health, Labor, and Social Welfare of Japan, the requirement for evaluation is that there must be at least 10% of the population in the area attending the program. From the data collection, Municipality B did not emphasize the criteria set by the Ministry. Instead, they focused on getting the older adults to join various activities because it was possible that one person could join more than one activity. To recruit 10% of the population was exceedingly unlikely. Therefore, they shifted their focus on different goals instead; that is, 1) to reduce the number of older adults registered in the long-term care system, 2) to slow down the

deterioration into what is qualified as an elderly dependency, and 3) to encourage more volunteers by considering the number of elderly volunteers who registered with the municipality and the number of participants in the program compared with the previous year. A self-evaluation form was distributed to the participants to let them reflect on how they were before and after the activities. An example of the question is "*Can I do better or do I have a better life*?".

2. Strengths and Weakness of the Care Prevention Program

2.1 Strengths

After interviewing the participants in this research, the strong points of this program can be summarized as follows:

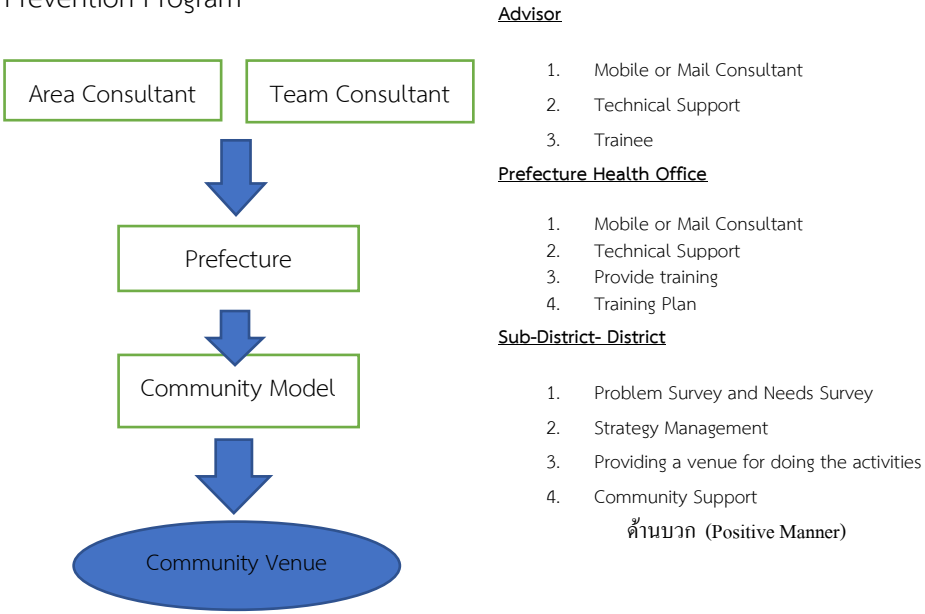
1) The Structure of the Consultant System

In the program, there was a consultant system from professionals who both worked inside and outside the community. This system empowers people to be confident in designing and implementing activities appropriate to their community. In addition, the consultants helped advise the community administration about how to manage the activities, such as finding venues, generating interest and attendance, and managing funds. The consultant system was initiated under the concept of cooperation and community support. Under the 3-year operation plan of this program (2014 – 2016), in the first year of this period, each prefecture in Japan supported the community to build up the consultant system with a qualified team by learning from the best practice model in order to

take care of the older adults in the community. The model in Figure 2 shows the structure of team building with the aim of taking care of the older adults under the care prevention program.

Figure 2

Team Building Model Taking Care of the Older Adults under Care Prevention Program



Source: Manual for Community Care Prevention Program, *Ministry of Health, Labour and Welfare of Japan, 2017*

2) Frailty Checking

Frailty checking is a Japanese tool used as a measure to check the deterioration of the older adults in terms of

physical, mental, and social dimensions. This checklist was created and designed by the University of Tokyo's research team. Any older adults interested can be checked for frailty every 6 months. It was found that frailty checking was one of the strong points of the program as it helped the older adults to become aware of their health problems. Once they recognized their health issues, they could make a decision about which healthcare activities they could participate in.

In addition, this frailty checking could benefit people at any age. For instance, if people under 65 wanted to be checked for frailty and deterioration was discovered, they could be included in the target group of the program. It is noticeable that the target group of the program was selected by the condition of the older adults' health, not by their age. Therefore, the care prevention program was offered to a broader target group. As to the data collection, Municipality B stated that they were the first to apply this frailty-detecting checklist, and now this tool has been used in more than 60-70 cities in Japan.

3) Volunteer System

The volunteer system has also been one of the strong points of this program. From the data collection, Municipality A mentioned implementing a volunteer system in the program. When new activities were organized, such activities would be tried out with the volunteers first and evaluated by the volunteers as to whether

they felt better after their participation. The volunteers' health conditions would also be checked to see if their health improved or not. The results of an evaluation from the volunteers affected the municipality's decision whether or not to extend the activities to local communities.

In terms of Municipality B, they stated that they created a volunteer system called the "supporter," responsible for encouraging the older adults to participate in the activities and do a health checkup. The supporter also looked after the older adults in the community. These supporters may work as volunteers in nursing homes or at older adults' homes. Some volunteers look after older adults who live alone, some look after dependent groups, some look after the older adults who have health problems like depression or dementia. According to a survey conducted by Municipality B, 30% of the older adults who do frailty checking and were found to be in a good health were willing to be volunteers/ supporters in the community.

2.2 Program Weaknesses

After interviewing the participants in this research about the weaknesses of the program, only Municipality B stated that they faced some difficulty in finding public space for organizing the activities. Some communities could provide several public areas to organize the activities, while others had none. This was a major weakness that prevented the activities from being held. Some communities needed to organize several activities, but there was no venue available for them. Therefore, in 2020, Municipality B set a goal

to provide at least one public venue for one community. However, it was not easy to find public spaces in Japan due to the population density and high rental price. As a result, they adjusted the plan to use a home as a venue to do the salon activity[8] instead.

3. Factors that Make the Care Prevention Program Effective

From the data collected during an in-depth interview, three factors that made the Care Prevention Program successful were found as follows:

3.1 Selecting a community venue

From documents and data collection from Municipality A and B, it emerged that a venue used to organize the activities was a key factor that helped make the program successful because the activity venue would affect the older adults' decision to participate in the program. In order to determine whether the program was successful or not, it depended on how many people took part in the activities. However, from the viewpoint of Municipality B, they thought that utilizing the venue continuously could reflect the effectiveness of the program.

According to Care Prevention Program Manual, both municipalities agreed that the activity venue was regarded as a vital

[8] Salon activity is the activity for social gathering. The older adults can meet and chat with others. The older adults can participate in the social program, such as arts, crafts, music, health, education, seminar and exercise. These kinds of activities are called "SALON" (Saito, Haseda, Amemiya, Takagi, Kondo and Kondo, 2019)

community space for people in the communities. Its fundamental principle was to make people feel a sense of belonging and make the venue lively, as written in the manual: “As long as the space seems lively, a social assistance system will emerge automatically”. Such a venue should also be administered by local people. Also, it should not pose any challenges for the older adults to access. In addition, the number of venues was not as important as the number of people and their needs. Using most benefits from the venue would lead to the success and effectiveness of the program. Besides, the activity context and target groups should be taken into consideration when choosing the venue. For example, the needs of people in urban cities and rural towns may be different. It may be more challenging to find available venues in urban cities, so renting an activity venue may be the solution. On the other hand, it was easier to find available venues in rural towns, but it might be difficult for the older adults to travel to the venue. In this case, using someone’s house or providing a shuttle bus may be the solution. Instead, without building the new venues, some examples of the activity venues that could be used are shrines, supermarkets, local grocery stores, condominiums’ common areas, parking garages, nursing homes, or schools.

3.2 Creating a mechanism for public civil society

From data collection, it was found that another factor that helped this program successful was community support. Having a mechanism that helps members of the community support one

another was very crucial for organizers to focus on. This mechanism led to effective participation within the community. As mentioned earlier in the process of establishing this program, committees were formed to take care of the older adults in the area and worked closely with the Life Support Center to assist older adults' living in the community. The primary purpose of this mechanism was to raise awareness and foster critical thinking. It was also aimed at encouraging people to actively participate in the activities by themselves, not because of a government mandate. Figure 3 below illustrates the relationship between committee members who looked after the older adults and the Life Support Center, which provided life support and the activities in the center.

Figure 3

The Relationship between Committee Members and the Life Support Center

Source: Adapted from Manual for Community Care Prevention Program, *Ministry of Health, labour and Welfare of Japan, 2017*

This figure is from the Care Prevention Program Manual, illustrating that the effectiveness of the program depends on help and support among people in the community and government officers. It is likely that all factors would help the program to be successful when all relevant parties, including people, government officers, supporters, volunteers, village committees, among others, are involved. As shown in Figure 3, the government officers are in front while cycling, followed by people and other community supporters. Everyone is holding the handlebars together in order to control the direction to achieve the goal (Ministry of Health, Labour and Welfare of Japan, 2017).

3.3 Providing an operation manual

During an interview, both Municipality A and B addressed the Manual of Participatory Preventive Health Promotion of the older adults. The data revealed that the manual was a crucial tool that provided guidelines and allowed people to see the connection between policy and actual practices. Although it was understood that the older adults should follow the manual, both municipalities reported that they didn't require that the older adults follow everything throughout the manual if it was not possible. As a matter of fact, this manual could help them understand that the practices in each area can vary. For this reason, providing operation manuals was one of the factors that made the program more effective and could be used as a systematic guideline for every municipality.

Discussion

In the result section, the care prevention program's characteristics, its process, strengths and weaknesses, as well as factors that made the program more effective were presented. The results suggested that the Care Prevention Program was attended by a wide range of participants, both healthy people under 65 and extended to cover people with deteriorating health (older adults aged 70-74) and people at risk (e.g. elderly men, elderly people who liked to stay home, and people with less dependency). The main policy of the program is creating a community venue where the older adults could be more active and more social. The results indicated that there were 5 significant processes in this program as follows: 1) conducting a survey 2) network mobilization 3) activity planning 4) promoting the program and 5) evaluation.

A survey in step 1 showed the older adults' needs and problems, which could help identify target groups of the program based on D1-D5 groups. Thus, this program was unique and different from other programs, which usually targeted only healthy persons (D3). In addition, other programs were often designed by focusing on improving physical health. However, based on the survey, healthy older adults who later might become dependent elderly were not the focus of physical health improvement. As a result, different networks and experts had been drawn together to provide the service in step 2. The program was not limited only to older adults, but was in fact

offered to the general public and focused on network mobilization. Activity planning in step 3 was also influenced by the results in the survey in Step 1.

In addition, the activities covered different dimensions, including physical, mental, and social dimensions. Furthermore, all activities (both general and specific activities) were designed with the characteristics of the older adults in mind. In step 4 of the process, there was an interesting point: the program had been promoted to encourage voluntary participation from the older adults without forcing them to do so. The program focused on crafting the message in such a way as to entice the older adults to select the activity they would like to do. Their motivation came from the experience of an activity that had been proven to be successful. However, from the final process of evaluation, they could not reach the criteria set by the Ministry as it required 10% of the population to participate. The survey also found that one person was able to join more than one activity. Besides, the older adults were asked to do a pre- test and post-test to check their feeling before and after doing the activities, both mentally and physically.

In terms of strength of the program, some attributes such as forming a consultant system, volunteer system, and frailty checking were found in this program.

The last part of the results offers essential factors that lead to an effective program. This includes:

1) Selecting a community venue: if the venue was too far from the community, the older adults might find it inconvenient to travel to and they did not want to go. This led to fewer participants, and the activities could not be described as lively. On the other hand, if the older adults were happy with the venue, it would of itself prompt the attendees to help one another during the activity. The number of venues was not as crucial as utilizing the venue as much as possible.

2) Creating a mechanism for public civil society: the elderly care committee was established to take care of older adults. They were also responsible for planning and organizing activities by seeking support from government officers.

3) Providing an operation manual: this manual could be used to help achieve the goal. It served as a roadmap to the program goals.

The key points in this study can be explained as follows:

1. Effectiveness of the program came from the provision of services in various dimensions

The findings in this current study are relevant to the definition of WHO, stating that active aging refers to continuing participation in social, economic, cultural, spiritual, and civic affairs, not just the ability to be physically active or to participate in the labor force (WHO, 2002). It was found in this research that the older adults have different needs and problems in various respects, not only health problems. Therefore, this research attempts to illustrate the program and its fivefold approach to stimulating citizens toward a more active

life: 1) health promotion activities, 2) rehabilitation activities, 3) life skills activities, 4) consultant activities, and 5) social activities. This result was supported by the work of Ruvalcana and Arias-Merino (2015), which presented the impact of a health promotion program; for example, an active program promoted the improvement in the various dimensions of active aging. However, in their study, there were four aspects (physical health, nutrition, cognitive function and quality of life).

This is also in line with the study of Fernandez-Ballesteros, Molina and Santacreu (2012), which found a four-domain model of aging well (health and independence, physical and cognitive functioning, positive affect and control, and social engagement). In addition, Caprara et al., (2012) divided her/his study of aging four ways: (1) behavioral lifestyles, (2) cognitive activity and training, (3) positive effect, coping and control, and (4) social functioning and participation. In conclusion, it is noticeable that an effective program requires a multifaceted approach to creating activities no matter how many dimensions there are. Furthermore, the activity in each program will be the same or different depending on the particular microculture of that area.

2. Network Mobilization was a vital process that led to the effectiveness of the program

The results in this current study revealed that networking played an important role in program management, providing activities, and supporting several resources such as knowledge, manpower, and

services. Network mobilization was also found in the study of Schutter & Vandenabeele (2008), who explained that social connection, cultivation and contribution are factors under the umbrella of meaningful activity which could motivate the older adults to participate in the social activity and/or game. It sounds clear that the program must involve cooperation across program stakeholders and mobilize the network based on the survey's need. Furthermore, the results of this study were also supported by the explanation of WHO (2002) about the support concepts in all conditions relating to older adults. It is known that older adults cannot maintain their independence without social support, so active aging should be concerned with the involvement of others- friends, work associates, neighbors and family members as that can augment their network.

3. Understanding the local context helped make the program effective

It was found in this research that an important factor leading to the effectiveness of the program was selecting appropriate venues to hold the activities. The findings showed that the activity venue was regarded as a vital community space for people in the community. Thus, the organizers of the programs should understand the local culture of that community in order to select the appropriate venues to hold the activities. The findings also revealed that the organizers needed to take the nature of the activities and target groups into consideration. For example, the location should be convenient for

people to travel to. This result echoes the study of Glanz & Rimer (2005, cited from Rainguber, 2017), which stated that theories provide a roadmap and step-by-step summary of what factors to consider when designing, implementing, and evaluating a health promotion program. It is vital to have a theoretical understanding of why people and communities make health-related choices and offer a systematic way of understanding situations, examining relationships, and predicting outcomes.

4. Frailty checking used in this Care Prevention Program facilitated the effectiveness of the program

The result showed that frailty checking is one of the strong points of the program as it helped the older adults to become aware of their health problems because the assessment could reveal the early signs of disease or other health issues. Also, frailty checking could help the older adults choose the program that can help combat any ailments that they are experiencing. This result is supported by the concept of secondary prevention proposed by Fertman & Allenworth (2010), which explained that secondary prevention is a type of the health promotion that can curtail problematic behavior. This is reflected in the Care Prevention Program in so far as it is concerned with both primary and secondary prevention. In addition, it is similar to the results of the study of Saito et al., (2019) which suggested that secondary prevention can prevent the necessity of long-term care of the older adults and provide early

prevention care programs for functional decline in order to delay the need for long-term care.

Conclusion and Suggestions

This article has presented one process of a community care prevention program in Japan. It also offers the strengths and weaknesses along with the factors of the effectiveness of the program by using the formative evaluation. It was found that the process of the program has five steps and it was focused on five dimensions activities for a more active life (health promotion activity, rehabilitation activity, life skill activity, consultant activity, and social activity.) Frailty checking was the main strength of the program while the weakness of the program was the difficulty in finding public space for organizing the activities. In terms of factors that make the program effective, it was found that selecting a community venue, creating a mechanism for public civil society and providing operation manual influenced the effectiveness of the program.

It is suggested that the information from the results outlined in this article can be used by other municipalities which are interested in managing a care prevention program. It is essential that the municipality should use this information as a guideline for program planning, writing the manual, and formative evaluation. Most importantly, tailoring the program to meet the needs and preferences of the local context of the community is suggested by these results.

Limitations of the Study

As this study was conducted in order to study the lessons learned from the formative evaluation by collecting the data during the program implementation, there were no concrete outcomes or examples from the older adults that could be used in the data analyses. Another limitation is that during the data collection phase, interviews were conducted in Japanese and was translated into Thai. However, the researcher is not Japanese and so there exists the potential for subtleties to have been lost during these meaning-based exchanges.

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