Caring neighbourhoods in Belgium: lessons learned on the development, implementation and evaluation of 35 caring neighbourhood projects

Liesbeth De Donder, Hannelore Stegen and Sylvia Hoens

Abstract

Background: In recent years, there has been a rise in international (care) movements that prioritise community-centred initiatives such as age-friendly communities, compassionate communities or integrated community care. Although these movements have different focal points, they share common features: seeking to address systemic failures in (care) services, value the participation of end-users, focus on unmet (care) needs, through a local, neighbourhood-oriented approach. In the Flemish and Brussels regions notably the concept of Caring Neighbourhoods is experiencing rapid growth.

Objectives: The objective of the present study is to examine the development and implementation of 35 Caring Neighbourhood initiatives in Flanders and Brussels (Belgium) to explore the added value of such projects, as well as the crucial elements for creating Caring Neighbourhoods.

Design: Thirty-five caring neighbourhood projects were examined by means of five focus group interviews with project coordinators (n=34) and five focus group interviews with neighbourhood residents (n=27), using participant-generated photo elicitation.

Methods: The focus group sessions were recorded, transcribed and data were labelled using an inductive analytical framework, following the steps of reflexive thematic analysis.

Results: The analysis of the 35 Caring Neighbourhoods showed that fostering connections was key in building Caring Neighbourhoods: connections among residents, connections between residents and care and support services and among care services themselves. The three primary ways to connect people were through activities, places and people. Also, the role of the Caring Neighbourhood coordinator is highlighted as key, which should focus on weaving existing resources, facilitating and coaching instead of organising. Altogether, the projects brought meaning and value to participants’ lives, enhancing overall life satisfaction and well-being, with an emphasis on physical and psychosocial care and support.

Conclusion: Through critically reflecting on our results and other research, we call on researchers to pay increased attention in research on community-centred care initiatives to death, dying and grief, equity and social justice and the need for both warm and cold solidarity.

Keywords: age-friendly, Caring Neighbourhoods, community care, community development, compassionate communities
Introduction

Since 2014 communities in Flanders and Brussels have been experimenting with Caring Neighbourhoods. This article aims to present lessons learned of these Caring Neighbourhoods, that could be valuable for similar neighbourhood-oriented initiatives, such as age-friendly cities and communities,1,2 compassionate communities3,4 and integrated community care.5,6

In recent years, there has been a rise in international (care) movements that prioritise community-centred initiatives. For example, the WHO Global Network of age-friendly cities and communities movement places not only the needs of older adults at the centre to enable them to age well1 but also values the bottom-up participation and involvement of older citizens in voicing their concerns as well as their participation in decision-making and planning.2 Another example is the compassionate communities movement in end-of-life-care which has shifted the focus away from medicalisation in palliative care and recognises the essential role of the community in moments of death, dying and bereavement.3,4 A final example is integrated community care. Although integrated care as a concept has been widely used the past years to denote an approach to integrate health and social care, integrated community care is a rather new concept that has been launched by the international partnership of philanthropic organisations known as TransForm which came into being in 2018. Integrated communities refers to bottom-up initiatives, which involve citizens, neighbourhood networks, community-based organisations and informal carers, as inspiring for cooperation and innovation in care services.5,6

Although these movements have different focal points, they share common features. They seek to address similar systemic failures in care services: fragmentation in care, unmet care needs and little participation of end-users. They do so by promoting more integration of health and social care provision,3 by recognising the value, potential and power of the neighbourhood-level,7 while also recognising the need of accessible care services8 and the participation of end-users.4 Although these community initiatives, such as age-friendly communities, compassionate communities and integrated community care have been expanding over the past years, all have been struggling with the question how to describe, assess and evaluate their development and implementation processes and outcomes. As for area-based compassionate communities a recent review concludes that only a handful of initiatives have been described, and the lack of formal evaluations of their envisaged benefits indicates a ‘pressing need for rigorous research about ongoing and future initiatives’.4 Also for age-friendly cities, little is known about the progress made by cities developing this work around the world. In response, a multiple case study approach9 compared the experience of 11 cities in 11 countries, concluding that future research and projects should focus on collecting more data and conducting more evaluations. Demonstrating benefits of developing this work which might also help convince influential stakeholders to support and invest in age-friendly cities and communities.9 If projects do conduct an evaluation, they often use traditional methods, such as questionnaires, qualitative interviews, focus groups or document analysis.5,9,10 As for future studies, it is recommended they consider non-traditional qualitative data collection techniques such as photovoice or the most significant change technique because they may provide rich and diverse data,4 and recommended they gain ‘insights on the emergent and shifting interplay between agency, social processes, and contextual factors that shape the development and implementation of community initiatives’ (i.e. compassionate communities).11

Against this backdrop, the Caring Neighbourhood movement emerged in Flanders and Brussels over the past decade. Initially rooted in care for older people, the movement’s first project, launched in 2014, defined an ‘Active Caring Neighbourhood’ as a ‘community supporting ageing in place; where residents of the community know and help each other; where meeting opportunities are developed; and where individuals and their informal caregivers receive care and support from motivated professionals’.8 The scope of this concept later expanded to encompass the wider population of people in need of care. At present, the Ministry of Care and Wellbeing in Flanders uses the following definition: ‘In a Caring Neighbourhood, individuals live comfortably in their homes or familiar neighbourhoods, where young and old provide mutual aid. This neighbourhood prioritises the quality of life, ensuring accessibility of facilities and services to all. All individuals receive assistance, irrespective of their support needs’.12

In the Flemish and Brussels regions, the concept of Caring Neighbourhoods is experiencing rapid
The first initiative, launched in 2014, was a ‘care living lab’ aimed at supporting older individuals in urban neighbourhoods with lower socio-economic status, to age in place. This initiative focused on improving housing quality for older adults, implementing case management for complex care situations and fostering informal care and support networks. Subsequently several neighbourhoods followed their example, and between 2018 and 2019, the Dr Daniël De Coninck Fund, a prominent charitable organisation in Belgium, financially supported experiments in 35 Caring Neighbourhoods, the results of which are discussed in this article. In 2022, the Flemish Minister of Care and Wellbeing launched a 2-year initiative to support the development and evaluation of 132 Caring Neighbourhoods.

**Aim**

The aim of this study is to examine the development and implementation of 35 Caring Neighbourhood projects that received funding by the charity organisation: How do they experience the added value of Caring Neighbourhoods in their communities? What did they consider to be crucial elements for creating Caring Neighbourhoods?

**Methods**

**Study design**

Our study employs a phenomenological approach to describe and understand the lived experiences of individuals in caring neighbourhoods. A qualitative methodology was chosen to explore the subjective reality, meanings and unique perspectives of the participants. Phenomenology, while traditionally individual-focused, acknowledges that participants may have commonalities in their experiences. Conducting focus groups allows participants to collectively explore and validate some of these shared elements of their experiences. But more importantly, group discussions can trigger memories and reflections that individual interviews may not elicit, while also generating conversation and connection across participants. Participants may recall aspects of their experiences based on prompts and contributions from others, leading to a more comprehensive exploration of the depth and richness of their lived realities.

The focus groups started from a participant-generated photo-elicitation method. This visual research technique used during the focus groups involved requesting participants to bring along images of a particular phenomenon related to the project being evaluated. The images were then closely discussed and interpreted within the focus groups. The use of participant-generated photo-elicitation aligns well with the phenomenological paradigm, as it provides a unique and powerful method for participants to express and articulate their lived experiences.

We followed the EQUATOR COnsolidated criteria for REporting Qualitative research checklist guidance to report the method of our study (see Supplemental File 1).

**Sample**

Recognising that there may be varying perspectives between people who were project coordinators, and neighbourhood residents involved in the project, we invited two people from each of the 35 projects to participate in a focus group. In total, we conducted 10 focus group interviews. Six focus groups took place in September 2019 and four in September 2020. We contacted the project coordinator by mail, and based on our invitation and information (about the goal of the research, and the role of our research group in this evaluation), they could decide themselves who to send as representatives of the project. Two warm reminders were sent by e-mail. Of the 35 projects invited to participate, we had 2 people participate from 27 projects, we had 1 person (i.e. the coordinator) participate from 7 projects and 1 project did not participate in the focus group but provided input through mail. In total, 34 project coordinators and 27 neighbourhood residents involved in the projects, of which 17 men and 44 women, took part. We conducted the focus groups at central urban locations, easily reachable by public transport, hosted by the funding charity. Representatives of the funding charity were present at the location during the network lunch, but did not participate in the focus groups.

**Data collection**

The main goal of the focus groups was to delve into individual experiences, foster sharing and to generate valuable reflections and inquiries. We instructed participants beforehand to bring four photos (in print) to the focus group session:
• Photo 1: What is your project about: what did you do?
• Photo 2: What was the greatest added value of your project?
• Photo 3: What are you most proud of in your project?
• Photo 4: What was crucial for you to create a Caring Neighbourhood?

In each focus group session, we gave participants the opportunity to get to know the viewpoints of their peers and share their own additional or differing perspectives. We started with an introduction round to get where participants and researchers shared who they were and in which roles and capacity they participated. Each round, the conversation was initiated by sharing the photographs the participants brought along. We guided the further discussion with a flexible interview scheme with a list of discussion topics and potential follow-up questions. Utilising the photographs, and the flexible interview scheme enabled the collection of a diverse range of experiences and meanings, rather than solely focusing on the interviewers’ predetermined objectives.17

Each focus group lasted approximately 2 h. The focus groups were facilitated by seven female researchers of our SARLab research group (of which three professors and four PhD researchers in the field of adult education, social gerontology and community development, including the three co-authors of this article). In each focus group, one researcher was the moderator, and a second one took notes.

Data analysis
The analysis was conducted in multiple phases to optimise the processing of the focus groups. In the initial phase, we recorded the sessions with a smartphone or laptop to facilitate further analysis. We transcribed the recorded files verbatim and analysed them inductively. In general, we followed the steps of reflexive thematic analysis18,19: (1) familiarising with the data, (2) generating initial codes (i.e. line-by-line inductive analysis of the transcripts), (3) searching for first themes, (4) reviewing themes, (5) defining and naming themes and (6) writing up the report. The analytic process involved iterative work, moving back and forth between reading, reflecting, wondering, writing, returning, etc.18,19 Throughout the process, all co-authors collaborated during designated co-working days, where they collaboratively analysed and discussed the data. Our different profiles (e.g. no experience at all in caring neighbourhood versus been involved over 10 years in action-research on caring neighbourhoods, living in an urban and divers environment versus semi-rural area) enriched discussions and made us critically reflect on our own preconceptions, experiences and perspectives how our background may shape the interpretation of data. Data were analysed using MAXQDA. The final coding tree is used as the structure for the ‘Result’ section. We translated eventually relevant quotes from Dutch to English.

We did not conduct a posteriori analysis of the photos. Photos were solely used to increase voicing of individual experiences. They offered a visual representation of participants’ subjective realities, allowing them to express aspects of their experiences that would have been challenging to convey solely through verbal communication.15

Ethics
The study was conducted in conformity with the guidelines of the Human Sciences Ethical Committee of Vrije Universiteit Brussel (VUB) and the European Framework for Research Ethics.20 The research process, with any possibly associated harm and discomfort, was reflected upon by the team of researchers. The details of the study were explained orally to participants prior to the interview, including the broader objectives, the right to withdraw at any time, data governance and information on confidentiality. All participants gave both written and verbal consent for an audio-recorded interview. Any identifying information was removed (e.g. participants’ real names and places) to protect confidentiality. As the goal of the study was also to showcase the different projects, the projects themselves were not anonymised, but deliberately made explicit. All participants were given a preview of the full Dutch report, with the possibility to provide feedback and make adaptations.

Results
Central goal: fostering connections
The analysis of the 35 projects revealed that fostering connections was a central objective for
building Caring Neighbourhoods. Connections manifested in various forms: connections between residents, connections between residents and care and connections among care services (see Table 1).

Firstly, almost all projects aimed to connect residents in the neighbourhood and promote social cohesion. Such projects invested in activities or communal spaces to encourage interactions between individuals. These connections, in turn, could foster a sense of empathy and support within the community. The ultimate goal for many projects was to create a warm and nurturing environment. They used the word ‘warm’ to express a closely knit neighbourhood where people were familiar with and valued one another. Several participants emphasised that a Caring Neighbourhood could not develop without having such a ‘warm’ neighbourhood. Social cohesion provides the foundation for a Caring Neighbourhood to flourish. As one participant expressed:

When it comes to creating a Caring Neighbourhood, I believe it’s all about fostering a sense of community through social interactions. A warm and welcoming neighbourhood is a prerequisite for a caring one. By establishing a friendly atmosphere, a Caring Neighbourhood can naturally emerge. (Neighbourhood resident)

Secondly, several projects aimed to increase access to care by facilitating the matching of demand (i.e. needs and aspirations) with supply (i.e. care and support). Typically, these projects started by identifying care and support needs and aspirations from neighbourhood residents. To identify these needs and aspirations, the projects used inclusive and personalised outreach methods (i.e. low-threshold, pro-active contact in the living environment of people) and warm referral to professional or informal care. Approaching the neighbourhood from an asset-based perspective, these projects aimed to leverage the strengths of the neighbourhood rather than solely addressing shortages or problems. After this so-called detection phase, the next step was to guide the residents towards care and support (i.e. the warm referral phase). Such connections could be formal, such as referring individuals to professional care services and providers, or informal, such as informal carers, volunteers or neighbourly support networks [e.g. Local Exchange Trading Systems (LETS) or a time banking scheme].

Thirdly, connections also emerged between organisations and services. Many projects experienced increased cooperation among different initiatives, organisations and networks. Connections resulted in a number of positive consequences for
the participating organisations, such as growth of existing networks, more knowledge of local network dynamics, more shared insights, mutual inspiration and learning, broadening of their perspectives and development of new actions. As one respondent stated:

It was nice to see that the social partners were now sometimes working together with each other instead of next to or against each other. (Neighbourhood resident)

Networking was certainly not only useful with primary care professionals, but also, for example, partnerships with local traders were valued. Although connections among these entities appeared to be vital in expanding existing networks, exchanging knowledge and insights, creating stronger support systems for residents and facilitating referrals, this was a struggle in many Caring Neighbourhoods. Organisations that genuinely worked together on a project (i.e. rather collaborating than merely connecting) were still uncommon. At the moment, partnerships tended to be rather instrumental (e.g. for having access to participants) or informative (e.g. exchanging information about their respective activities). These ‘smaller’ forms of cooperation were often introductory, helping the organisations get to know each other and learn about each other’s operations. Although these ‘weaker’ ties may lead to ‘stronger’ ties in the future, they remained to be superficial at the moment of the interview.

**Connection methods: activities, places and people**

Albeit the projects included a wide variety of actions, analysis shows that connection was generally created in three ways: through activities that connect, places that connect and people that connect (see Table 2).

Simply bringing people together around a common goal, no matter how small, proved to be a fertile ground for generating new initiatives, ideas, collaborations and energy. For instance, the project ‘Facilitating a Neighbourhood Care Network’ started with making soup. As one of their first community-building activities, the social worker stood in the central village square holding an empty soup bowl and a stone. He asked passers-by to bring an ingredient to add to the ‘stone soup’. Although the social worker took the initiative, it was the people themselves who determined the taste of the soup by bringing in ingredients. The social worker testified how he saw that this sense of ownership was strongly felt by the community. The ‘soup-making activity’ was a clear symbol for them. As the social worker concluded in the focus group: ‘We can be caregivers in the neighbourhood and provide frameworks, but ultimately, it’s the people in the neighbourhood who decide how the soup will taste.’ Other examples of connecting activities were the ‘Storytelling Project’ that focused on creating an artwork using personal objects collected in a box from the residents. The ‘Buurtsport Oudenaarde’ project focused on promoting sports activities in the neighbourhood and targeted not only children but also their parents and grandparents. Respondents expressed that possibilities for such connecting activities were endless and diverse. Such connecting activities were experienced by the respondents as a breeding ground for new initiatives or collaborations:

We organise very accessible activities such as a senior citizens’ party or a festive afternoon with cake and coffee to create some momentum and start thinking about what’s needed in the village. (Project coordinator)

Several projects concentrated on providing a ‘connecting place’ where people could come together and meet. Connecting happened in and through (semi-)public spaces. This location was indoor or outdoor, with a focus on one or multiple activities, such as a social restaurant or a grocery shop. It was managed by an organisation or by the group itself, with activities either pre-planned or arising spontaneously. Moreover, this location was not necessarily a fixed site (e.g. community service centres, or community gardens); some projects relied on mobile spaces to bring people together. For instance, the LINC (Laarne Inclusive) project carried out neighbourhood rounds using coffee and soup caravans. By providing a space for people to come together, it fostered the development of fresh initiatives and promoted social cohesion within a Caring Neighbourhood. As ‘Grondig Anders Zorgen’ (a caring garden) put it, ‘a place where vegetables and people grow’. Many participants agreed that having a dedicated place was crucial for fostering connections and building relationships. As one project coordinator explained, ‘I was fortunate to have the care centre and the nearby parish house, which has allowed me to establish regular visits and connections’. However, the coordinator also
Table 2. Overview of connection methods and project examples.

<table>
<thead>
<tr>
<th>Connection method</th>
<th>Examples of projects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td></td>
</tr>
<tr>
<td>• ‘Tegoare in de Stroate – Poperinge’: The local service centre brings local residents together on the sidewalks for a chat and stimulate social contact. They pay extra attention to farmers.</td>
<td></td>
</tr>
<tr>
<td>• Roeselare: ‘Talento is actually a virtual currency, whereby organisations offer opportunities for voluntary work to earn Talento. These Talentos can be exchanged for goods and services, such as a cup of coffee in other organisations, or even access to theatre performances that would otherwise be inaccessible. This creates a relationship between volunteers and organisations, opening doors and facilitating new experiences’ ‘Buurtspor Oudenaarde – Join us for sports:’ organises sports activities in neighbourhood squares, where children can play outside and older residents can connect with the community.</td>
<td></td>
</tr>
<tr>
<td>• ‘Storytelling in Menen – The Box in My Front Garden’: aims to collect positive stories from people residing in the neighbourhood and about the neighbourhood, and ultimately create one artwork that connects people.</td>
<td></td>
</tr>
<tr>
<td><strong>Places</strong></td>
<td></td>
</tr>
<tr>
<td>• ‘LINC project (Laarne Inclusive)’: have built a pop-up coffee bar, that travels from neighbourhood to neighbourhood and aims to connect people in an approachable manner, with the hope of establishing meaningful relationships.</td>
<td></td>
</tr>
<tr>
<td>• ‘Superette Capellehof Ledegem’: is a vibrant neighbourhood grocery run by individuals with disabilities, volunteers and a supervisor. Goal is not only to supply herbs and fresh products to the local community but also to become a meeting hot-spot in the community.</td>
<td></td>
</tr>
<tr>
<td>• ‘Warm Garden in Sint-Truiden’: promoting collaboration among local community members and building connections through gardening or enjoying the pleasant, accessible garden together. The garden serves as a meeting point for the neighbourhood.</td>
<td></td>
</tr>
<tr>
<td><strong>People</strong></td>
<td></td>
</tr>
<tr>
<td>• Buurtzorg 2.0 Knokke-Heist emphasises collaboration between a voluntary ‘neighbourhood ambassador’ who detects care or support needs and a professional ‘neighbourhood director’ who further dispatches to primary care professionals.</td>
<td></td>
</tr>
<tr>
<td>• In Roeselare, a professional neighbourhood ambassador is instrumental in establishing a sustainable neighbourhood-oriented network between city services, organisations and residents.</td>
<td></td>
</tr>
<tr>
<td>• In Mechelen, an outreach health worker assists residents in making decisions about health and illness. The health worker also seeks out ‘key bridge figures’ to support the residents.</td>
<td></td>
</tr>
</tbody>
</table>

noted that having a community house in close proximity would have made it easier to connect with others and create a sense of continuity. As the coordinator explained, ‘If there was a community house nearby that I could visit every week, it would provide a consistent location to communicate and build relationships. Unfortunately, such a resource was not available, and I had to seek out other opportunities elsewhere’.

Finally, several projects relied on ‘connecting figures’ who were embedded in the neighbourhood and facilitated local collaborations between different actors in the Caring Neighbourhood landscape. The status of these figures was more formal or less formal depending on the project, with some offering training and paid positions while others relied on volunteers. Some projects used the term ‘neighbourhood care coordinator’ or ‘(culturally sensitive) care ambassador’ to describe individuals specifically focused on formal or informal care. Other projects used terms like ‘neighbourhood ambassador’, ‘neighbourhood matchmaker’, ‘neighbourhood coach’ or ‘neighbourhood talent scout’. These people had extensive networks and established connections in the neighbourhood, connected neighbours with each other or contributed to detection (of needs and aspirations) and referral to care. Who fulfilled this role was very different: it could be associations, neighbourhood committees or local tradesmen. For example, in Beringen, employees of the non-profit organisation IN-Z were trained as
culturally sensitive care ambassadors to reach older migrants. However, also neighbours themselves could be connecting figures. In the Zorgzaam Deerlijk project, for example, they preferred the term ‘caring neighbour’ to ‘neighbourhood ambassador,’ which involved not only providing minor help to residents (e.g. doing the groceries) but also caring for the neighbourhood (e.g. reporting broken street lights). Overall, the involvement of these people contributed to a more caring and inclusive neighbourhood.

**Experienced added value of the caring neighbourhood projects**

According to the respondents, participation in the Caring Neighbourhood projects brought meaning and value to the lives of the neighbourhood residents. For example, the Village Point project in Beveren established a social restaurant that offered healthy food and provided a space for social interaction among people from the neighbourhood. The project also facilitated accessible information on health and care. Notably, the project was operated by people with intellectual disabilities, who found the experience to be meaningful and enriching. As one project coordinator explained:

> It gives meaning and value to their lives and day-to-day activities. What they do . . . Well, with people who have mental disabilities, you could put them at a table and let them tinker with toilet rolls, for example. But in this project, they are integrated into meaningful activities that enrich lives. (Project coordinator)

The projects also enhanced the participants’ overall life satisfaction, including feelings of pleasure, happiness, appreciation and enjoyment of life. As some respondents noted, ‘We find happiness in doing things’, and ‘I feel a joy of life’, indicating the positive impact of the projects on their well-being. As a neighbourhood resident expressed: ‘People also really say: we get happy from what we do, and especially, we do things’. A neighbourhood resident described the Caring Neighbourhood as ‘a joy of life’, adding, ‘Last year I had no network, really zero, so it’s actually there, with NN (i.e., the organisation coordinating the project), by participating in their meetings and activities. . . That’s where I learned to trust people again. Then you build up something, and then you can realise (yourself) very nice things’.

In terms of community development and feeling of inclusion, several projects aimed to acknowledge and appreciate the diversity of residents, providing them with a sense of belonging and a place in society. The projects fostered a welcoming and inclusive environment, with the goal of creating a sense of community among participants. As one respondent noted, ‘We want everyone to feel included and participate in the group’. The following quotes from two focus groups illustrate this point:

**Project coordinator:** ‘To illustrate what a Caring Neighbourhood means for me, I brought following photograph: a picture of people with limited mobility who use wheelchairs, and yet, they would have liked to ride in the garden’.

**Interviewer:** ‘I see. And for you, the caring aspect is ensuring that these individuals . . .’

**Project coordinator:** ‘That everyone who desires it can experience and participate. We do not want to leave anyone behind and we aim to include everyone in the group’.

**Neighbourhood resident:** ‘We also place great importance on welcoming new residents. For example, during barbecues, we send a letter to new residents who have moved in within the last year, inviting them to an aperitif. This is how we let them know that they are welcome in the neighbourhood’.

The notion of changing perceptions and stereotypes emerged as a frequently cited added value of the projects. This pertains to altering perceptions of participating organisations (such as the CPAS, the local social service which is often associated with a negative ‘poor people’ image), neighbourhoods (such as ‘problem neighbourhoods’) or the participants themselves, particularly concerning people with care needs. During a focus group session, one participant explicitly stated that people with limitations were no longer viewed solely through the lens of their limitations within the project, and likewise were not treated differently as a result of it. This was both mentioned for older people who had care needs, as people with disabilities.

**Project coordinator**

> These actions aim to see people with disabilities as individuals first and foremost, rather than solely focusing on their disabilities. By doing this, I believe that we are less focused on their limitations. . . we accept them more for who they are as a person, and their disability becomes less significant. (Project coordinator)
Their dependence and limitations are reframed as ‘we need you, you have talents’. (Project coordinator)

However, Caring Neighbourhoods not only contributed to more social or warm neighbourhoods but also explicitly focused on care and support. The projects evaluated in this article worked mainly on two types of care and support: physical and psychosocial. With regard to physical care and support, a significant emphasis was placed on preventative measures in the area of ‘healthy food’. Initiatives included community gardens, neighbourhood groceries run by individuals with disabilities offering fresh products and herbs, co-creation of a ‘neighbourhood-soup-cookbook’ with healthy recipes and neighbourhood ‘social’ restaurants serving healthy food. In addition, there were efforts to increase health literacy through courses on ‘health’ for example for the mother group in a language course for migrants, as well as individual support such as teaching individuals how to administer eye drops. Another area of focus was mobility support, with projects such as carpool services, bike rentals and bike repair services. Secondly, the projects also focused on psychosocial care and support, including both the promotion of social connections by establishing pop-up coffee bars and organising activities in the community centre as facilitating individual contacts: for example, through telephone circles.

Table 3. Professional qualities of the caring neighbourhood coordinator and their key-elements.

<table>
<thead>
<tr>
<th>Professional qualities of the coordinator</th>
<th>Key elements</th>
</tr>
</thead>
</table>
| Focused on weaving a neighbourhood care infrastructure | • Starting point is not developing new care and support services  
• Neighbourhood mapping to describe the existing social and care infrastructure  
• Connect the neighbourhood existing care infrastructure  
• Work complementary with the existing offer |
| From care provider to care ‘reinforcer’ | • Instead of providing care and welfare, care and social workers are expected to act as reinforcers of care and welfare  
• Instead of organising and providing the solution to the client, facilitating and coaching  
• Attach great importance to participation and ownership of the neighbourhood  
• ‘Let go’ |

The focus of creating Caring Neighbourhoods did not revolve around the development of new care or support services or organisations, but rather on recognising and connecting existing resources, that is, to weave the neighbourhood care infrastructure. Respondents stressed that the goal was not to compete with existing initiatives but rather to work complementary to the existing offer. As the following project exemplifies:

We do all sorts of small jobs that our staff enjoy and are skilled at, and where there is no local offer or competition. For example, in our meeting place, alcohol is not served because there is a café across the street. (Project coordinator)

To achieve this, many respondents considered it a critical first step to become familiar with the neighbourhood and gain a full understanding of the local context. Typically, a project began with a neighbourhood analysis, often using mapping tools to describe the composition of the neighbourhood population and the existing social and care infrastructure. This included local actors, associations, care services, key players, companies and tradespeople, all of whom could play a role in a Caring Neighbourhood. The neighbourhood
analysis provided according to participants, a comprehensive picture of the neighbourhood, incorporating both qualitative and quantitative data. Qualitative data was collected on different ways: through community cafes, individual interviews or neighbourhood discovery walks. Additionally, some projects used census data, regional and city data to map characteristics such as age, income and family composition of the neighbourhood residents.

In addition, the participants in the study highlighted the importance that care and social workers in projects that aim to create Caring Neighbourhoods adopted a distinct professional approach: instead of simply providing care and welfare, care and social workers were expected to act as reinforcers of care and welfare. This entails facilitating and coaching instead of organising. Care and social workers need (to be able) to establish connections and being present, to adapt flexibly to changing circumstances, demonstrating commitment and enthusiasm, possess a comprehensive understanding of the neighbourhood context and support, motivate and value neighbourhood participants. Respondents stressed that the care and welfare reinforcer should primarily focus on facilitating rather than organising and taking things out of hands of the neighbourhood actors. As a care and welfare reinforcer, one must be willing to let go control, predefined goals and plans their old way of working and work collaboratively with the neighbourhood to determine how things can and should be accomplished. This became very evident in a quote from the social worker in the stone project. When he was asked, what was for him the main message he would give to new Caring Neighbourhoods, he answered: ‘I would say “let it go”. Let people go, let end results go, let project plans go, let people do their thing. That does not mean abandoning or deserting them. It’s holding on differently.’

A specific example of this approach is the ‘Stuyfplekken’ project in Roeselare from VOC Opstap. In the past, the organisation would guide individuals with leisure needs towards specific leisure activities, using one-to-one sessions to identify their interests and needs before searching for solutions online or through their personal networks. The focus was on identifying needs and providing individual solutions. However, the organisation has since shifted towards a care network-enhancing approach, organising regular ‘Connector Tables’, meetings that they describe as ‘the perfect place to give your dreams a boost’. At these meetings, participants share their current dreams, ideas, projects or activities, inspiring others to provide tips and ask questions. Through Connector Tables, ideas from neighbours, clients of VOC Opstap, neighbourhood actors and organisations are transformed into concrete actions. ‘The community worker facilitates the enthusiasm that exists within people’, stated the coordinator of this project.

Discussion

Discussion of results

When examining the development and implementation of Caring Neighbourhoods across 35 projects, our findings have highlighted the critical importance of establishing meaningful connections. These connections can take different forms, such as social cohesion among residents, links between residents and care providers to facilitate matching of demand and supply or fostering greater collaboration among care services. Previous research on age-friendly social environments supporting frail older people to age in place has emphasised initiatives should not merely focus on creating new connections but on making existing connections ‘visible’. Community-initiatives should value the connections, which exist at present, and support and valorise them.10 Our research also demonstrated that fostering collaboration among care services seemed to remain largely instrumental or informative. From the point of view of Integrated Community Care, this can be considered as a weakness, as real integration presupposes ‘collaboration and a shared vision of the roles and responsibilities of the players intervening on the same territory’.6

We have identified three primary ways of creating such connections, which often in the real-life projects do not occur in isolation but are intertwined. Firstly, through activities that aim to bring people together around a common goal. Secondly, by having people embedded in the neighbourhood who can facilitate collaborations between different actors to foster a more caring and inclusive community. Thirdly, by creating places where people can meet and interact, providing a sense of continuity. In the creation of Caring Neighbourhoods, neighbourhood coordinators play an essential role. They weave a neighbourhood care infrastructure and adopt a professional approach that goes beyond merely providing care.
and welfare services. Instead, they are expected to act as reinforcers of care and welfare, with a particular emphasis on participation and ownership within the community. Future research could disentangle these potential roles more. Possible inspiration can be found in literature on community health workers and how they try to reach and engage people most in need of care or street professionals, and how they combine different roles – as friend, leader, representative and mediator – in order to empower and include their target audience and create a sense of community.

Our findings also described the added value of these Caring Neighbourhood projects as experienced by the research participants, which include enhancing participants’ life satisfaction, bringing meaning and value to their lives, promoting a sense of belonging and challenging stereotypes and perceptions. Participants did not discuss broader, macro-level benefits such as creation of an integrated healthcare system, or policy changes. This aligns with a recent literature review on area-based compassionate communities, which found that these aims were addressed in only 27–9% of the studies, respectively. Notably, although the initial reason for starting these projects was to address gaps in current healthcare systems, the development and realisation of such community-based projects have shown that effecting such structural or systemic changes is significantly more challenging.

Strengths and limitations
One of the main strengths of this study is the heterogeneity of the assembled focus groups, which included a wide variety of neighbourhoods and projects. This allowed for in-depth insights to be gained from multiple perspectives. Additionally, the use of participant-generated photo-elicitation during all focus groups proved valuable as it facilitated a rich exploration by eliciting emotions, memories and ideas, and providing diverse perspectives and insights.

However, some limitations were apparent during the course of the research. The cross-sectional measurement, which occurred at the end of the project, only allowed for short-term outcomes to be measured. If the focus groups had been conducted over a more extended period, additional outcomes may have emerged, allowing for a more comprehensive understanding of the project’s impact. Despite this, the relatively short time frame of the study enabled rapid conclusions to be drawn, which can inform future projects.

In addition, despite the heterogeneity of the assembled focus groups, recruitment of respondents was left to the project coordinators themselves, so participants probably were already positively engaged to the project. In other words, selection bias is possible. The diversity of the researched population may not be reflected in the people who wanted to participate, as individuals unhappy with the project might have not wanted to participate or were not invited to do so by the project coordinator, possibly leading to more positive results.

Reflection on the findings
At first glance, the 35 projects on caring neighbourhoods appear to be yielding impressive results, with participants expressing genuine satisfaction and the projects effectively addressing unmet care needs. However, from an outsider’s perspective, three key areas of concern can be identified.

Firstly, all projects aspired to create neighbourhoods where residents look out for each other and are willing to provide support to those in need. This includes things like checking in on neighbours who need care, offering to help with household tasks or organising community events to build connections and promote social cohesion. Although the current focus on providing ‘low care’ and ‘little help’ is commendable, it raises the question of whether caring neighbourhoods should also support people with complex needs during the most challenging moments of their lives, including end-of-life care. It is striking that issues around death, dying and grief were not discussed in any of the focus groups. How can we talk about ageing in place without addressing dying in place? How can caring neighbourhoods become more compassionate neighbourhoods? Recently, Canadian academics in the field of age-friendly cities and communities have raised similar questions: Are these communities also accommodating for aspects of death, dying, grief and bereavement? A ‘death-friendly’ approach in caring neighbourhoods, which not only recognises end-of-life issues, bereavement support and death literacy but also integrates existential care stories with critical questions about the structural and political environments conducive
to appropriate end-of-life care, could significantly advance the field.

Secondly, the projects have paid little attention to issues of equity and social justice. While the caring neighbourhood projects have emphasised individual acts of kindness and support, there has been little focus on systemic change that addresses the root causes of social problems. The increased emphasis on local neighbourhoods as crucial contexts for care cannot be fully understood without considering the decentralisation of welfare and welfare reforms that largely depend on heightened citizen participation. An international workshop on caring communities held in Vienna, which included 40 experts from Austria, Germany and Switzerland, highlighted the importance of incorporating reflections on the ethics of care and the politics of care. Key questions emerged:

‘How can we connect private, individual experiences and needs with political frameworks’? ‘How can we avoid the instrumentalisation of compassionate communities as an economic measure’? And ‘how can we shift focus to the social determinants of both receiving and providing care’? Although these questions are vital for the general population, they are even more critical for low-income neighbourhoods. Future studies and project could seek answers to: How can caring neighbourhoods take the next step and actively seek to address social inequalities and promote social justice? There is for example a risk that caring neighbours may become a cheap workforce in disadvantaged situations. How can we prevent this and ensure that caring neighbourhoods do not become the (only) solution for the care crisis faced by marginalised and disadvantaged communities?

Thirdly, it is important to acknowledge that caring neighbourhoods are more than caring neighbours, more than merely neighbourhoods where neighbours care for each other as a means of compensating for ill-functioning government care provision. Social security remains a necessary institutional instrument for combating the lack of access to quality care. Is it really everybody’s responsibility? Although a lot of people have a role to play which to date remains too often unseen and unvalued, this does not necessarily imply a shared responsibility. It is crucial to distinguish between ‘warm solidarity’, that is, the interpersonal and community-level engagement where individuals actively participate in supporting and helping each other, and ‘cold solidarity’, that is, the structural and institutional foundations that support and facilitate the community engagement described as warm solidarity, for example, policies, systems and frameworks, such as social security programmes, which provide a broader and more systemic form of support. Both are necessary for a caring neighbourhood to thrive.

Conclusion

The primary objective of this study was to evaluate 35 Caring Neighbourhood initiatives in Flanders and Brussels, Belgium, with the aim of identifying the added value of such projects and the essential elements for creating Caring Neighbourhoods. The analysis of the 35 projects revealed that while fostering connections among residents, among residents and care services, and within care services themselves, was crucial in building Caring Neighbourhoods, the collaboration between care services remained largely instrumental or informative. It did not constitute genuine collaboration in terms of developing a shared vision, nor in the division of roles and responsibilities among care services operating within the same neighbourhood. The three primary connection methods ways were through activities, places and people, highlighting the importance of the Caring Neighbourhood professionals’ role, which should focus on making existing resources visible, weaving them together, facilitating and coaching, rather than organising and developing new, separate initiatives. Finally, the projects brought meaning and value to the lives of participants, enhancing overall life satisfaction and well-being, with a focus on physical and psychosocial care and support. However, although the experienced added value of Caring Neighbourhood projects is significant, there are concerns over the lack of attention to end-of-life care, equity and social justice, and the need for both ‘warm’ and ‘cold solidarity’. Although age-friendly initiatives, compassionate communities, integrated community care and caring neighbourhoods are distinct movements, they all could gain from more critical reflections. It is important to avoid ‘romanticising’ communities, to recognise the historical context of welfare reforms and the dismantling of local care infrastructure and to work towards the institutionalisation of neighbourhood care. Although we do recognise the importance of end-user involvement and participation, we like to emphasise these community-based initiatives should focus on establishing
formal support structures rather than shifting responsibilities onto informal carers, volunteers and neighbours. It is not everybody’s responsibility.

Declarations

Ethics approval and consent to participate
Ethical approval was not required because the research (1) did not involve a vulnerable group or people who cannot give informed consent, (2) did not work with patients and/or patient data and (3) did not take place in a healthcare institution, or involve medical professions. In addition, the study was conducted in conformity with the guidelines of the Human Sciences Ethical Committee of Vrije Universiteit Brussel (VUB) and the European Framework for Research Ethics. Participants gave written consent for participation. The final report in Dutch was sent to all participants for check, consent and feedback. Feedback was incorporated in a revised version of the report.

Consent for publication
Not applicable.

Author contributions
Liesbeth De Donder: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Supervision; Validation; Visualization; Writing – original draft; Writing – Review & editing.

Hannelore Stegen: Formal analysis; Investigation; Methodology; Writing – original draft; Writing – review & editing.

Sylvia Hoens: Formal analysis; Investigation; Methodology; Project administration; Writing – original draft; Writing – Review & editing.

Acknowledgements
The authors acknowledge and wish to thank the participants of the Caring Neighbourhoods for generously sharing their valuable insights and the reading committee of the original Dutch report for their constructive feedback. They also thank the anonymous reviewers for their insightful and helpful comments.

Funding
The authors disclosed receipt of the following financial support for the research, authorship and/or publication of this article: The research and the publishing of the original Dutch report was commissioned and supported by the Dr. Daniël De Coninck Fund.

Competing interests
The authors declare that there is no conflict of interest.

Availability of data and materials
Not applicable.

ORCID iDs
Liesbeth De Donder  https://orcid.org/0000-0003-4999-5902
Hannelore Stegen  https://orcid.org/0000-0001-7954-645X
Sylvia Hoens  https://orcid.org/0000-0002-3305-5003

Supplemental material
Supplemental material for this article is available online.

References


