

## Towards Global Age-Friendly Cities: Determining Urban Features that Promote Active Aging

Louise Plouffe and Alexandre Kalache

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**ABSTRACT** *At the same time as cities are growing, their share of older residents is increasing. To engage and assist cities to become more “age-friendly,” the World Health Organization (WHO) prepared the Global Age-Friendly Cities Guide and a companion “Checklist of Essential Features of Age-Friendly Cities”. In collaboration with partners in 35 cities from developed and developing countries, WHO determined the features of age-friendly cities in eight domains of urban life: outdoor spaces and buildings; transportation; housing; social participation; respect and social inclusion; civic participation and employment; communication and information; and community support and health services. In 33 cities, partners conducted 158 focus groups with persons aged 60 years and older from lower- and middle-income areas of a locally defined geographic area (n=1,485). Additional focus groups were held in most sites with caregivers of older persons (n=250 caregivers) and with service providers from the public, voluntary, and commercial sectors (n=515). No systematic differences in focus group themes were noted between cities in developed and developing countries, although the positive, age-friendly features were more numerous in cities in developed countries. Physical accessibility, service proximity, security, affordability, and inclusiveness were important characteristics everywhere. Based on the recurring issues, a set of core features of an age-friendly city was identified. The Global Age-Friendly Cities Guide and companion “Checklist of Essential Features of Age-Friendly Cities” released by WHO serve as reference for other communities to assess their age readiness and plan change.*

**KEYWORDS** *Age-friendly city, Community assessment, Age-prepared, Elder-friendly*

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### INTRODUCTION

Demographic aging and urbanization are converging global trends with significant implications for human development in the twenty-first century. The number of people aged 60 years and over as a proportion of the global population will double from 11% in 2006 to 22% by 2050, by which time there will be more older people than children (aged 0–14 years) in the population for the first time in human history.<sup>1</sup> Developing countries are aging at a much faster rate than developed countries: by 2050, 79% of the world’s older people will be living in those countries.<sup>2</sup> At the same time, over half of the global population now lives in cities, and the number and proportion of urban dwellers will continue to rise.<sup>3,4</sup> Again, this

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Plouffe is with the Centre for Health Promotion, Division of Aging and Seniors, Public Health Agency of Canada, Ottawa, ON, Canada; Kalache is with the New York Academy of Medicine, New York, NY, USA.

Correspondence: Louise Plouffe, Centre for Health Promotion, Division of Aging and Seniors, Public Health Agency of Canada, 200 Eglantine Driveway, Ottawa, ON K1A 1B4, Canada. (E-mail: louise.a.plouffe@phac-aspc.gc.ca)

growth is happening much more rapidly in developing regions: by 2030, about three out of every five people in the world will live in cities, and the number of urban dwellers in the less developed regions will be almost four times as large as that in the more developed regions.<sup>5</sup>

Population aging and urbanization are the culmination of successful human development during last century. Older people are a resource for their families and communities, and for the economies in the cities where they live. However, to tap the potential that older people represent for continued human development, cities must ensure their inclusion and full access to urban spaces, structures, and services. The United Nations endorsed designing enabling and supportive environments as one of three priority directions in the 2002 *Madrid International Plan of Action on Ageing*.<sup>6</sup>

To encourage world cities to plan for aging as an integral part of planning the built and social environment, the World Health Organization (WHO) initiated a global, collaborative project in 2005 to identify the key features of an “age-friendly” city that would be meaningful to communities in developing as well as in developed countries. Based first and foremost on the lived experience of older residents, this set of age-friendly urban features would guide a city’s self-assessment and serve as a tool for community advocacy.

### **ELDER-FRIENDLY COMMUNITIES IN THE DEVELOPED WORLD**

Elder-friendly community development is a recognized and growing movement concentrated in the United States, represented notably by American Association of Retired Persons *Livable Communities*<sup>7</sup> and the *AdvantAge Initiative* led by the Center for Home Care Policy and Research, Visiting Nurse Association of New York,<sup>8</sup> although similar projects have been undertaken in communities elsewhere, such as the City of Calgary’s Elder-Friendly Community<sup>9</sup> in Canada. Other initiatives have focussed on adapting services to accommodate older clients, including health,<sup>10</sup> financial,<sup>11</sup> and other public, private, and non-profit services.<sup>12</sup> Originating in Lawton and Nahemow’s ecological perspective,<sup>13</sup> which articulated the dynamic interplay between individual adaptation and environmental alteration to maintain optimal functioning in older age, the elder-friendly community movement has emerged from several related-but-distinct trends and concepts in urban design and in service planning for disability and for aging services, including universal design, accessibility, healthy cities, livable communities, walkable communities, and aging in place.<sup>14,15</sup> Elder-friendly community models are multisectoral and incorporate all aspects of the natural, built, and social urban environment. Typically, these initiatives identify the characteristics of the community that are salient for older persons’ wellbeing through individual interviews, focus groups, or surveys with older persons, as well as with caregivers, service providers, and expert groups. These features then serve as the basis to develop specific standards or criteria to guide community assessment and action. As Alley et al.<sup>15</sup> observed, there is much congruence between initiatives in the characteristics of elder-friendly communities identified by older persons and other respondents. They all address needs related to health (e.g., accessible and affordable health and health care services and opportunities to stay active), participation (e.g., accessible public transportation, information services, recreational programs, social connections, volunteer opportunities, place to worship, and the need to be valued and respected), and security (e.g., home and community safety, transportation safety, financial security, and affordable housing and services).

## THE WHO AGE-FRIENDLY CITY CONCEPT

The WHO project proposed that an “age-friendly” city is one that promotes active aging;<sup>16</sup> that is, it *optimizes opportunities for health, participation, and security in order to enhance quality of life as people age*. The realization of *active aging* is determined by multiple personal, social, economic, and environmental factors affecting individuals over the life course, such that functional capacities in older adulthood vary widely as a result of the combined and cumulative effects of all these factors. These determinants account for the considerable gaps in life expectancy, health status, and social wellbeing between older persons in wealthier and poorer countries,<sup>17</sup> as well as between older people from wealthy and deprived areas within an individual city. To explicitly acknowledge that active aging is a life-long process and that people of all ages vary in their functional capacity, WHO purposely chose the term “age-friendly city.”

## METHODOLOGY

The research protocol was designed to guide collaborating groups in cities in developing and developed countries to use a standardized method to assess their community’s age-friendliness and identify areas for remedial action at the same time as they contributed to WHO’s objective of identifying the essential features that constitute an age-friendly city. The protocol had to be straightforward, require a minimum of material and technical resources, and be adaptable to varying cultural and economic contexts. The broad lines of the methodology were defined in consultation with a group of advisers who had expertise in policy, community action, or qualitative research, and who were familiar with the social context of developing as well as developed countries. The draft protocol was then reviewed and finalized at a workshop in Vancouver, Canada, in March 2006, attended by project leaders from most of the participating cities then enlisted. The “Vancouver protocol,”<sup>17</sup> as it became known, was adopted in all cities that participated in the research.

With adaptations to accommodate communities in widely varying countries, a set of eight features of urban life was identified for examination in the Vancouver protocol based on the WHO concept of active aging as well as on the key features identified by existing elder-friendly community models. The topic areas explored in the focus groups were: outdoor spaces and public buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, community support, and health services. In semi-structured focus groups, participants were asked to identify the positive and negative features of the city in each of these eight major areas and to offer suggestions for improvement. To prepare participants for the discussions, local project leaders were encouraged to distribute the list of topic areas when participants were recruited.

In all, the focus group research was conducted in 33 cities\* situated in 22 countries of North and South America, Western Europe, Russia, the Eastern

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\*New York and Edinburgh were included in the original network of cities participating in the WHO initiative, although focus groups using the Vancouver protocol were not conducted in these cities at the time of this research. Edinburgh had previously surveyed older persons on their experience of city living and participated in the information exchanges with the other cities in the WHO initiative. Through the New York Academy of Medicine, New York participated in the analysis of the focus group data and preparation of the WHO *Global Age-Friendly Cities Guide*.

Mediterranean, Africa, the Indian sub-continent, Oceania, and the Pacific Rim. Of the 33 participating sites, 19 were in developing countries, and 14 were in industrialized countries. The cities represent the diversity of contemporary urban settings. There were seven mega-cities with over 10 million inhabitants (Mexico City, Moscow, New Delhi, Rio de Janeiro, Istanbul, Shanghai, and Tokyo) and large metropolises, such as Nairobi and London. Also included were smaller but regionally significant urban centers such as Geneva, Amman, Melbourne, Islamabad, Kingston, and Halifax, as well as towns located near metropolitan areas [e.g., Melville, adjacent to Perth, Australia; Saanich, near Buenos Aires, Argentina; and La Plata, close to Buenos Aires (Argentina)]. Project sites and leaders were recruited through informal networks of the WHO project leaders, formal representation to municipal or state governments, and promotion of the project at professional conferences. A grant from the Public Health Agency of Canada allowed WHO to award small research contracts to non-government organizations and research centers to enable the inclusion of several project sites in the developing world: Kingston, Montego Bay, Mexico City, San Jose, Rio de Janeiro, La Plata, Tripoli, and Nairobi. Also, Help the Aged UK contracted with HelpAge India to conduct the research in two sites in India: New Delhi and Udaipur.

Informed consent and local ethics review was mandatory, recognizing variations in local practices and legal requirements. A procedure for obtaining informed consent adapted from the Pan-American Health Organization SABE Survey (Survey on Health, Wellbeing and Aging in Latin America and the Caribbean)<sup>18</sup> was proposed for study sites which had no accepted practices in place.

### **DEFINING AND DESCRIBING THE CITY**

Within large urban agglomerations, the urban setting that defined “the city” and from which the research participants were selected, was a distinct neighborhood, district, or borough, administratively defined or not, in which most residents conduct most activities of daily living. In smaller municipalities, the urban setting under study could encompass the entire city. In recognition of the challenges in defining territorial boundaries of interest to community health,<sup>19</sup> it was left to project leaders to determine the most appropriate way to circumscribe and define the city.

City project leaders developed a community profile from available administrative data sources highlighting the geographic, topographic, demographic, social, and economic characteristics of the city area, as well as descriptions of the urban infrastructure and services. This information provided the context to understand the local assets and barriers described by the research participants.

### **PARTICIPANT SELECTION AND RECRUITMENT**

Participants included 1,485 older adults classified by age (60–74 years; 75+ years) and residential socioeconomic status (low; middle). Other participants included 250 persons who reported they provided direct care to an older adult, informally or formally, and 515 providers of service to older persons in the public, voluntary, and private sectors (e.g., bus drivers, community center staff, and local merchants). All participants were recruited through convenience sampling. Income classifications of older persons could not be made in a few sites owing to the relative economic homogeneity of the older population.

A minimum of four (age X SES) semi-structured focus groups consisting of eight to ten older persons were held, as well as one focus group (or individual interview if necessary) with the caregivers and the service providers. Each topic area was raised with an open-ended question about positive and negative experiences and suggestions for improvements. Specific questions to prompt exploration were asked if issues were not addressed spontaneously. The sessions were recorded and transcribed for analysis.

## DATA ANALYSIS

The transcribed discussion material was manually content-analyzed at each study site and a report of the findings sent to WHO. For each of the topic areas, the analysis categories were age-friendly features, barriers, and suggestions for improvement. Many site reports included direct quotes illustrating specific themes.

The data from the 33 sites were manually tabulated, and categories of themes were identified by small analysis teams assembled for this purpose at the WHO headquarters, the Government of British Columbia, and the New York Academy of Medicine. The data capture and synthesis were compared for reliability and comprehensiveness within each team. The WHO project coordinator made a final comparison between the theme descriptions and the tabulated data to ensure that the analyses fully and accurately covered the reports from the participating sites.

## RESULTS

The recurring themes and variations among communities are reported in detail in the WHO *Global Age-Friendly Cities Guide*, the project's main report.<sup>19</sup> No systematic differences in themes were noted between reports from communities in developed and developing countries, except the listing of positive, age-friendly features and services tended to be much longer in cities in the developed world. Physical accessibility, proximity, security, affordability, and inclusiveness appeared as important characteristics in all locations. Based on the recurring themes that emerged across the sites, a set of core features of an age-friendly city was identified in the Guide and in a four-page brochure-format *Checklist of Essential Features of Age-Friendly Cities*.<sup>20</sup> These features are intended to serve as reference for other communities to assess their strengths and gaps, advocate for and plan change, and monitor progress.

## DISCUSSION

The assets and barriers reported by the older people, caregivers, and service providers in this global project illustrate how the determinants of active aging<sup>18</sup> play out in many interconnected ways in urban settings. The city's landscape, buildings, transportation system, and housing contribute to confident mobility, healthy behaviors, social participation, and self-determination, or, conversely, to fearful isolation, inactivity, and social exclusion. A wide range of opportunities for age-integrated as well as age-targeted social participation fosters strong social connections and personal empowerment. Empowerment and self-worth are reinforced by a culture that recognizes, respects, and includes older people. Relevant information in appropriate formats also contributes to personal empowerment as well as to healthy behaviors. Accessible and well-coordinated health services have an obvious influence on older people's health

status and health behavior. Although opportunities for paid work are one economic contributor to active aging, more important still are policies that reduce economic inequalities in access to all of the city's structures, services, and opportunities.

Design for diversity emerged as another cross-cutting characteristic of an age-friendly city. According to the project participants, it should be normal for the natural and built environment to anticipate users with different capabilities: an age-friendly city emphasizes enablement rather than disablement: it is thus friendly for all ages and not just "elder" friendly.

This project has served as a starting point for age-friendly community development initiatives in more cities, including New York City.<sup>21</sup> Many more cities, as well, are participating within growing national networks, notably in Canada, France, Portugal, Spain, Brazil, and South Africa. In Canada, an *Age-Friendly Rural and Remote Communities Guide*<sup>22</sup> was developed using the Vancouver protocol as a companion tool to assist numerous small communities conduct similar assessments of their age-friendliness. A larger, global network of age-friendly communities is developing, with information exchange and sharing facilitated by organizations collaborating with WHO including the International Federation on Ageing, national governments, and non-government organizations. Partners in collaborating cities and countries have hosted meetings to promote the sharing of experiences and promising practices. The WHO Ageing and Life Course Department will continue to provide the institutional leadership for the *WHO Global Age-Friendly Cities Network*, building on the initial work described here by articulating implementation guidelines and by defining a minimum set of standards for communities that wish to participate in the *WHO Global Age-Friendly Cities Network*. WHO will also maintain ongoing partnerships with governments and civil society to promote age-friendly cities, monitor their development, and exchange knowledge generated from projects in numerous and diverse cities.

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