Chapter 2
A Critical Review of the WHO Age-Friendly Cities Methodology and Its Implementation

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2.1 Introduction

In 2007, the World Health Organization released the report: *Global age-friendly cities*: *A Guide* (World Health Organization 2007a) to stimulate the creation of accessible and inclusive urban environments in order to promote active aging as defined by the WHO (2002). The Guide identified the key features of an age-friendly city from the perspective of older persons and service providers to serve as a reference for cities in developing as well as in developed countries (Plouffe and Kalache 2010; World Health Organization 2007a). The WHO initiative has rapidly spread and gained recognition as a global movement (Barusch 2013; Golant 2014; Liddle et al. 2014; Lui et al. 2009). The WHO Global Network of Age-Friendly Cities includes 209 cities and communities in 26 countries (WHO, Personal communication 2014) in addition to 10 affiliated country- or state-level programs. In Canada alone, over 850 municipalities now participate in age-friendly initiatives promoted by municipal, provincial and federal, governments (Plouffe et al. 2012).

The methodology developed for the Guide and subsequently for communities eager to become age-friendly using this approach was the Vancouver Protocol (Plouffe and Kalache 2010; World Health Organization 2007b). The foundation of

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the Vancouver Protocol was the WHO (2002) concept of active aging, defined as: "the process of optimizing opportunities for health, participation and security over the life course in order to enhance quality of life as people age" (World Health Organization 2002, p. 12). Building on this definition and on a thorough review of elder-friendly community initiatives at that time in North America, the protocol proposed a qualitative assessment of the built, social, and service environments in eight domains: 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. The Vancouver Protocol was finalized at an international workshop organized by the WHO in association with the Public Health Agency of Canada and the Government of British Columbia and with representatives from 12 cities (of the eventual 33 cities) that had already committed themselves to conduct the multicentric international study. Specific elements of the age-friendly cities assessment methodology included: documentation of the profile of the city and the older adult population and an inventory of programs and services for older persons; semi-structured focus groups with older persons differing by age and socio-economic status, and, where possible, differing along other characteristics that represent their diversity, as well as with a group of caregivers of older persons unable to participate in focus groups owing to disabilities and a group of service providers from the public, private, and voluntary sector.

The WHO Guide (2007a) offered the added benefit of a checklist of features of an age-friendly city for cities to use as a tool to guide municipal self-assessment. Emerging from the 'bottom-up' consultation in the 33 cities that participated in the WHO study, the checklist was intended to provide a standard set of features with which a city could compare the findings from its assessment in consultation with its older residents.

In the online instructions to join the Global Network of Age-Friendly Cities and Communities, WHO (n.d.) continues to emphasize that older persons should be closely involved in all phases of age-friendly assessment, planning, and action. Applicants are required to include the eight domains in their assessment, but they have flexibility in the assessment method in light of the diversity of cities and communities; WHO does not specify whether or how to use the checklist.

The aim of this chapter is to review how the Vancouver Protocol and checklist of age-friendly city features have been applied in diverse municipalities, regions, states, and countries in order to determine the 'lessons learned' both from experience and from further scrutiny by gerontologists. Locations listed in table below were chosen in North and South America, Europe and Australia to represent a variety of municipalities, regions, states, and countries (Table 2.1).

Published reports, online materials, and gray literature written in English, French, Portuguese, and Spanish were consulted. Firsthand accounts from persons who have led age-friendly initiatives are included as well. The initiatives were selected from those with which the authors are most familiar, are in languages they know, and/or for which program materials are accessible. Several lines of enquiry have guided the exploration.

Table 2.1 Age-friendly cities and communities initiatives reviewed

Country	Location	Jurisdiction
Australia	South Australia	State
Brazil	Sao Paulo	State
Canada	Canada	National
	Québec	Provincial
	Ontario	Provincial
	Montreal	Municipal
	Ottawa	Municipal
	Toronto	Municipal
France	Lyon	Municipal
Northern Ireland	Belfast	Municipal
Republic of Ireland	Ireland	National
	Louth	County
	Kilkenny	County
	Fingal	County
Spain	Basque Autonomous Region	State
USA	New York City	Municipal
	Portland, Oregon	Municipal

- How have the eight domains stood up to critical examination and application in different contexts?
- What methods have been used to assess a community's baseline age-friendliness, and what role has the checklist played?
- What population groups have been included in community assessments and have they represented the diversity of older adults, including those from low-income groups?
- What has been the role of older persons in the age-friendly cities' process?

In assessing these issues, the review also considers critical analyses of the WHO methodology that has appeared in the gerontological literature.

2.2   Are the Eight Domains of Age-Friendliness Adequate?

Gerontologists using the Vancouver Protocol have sought to determine the extent to which the eight domains are supported by empirical research on the environmental and social factors associated with well-being in older age. With some slight divergences, these reviewers have confirmed the consistency of the domains with gerontological research (Liddle et al. 2014; Menec et al. 2011; The New York Academy of Medicine n.d.). A recent study by Menec and Nowicki (2014) also provides empirical evidence linking six of the original domains to life-satisfaction outcomes among older persons in rural communities: physical environment

(outdoor spaces and buildings), transportation, opportunities for participation (which includes social as well as civic participation and employment), communication and information, and community support and health services.

The area of *respect and social inclusion* has been the subject of criticism by Menec et al. (2011), who regard it as a basic value of the initiative rather than as a separate domain. Instead, these authors propose that variables of economic inequality and social disorder that lead to social exclusion be part of a new domain of *social environment*. While they agree that respect and social inclusion is an underlying value orientation, Liddle et al. (2014) accept it as a distinct area in view of the importance of identifying and addressing ageism and the exclusion of older persons from community decision processes. The literature review for the Age-Friendly New York program (n.d.) also supports social inclusion as an age-friendly feature and further documents the research evidence supporting *Respect*, understood as the absence of age discrimination.

The Vancouver Protocol did not give adequate coverage of social networks and social support and of protection from harm (physical safety and crime protection). The domain of Social participation considered activities, but did not specifically include unstructured contact with family, friends, and neighbors. Menec et al. (2011), the New York Academy of Medicine (n.d.) and the Basque Regional Government/Matia Foundation age-friendly municipalities assessment questionnaire (Barrios and Sanchez 2013) highlight the importance of having regular contact with family and friends as an age-friendly community feature, apart from participation in formal social activities. Access to informal support from family and friends was not considered in the domain of Community Support and Health Services, but was signaled for inclusion by Menec et al. (2011) and added to municipal assessments by Barrios and Sanchez (2013) in the Basque County and by the City of Lyon (2011).

Harm protection is featured in items within the WHO domains of outdoor spaces and buildings, transportation and housing. However, a few municipal and state projects have identified this as a distinct domain, notably the cities of Toronto (2013) and Montreal (2013) and County Fingal (n.d.). The Basque Region program examined crime security only (Barrios and Sanchez 2013).

Implementing the age-friendly city initiative has shown that some features are less relevant for older persons in less developed countries. One example relates to the availability of housing options and to community support and health services. In the municipality of São Paulo, experts responsible for conducting the age-friendly city assessment told the authors that questions about housing options were not understood in the consultations. In Brazil, the vast majority of older persons have no choice but to remain in their current dwellings or live with family because adapted, assisted-living, or congregate dwellings in both the public and the private sector are extremely scarce. They could not criticize the lack of possibilities that they did not know could exist. Similarly, because support and care of older persons is by law the responsibility of the family in Brazil (Presidência da República 2003), publicly funded support services are virtually nonexistent and private services are limited to the privileged minority. Thus, for older Brazilians, the domain of

Community support and health services is understood only in terms of services that are publically available, i.e., primary health care and hospital care. These observations underscore the requirement to complement older persons' perceptions with a community profile that documents the existing services and the views of experts and informed advocates and with an inventory of services and policies to fully assess the community's strengths and gaps.

Further modifications have been made to the WHO domains in various locations. One is to group Social Participation and Civic Participation and Employment into a single category, e.g., 'Opportunities for Participation' (Liddle et al. 2014; Menec et al. 2011), which highlights the dimension of participation itself, in all forms, as a vector for social integration and individual fulfillment. Alternatively, both the Province of Québec (Government of Québec 2013) and the City of Lyon (2011) distinguish Civic participation from other forms of participation to place particular value on the engagement of older persons as citizens and to their contribution as volunteers to formal and informal community support. County Kilkenny (n.d.) identified employment and income in order to capture needs for financial security within the scope of community services (e.g., financial literacy, banking services, and protection against fraud).

Overall, the original WHO dimensions of age-friendliness have been supported in their application in diverse locations and by gerontological research, with some additions and refinements along the way. To the question of how many dimensions are needed to assess age-friendliness, Menec et al. (2011, p. 482) reply pragmatically that "including more domains can emphasize aspects of the community environment that otherwise might not be considered". Empirical association between age-friendly community domains and the well-being of older persons, and, eventually, outcome evaluations of age-friendly community interventions in various domains may provide more conclusive answers. At the leading edge of this research is the study by Menec and Nowicki (2014) in 29 Canadian rural communities that showed that seniors' life-satisfaction was positively associated with their assessments of six dimensions of their community's age-friendliness (physical environment, social environment, opportunities for participation, informal and community supports and health care services, transportation and communication, and information) while associations with seniors' self-perceived health were found for four of the above dimensions.

Rather than focusing on which domains are the 'right' ones, Menec et al. (2011) and Liddle et al. (2014) caution us against using a model with fixed and discrete features. These authors note the interdependence among the features and the need to regard them as a dynamic whole. The interactive and dynamic nature of the domains was noted frequently in the consultation reports upon which the *Guide* is based. In distilling the 'essential' features of each domain to create the checklist, however, this interdependence was attenuated. Similar quantitative questionnaire approaches to assessing age-friendliness with discrete items for each domain may fail to capture the interrelationships that show what policy areas need to be considered jointly for effective action. Combining quantitative and qualitative methods is more effective to get both the breadth of views about the city's various features,

as well as a more holistic perspective that captures their interrelationships. The WHO *Age-Friendly Cities Guide* (2007a) emphasizes the strong interconnections among the different domains, referring to them as "integrated and mutually enhancing" (p. 73) and calls for coordinated policy action, for instance, considering housing policy in connection with policies for the built environment and for opportunities for participation. Accordingly, intersectoral representation on steering or planning groups figures prominently in the actual or recommended implementation of age-friendly initiatives, for instance: Ireland (n.d.), Québec (2013), Sao Paulo (2013), and South Australia (2012a). In Sao Paulo, the decree establishing Age-Friendly Sao Paulo (AFSP) created a committee with representatives from all State Secretariats (ministries) and an executive secretariat based at the Secretary of Social Development assisted by Alexandre Kalache, as the senior consultant. The decree also instructed each of the State Secretaries to launch an 'emblematic' project, which would signal the Governor's resolve and commitment to ASFP, further ensuring the indispensable intersectoral nature of the program.

2.3 International Approaches to Assessing Age-Friendliness

The checklist of age-friendly features has led to the categorization of the WHO age-friendly city model presented in the *Guide* as being a 'top-down' approach to planning, directed by local authorities to achieve preestablished criteria (Barusch 2013; Lui et al. 2009). The checklist has received criticism on a few counts. The first is that it fails to recognize the diversity of older persons and of communities and the ongoing changes in living environments. A second, and somewhat contradictory charge, is that the checklist is unrealistically broad in the range of needs identified. And the third is that it subverts citizen engagement by older persons.

Menec et al. (2011) and Keating et al. (2013) contend that what makes a community age-friendly is having a good fit between the older person and his/her living environment, not conformity with a standard and fixed set of features. The fact that there are many diverse groups of older persons with different needs implies that there are correspondingly different 'age-friendly' environments with matching resources. Moreover, places evolve over time; a city that is age-friendly at one time may become unfriendly at another; thus, becoming or remaining age-friendly is an ongoing process.

Golant, on the other hand, makes the case that the age-friendly cities initiative, as reflected in the checklist, tries to reach too many groups with diverse needs in the community. Arguing that public resources are too limited to meet all needs, this author advises that "communities should rely on carefully tuned diagnostic and evaluative methods to prioritize the implementation of their programs" (Golant 2014, p. 11).

Starting from the perspective that an age-friendly city is one where older persons enjoy 'urban citizenship', i.e., the right to benefit from all the resources offered in the city and to participate in decisions about these resources, Phillipson (2010), Buffel et al. (2012), and Liddle et al. (2014) argue against the imposition of an arbitrary checklist of an 'ideal city' by authorities. Rather, using a "strictly bottom-up" approach, older persons themselves should be the main protagonists in defining the "actual opportunities and constraints in cities for maintaining quality of life as people age" (Buffel et al. 2012, p. 601).

In practice, different diagnostic approaches have been adopted or recommended. Approaches that rely entirely on local consultations referring to the WHO domains, but not specifically to the checklist are common. This is the case for Québec's *Municipalités-amies des aînés* (2013), the Pan-Canadian Age-Friendly Communities (Public Health Agency of Canada n.d.), and Ireland's Age-Friendly Counties (n.d.). The municipal age-friendly action plans developed by the cities of Toronto (2013) and Montreal (2013) reflect the issues identified by internal analysis and in public consultations, not the WHO checklist. A number of sites have used the checklist items in a survey questionnaire to complement qualitative data from forums or focus groups. This is evident, for instance, in the assessment materials developed for the City of Belfast (McClean 2013) and for the Basque Autonomous Region (Barrios and Sanchez 2013; Basque Government and Matia Foundation n.d.).

The Province of Ontario's *Age-friendly community planning guide* (2014) aims to marry local person-environment fit with a tailored selection of various evidence-based community assessment guidelines, including the WHO checklist. The Guide recommends that age-friendly stakeholders first consult widely within the community, via meetings, interviews, and focus groups, to identify a collective age-friendly vision and goals for the community and to choose priorities from and within the WHO age-friendly domains. Having identified the unique realities and aspirations of the community, stakeholders create a customized needs-assessment survey, drawing from existing age-friendly community and quality of life questionnaires, to address the issues of interest in the priority domains. The tailored instrument should contain questions that address individual needs (the 'person') from quality of life questionnaires with corresponding questions touching on community resources ('the environment') from the age-friendly survey instruments. The WHO checklist is one among the age-friendly questionnaires within the inventory of instruments suggested. Some, all, or none of the checklist items may be selected, depending on local priorities. With a wide distribution of the instrument in the community, the custom questionnaire data can be disaggregated at the neighborhood level to obtain even more fine-grained information about baseline age-friendliness. This guide is a new and innovative approach to harness standard instruments to respond flexibly and strategically to particular circumstances. Repeated use of this approach over time and in many communities will shed light on both the similarities and differences between communities with respect to person-environment fit, possibly contributing to community typologies (Keating et al. 2013). It will also reveal what instruments and items are the most useful in

assessing age-friendliness. Finally, it could respond to requirements of communities to target age-friendly strategies to distinct groups within the older population.

The states of Sao Paulo and of South Australia have each developed programs that are modeled on the WHO checklist to achieve state-wide policy objectives, but which also rely on 'bottom-up' engagement of older persons, although in different ways.

The Age-Friendly Sao Paulo program was established through a process spanning four years until it was officially launched as a state program in 2012. The age-friendly initiatives that preceded its launch were aimed at creating a critical mass, with several municipalities adopting age-friendly approaches lead by a variety of partners: local municipal governments, academic institutions, civil society, and even private organizations. From 2008 to 2012, in close partnership with the Coordinator of the Program on health of older persons, State Secretary of Health, Marilia Louvison, Alexandre Kalache visited some 40 municipalities, making presentations, organizing seminars, and workshops or simply visiting municipal authorities with the objective of disseminating the principles behind the age-friendly cities approach, in particular, describing the WHO Active Aging Policy Framework. As a result, a number of initiatives were established at a local level, always espousing the binomial 'top-down/bottom-up' approach with government commitment to act based on views and opinions given by older people on their actual experience of growing older where they lived. A number of such local age-friendly initiatives can be found in the book edited by Rosa et al. (2013).

In a public event in November 2011, these various 'bottom-up' experiences were offered to the Governor as the foundations for a state-wide program. In May 2012, by an executive decree, the Age-Friendly State of Sao Paulo (AFSP) was launched at the Governor's Palace in the presence of over 1000 individuals, most of them older persons composing delegations representing a wide range of municipalities. The committee charged with developing the State program was chaired by the President of the State Council of Older People, to underscore the centrality of older persons' voices in developing the State initiative.

On one hand, AFSP is a highly structured, state-led initiative. It adopted a strong focus on the three pillars of the WHO Active Aging Policy Framework (2002): health; participation and security to which a fourth pillar of life-long learning has been added (Kalache 2013). It was also structured to achieve the policy obligations in the federal *Statute for Older Persons* (2003) and the *National Health Policy for Older Persons* (Ministério da Saúde 2006). The *Statute for Older Persons* affirms the rights of older persons in Brazilian society and obliges public authorities at federal, state, and municipal levels to provide a wide range of services and benefits in the areas of Health, Transportation, Housing, Labor, Social Welfare, Income Support, and Education/Sport/Recreation/Culture. The *National Health Policy for Older Persons* (2006) further mandates specific programs for older persons in disease and injury prevention and health promotion, as well as for enhancement of professional education in gerontology and geriatrics. This federal legislative framework is encompassing, ambitious, and legally binding, but implementation has been uneven and fragmentary (Kalache 2012). Thus, the implementation of the

AFSP program was an opportunity for government to fully implement these policies at the State level. On the other hand, AFSP also adopted a highly participatory approach by giving a central role to the Councils of Older Persons (*Conselhos dos Idosos*). These councils are required by federal law and are expected to be active at all government levels: federal, state, and municipal. Their main function is to oversee the implementation of the Statute within their jurisdiction and to ensure an active voice of older persons in policy development: according to the dictum "nothing about us without us."

The Age-Friendly Sao Paulo Program (2013) identifies 40 policy actions for participating municipalities, all of which are aligned with the eight WHO domains of age-friendliness and checklist. Ten of them are mandatory and must be achieved in the first year of the program. The first required action is to establish and/or strengthen the Council of Older Persons, again reinforcing the critical importance of older persons' voices in shaping age-friendly actions. In the two following years, municipalities choose four from among 30 elective policy measures, based upon local consultations with older persons and with public sector managers. To maintain full status in the program in subsequent years, municipalities must measure implementation of actions taken, renew the cycle of consultations and select further elective actions. The protagonist role of older persons through the Councils and consultation groups is again a key feature of this evaluation process.

The WHO checklist has been used to develop an 80-item questionnaire, with 10 items for each age-friendly domain to assess how and where the Statute for Older Persons is achieved or lacking. Each question is discussed fully in workshops with representatives of older persons' organizations to collectively determine a score for the item on a three-point scale (yes, partly, no). The pattern of strengths and weaknesses across the domains become the 'bottom-up' input of older citizens in the selection of municipal priorities within the predetermined requirements of the *Statute*.

In South Australia, the state-wide program was designed to develop in the opposite direction: first, the production by the government of a set of guideline documents based on the WHO checklist, and then extensive consultations with older persons and their organizations at the municipal level to decide on local priorities. *South Australia's Communities for All: Our Age-Friendly Future* (2012b) consists of three age-friendly guidelines booklets which apply the WHO checklist to orient action at the level of the state, local government, and residential development projects, respectively. The booklets map existing guidelines, standards, plans, and requirements against the checklist in the eight domains. For each domain, the booklets support implementation of the checklist items, which are identified as the 'WHO criteria', by providing corresponding guidelines, good practices, and a list of resources and technical references. Within the age-friendly guidelines as the range of potential actions, local governments have the opportunity to establish local priorities by conducting a self-assessment. Consultation with internal and external stakeholders, and with the community at large, using the WHO Vancouver Protocol was the next step. Council on the Aging (COTA), the national organization present in all states that represents older peoples' interests in policy, actively participated in the

consultations that were held. However, not long after the release of the program, there was a change in government, and the state support for the community consultations on the guidelines reports has waned (for further developments on the Australian case, consult the chapter of Brasher and Winterton).

Both Sao Paulo (2013) and South Australia (2012b) made explicit use of the WHO checklist as a vehicle for identifying areas for action. In Sao Paulo, legislative requirements were the key drivers for adopting the checklist as the model, while in South Australia, the checklist served as an anchor and stimulus to advance current policy directions and existing standards of good practice. In both instances, however, the top-down action at the state level was balanced and complemented by processes (at least initially) to ensure the active engagement of older persons in local decision-making.

2.4   Capturing Diversity: Whose Voices Are Heard in the Assessment of Age-Friendliness?

Contrary to the critiques that the WHO initiative fails to acknowledge the need for a person-environment fit (Keating et al. 2013; Liddle et al. 2014; Menec et al. 2011), the age-friendly assessment method developed by WHO in the Vancouver Protocol does recommend reflecting the diversity of older persons in the community in order to capture and respond to their heterogeneity. At a minimum, the Protocol advises that assessments should include older persons varying by age, by socio-economic status and by ability level, and ideally, assessments should be conducted at a neighborhood level, considering their diversity within a city. A line of enquiry therefore was the extent to which this advice has been followed in age-friendly initiatives undertaken in different locations.

Many local initiatives have focused on large public events. Some have focused on getting views from as many older persons as possible; others have included older as well as younger persons and stakeholder groups with shared interests, such as disability advocates. Web-based and paper-and-pencil consultations also have been made open to the general public. This approach to inclusion is to be expected, given that municipal governments are concerned with meeting a broad range of population needs at the same time and with getting support for initiatives from a critical mass.

Yet some cities have made extensive efforts to be inclusive of diversity, using different consultation approaches to reach out to older persons who are less visible to decision-makers. Efforts have been made as well to broaden the age-friendly consultations to include other generations and interest groups with potentially similar issues, in particular, disability groups.

Consultations for Age-Friendly New York City (2008) systematically assured diversity with respect to geography, race, culture and language, socio-economic level, and disability as well as LGBT. Town hall meetings have been conducted in different community centers and in different languages to draw in people reflecting this diversity. Immigrants were interviewed individually as required. Focus groups

were held with marginalized persons, such as persons who lived in poverty, who were previously homeless or HIV positive. Age-Friendly Portland (Orca Planning 2013) also used a range of approaches to reach a similarly diverse older urban population. The City of Ottawa (2012) used focus groups to capture the diversity of voices, including First Nations, and persons with developmental intellectual disabilities. The City of Toronto (2013) translated its age-friendly city consultation workbook into 11 languages to reach a highly multi-cultural population. Within the City of Sao Paulo, the diversity of neighborhoods (*bairros*) was respected with specific consultations in, for example, Vila Clementina (Costa Rosa et al. 2013), Mooca (Casado 2013), and the Zona Norte (Uehara et al. 2013). The City of Lyon (2011) organized focus groups with older persons in all neighborhoods, and then classified older persons into distinct groups based on expressed needs and profiles. In Belfast (McClean 2013), peer facilitators held focus groups to reach persons at the risk of social exclusion, in particular, blacks and minorities, isolated and less mobile persons in sheltered accommodation, older caregivers and older men. In this city as well, disability groups included persons who were deaf or blind. In Québec (2013) the provincial program guide specifically recommends municipal groups to ensure the participation of vulnerable persons by having them well-represented in community consultations. The Pan-Canadian Guide (Public Health Agency of Canada and Mount St Vincent University 2013) recommends that different groups in the population be represented on the project advisory committee that steers the local initiatives. These examples show that for many age-friendly programs, identifying the diversity of needs in the community is important.

Does inclusion of diversity in consultations result in action plans that respond to different needs? That is, do age-friendly initiatives attempt to provide urban resources tailored to varying needs? From the initiatives reviewed here, five cities do address diversity issues. *The Toronto seniors' strategy* (2013) adopts a general diversity lens to municipal planning rather than formulating actions targeted to specific needs. For example, commitments include ensuring that: "diverse older adults are fully involved in the development of programming"… (p. 45); "reduce financial barriers to its programming for older adults" (p. 52); and "training City staff to effectively serve all older adults including those who are vulnerable or have special needs" (p. 34). In *Age-Friendly NYC: Enhancing our city's livability for older New Yorkers* (The New York Academy of Medicine 2009) the city articulated actions targeted to the needs of specific vulnerable groups, such as improving processes for creating low-income housing and providing taxi vouchers for people unable to use public transportation. Belfast (McClean 2013) was unique in that it mentioned having compared the priorities among the WHO age-friendly domains selected by at-risk older persons with those chosen in general consultation events. The priorities were similar for both groups. Several of the city's actions focus on reducing social exclusion and disadvantage in concrete ways. In its 2012 *Older Adult Plan*, the City of Ottawa systematically identifies "target groups to benefit" from the age-friendly actions (City of Ottawa 2012). The last example is the *Lyon, Ville amie des aînés* report (2011) where the recommended actions in each domain respond to the needs of different group profiles identified.

A dissonant voice on the matter is Golant (2014), who cautions against over-ambitious age-friendly agendas which try to meet the needs of all groups in the community. Claiming this shotgun approach to be unrealistic and at times redundant with other similar urban initiatives, he advises targeting age-friendly initiatives to reach the large group of "modest or moderate income" older persons who are not so well-off that they can purchase the resources to meet their own needs nor who are so poor that their basic needs are met by a public social safety net. To date, no city has yet adopted this focus for its age-friendly city initiative. If it does occur, it will be interesting to compare the actions taken, outcomes and sustainability of the program with those of communities who target diversity.

The potential of age-friendly cities to reduce health and social inequalities at the local level has been highlighted by Kendig and Phillipson (2014) and Scharf (2013). The explicit inclusion of older persons from low-income neighborhoods in the WHO Vancouver Protocol was intended to promote this goal and several items in the checklist deal with economic barriers. Initiatives in some places have targeted income inequality, as illustrated in the examples above. In Sao Paulo, many of the actions created by the State for municipalities target low-income older persons, both because they constitute the majority of the population, and because they are the principal beneficiaries of public policy in many areas, e.g., housing, public transportation, community support, and health services.

In Europe, Scharf (2013) notes that there is little evidence of use of the age-friendly cities initiative as a community development tool in disadvantaged communities. Golant (2014) makes the same observation for North America and suggests that a lack of community leadership in disadvantaged communities is a key explanation. The importance of having leadership for successful age-friendly community development is supported by the implementation evaluations conducted in the provinces of British Columbia (Gallagher and Mallhi 2010) and Manitoba (Menec et al. 2014). While Golant (2014) and others, including the present authors, advocate for public investment in age-friendly development in disadvantaged communities, it is difficult to imagine that efforts would be sustainable or successful without including leadership development as a significant component of an implementation program.

2.5   How Does the Age-Friendly City Assessment Process Engage Older Persons?

Critics of the WHO Age-friendly cities initiative have characterized it as a 'top-down' model of intervention in which change is directed by government authorities and experts, with older people involved only in providing information to decision-makers (Barusch 2013; Buffel et al. 2012; Lui et al. 2009). Buffel et al. (2012) in particular, strongly advocate for an approach that promotes the active participation of older persons:

> Involving older people in the development and maintenance of age-friendly environments
> represents a crucial goal for social policy. Achieving this {…} will require a radical shift
> from producing urban environments *for* people to developing neighborhoods *with* and *by*
> older people (Buffel et al. 2012, p. 609).

For these authors, as for Liddle et al. (2014), participation of older persons in decisions about the community in which they live is inherent to the goal of enhancing social inclusion, which defines age-friendliness.

Possibly because the WHO initiative is summarily seen as a 'top-down' checklist, criticism of the WHO Guide (2007a) has overlooked its emphatic call for the active engagement of older persons in age-friendly community development:

> The same principle followed in creating the Guide applies to using it: that is: involve older
> people as full partners at all stages. {…} They will provide suggestions for change and they
> may participate in implementing improvement projects. {…} In the follow-up stages of
> 'age-friendly' local action, it is imperative that older people continue to be involved in
> monitoring the city's progress and acting as age-friendly city advocates and advisers
> (World Health Organization 2007a, p. 11).

The WHO Global Network has maintained this original position by requiring that groups wishing to join the Network must establish mechanisms to involve older persons through all phases of the initiative. The WHO 'model' was created as, and remains, a 'top-down' and 'bottom-up' approach, requiring the joint engagement of local decision-makers with older persons.

In practice, initiatives that have been undertaken vary considerably in their involvement of older persons. The Sao Paulo State program began with strong participation from older persons in voicing their issues and with the intention to involve them in making decisions and monitoring government action through the Councils of Older Persons. However, their involvement has been made ineffective by government control of the Council of Older Persons at the state level, and inevitably at municipal levels as well. This situation has arisen because, within the Brazilian system, presidency of the Older Persons Councils alternates every two years between the government and the civil society sectors. Unfortunately, this has led to a slowing of the program's implementation and is effectively denying older persons their right to have the critical role in monitoring it. In South Australia, following a change in government, the process of consultations with older persons in age-friendly decision-making has been eclipsed. In five initiatives in Europe and North America, involving older persons as full partners respects the principles of social inclusion and participation, which are keys to age-friendliness. The Louth Age-Friendly County Strategy Document (n.d.) announces that it is "A plan developed with older people, not for them". The Québec Guide (2013), developed with the ongoing experience of over 600 communities engaged in the initiative, advises that one of the winning conditions of the initiative is the active participation of older persons in every stage of the process and the contribution of the entire community. Age-Friendly New York City's (The New York Academy of Medicine 2012) program to create Aging Improvement Districts (that is, age-friendly neighborhoods) mentions that "leadership by older people" is one of the four things a community

needs to succeed. In all these initiatives, participation of older persons on the local advisory committee is a requirement. Describing the activities undertaken in each municipality, the Basque County initiative (n.d.) shows how older persons' organizations have been involved in publicizing the initiative, garnering public support and generating wide participation in the age-friendly assessment process, and in implementing proposed age-friendly actions, and in monitoring projects undertaken.

2.6   Discussion

With the publication of the Age-Friendly Cities Guide (2007a), WHO advanced an initial model of an age-friendly city, based on the Vancouver Protocol and the checklist of frequently mentioned features in the eight areas of the Protocol (2007b). The Guide (2007a) strongly recommends the involvement of older persons in all phases of action and the adoption of an intersectoral approach to cities wishing to become more age-friendly. Since then, the WHO initiative has been implemented in varying social contexts in many locations. The methodology has undergone adaptations, and the eight original domains have been edited, adding some elements that were not sufficiently present, in particular informal social networks and social support and safety and security concerns.

The initiative has received criticism as well. One issue deals with recognizing and addressing the dynamic diversity of communities and of older persons. In this context, it is preferable to view the WHO checklist of age-friendly features as an inventory of commonly identified characteristics, a starting point for cities which may be enriched, pared down or modified, depending on the particular context in which it is used. Use and adaptation of the checklist in local questionnaires, sometimes in conjunction with other instruments, shows that it is a practical tool used flexibly by communities, but not a norm. Similarly, a flexible approach has been taken to the WHO domains, inviting people in consultations to choose their priorities from among the eight areas rather than 'imposing' all of them. To find the right fit between environments and persons within age-friendly initiatives has led to the inclusion of diverse population groups regarding their needs. Some cities have developed action plans that explicitly target diversity as well as mainstream needs, or have introduced neighborhood-level consultations and initiatives.

The initiative has been characterized as well as an arbitrary model, a checklist, with no expectation of real engagement by citizens, and especially, of older persons. As this review amply demonstrates, this view is inexact. Engagement of local older persons in age-friendly assessment and action, as recommended by the WHO Guide (2007a) and the current WHO Network of Age-Friendly Cities and Communities, is present in many programs, although the type and extent of engagement vary.

With growing practical experience in various settings, critical reflection and emerging evaluation research evidence, the WHO Age-friendly Cities and Communities initiative has perhaps reached a level of maturity that would justify a

revision of the original approach by the WHO Global Network. The areas for community assessment could be modified, and different instruments proposed for conducting the assessments. Clearer guidance regarding the 2007 checklist of Age-Friendly Features could encourage its use by communities as a suggested 'starter' list based on the results of the original WHO consultation research, but not a replacement for a thorough assessment and prioritization of the needs of older persons in individual communities.

2.7 Conclusion

Buffel et al. (2012) identified three issues requiring particular attention in the further development of age-friendly communities: the need to recognize the diversity of cities and their inhabitants; the requirement for a life-course perspective that takes into account needs of residents of all ages; the need to actively involve older persons in community planning and development actions. As shown here, these issues are being addressed in practical ways in various local initiatives on different continents. These issues continue to be relevant as the WHO Global Network of Age-Friendly Cities and Communities spreads. They are keys as well to the sustainability of the program—to favor 'mainstreaming' it in policy and planning and to maintain a critical mass of support within the population that plays heavily in political decisions. The sustainability of the Age-Friendly Cities initiative may be strengthened as well if it contributes to the policy priority of reducing social inequalities within living environments.

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