

Meeting Report Prepared by the WHO Centre for Health Development, Kobe, Japan

2nd WHO Consultation on Developing Indicators for Age-friendly Cities

8 SEPTEMBER, 2013, QUÉBEC CITY, CANADA

EXECUTIVE SUMMARY

This consultation is part of a series of consultations, started in 2012, organized by the WHO Centre for Health Development (Kobe, Japan) in an effort to develop new technical guidance on monitoring age-friendliness of cities. The objective of this consultation was to obtain expert opinion on how to advance the development of an Age-friendly City monitoring framework and core indicator set.

Fourteen international experts and seven WHO officers, representing five of the WHO regions, gathered for this one-day meeting. The main inputs for discussion were a draft monitoring framework and the preliminary results from a pilot study. Twenty cities from seven countries had participated in the pilot study which involved an evaluation of 61 indicators considered critical for monitoring age-friendliness of cities through previous consultation with officials and experts. The indicators were ranked by value scores assigned by local health officials and community representatives participating in the pilot study, and a short list of high-ranking indicators was constructed. During the meeting, the experts engaged in group work to provide specific feedback on the framework, the short-listed candidates for the core indicators and their proposed definitions.

The outcomes of the meeting suggest possible modifications to the structural and visual aspects of the framework, a narrower set of core indicators, and the development of an assessment tool that would help users apply the framework and core indicators to their own local context. Additional inputs will be sought before finalizing these products through further consultations with relevant experts as well as with local health officials and community representatives in Member States.

BACKGROUND

The WHO Centre for Health Development in Kobe, Japan (WHO Kobe Centre) initiated the development of globally applicable core indicators for assessing the “age-friendliness” of cities in 2012, employing its expertise in urban health metrics development and drawing upon the foundation which had been laid by WHO in developing the Active Ageing policy framework and, in particular, the Global Age-friendly Cities Guide. The core indicators are intended to provide direction for any area interested in evaluating and monitoring their age-friendliness including, but not limited to, members of the WHO Global Network of Age-friendly Cities and Communities; the Healthy Cities; and other cities engaged in developing healthy ageing profiles or otherwise investing in the use of indicators for planning, monitoring, and evaluation.

The first step in the development process was to conduct a comprehensive review of existing indicators related to issues of ageing, health and the urban environment to generate a master list of 195 indicators. As a second step, the first expert consultation was held in St Gallen, Switzerland in August 2012, where a group of experts short-listed 61 indicators from the master list as candidates for the core indicators. Since then, as a third step, those indicators have been evaluated in a pilot study by local government and community representatives of cities (i.e. target end-users) in Australia, Canada, China, Ireland, Japan, Korea, Sri Lanka, UK and USA.

The main aim of this second consultation was to obtain another round of feedback from experts on the candidates for the core indicators taking into consideration the preliminary pilot study results. This meeting was organized as a pre-conference meeting to the 2nd International Conference on Age-friendly Cities, 9-11 September, 2013, Québec City, Canada.

OBJECTIVES

To generate recommendations from an expert group on how to further develop and refine the core indicators and framework.

METHOD

PARTICIPANTS

The meeting was attended by 14 international experts and 7 WHO staff members. All WHO regions, except for the Eastern Mediterranean region, were represented. The full list of official participants is included as Annex 1.

BACKGROUND PAPERS

Three background papers were distributed in advance: 1) the summary report of the First Consultation held on this topic in St Gallen, Switzerland in August 2012; 2) a document describing a newly drafted framework that places the core indicators into context; and 3) a preliminary report on the indicator pilot study results. The pilot study report was preliminary

because the pilot study data collection was still ongoing at the time and not all responses had been analyzed yet.

All three papers are available from the WHO Kobe Centre (wkc@who.int).

MEETING PROCEDURES

The meeting comprised three plenary sessions and two group work sessions. The group work sessions were designed to enable in-depth discussions about the issues of main interest, namely the framework and the core indicators, and PowerPoint slide templates were provided for recording the group work results.

During the first plenary, the WHO Kobe Centre presented the objectives and methods for the meeting, an overview of the progress to date in developing the indicators, the newly drafted framework, and the preliminary results of the pilot study.

The participants were divided into three groups for the group work sessions. The first group work session elicited feedback on the new framework (see Figure 1). Each group was asked to identify positive attributes of the framework, as well as aspects of the framework they thought should be modified, specifying the proposed modification.

The second session focused on the 21 short-listed indicators based on the preliminary results of the pilot study (see Table 1). The groups were asked to review the list of 21 indicators and propose any changes (e.g. deletion, modification, replacement) to the indicators, their definitions, or both, as appropriate. The groups were provided with five resource documents for this session: 1) qualitative feedback received in the pilot study on the 21 short-listed indicators, 2) a matrix which maps the 21 indicators onto 11 other relevant indicator projects (e.g. Active Ageing Index, Livable Community Indicators) to highlight commonly used indicators, 3) a list of possible definitions for each of the 21 indicators taken from existing sources, 4) a complete list of the 61 indicators evaluated in the pilot study along with their ranking results, and 5) a list of all alternative definitions proposed in the pilot study for any of the 61 indicators.

Each group work session was followed by a plenary session during which the group work results were shared and discussed with the entire group.

The meeting was conducted in English.

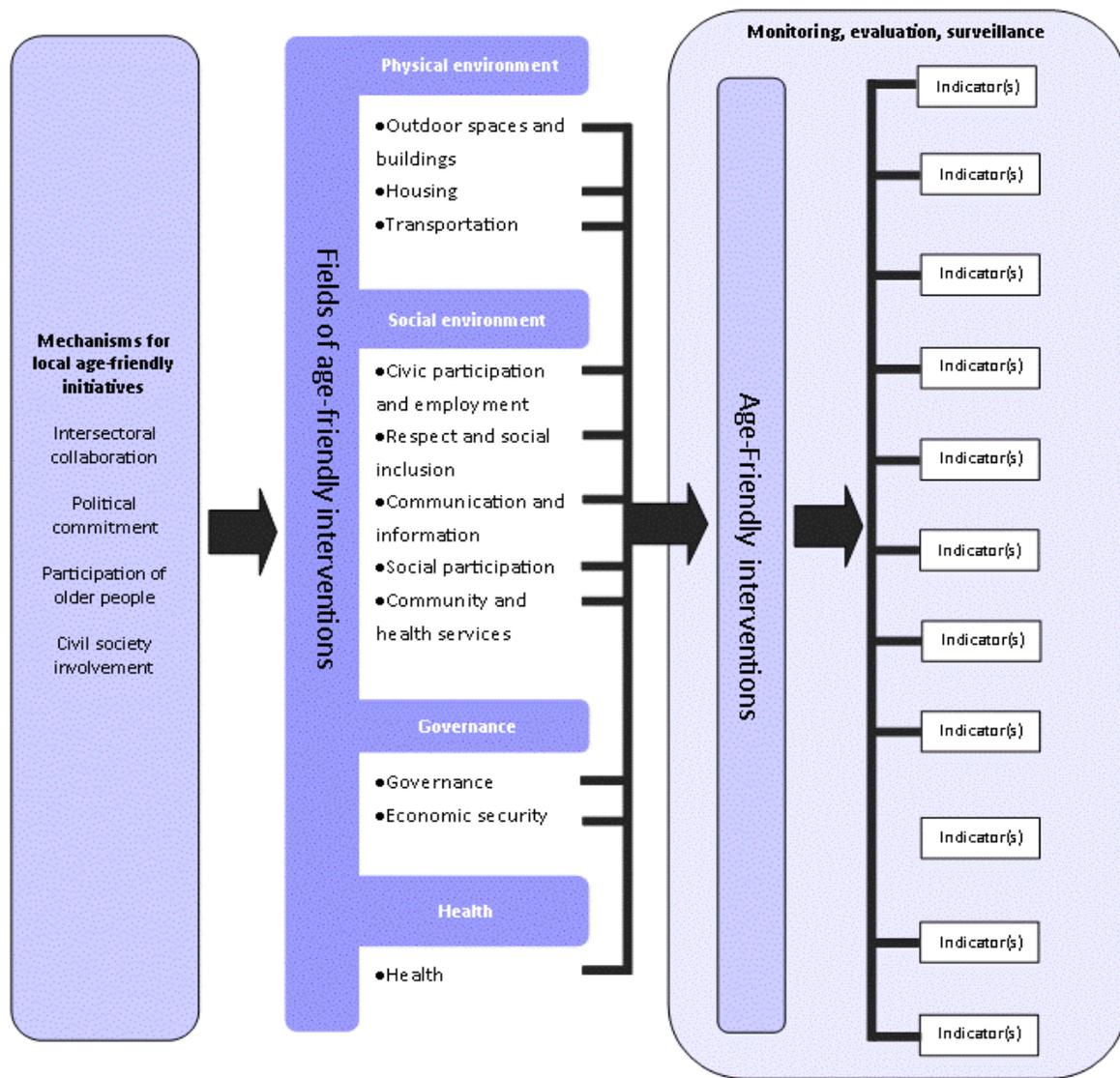


Figure 1. Draft monitoring framework for Age-friendly Cities (Focus of Group Work Session 1)

Table 1. List of short-listed indicators from the preliminary pilot study results (Focus of Group Work Session 2)

Domain	Indicator and Definition
Outdoor Spaces and Buildings	<ul style="list-style-type: none"> • <u>Accessibility</u> – Access to toilets: Number of older residents who perceive that public toilets are accessible when outside
Transportation	<ul style="list-style-type: none"> • <u>Quality</u> – Public transportation vehicles are physically accessible (A): Number of buses that are accessible for people with different disabilities • <u>Quality</u> – Public transportation vehicles are physically accessible (B): Number of older residents who feel public transportation stations/stops are far away from home • <u>Priority Parking</u> – Availability of adequate, designated priority parking for individuals with mobility challenges
Housing*	<ul style="list-style-type: none"> • <u>Accessibility</u> – Policy exists to guide the planning of new housing construction that ensures accessibility
Respect and Social Inclusion	<ul style="list-style-type: none"> • <u>Ageism</u> – Older people's perception of negative attitude on the basis of their age (A): Number of older residents who reported feeling alienated "sometimes", "often", or "always"
Civic Participation and Employment	<ul style="list-style-type: none"> • <u>Volunteering</u> – Engagement in volunteer activities (A): Number of older residents who engage in volunteer activities • <u>Volunteering</u> – Engagement in volunteer activities (B): Number of older residents who report feeling satisfied with availability of volunteer opportunities
Social Participation	<ul style="list-style-type: none"> • <u>Culture and Sports</u> – Participation in cultural activities, arts, and sports (A): Number of older residents participating in sports activities within a specific time period • <u>Frequency of participation</u> – Number of older residents who engage in social activities daily, weekly or monthly • <u>Life-long Learning</u> – Number of older residents who enrolled in formal education in the past year
Community and Health Services	<ul style="list-style-type: none"> • <u>Accessibility</u> – Home-based care/chronic home care (A): Number of older residents who received care/assistance for domestic tasks within last 12 months
Communication and Information	<ul style="list-style-type: none"> • <u>Information</u> – Resource guide of leisure-recreation programs for older persons • <u>Information</u> – Information about employment and volunteering opportunities for older persons • <u>Availability</u> – Source of information about health concerns and service needs of older persons • <u>Accessibility</u> – Internet access (A): Number of older residents with internet access at home • <u>Accessibility</u> – Internet access (B): Number of older residents who feel satisfied with computer and internet access in public spaces
Health	<ul style="list-style-type: none"> • <u>Risk Factor</u> – Physical activity: Number of older residents who engage in daily or weekly physical activity • <u>Quality of Life</u> – Proportion of older residents with high QOL (subjective wellbeing) (B): Number who rate overall QOL "very good" or "good"
Economic Security*	<ul style="list-style-type: none"> • <u>Financial Protection</u> – Financial protection for healthcare needs: Number of older people who have health insurance
Governance*	<ul style="list-style-type: none"> • <u>Resources</u> – Amount of local government budget allocated to health

*There were no indicators in these domains that consistently ranked within the top two quartiles across all four ranking categories (i.e. the criterion for short-listing); thus, the indicator with the highest average score indicator was short-listed as an alternative.

OUTCOMES

KEY THEMES FROM PLENARY DISCUSSIONS

Several key themes emerged from the plenary discussions as important considerations for developing the core indicators. These issues, summarized below, highlight some of the tensions, or trade-offs, between contrasting dimensions and values that must be considered in the process of selecting a small set of core indicators. In fact, many of these issues were also brought to light through recent experiences with other related initiatives which involved indicator selection, namely the Active Ageing Index¹ and the Global Ageing Index². These discussions also have broader implications for the development of the monitoring framework and other supplementary resources, such as the assessment tool, as well as for the technical support that WHO will offer to Member States to facilitate the uptake and implementation of the indicators.

PROCESS VS OUTCOME

The original objective of Age-friendly Cities is to facilitate the process of Active Ageing.³ Emphasis is placed on creating physical and social environments that are viewed by older persons and their caregivers as desirable conditions for realizing Active Ageing (i.e., those features described in the Age-friendly City Guide⁴), rather than on producing specific outcomes such as improved health. It was suggested that the core indicators reflect this fact by focusing more on those descriptive aspects of the physical and social environment which Age-friendly City initiatives are expected to directly affect, and relatively less on the distal, evaluative outcomes related to health, safety, or security (i.e. the three pillars of Active Ageing), which may be indirectly affected through influence on the process of Active Ageing.

As a means of monitoring progress and evaluating achievements, the core indicators should ideally include short- or medium-term process indicators as well as long-term outcome indicators. Also, preference is given to indicators which are sensitive to incremental change (i.e. indicators that can be measured on a scale rather than binary indicators). Process indicators monitored on a regular basis are important to demonstrate systematic progress directly related to Age-friendly City initiatives which, in turn, can help to sustain political commitment and

¹ Zaidi, A., K. Gasior, M. M. Hofmarcher, O. Lelkes, B. Marin, R. Rodrigues, A. Schmidt, P. Vanhuyse and E. Zolyomi. *Active Ageing Index 2012. concept, methodology, and final results*. Methodology Report, UNECE /European Centre Vienna/ European Commission, 2013 (http://www.euro.centre.org/data/aai/1253897823_70974.pdf).

² *Global AgeWatch Index 2013: purpose, methodology and results*. Paper prepared by A. Zaidi, Centre for Research on Ageing (University of Southampton, UK), with contributions from B. Azad, S. Beales, M. Gorman, A. Kulcsar, C. Knox-Vydmanov, A. Mihnovits, E. Mikkonen-Jeanneret, P. Ong, J. Scobie and M. Skinner. London, HelpAge International, 2013 (<http://www.helpage.org/download/524457e340b61>).

³ *Active ageing: a policy framework*. A contribution of the World Health Organization to the Second United Nations World Assembly on Ageing, Madrid, Spain, April 2002. Geneva, World Health Organization, 2002 (http://whqlibdoc.who.int/hq/2002/WHO_NMH_NPH_02.8.pdf).

⁴ *Global age-friendly cities: A guide*. Geneva, World Health Organization, 2007 (http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf).

support. The distal outcomes desired by Age-friendly City initiatives, such as those related to older people's welfare, may be measured at longer intervals to identify long-term impact.

UNIVERSAL VS CONTEXTUAL

The primary purpose of the core indicators should be to facilitate self-monitoring and evaluation by the cities and communities themselves, and not necessarily for comparison or benchmarking against all other cities. As such, the core indicators should be adaptable to local contexts, including the general sociocultural context as well as the specific goals and interventions adopted by the local community. Given that many of the indicators under consideration are not commonly used or standardized internationally, the operationalization of such indicators is best done locally.

At the same time, universality or comparability of indicators would also be desirable as it will permit comparisons and monitoring of progress across a meaningful set of cities or communities. While cross-city comparisons will not be the primary objective for using the indicators, it could be useful for promoting healthy competition, mutual learning and benchmarking. This may be of particular interest to the Global Network of Age-friendly Cities and Communities and its affiliate networks at national or regional levels.

Process indicators will tend to be context-dependent because they will be closely linked to baseline conditions, the goals and interventions that are adopted, and contextual factors that strongly influence the intervention process; whereas it may be possible to have more universal indicators to measure higher-order, long-term welfare outcomes.

CONVENTIONAL VS ASPIRATIONAL

The choice of "conventional" indicators for which data are readily available from existing sources, such as routine administrative surveys, can be more desirable considering that the validity and reliability of those indicators are likely to have already been established, and also that additional resources would not be required to gather the data. However, there is also value in selecting indicators that are most pertinent to the issue for which data will need to be newly generated, for example, using a new survey. Such indicators will be more challenging to measure given resource constraints and possible technical limitations (e.g. lack of standardized indicators), but adopting them can help spur desirable change and resource allocation toward those indicators which cities aspire to influence.

SUMMATION VS DISAGGREGATION

Indicators that are representative at the city level can be most useful in characterizing the overall age-friendliness of a city. However, these summative indicators at the macro level have a tendency to conceal disparities within a city which are important to identify and address. Thus, "distribution-sensitive" indicators, or indicators that can be disaggregated by social stratifiers (e.g. gender, age, socioeconomic status, neighborhoods/small geographic units) are needed in order to capture social inequities within cities.

STABLE VS DYNAMIC

In general, revisions to an indicator hamper comparisons over time and are costly to implement. Thus, indicators and their operational definitions should be kept unchanged for a time. However, there will also be a continuous process of feedback and learning from the participating communities and other stakeholders, which may make it necessary or appropriate to revise the indicators over time to reflect new conceptual framings, new ideas about causes of problems and appropriate interventions, and changes in health information systems.

DEVELOPED CONTEXT VS DEVELOPING CONTEXT

The chosen core indicators will have to be relevant not just for the developed countries but also for the less developed countries, especially in light of the fact that the trends of urbanization and population ageing are increasingly affecting low/middle-income countries. Just as the perspective of developing countries was taken into account in developing the WHO Age-friendly Cities Guide, the development of core indicators should also ensure applicability and relevance to developing contexts. Vastly different baseline conditions (e.g. public transportation systems are underdeveloped in general, not to mention being fitted for the elderly or disabled) and social concepts about “health-promoting/supportive” factors (e.g. physical activity among the elderly in developed contexts is likely to be voluntary and health-promoting, while in developing contexts it may be involuntary physical labor which is potentially harmful to their health) need to be taken into account. An indication was made that since the urban environment is barely “human friendly” in some developing contexts, the applicability and relevance of even conventional concepts and indicators need to be examined carefully.

OUTPUTS AND RECOMMENDATIONS FROM GROUP WORK⁵ ABOUT **THE FRAMEWORK**

OVERALL, THE DRAFT FRAMEWORK WAS FAVORABLY REVIEWED. ITS **MAIN STRENGTHS** ARE THE FOLLOWING.

- 1 It elaborates the “mechanisms for local age-friendly initiatives”, which are essentially the key success factors, or enabling factors.
- 2 It provides focus on specific domains, and links them to actions/interventions.
- 3 It allows for local adaptation.
- 4 It is simple, logical and intuitive while also being comprehensive.
- 5 It makes a clear and simple distinction between “physical environment” and “social environment”, which together comprise the original 8 domains for Age-friendly Cities.

⁵ Note: Outcomes and recommendations from group work listed here do not imply consensus among all meeting participants. They are the outputs of at least one of the three small groups which undertook the work.

THE FOLLOWING ARE **PROPOSED MODIFICATIONS** TO THE FRAMEWORK.

- 1 Incorporate an equity dimension/perspective into the framework as a guiding principle.
- 2 Modify the arrangement of columns in the framework.
 - 2.1 Interventions could be placed between Columns 2 and 3 as a separate, stand-alone column.
 - 2.2 A fourth (final) column could be added to indicate distal outcomes (see 2.7.1.3 below).
- 3 Modify Column 1.
 - 3.1 Modify the wording of key terms.
 - 3.1.1 “Mechanisms for local age-friendly initiatives” to “Success/Enabling factors for local age-friendly initiatives” (to make the term more simple, intuitive, and attractive).
 - 3.1.2 “Intersectoral collaboration” to “Collaborative intersectoral planning” (so that it encompasses both intersectoral collaboration as well as the development of a plan of action). Explain “intersectoral” in a footnote or other accompanying text (not in the figure itself) to clarify whether it refers to government sectors; private, public, civil society, etc; or both. Expand the concept to account for actors like private foundations.
 - 3.1.3 “Civil society involvement” to “Multistakeholder involvement”. Explain “multistakeholder” in a footnote/accompanying text and give examples, such as city administrators, researchers, civil society, faith-based organizations), etc.
 - 3.2 Include two additional factors in Column 1 – “Resourcing strategy” (both human and financial) and “Education/Sensitization” (of stakeholders).
 - 3.3 Add indicators to measure the degree of success/enabling factors in place (i.e. input indicators).
- 4 Modify the domains of intervention.
 - 4.1 In general, there was little support for keeping the domains of “Governance”, “Economic Security” and “Health” under Column 2 along with the original 8 domains of AFC. One proposal was to redistribute them as follows.
 - 4.1.1 Remove the domain of “Governance” from Column 2. Aspects of governance are encompassed in the factors listed under Column 1. “Economic security” could be considered a domain of distal outcomes rather than a domain of intervention.

- 4.1.2 Remove the domain of “Health” from Column 2. Health-specific interventions are encompassed in the domain of “Community and Health Services”. “Health” could be considered a domain of distal outcomes rather than a domain of intervention.
- 4.1.3 Indicators for “Economic security” and “Health” could be placed in a fourth/final column (to be added to the framework) which shows distal outcomes of age-friendly initiatives.
- 4.2 Create higher-order or cross-cutting domains such as “Accessibility” “Security” and “Inclusion” in order to allow communities that do not have the capacity to measure progress in specific domains to at least measure progress at these higher-order levels. (Note, however, that suggestions were not made about how these cross-cutting domains can be represented in the framework nor how they can be measured with indicators.)
- 4.3 Make the links between the domains/interventions and the indicators clearer.
- 5 Distinguish input, process, and outcome indicators, and give examples.

OUTPUTS AND RECOMMENDATIONS FROM GROUP WORK⁶ ABOUT THE **CORE INDICATORS AND DEFINITIONS**⁷

As a general principle, it was proposed that a uniform descriptive/conceptual definition be provided for each indicator, while leaving the specific operational definition to be determined locally (for example, the operationalization of terms like “adequate” or “accessible”). It was suggested that examples of operational definitions for the indicators be provided in an assessment tool (to be developed). It was also suggested that the response format for each of the indicators be scalable (for example, a 5-point Likert-type scale) instead of a binary measure (i.e. ‘yes’ or ‘no’).

While inter-city comparisons should not be the main objective - rather, the focus should be on evaluating progress against one’s own past performance or on monitoring intra-city inequalities, cities should be encouraged to use consistent operational definitions and response formats whenever possible in order to improve comparability across time, between geographic sub-units within the city, or between different cities within a country or region, or internationally.

Specific recommendations for the core indicators and their definitions are the following.

⁶ Note: Outcomes and recommendations from group work listed here do not imply consensus among all meeting participants. They are the outputs of at least one of the three small groups which undertook the work.

⁷ See Table 1 for the list of 18 indicators which were short-listed as candidates for core indicators based on the preliminary results of the pilot study.

OUTDOOR SPACES AND BUILDINGS

- 1 None of the groups were in favor of the indicator on access to public toilets because of its narrow scope. The suggestion was to replace it with an indicator that is broader and covers accessibility of all “public buildings (and spaces)”, which would include public toilets as well as sidewalks and buildings. The concept of “accessibility” would need to be operationally defined, for example, in terms of the extent to which they comply with Universal Design guidelines.
- 2 Consider a walkability indicator as another core indicator to represent this domain.

TRANSPORTATION

- 1 Slight modifications to the definitions of the two indicators on transportation quality were proposed.
 - 1.1 The first indicator could be “Percentage of public transportation vehicles that is physically accessible for people with different types of disability”. In general, percentages are more comparable than raw numbers. Public transportation vehicles would include but not be limited to buses.
 - 1.2 The second indicator can be “Percentage of older people who feel public transportation stops are too far from home”. “Too far” can be defined in terms of the time required to travel the distance or the actual distance (geographic density) of such stops. However, such a definition may fail to capture access to public transportation options that offer door-to-door service. Ways to account for such services need to be considered. Another suggestion was for this indicator to be eliminated from the core list and placed in a second-tier list.
- 2 The third indicator on accessibility of priority parking areas is very relevant but only in limited contexts (i.e. developed countries where personal car use is high). Thus, this is not suitable for a core indicator but may be important to list as a second-tier/optional indicator.

HOUSING

- 1 Alternative definitions for the “housing accessibility” indicator were proposed which focused on the “percentage of new (and/or existing) housing that are, or can be, adapted to the changing needs of an older person”.
- 2 An additional indicator on “housing affordability” was also suggested with “affordability” to be locally defined (for example, in terms of proportion of income being spent on housing).

RESPECT AND SOCIAL INCLUSION

The indicator of ageism was suggested to be defined in terms of feelings of “(dis)respect” rather than “alienation”. A possible definition could be a positively-worded one such as,

“percentage of older adults who feel respected and included”, with the response measured on a Likert-type scale.

CIVIC PARTICIPATION AND EMPLOYMENT

- 1 Opinions were in favor of keeping “engagement in volunteer activities” as a possible core indicator, but not the one on “satisfaction with engagement in volunteer activities”.
- 2 However, “engagement in volunteer activities” is more appropriate as a core indicator of “social participation” (or “civil participation”) rather than “civic participation”. A core indicator for “civic participation” should actually measure civic involvement in decision-making, and not volunteer activity.
- 3 It was suggested that “employment” can be reflected in the indicators for the domain of “economic security”.

SOCIAL PARTICIPATION

- 1 It was suggested that the indicator on “frequency of participation in social (and cultural) activities” be kept in the core list, while the indicator related to participation in sports activities be dropped. Both “frequency” and “social/cultural activities” will need to be defined.
- 2 Views were mixed regarding the indicator on “lifelong learning”. Some regarded it as a very important indicator to include in the core list. Others were not in favor of it because of the difficulty in defining and measuring it. Suggestions were made to remove the restriction to “formal education” and broaden it to “learning activity”, or to include “training activity” as well. Even then, the lack of conceptual clarity and the difficulty in making it adaptable and relevant to both developed and developing contexts remain a challenge.

COMMUNITY AND HEALTH SERVICES

- 1 Selecting a core indicator for this domain was found to be particularly challenging given the complexities and variability of community and health services. For example, the indicator and its definition would need to take into account the distinctions between medical care and social care, and between formal care and informal care.
- 2 There were suggestions to select an indicator that addresses the availability of services, or the responsiveness of the services to the needs of older people, rather than on the actual number/percentage of older persons who receive care.
- 3 Coverage of financial protection for receiving such services was also suggested as a possible additional core indicator.

COMMUNICATION AND INFORMATION

- 1 With regard to the three indicators related to information provided by the local government, the recommendation was to develop an indicator that takes the perspective of the older adults (i.e., availability and accessibility of information) rather than that of the government (i.e. provision/publication of information). It is also important to account for the wide range of possible information sources instead of limiting it to the local government. As for the type of information, the preference was for information on “health concerns and service needs” (over those on leisure/recreation or volunteer/employment opportunities).
- 2 As for the indicators on Internet access, some felt that these were only relevant in developed contexts and, thus, not suitable for a core indicator. At the same time, it was pointed out that Internet access will increasingly be an important information source and media for the older adult population, including in developed countries.
- 3 The key issue was seen as whether older adults had Internet access at all. Thus, the distinction between having Internet access at home or in other places or people’s satisfaction with Internet access were considered not as important.
- 4 It was pointed out that these indicators on access to information and the Internet address the domain of “Information” but not “Communication”. A suggestion was made to remove “Communication” from the domain name and, instead, reflect it in the domain of Social Participation. Depending on how it is defined, the indicator on Internet access may be relevant to the domain of Social Participation and/or Information.

HEALTH

- 1 The Quality of Life measure was recommended as a core indicator of long-term, overall (higher-order) achievement outcome of Age-friendly initiatives.
- 2 Physical activity (as currently defined) may not be an appropriate indicator of desirable behavior for an older adult in certain contexts (e.g. developing countries where older adults have no choice but to engage in physical labor to make a living). Thus, it was not recommended to be a core indicator but could possibly be an optional indicator with qualifications.

ECONOMIC SECURITY

The group was not in favor of the indicator on health insurance coverage as a core indicator for this domain given that it is not relevant to countries with universal health coverage and that it is often seen as being beyond the sphere of influence of local governments. Instead, preference was given to a broader measure of economic security such as access to a pension or perceived economic security. The core indicator for Economic Security was considered appropriate for a long-term outcome indicator, along with the core indicator for Health.

GOVERNANCE

The indicator for the amount of local government budget spent on health was not supported as a core indicator for this domain. As noted earlier, it was suggested that this domain be removed, and, instead, incorporate aspects of governance in the “Mechanisms for local age-friendly initiatives” within the framework (Figure 1).

ENABLING/SUCCESS FACTORS

Some suggested that the core indicators should also cover at least a few of the factors labeled “Mechanisms for local age-friendly initiatives” in the framework (Figure 1). For example, the indicators could be related to multi-stakeholder collaboration, resource commitment, political comment, and engagement of older adults.

CONCLUSIONS

The inputs received in this meeting have implications for the further development of the monitoring framework and core indicator set. Specifically, they suggest the need to modify some of the structural and visual features of the framework, and to further specify the list of core indicators while ensuring breadth, generalizability and contextual flexibility. In the follow-up to this meeting, the WHO will need to resolve some of the tensions/trade-offs highlighted in the meeting, as well as some of the contradictions that exist between the recommendations made in the meeting (which were not all based on consensus) through further external consultations and internal decision-making.

Additional inputs that will inform the final version of the framework and core indicators include further responses to the indicator pilot study (which were not yet received or analyzed at the time of this meeting), ongoing consultations with external and internal (WHO) experts, and any new developments in research and practice related to age-friendly environments and health.

Recommendations from this meeting also imply the need to develop an assessment tool, that is, a document that would describe how to apply the framework and core indicators in practice. This tool could provide guidance on how to adapt the framework, select an indicator set, and operationalize the indicators in order to optimize relevance to the local context while also retaining some value for inter-city comparisons at national, regional or global levels.

Several participants mentioned that the cities engaged in age-friendly initiatives are seeking further direction and technical guidance from WHO, and that the current work on developing a monitoring framework and core indicators responds to these expressed needs. At the same time WHO needs to be aware of and accept the validity of recommended indicators that are developed through appropriate processes at the country, regional, or community levels.

Finally, it was recognized that “Age-friendly Cities” is an evolving field of work which naturally requires periodic review and updating of existing technical guidance to reflect changing needs as well as new developments. These views lend strong support to the progress being made by the WHO Centre for Health Development and its various collaborators on this project.

NEXT STEPS

- Complete the analysis of the pilot study results
- Revise the framework and core indicator list in light of the outputs of this meeting and the final results of the pilot study
- Circulate the revised framework and core indicator list to relevant external and internal (WHO) experts for peer review
- Finalize the framework and core indicator list in light of the peer review outcomes
- Draft an assessment tool that explains how to apply the framework and core indicators to practice
- Pilot test the assessment tool in select cities/communities representative of WHO Member States
- Finalize the assessment tool based on pilot test results and additional expert consultations

ANNEX 1 List of Participants

Invited Experts

Jeanne Anthony, Senior Project Manager, AARP Livable Communities, Washington, DC, USA

Senarath Attanayake, Attorney-at-Law/Councillor, Uva Provincial Council, Wellawaya, Sri Lanka

Pierre-Marie Chapon, Research Director, ICADE, WHO AFC French Network Facilitator, Lyon, France

Josh Collett, Vice President for International Affairs, AARP, Washington, DC, USA

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Suzanne Garon, Professor, School of Social Work, University of Sherbrooke, Québec, Canada

Rodney Harrell, Public Policy Institute, AARP, Washington, DC, USA

Nadine Jodoin, Specialist, Strategic Programs and Projects, Strategic Community Initiatives Branch, Community and Social Services, City of Ottawa, Ottawa, Ontario, Canada

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***Ding Xiaocang**, Vice-Director, Health & Family Planning Commission of Jingan District, Shanghai, China

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WHO Secretariat

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Megumi Kano, Technical Officer, Urban Health, WHO Centre for Health Development (Kobe, Japan)

Khadidiatou Mbaye, Medical Officer, Family and Reproductive Health, WHO Regional Office for Africa (Brazzaville, Republic of the Congo)

***Amit Prasad**, Technical Officer, Urban Health, WHO Centre for Health Development (Kobe, Japan)

Alex Ross, Director, WHO Centre for Health Development (Kobe, Japan)

Lisa Warth, Technical Officer, Ageing and Life Course, WHO Headquarters (Geneva, Switzerland)

***Unable to attend.**

ANNEX 2 Meeting Programme

Time	Session
8:30-9:00	Registration
09:00-09:15	Welcome remarks Introduction and overview
09:15-09:45	Presentation of indicator development process Presentation of indicator framework and pilot study results
09:45-10:15	Q&A discussion
10:15-10:30	<i>Coffee break</i>
10:30-11:30	Group work on refining the framework and indicator domains
11:30-12:00	Report back to plenary
12:00-12:30	Plenary discussion on the framework and indicator domains
12:30-13:30	<i>Lunch</i>
13:30-15:00	Group work on refining the core indicators and definitions
15:00-15:15	<i>Coffee break</i>
15:15-16:00	Continue group work on refining the core indicators and definitions
16:00-16:30	Report back to plenary
16:30-17:30	Plenary discussion on the core indicators
17:30-18:00	Conclusions and the way forward