

# Age-friendly Environments: Baseline Assessment in Latin America with reference to Costa Rica





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The publication is part of the series The Decade of Healthy Aging in the Americas: Situation and Challenges, an inter-institutional initiative. The series was coordinated and edited by Patricia Morsch and Enrique Vega, with the supervision of James Fitzgerald, of PAHO.

The purpose of the series is to provide continuous updates on the different areas of action in the context of the Decade of Healthy Aging (2021-2030) in the Region of the Americas, and other related aspects.

We appreciate the collaboration of experts from PAHO, the United Nations system, the Inter-American system, and academia who participated in the initiative and made observations and recommendations to bring the project to fruition.

## Introduction

The Decade of Healthy Aging (2021–2030) is a United Nations initiative to launch and support actions aimed at building a society for all ages. It includes four priority action areas, the second of which aims to “ensure that communities foster the abilities of older people.” (1) Physical, social, and economic environments are important determinants of healthy aging and powerful influences on the experience of aging and the opportunities it offers. (1)

In addition, previous global strategic developments, such as the Sustainable Development Goals (SDGs), the World Report on Ageing and Health, the Global Strategy and Action Plan on Ageing and Health, and the New Urban Agenda, have shown that creating age-friendly cities and communities is a priority. Within this framework, the World Health Organization (WHO) Global Network for Age-Friendly Cities and Communities (the Network) is a highly valuable tool to accomplish this task.(2)

In the Region of the Americas, under the leadership of the Pan American Health Organization (PAHO), the Network has expanded significantly; cities and communities in the Americas account for more than half of their active members, and Latin American countries in particular have experienced exponential growth since 2019. (3)

One of the fundamental stages for cities and communities that commit to advancing their age-friendliness strategy is the baseline assessment, which makes it possible to identify what older people value, and what they identify as barriers and challenges in their local environment.

The tool developed by WHO to carry out this assessment is the Vancouver Protocol (the Protocol), a set of standards to measure how age-friendly a city or community is. The Protocol proposes a qualitative and focus group methodology, which cities can then use to design a strategy and an action plan based on the results obtained. (4)

To build technical capacity so that cities and communities can increase how age-friendly they are, especially in low- and middle-income countries in the Region, this report compiles novel Latin American experiences in the development of baseline diagnostics and concrete adaptations of the Protocol and identifies advances and common challenges in the cases surveyed. It highlights specific examples of the Age-Friendly Cities and Communities Program in Costa Rica because the Protocol was adapted in that country through intersectoral organization, based on local resources and characteristics.

## Age-Friendly Cities: A Diagnosis

The Age-Friendly Cities and Communities Program proposes a process of continuous improvement that starts with a diagnostic study of cities and communities using the Vancouver Protocol. (4) An action plan focused on the needs identified in the diagnostic study is then developed and implemented, the results are assessed, and a new plan is developed as these needs change. (2)

The Protocol contains several parameters and definitions designed to optimize opportunities for health, participation, and safety to improve people's quality of life as they age. It also recognizes the great diversity among older people, promotes their inclusion and contribution in all aspects of daily life, fosters respect for their decisions and lifestyle choices, and anticipates and responds flexibly to needs and preferences throughout the aging process. It focuses on cities or towns and the neighborhoods or districts where they live and proposes a bottom-up participatory approach. (5)

Implementation of the Protocol starts with creating a community profile that provides information about the community's main problems and resources. The proposed methodology is qualitative and is based on consultations with stakeholders—mainly older people, through focus groups—to understand citizen perceptions about how age-friendly their cities are and to hear their proposals for improvement.

The formation of different groups is recommended with at least four focus groups of older people, depending on the size of the locality. The members are selected based on their age (between 60-74 and 75+) and socioeconomic level, defined according to the neighborhood where they reside. To represent a heterogeneous population, participants also should come from different spaces to ensure sufficient cultural, ethnic, religious, socioeconomic, and gender diversity.

Focus groups should also be conducted with providers of public, private, and non-governmental organizations (NGOs), and with caregivers of older people who have some degree of dependency. In these cases, interviews can be held one-on-one or in the workplace.

The Protocol contains a detailed description of the procedures required to conduct focus groups. First, there is a questionnaire that looks at the eight topic areas of an age-friendly city or community: outdoor spaces and buildings; transportation; housing; respect and social inclusion; social participation; communication and information; civic participation and employment; community support and health



services. It also presents a series of recommendations for data analysis and includes a participant information guide and an informed consent form. (4,6)

The Protocol has become a standardized tool for all cities in the world that want to be part of the Network. However, due to the differential characteristics of each site, as well as their technical capacities and resources, each city or community adjusts this instrument to local realities. In addition, the COVID-19 pandemic has presented new challenges for the implementation of the Protocol--which was designed as a qualitative research tool to be used in the field--since new resources, including technology, have had to be incorporated to advance the diagnostic process.

Without losing its methodological rigor, adaptations to the Protocol have made research more accessible, offering essential inputs for public policies designed for older people, with a rights-based and intersectoral approach.

## Experiences in Implementing the Vancouver Protocol in Latin America

### Context

Latin American countries are at different stages of the process of population aging. Some, like Cuba and countries in the Southern Cone, are at an advanced stage of their demographic transition, while others in Central America and the Caribbean, are beginning that process. (7,8)

The subregion is also characterized by historical social and economic inequality, which causes large sectors of society to live in poverty and exclusion, including a high percentage of older people. It also includes a wide diversity of cultures, customs, traditions, and political and religious systems. (9)

Because of this complexity, the application of a standardized tool such as the Vancouver Protocol required adaptations to include the distinctive features of the place where the research was carried out. For example, as described in Box 1, in Costa Rica, the Age-Friendly Cities and Communities Program was developed at the national level, which made it possible to design country-specific tools and adapt the Protocol through an intersectoral strategy.

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**Box 1.** Adapting the Vancouver Protocol to the local context in Costa Rica

The Age-Friendly Cities and Communities Program was implemented in Costa Rica through an intersectoral coordination panel that included the country's PAHO office, the Ministry of Health, two organizations that bring together municipalities (the Institute for Municipal Development and Advisory and the National Association of Mayors and Intendancies), and the Yamuni Tabush Foundation.

In 2020, a manual was developed that allows cities and communities to adapt the Protocol to the local reality, and facilitating the understanding and applicability of the initiative.

Among other factors, the intersectoral coordination table identified the need to group some of the topics proposed by the Vancouver Protocol and to provide the municipal task forces with simple, concrete tools to develop the program.

## Adaptations to the Vancouver Protocol

The following sections present a compilation of experiences carried out in Latin America that involve adapting and modifying the Vancouver Protocol to the local context and the circumstances of different cities and communities.

The information collected was incorporated into each of the Protocol's suggested dimensions of research and analysis, based on:

- Core definitions and parameters
- Community profile
- Qualitative methodology
  - Human resources
  - Number and organization of focus groups
  - Recruitment
- Questionnaire
- Data analysis

## Core definitions and parameters

In the 15 years since the Vancouver meeting established the Protocol as a key implementation tool for the WHO Age-Friendly Cities and Communities program, new approaches and conceptual frameworks have emerged, such as the Inter-American Convention for the Protection of the Human Rights of Older Persons, the World Report on Ageing and Health (10), the National Strategy for Healthy Aging (WHO/PAHO 2018–2020), the SDGs, and the Decade of Healthy Aging (2021–2030), which have been included in some of the adaptations surveyed (see Box 2).

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### Box 2. Example of updating the conceptual framework of the Vancouver Protocol

In addition to integrating updated concepts on healthy aging and areas of cross-cutting analysis, the Age-Friendly Cities and Communities Program in Costa Rica fostered the inclusion of the social and disability rights model. This helped raise awareness among people in cities and communities about inclusive aging and encouraged the participation of older persons with disabilities in their communities, including community consultations and processes for response to the initiative's action plan.

## Community profile

As described in the Vancouver Protocol, the development of a community profile is of great value for understanding the characteristics of the city or community itself (geography, demographics, economic and social situation), the older population, the resources allocated to their care, and the persisting challenges. In addition, the community profile provides contextual information that helps detect the main problems or challenges at the local level and identifies the organizations and individuals who can be consulted in focus groups. (4)

The experiences in Latin American communities stressed the importance of having municipal leaders as active participants in the preparation of the profile, so that they contribute knowledge from each sector and are committed to the program from the beginning.

The development of a resource list that includes local programs and services, as well as organizations and services from the private sector, civil society, and academia, and programs in other jurisdictions that target (or may be useful to) older persons is considered an essential resource for laying the groundwork for diagnostic research.

Above all, it facilitates the incorporation of the intersectoral approach of the Age-Friendly Cities and Communities Program from the start and ensures its sustainability over time (see Box 3).

However, some cities and communities felt that some of the background information needed to build the profile was excessive. They could not always apply the collected information in the design of the subsequent plan, and there was a lack of secondary data (national surveys of older people, health, and human development surveys) disaggregated at the local level.

In many cases, technical teams also reported not having sufficient resources to consult reliable official databases or secondary sources of information, or to carry out the required data analysis.

Finally, it must be noted that management models and institutional culture also influence how the actions proposed by the Vancouver Protocol are implemented. These factors greatly affect the resources available to cities and the ability to work in an intersectoral manner, since it is necessary to involve academia and local government, to identify different groups of older people and coordinate with regional or national levels of government.

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**Box 3.** Guidelines for the community profile design in Costa Rica

In Costa Rica, local studies have been recommended to develop the community profile, such as the Comprehensive Health Status Analysis (ASIS), prepared by the Ministry of Health. This reduces the amount of additional data that needs to be collected. A template was also developed to systematize data collection between different municipalities and improve the comparability of the analysis.

The intersectoral technical coordination table of the Costa Rica program provides the necessary technical support for the initiative at the national level, along with regional and local health levels and municipalities. This fosters inter-institutional and intersectoral action, and includes contributions from the public and private sectors, for-profit or not-for-profit, and social participation at the local level to implement the program.

## Focus groups

The application of a qualitative research technique, such as the focus groups proposed by the Vancouver Protocol, makes it possible to collect information comprehensively and deal with the issues in depth.

However, this type of instrument requires specialized human resources, and recruiting participants for focus groups is a technical challenge.

### Human resources to conduct the focus groups

This is one of the most challenging points in Latin America, since few cities or communities have human resources with the appropriate qualifications, and local governments do not always have the necessary capacities.

Faced with this situation, several cities and communities in Latin America that joined the Network to carry out the focus group analysis adopted the strategy of working with universities or academic and research institutions (see Box 4). This allowed them to obtain the support of professionals specialized in the collection of qualitative data and data analysis, with knowledge of gerontology.

Regional examples show that academic institutions and universities often take on a counterpart role in conducting research, ensuring methodological rigor.

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**Box 4.** University support in the diagnostic phase

Universities in Latin America have provided significant support for the implementation of the Vancouver Protocol through different collaborative strategies. In some cases, they assumed responsibility for carrying out the entire adherence and diagnosis phases and requested the participation of organizations for older persons in the recruitment process.

In others, they were intensively involved in dissemination and training activities alongside the regional government and provided direct support to the local government in the diagnostic stage.

In a third group of experiences, the university was entirely responsible for the diagnosis, both for coordinating focus groups and data analysis, while the municipality handled recruitment.

Likewise, through face-to-face courses and online monitoring, knowledge, and technology were sometimes transmitted to all stakeholders involved in developing the reference study, to help them implement each stage of the process.

This occurred when implementing the Vancouver Protocol with the support of an Affiliate Program<sup>a</sup> to the WHO Global Network of Age-Friendly Cities and Communities that promoted an inter-jurisdictional agreement between the national government, the provincial government, and six local governments in Argentina. The participation of the university, in collaboration with the Affiliate Program, made it possible to train the professionals and technicians from the three levels involved. They assumed responsibility for the entire protocol implementation, from the preliminary report and recruitment to coordinating the focus groups and preparing the final reports.

In some cases, the project was entirely directed by a university, which hired a local researcher to provide technical support throughout the diagnostic phase.

The establishment of a local coordination body composed of local government, universities, civil society organizations, and international organizations has proven very relevant for compliance with each of the procedures established in the Protocol.

The university representatives involved in applying the Protocol in different cities and communities highlight the importance of the technical support received through partnerships with the municipal teams. They value their participation in the program since it is a motivational learning opportunity that enables the implementation of innovative planning strategies.

Universities also benefit because this work opens spaces for student internships, work placements, and thesis work. Some have established specific lines within the areas of community extension, and several have negotiated agreements with national and/or international organizations to formalize technical support and consulting actions.

<sup>a</sup> The Affiliate Programs of the WHO Global Network of Age-Friendly Cities and Communities comprise civil society, academic, or governmental institutions at the global/regional, national, or sub-national level. Within a specific territory, they promote the Network and generate knowledge about the age-friendly cities and communities initiative. For more information, see: <https://extranet.who.int/agefriendlyworld/network-affiliates/>.

## Number and organization of focus groups

The Protocol does not specify a precise number of focus groups, since this depends on the population size of the city or community and there is no defined criterion for data saturation.

In terms of organization, the dynamics and arrangement of some of the regional meetings were modified with respect to the original methodology. For example, meetings were designed by theme or by questionnaire, with participants who expressed interest in a particular topic, and the conclusions of each group were shared at the end of the day (see box 5).

The WHO checklist (17) was also used to supplement the information from the focus groups.

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### **Box 5.** Designing a local strategy to implement the Vancouver Protocol: Costa Rica's "task forces"

Costa Rica adapted the dialogue-generating questions and the eight topics of the Vancouver Protocol, regrouping them into four main groups: 1) health, long-term care, and social protection; 2) education and work; 3) information and communication; and 4) urban development, including transportation and housing. Three cross-cutting themes were also established: gender, interculturality, and disability.

In addition, the "focus groups" became part of "task forces" to facilitate the methodological approach. There were two teams: a tactical policy team and an executive team.

The main function of the tactical policy team is to agree on the policies and strategic guidelines to implement the program and to approve the projects and plans drawn up by the implementing team. Both teams are made up of older people, representatives of local government agencies, representatives of the national intersectoral table, and other representatives from different sectors involved in community life and the well-being of older people at the local level.

It was also recommended that the municipalities carry out community consultations, as a complementary stage to the focus groups, in order to obtain equitable and representative recruitment and to understand the reality of each place and integrate the understanding of the concept of healthy aging throughout the life course.

These types of adaptations made data collection more flexible, as they were not limited to a group of professionals who were experts in the methodology of focus groups. As part of this process, the country developed a toolbox manual that condenses all the adaptations and is shared with communities that wish to advance age-friendly strategies.

## Recruitment of participants for focus groups

Given the characteristics of the methodology, good recruitment that guarantees heterogeneity in the group composition is essential to the success of the research. Focus group participants should be composed of older people and caregivers, as well as providers of age-oriented services. (4)

However, this task often represents a challenge for local governments, especially since the selection should be heterogeneous and representative of the diversity of the older population. It should be noted that, in this instance, bringing participants together and ensuring that focus groups represent and express the plurality of socio-economic statuses of older people tends to be a greater challenge in rural communities with dispersed populations, as is characteristic of Latin America.

Through their different areas of management and thanks to their relationship with the community, local governments often have close links with the citizens who participate in local activities and programs. However, there are many who do not participate. Some communities expressed difficulties in overcoming the resistance of certain sectors that prefer not to respond to the invitations.

It is easier to recruit focus group participants when local governments have associated management models and/or maintain stable ties with civil society organizations (CSOs), as these are often the main allies in identifying who should be involved.

As mentioned in Box 4, partnerships with national universities have facilitated an effective, broad, inclusive, and representative convening of communities during the diagnostic process. Other strategies exist, such as those related to work between public-private institutions and CSOs (Box 6).

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### **Box 6.** Strategies to navigate the challenges of reaching as much of the older population as possible

In Costa Rica, the challenge of bringing together the task force participants was overcome thanks to the program's intersectoral partnership. The cooperation and involvement of the public and private sectors made it possible to accelerate and provide technical and economic resources to the municipalities so that the diagnostic stage could be completed, and action plans could be developed.



## Questionnaire

The multidimensional design of the Vancouver Protocol questionnaire (with eight topic areas) has proven effective in identifying cross-cutting issues affecting the health and well-being of older people in their communities (6). However, conducting focus groups can require long surveys that can lose the attention and interest of the interviewees, leading to results that are not reliable.

In the experiences of cities and communities in Latin America, two contrasting situations require a brief analysis to understand the need to update the Protocol.

First, the questionnaire is considered to be extensive. In addition, some municipalities and universities proposed including more topics associated with the environment, such as support networks, food, technological abuse, elder abuse, and mental health.

Second, some tension has arisen between maintaining the eight topics suggested by the Protocol or reducing the number, while retaining its cross-sectoral spirit (as shown in Box 7). Each topic would be assessed in terms of whether it involves issues that fall within the jurisdiction of local government, whether there is a sufficient budget, and whether it is a priority among groups of older people. In some cases, semi-structured surveys were used to identify key concerns or interests and to conduct focus groups based on those results.

Although certain requirements may arise during the consultation process in the diagnostic phase (in which municipalities have no political intervention), the initiative provides the opportunity for local governments to provide interprogrammatic responses between the different levels of government to ensure the well-being of the community and its environment. This highlights the importance of working in an intersectoral manner to meet the needs of older people in the community.

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**Box 7.** Redefining the scope of the Vancouver Protocol

The Age-Friendly Cities and Communities Program in Costa Rica defined four areas to facilitate both the baseline assessment and the development of the action plan. The objective was to unify those topics that were most related and similar, and whose strategic actions could be addressed together. The topic areas are as follows:

1. Health, long-term care, and social protection
2. Education and work
3. Information and communication
4. Urban development (including transportation and housing)

### Data analysis

As established by the Vancouver Protocol, in the process of collecting and analyzing data, the sessions should be recorded and then transcribed, and the informed consent of the participants must always be obtained. The Protocol also details a series of points that must be respected in the data analysis: examine the topics of each of the focus groups, using a summary sheet of results; compare problems that have arisen among different groups of older people (i.e., by age category and socioeconomic status); and contrast the results of the focus groups with older people with that of the focus group made up of caregivers and service providers. (4)

The work of transcribing the focus group sessions and interviews and the subsequent data analysis are two aspects of the methodology that, in several cities and communities of the subregion that make up the Network, have been complicated to implement and have required appropriate technological and technical resources. In some Latin American cities, this work has taken two to three months, and external technical assistance was needed.

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**Box 8.** Data analysis based on the task force strategy

The development strategy of the Costa Rican task forces has made it possible to deepen and broaden the analysis of the data collected.

Before starting the sessions, participants are always asked to give their informed consent. Recordings are not considered mandatory during the consultations: they are held with the understanding that all participants are building the information collaboratively and voluntarily within a team framework, so that at the end of each session a validated product is obtained.

## Implementing the Vancouver Protocol during the COVID-19 pandemic

In Latin American countries, the WHO Global Network of Age-Friendly Cities and Communities grew exponentially during the COVID-19 pandemic. This meant that many cities remained active throughout this period, and some even began the process of joining the Network and made progress in the baseline assessment.

New modifications were made to the Vancouver Protocol to adapt the methodology to virtual connection and social distancing. In these cases, it was essential to coordinate with other municipal government departments to design the necessary instruments, in many cases using mixed collection techniques (quantitative and qualitative).

The focus groups were conducted online and supplemented with questionnaires sent via WhatsApp, Google Forms, and other web platforms. In some cases, AARP questionnaires were adapted using supporting software and content analysis methodology.<sup>1</sup> (12) Semi-structured individual and group telephone interviews were also used to collect data. Finally, in-depth interviews were conducted with municipal officials, specialists, and private service providers for older people.

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<sup>1</sup>Since 2012, AARP's Network of Age-Friendly Communities has been an affiliate member of the Global Network and, as such, promotes the development of the Network in the United States of America. AARP is a non-partisan, non-profit organization founded in 1958 in the USA to work for the rights of older people in their country. For more information, see: <https://www.aarp.org/livable-communities/network-age-friendly-communities/>.

## Opportunities to improve the Vancouver Protocol

The Vancouver Protocol is a resource that has been internationally validated by technical and academic experts. It guides research, taking a comprehensive and intersectoral approach that promotes the participation and inclusion of older people and places them at the center of strategic policy. (6)

Based on the collected data, partnerships between local governments, CSOs, national governments, international organizations, and academia have supported the implementation of the Protocol and the program by strengthening an intersectoral and comprehensive approach to planning.

Given the social, economic, demographic, and geographical characteristics of the Latin American subregion, as well as the existing local structures and management models, the implementation of the Protocol, as originally designed, has been very challenging for local governments. It has also been observed that most municipalities find it very difficult to implement without external technical support.

In light of Latin American experiences with strategies to implement the Vancouver Protocol and effectively develop the WHO Age-Friendly Cities and Communities program, the following is suggested:

1. **Key definitions and benchmarks:** Incorporate new conceptual frameworks and perspectives that have been developed in recent years, especially those related to healthy aging; and highlight the importance of including human rights, intergenerational, intercultural, and gender approaches.
2. **Community profile:** Orient the profile towards aspects that are useful for research; include indicators that can be constructed with information available in the municipality; emphasize offering more programs and services in different areas of the public and private sectors, and social organizations.
3. **Qualitative methodology:**
  - a) Offer flexible recommendations on the use of methodologies and include a combination of quantitative and qualitative, face-to-face, and virtual techniques.
  - b) Incorporate the lessons learned from the COVID-19 pandemic, during which it was possible to adapt to virtual modalities

using digital technologies and to conduct telephone interviews or online surveys, allowing consultations to be extended to more older people.

- c) Review the specifications on the composition and number of focus groups.
- d) Consider carrying out consultations on specific topics, at different times, or with different groups, in order to shorten the process without losing diagnostic comprehensiveness.
- e) Expand opportunities for in-depth interviews with people who do not have time, or based on the type of functions they perform (family members, caregivers, high-ranking officials, company directors, etc.).
- f) In terms of recruitment, highlight the importance of having participants who represent the heterogeneity of the older population in the locality. At the same time, promote periodic consultations in the meetings that local governments regularly hold with older citizens and other stakeholders.

#### **4. Questionnaire:**

- a) Review the environments of an age-friendly city or community, considering the challenges posed and, at the same time, consider including newly relevant issues and new conceptual frameworks, while ensuring the intersectoral approach.
- b) Apply the questionnaire to dependent older people, who receive care in day centers, residences for older people, and other facilities, as well as to those cared for at home.
- c) Adapt the questionnaire to different territorial contexts, rural areas, areas of social vulnerability, Indigenous communities, etc.

The following is also suggested:

#### **1. Communication, awareness-raising, and training:**

- Establish a communication strategy that involves all phases of the baseline assessment process.

- Raise awareness and inform older citizens as a starting point for the project, facilitating their participation in consultations and community dissemination in order to achieve their adherence.
- Establish a communication strategy that fosters direct links between older people and the media to inform them about the project's progress and develop a fluid information agenda with the support of local officials.
- Train municipal stakeholders and community leaders who will develop the project locally.

**2. Participation:** Recognize the value of involving older people and promote strategies that include them as true protagonists and not just as informants. The response to the needs of this population must be rapid and effective, so the baseline assessment stage must be deployed correctly, and the process should be carried out in a smooth, efficient, and effective manner. The diagnostic should always be prepared with older people, but the local government and supporting institutions should facilitate the processes.

## Final Thoughts

The experiences collected in these pages can inspire other communities, countries, and regions, as they highlight the importance of implementing an intersectoral strategy that reflects the technical capacities and particularities of local governments, and that considers the specific population of older people in each place in the assessment of an age-friendly city or community. The actions deployed in Costa Rica constitute a body of good practices that can be imitated when implementing the Age-friendly Cities and Communities initiative.

The common objective and important process is to adapt and modify strategies based on a good baseline assessment that achieves actions that respond to the needs of the population, and on the idea that an age-friendly city or community is a friendlier place for all people.



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Consolidating age-friendly environments is a goal of the Decade of Healthy Aging (2021–2030). Under the World Health Organization (WHO) Age-Friendly Cities and Communities Framework the first step is to carry out a baseline assessment, with the active participation of older people, in order to determine the areas in which cities and communities must work to remove the barriers experienced by older people and create increasingly friendly environments adapted to their requirements.

The WHO program recommends using the Vancouver Protocol to conduct this assessment. Due to particular complications, many Latin American countries have adapted it for local implementation in order to overcome difficulties that arose. Outlining the current knowledge available in Latin America and noting the experiences of cities and communities in the subregion, this document compiles examples and case studies of these adaptations, such as the program implemented in Costa Rica, which will guide policy actions that foster people's full development throughout the life course.

In order to respond to the challenges posed by demographic transitions, it is essential to create tools that allow environments to be adapted in ways that promote healthy aging. This requires accurate, up-to-date, and effective information. The Decade of Healthy Aging establishes a period of focused action aimed at producing and monitoring information. This is the strategy that serves as the framework for this report.