

**Research Paper****A Comparison of Older Adults' and Managers' Attitudes Towards Age-Friendly City Indexes**Ehteram Sadat Ilali<sup>1</sup> , \*Zohreh Taraghi<sup>1</sup>

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**ABSTRACT****Objectives** The process of development of age-friendly environments is one of the key challenges of policy makers. The aim of present study was to compare the elderly people's and managers' views towards age-friendly city indexes.**Methods & Materials** In this descriptive-analytic study, the attitudes of 379 older adults and 57 managers were compared. Data collection tool was WHO age-friendly cities indicators (2013). Data were analyzed with descriptive statistics (mean, standard deviation, frequency percentage) and gamma test using SPSS software V. 21.0.**Results** Of the 379 older adults, 64.9% (246 persons) were female. The mean age of the elderly was 68.31±8.25 years (minimum 60 and maximum 89 years). There were significant differences between older adults' and managers' views in 13 indicators of 21 indicators. The major indicators were evaluated 'bad to very bad' from elderly people's views. The significant difference from the managers' views includes availability of source of information about health concerns and service needs of older persons (57% of elderly versus 14% of managers) (P=0.001). The policy-making status to guide the planning of new housing construction with regard to elderly person's needs (57% of elderly versus 31.6% of managers)(P=0.014).**Conclusion** Collaboration of organizations' custodian of elderly with older adults seems necessary in order to obtain the age-friendly city indexes.**Keywords:**

Age friendly cities, Older adults, Managers, Attitudes

**Extended Abstract****1. Objectives**

**A**t the moment, more than half of the world's population lives in cities, and their number is steadily increasing [1, 2]. Urban population growth is more pronounced in developing countries, and it is expected that three-fifths of the world's population will live in these cities by 2030 [3]. Based on

the latest census results in Iran (2016), the population of people aged 60 years and over is 9%, i.e. 7 million people. Therefore, the demographic pattern in Iran, like other countries, is changing towards aging [4]. The process of creating an elderly-friendly environment is a key challenge for policymakers at the international level [3].

The World Health Organization in 2007 launched the project of determining age-friendly cities based on a checklist. This checklist was reviewed in 2012 and then in 2013 and was summed up to 21 indicators. The main

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goal of the age-friendly cities was to facilitate the active aging process [5]. The purpose of this study was to compare the attitudes of the elderly and managers toward the status of indicators of the age-friendly cities.

## 2. Methods and Materials

In this descriptive-analytic study, the researchers compared the views of 379 elderly, who were selected via random sampling, and 57 managers, who were selected via sampling method. The research population for managers was obtained from centers related to the elderly people (Municipality; Welfare Organization; Imam Khomeini Relief Committee; Deputy of Medical Sciences; Health Centers; Physical Education; Islamic Republic of Iran Broadcasting Corporation; Department of Islamic Culture and Guidance; Co-operative Organization, Labor and Social Welfare; Department of Housing and Urban Development; Road Administration; The Department of Justice; and the City Council). Research population for the elderly was all the elderly in Sari City. Inclusion criteria for the elderly were age of 60 years and above and the ability to answer questions. Exclusion criterion for both the managers and the elderly was the lack of cooperation. Family Physician Database was used to access data regarding the elderly. After providing their name and address, 24 physicians were selected randomly from the three regions of the city using a random number table, and the elderly they support were interviewed. Permission was obtained from the Ethics Committee of Mazandaran University of Medical Sciences (IR.Mazums.REC.95-2310).

Data collection method included demographic characteristics and Checklist of the World Health Organization (WHO) (2013) including 21 indicators [6], along with the 5-point Likert scale (Very good, good, bad, very bad, and I do not know). After obtaining permission from the World Health Organization, the translation and retranslation process was carried out by two fluent English and Persian speakers outside the research team and was confirmed by content validity method [7]. Simplicity and difficulty of the questionnaire were evaluated and verified by 6 elderly persons with different levels of literacy (illiterate, elementary, and secondary levels). Reliability of the questionnaire was determined by Cronbach's alpha of 0.76. Using descriptive statistics (mean, standard deviation, percentage of frequency) and inferential statistics (gamma test) and SPSS software version 21, data were analyzed.

## 3. Results

Among the 57 managers surveyed, 22.8% (13 persons) were women, and 77.2% (44 people) were male. Among the 379 elderly persons surveyed, 64.9% (246) were female, and 35.1% (133 people) were male. The average age of managers was  $39.78 \pm 5.37$  years (age range: 30 to 51 years, median was 40 years, and with a 95% confidence interval of 38.36 to 41/21). The mean age of the elderly was  $68.31 \pm 8.25$  years (age range: 60 to 89 years, median of 65 years, and with a 95% confidence interval of 67.47 to 69.14).

Among the 379 elderly, 29.3% (111 people) were illiterate, 38.5% (146 people) had under the diploma education level, 18.5% (70 people) had diploma, and 13.7% (52 people) had a degree above the diploma. In terms of income status, 57.5% of the elderly (218 people) had income less than expenses, 38.3% (145 people) had income equal with their expenses, and 4.2% (16 people) had income level more than expenses. In terms of living companions, the majority of the elderly (50.1%, 190 people) lived with their spouse, 19.8% (75 people) lived with spouse and child, 17.4% (66 people) lived with children, and 12.7% (48 people) lived alone. In terms of performance status, 88.4% (335 people) were independent, and 11.6% (44 people) were dependent. Findings revealed that there is a significant difference between the viewpoints of the elderly and the managers in 13 indicators out of 21 indicators.

A significant portion of the elderly believed that there is no place to get information in order to eliminate health concerns and the service needs of the elderly and assessed the following as bad to very bad: Policies to build new housing according to the needs of the elderly, accessibility status for people with motorized problems to private parking lots, access of people with various disabilities to city buses, the status of receiving guidance on how to spend leisure time and recreational programs, the status of giving information about employment status and voluntary activities, and the status of Internet access at home. However, the percentage of managers who had such a view was significantly lower. The number of elderly people who were not dissatisfied with access to computers and the internet in public places and considered the health insurance bad was significantly more than managers. Percentage of the elderly who believed that the state budget of a city that is dedicated to health is very good was significantly less than the managers. Number of managers who believed that older people feel alienated due to age discrimination was significantly more than elderly.

Elderly are significantly more likely to participate in social activities and considered physical activity more than managers.

#### **4. Conclusion**

Succeeding in achieving the Elderly-Friendly environments needs partnership of policy makers, managers of institutions and agencies responsible for aging affairs, gerontologist and elderly associations. There is a place to get information to eliminate health concerns and the needs of the elderly; policy making to build new housings according to the needs of the elderly; providing the opportunity for participation in formal education programs and voluntary activities; providing the opportunity for participation in cultural, artistic, and sport activities; providing access for people with motorized problems to private parking lots; access of people with various disabilities to city buses; the availability of computers and the Internet in public places, providing guidance for how to spend and use leisure time and recreational programs; improving the health insurance status; improving urban budget condition which is dedicated to health; all are among the things that need to be addressed as priorities in the agendas of the managers.

#### **Ethical Considerations**

##### **Compliance with ethical guidelines**

This research was approved by Ethics Committee of Mazandaran University of Medical Sciences with the Code of IR.Mazums.REC.95-2310.

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##### **Conflict of interest**

The authors declared no conflicts of interest.

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