DECADE OF AGEING SURVEY (3RD draft)

Introduction

This survey was conducted by AFSM in order to assess members' awareness of and involvement with the four areas of work in the WHO Plan of Action for the Decade of Ageing, namely:

- Combating ageism by changing how we think, feel and act towards ageing;
- Cultivating age-friendly environments;
- Creating integrated and responsive health care systems and services;
- Ensuring access to long-term care for older people who need it.

To this end, questions were asked about members' interactions with their environments and the health care services.

Methodology

The membership of the PAHO/AFSM was surveyed through emails. This was a self-selective, non-random sample using the methodology that had been used for the previous survey, and thus allowing for some validation**.** Prior to distribution, email blasts were sent to members advising of the forthcoming survey and requesting their participation. Members were given two weeks to complete and submit the survey.

Information was captured on the demographics of respondents (age-group, gender and place of residence) and thirteen questions framed around the four areas outlined above, via an instrument developed using Google Forms and distributed (in English and Spanish) by email to the PAHO/AFSM membership **(Appendix 1).**

Data was captured in two databases, one for each language. The Spanish database was translated into English using Google translate and merged with the English database into an Excel spreadsheet. Analysis, mainly frequency tables and cross-tabulations with illustrations, was done using EpiInfo, an SPSS-based freeware statistical package.

While most questions were close-ended, one was deliberately open-ended to capture members' views on how PAHO can better promote the Decade of Healthy Ageing in their community. This question was subject to content analysis with an inductive approach to coding.

Results

The response to this survey was lower than the previous one, as just 97 of the 544 AFSM membership responded. Survey fatigue could have contributed to this lower response rate.

Demographics

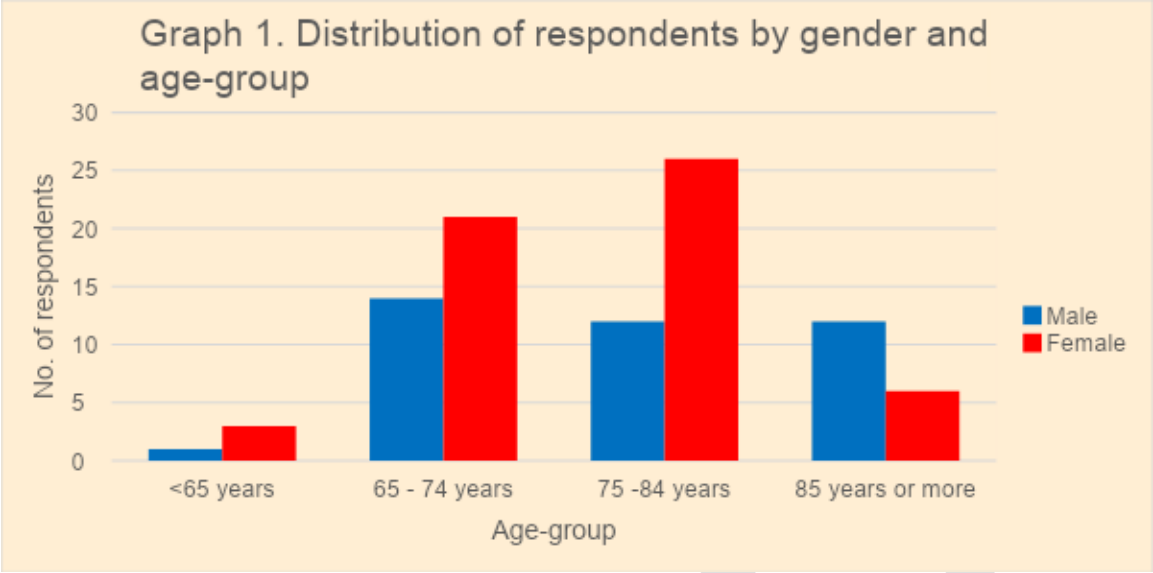
More than half of the responses were from the USA (53.6%), and approximately one-quarter from South America **(Table 1).**

Table 1. Responses by Zone of Residence

Country of Residence	#	%	% from previous survey
United States of America	52	53.6	56.4
South America	25	25.8	23.6
Central America & Caribbean (Spanish)	14	14.4	7.0
Central America & Caribbean (English)	4	4.1	9.9
Other (Europe)	2	2.1	2.1
TOTAL	**97**	**100.0**	**100.0**

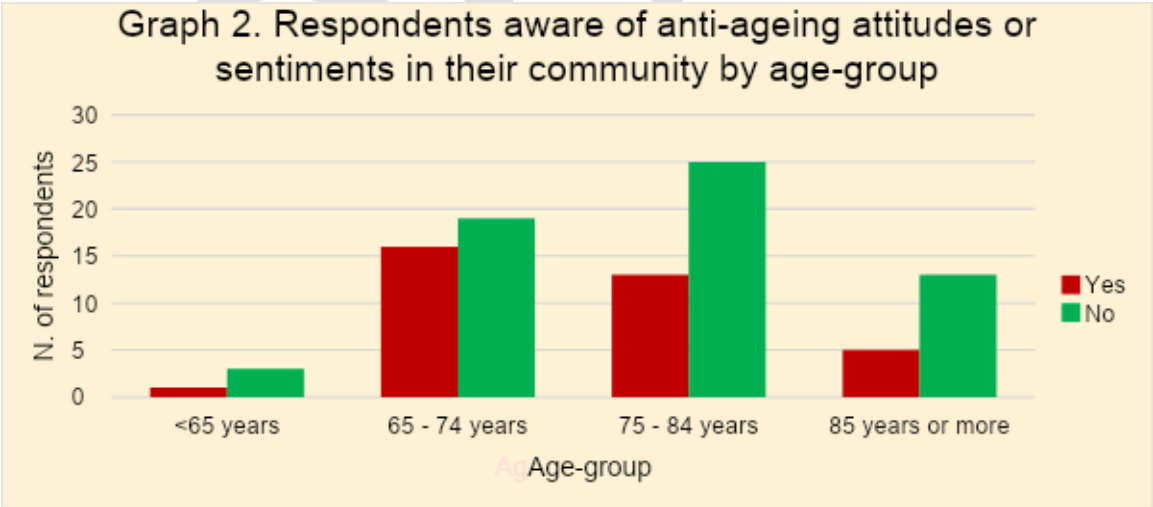
Note: Zones were defined thus:
United States of America (USA)
Central America and Caribbean (CAC) Spanish – Mexico, Guatemala, Honduras, Nicaragua, El Salvador, Costa Rica, Panama, Cuba and Dominican Republic
Central America and Caribbean (CAC) English – Belize, Guyana, Jamaica, Barbados and Trinidad and Tobago
Other – Switzerland and Belgium

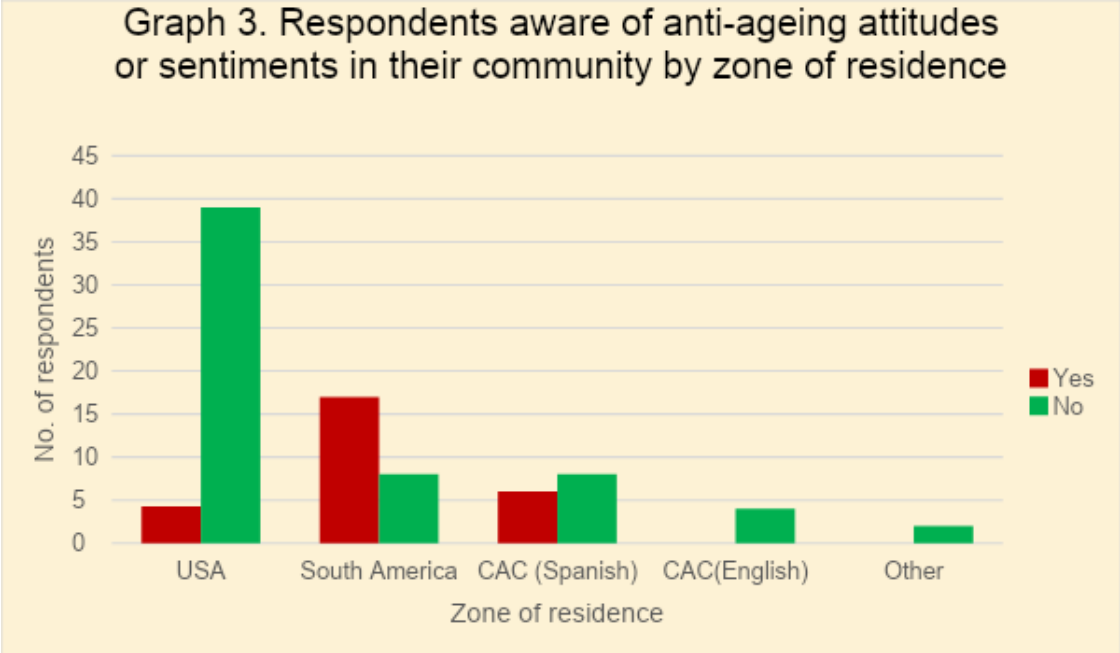
There were more female respondents than male (59.8% and 40.2%), compared to previous percentages of 58% and 42% respectively. Most respondents were in the 65-74 and 75-84 year age-groups (36.1% and 39.2% respectively), with more females and males in all age-groups but the last **(Graph 1)**.



Attitudes towards ageing

More than one-third (37.1%) of respondents were aware of attitudes or sentiments against ageing in their communities, an awareness that was heightened among the 65-74 year olds where nearly as many were aware as were unaware (45.7% aware) but which lessened very much among older members (37.1% aware in the 75 – 84 year olds and 14.3% aware among the 85 years plus age-group **(Graph 2)**. Awareness of anti-ageing sentiment was greatest among members living in South America, followed by those in Hispanic Central America and the Caribbean **(Graph 3).**





Age-friendly environments

Most respondents (82.5%) felt that their communities were age-friendly, allowing them to enjoy life despite whatever limitations of age or disease they may have. Age-friendliness of community was only slightly lower in South America and for persons aged 75-84 years but not significantly so **(Tables 2, 3))**

Table 2. Age-friendliness of community by zone of residence

Zone of Residence	Yes	All respondents	%
United States of America	42	52	80.8
South America	19	25	76.0
Central America & Caribbean (Spanish)	13	14	92.9
Central America & Caribbean (English)	4	4	100,0
Other (Europe)	2	2	100.0
TOTAL	**80**	**97**	**82.5**

Table 3. Age-friendliness of community by age-group

Age-group	Yes	All respondents	%
<65 years	4	4	100.0
65 – 74 years	28	35	80.0
75 – 84 years	30	38	78.9
85 years or more	17	18	94.4
Not stated	1	2	50.0
TOTAL	**44**	**97**	**82.5**

Nearly everyone (95.9% of respondents) was able to engage socially with family and friends. The exceptions were four cases, physical difficulties in trying to communicate because of stroke, hearing and vision loss or other illness and loss of friends were the reasons for two cases while safety concerns and fear of COVID-19 were the barriers in the other two.

Nevertheless, more than one-third (35.1% or 34) of all respondents do limit their physical or social activity because of age. Not surprisingly, this percentage rises to 72.2% of persons aged 85 years or more, compared to 0% in the four under-65 year olds, and less than 30% in members 65 – 84 years old **(Table 4)**. There was no significant difference amongzones of residence **(Table 5).** The reasons given seem to bear more upon limited physical rather than social activity. Two limitations on social activity were avoiding night functions because of difficulty of driving at night and having to care for a relative. Other limitations mentioned were reduced mobility/arthritis/leg pain/fair of falling (16), tiredness/weakness/unspecified health condition (14), old age (2), lack of sidewalks, feeling unsafe, difficulty getting from one place to the other (?Transportation) **)Appendix 2)**.

Health care systems

63.1% of respondents have access to person-centered care, 70.5% have access to coordinated health care while more than ¾ (78.5%) of respondents have access to affordable age-appropriate health care service. But less than half (41.2%) of respondents have access to age-appropriate health care that is person-centered, coordinated **and** affordable. Respondents in South America had marginally less access than the rest of the membership but the reduction in access among the 75-84 year olds was significantly less than the population rate **(Tables 6,7).**

Table 6. Respondents with access to person-centered, coordinated and affordable age-appropriate health care by zone of residence

Zone of Residence	Yes	All respondents	%
United States of America	24	52	46.2
South America	10	25	40.0
Central America & Caribbean (Spanish)	6	14	42.9
Central America & Caribbean (English)	3	4	75.0
Other (Europe)	1	2	50.0
TOTAL	**44**	**97**	**42.1**

Table 7. Respondents with access to person-centered, coordinated and affordable age-appropriate health care by age-group

Age-group	Yes	All respondents	%
<65 years	3	4	75.0
65 – 74 years	18	35	51.4
75 – 84 years	13	38	34.2
85 years or more	10	18	55.6
Not stated	-	2	-
TOTAL	**44**	**97**	**42.1**

Long-term & other care options

Little more than half (55.2%) of respondents were assured of long-term health care, should they need it, with slightly worse options for members resident in Central American and the Caribbean (Hispanic and English) and for members aged 65 – 74 years. (**Tables 8, 9).**

Table 8. Availability of options for long-term care by zone of residence

Zone of Residence	Yes	All respondents	%
United States of America	28	52	53.8
South America	14	25	56.0
Central America & Caribbean (Spanish)	7	14	50.0

Central America & Caribbean (English)	2	4	50.0
Other (Europe)	2	2	100.0
TOTAL	**53**	**97**	**55.2**

Table 9. Availability of options for long-term care by age-group

Age-group	Yes	All respondents	%
<65 years	4	4	100.0
65 – 74 years	16	35	45.7
75 – 84 years	21	38	55.2
85 years or more	11	18	61.1
Not stated	1	2	50.0
TOTAL	**53**	**97**	**55.2**

A little more than one-third of respondents (35.1%) did not think that they could access at-home assistance if needed. This was consistent in all age-groups but was lowest in South America **(Table 10).**

Table 10. Respondents unable to access at-home assistance by zone of residence

Zone of Residence	#	All respondents	%
United States of America	20	52	38.5
South America	8	25	32.0
Central America & Caribbean (Spanish)	6	14	42.9
Central America & Caribbean (English)	2	4	50.0
Other (Europe)	0	2	0.0
TOTAL	**34**	**97**	**35.1**

Caveats

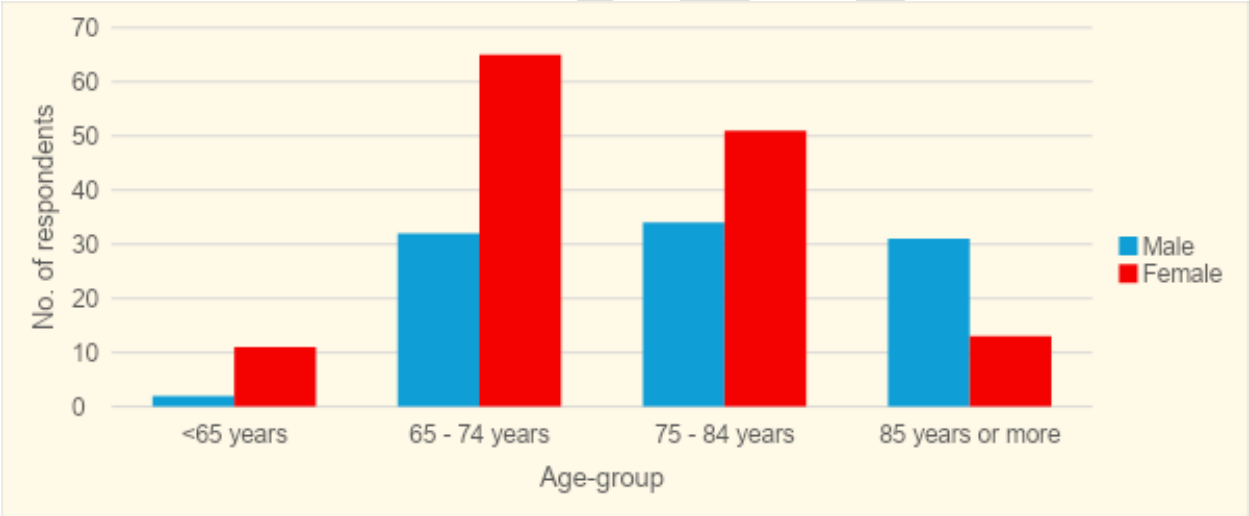
The response rate of this survey was lower than the previous one - 17.8% vs 44.7%, although still exceeding the range of 3%- 15% which is the norm for such surveys. An extra effort nearer the deadline may have improved the rate. However, the distributions by age-group and sex were very similar to those of the previous survey, giving some

assurance that the key physical demographics of the respondent population was consistent **(Table 1, Graphs 2 and 4).** The exception was the zone of residence variable where the Anglo-CAC retiree population was under-represented with a concomitant over-representation of the Hispano-CAC one.

Altogether, this survey was subject to the same self-selection biases caused by the factors that would have contributed to the previous survey, namely access to a computer and email, ability to understand and navigate the questionnaire, short and simple as it wa, interest or lack thereof (persons who are in good health may not see the relevance or may be too busy to respond while persons who are severely incapacitated may not be able to). To these is added the inability to make inferences that relate to the Anglo-CAC sub-population and this may warrant a separate study of this sub-population.

Despite these factors, the data collected identifies several issues, some relevant to certain sub-populations but most of them universal.

Graph 4. Respondents of previous Ageing Survey by sex and age-group



Discussion

Negative attitudes towards and sentiments against ageing are not negligible. That younger persons are more aware than older members may be attributed to a heightened sensitization as well as a greater prevalence of such behaviours among peers within their cohort (or younger), while the reverse may be true for older respondents.

That there was greater anti-ageing sentiment among the Hispanic countries was surprising given their cultural traditions of honoring the elderly and the deceased. It may be hypothesized that increasing urbanization, economic pressures that see the elderly as non-contributors to society and changing cultural norms may contribute to this trend. It is also worth exploring if these factors may also affect the slightly lower perception of age-friendliness of communities in South America.

The responses to limitations to activity seem to imply a paucity of support systems for persons who may be physically or socially challenged. The lack of sidewalks, the insecurity and difficulty in getting from one place to another, the need to have company when walking or going anywhere, were just some of the issues mentioned reflect those difficulties. Although there was only one respondent who attributed social disengagement to COVID, this was a very elderly respondent and the vulnerability of the elderly to COVID or any highly contagious infection must be acknowledged as a potential barrier to social interaction and fulness of enjoyment of life. It is noted that there was little mention of mental obstacles but it is reasonable to assume that if physical support is limited, so too is mental support for the elderly.

Of concern is the 58% of respondents who do not have access to age-appropriate health care that is patient-centered, coordinated and affordable. A significant proportion of these respondents are in the 75 – 84 year age-group, now identified as an at-risk, potentially underserved sub-population.

Options for long term-care appear to be slightly more available in all regions but it is noted that response was lower among the 65 - 74 year olds. It may be that this relatively younger cohort may not have yet considered the need for such care later in life. The need too, for at-home assistance was evident in nearly all regions (Europe being an exception for several reasons including sample size). Further examination of the data revealed that respondents aged more than 75 years in the USA were least able to access at-home assistance with 44% of them unable to get such help.

Conclusions

The survey identified some areas for action and some for further study.

The following are some issues identified:

1. How to assure protection of the elderly and most vulnerable as they socially engage;
2. How to change negative attitudes to ageism, especially those that may be influenced by culture;
    a. Specifically, what are the negative behaviours and sentiments and where or how are they exhibited or expressed;
3. How to facilitate members' access to patient-centred, coordinated **and** affordable health care;
4. How to facilitate members' access to long-term care and to prompt older staff and young retirees to plan for long-term care
5. How to encourage staff to plan for ageing, especially considerations such as long-term care including at-home assistance

Members themselves had a laundry list of suggestions, which may be grouped, summarized and prioritized thus **(Table 11, Appendix 3)** :

1. Improve HIS service making it more accessible, user-friendly and facilitatory of long-term care;
2. Education of politicians, of Governments, of health professionals (including instruction on geriatrics in medical schools), of staff and retirees, through webinars, curricula especially of geriatrics in institutions of higher learning;
3. Intense promotion of healthy ageing at community and national levels, with supportive legislation, through networks and advocates
4. Widespread information through webinars, dissemination of relevant publications etc.

Table 11. Responses to what respondents think that PAHO can do

Response	#
Information dissemination	22
Raising awareness	5
Education/training of staff and caregivers	6
Health promotion	13
Advocacy – national policy, health authorities, legislation,	7
Health insurance support for better access to appropriate care	10

Long-term care	5
Staff networks and meetings	3
Research survey/monitoring and research	4
Nothing – ir's not PAHO's responsibility, it is an international organization and has/can have little impact	5

Recommendations

It would be useful to repeat this survey to monitor changes. However, a few changes are recommended:

1. The question on the age-friendliness of a community should be followed by one to elicit information on why it is not perceived as age-fiendly;
2. The question on limitation of activity by age should be two separate questions, one on physical activity and another on social activity as age may limit one, but necessarily both

Appendix 1. Data collection instrument (English)

AFSM Ageing Decade Survey (Version 7)

In the Spirit of the Decade of Healthy Ageing, AFSM is conducting this survey to assess our members' awareness of the four areas of work included in WHO plan of Action for the Decade. AFSM will share with PAHO the aggregate responses to the survey. We also plan a series of joint activities with PAHO to address the needs of PAHO retirees.

TO COMPLETE YOUR SURVEY, PLEASE PRESS SUBMIT AT THE END

1. Country of residence

2. Age (years)

3. Gender

4. Is your community age-friendly i.e. allowing older persons to enjoy life despite any limitations caused by age or disease?

5. Are you able to engage socially with family and friends?

6. If not, what is the main barrier?

7. Are you aware of anti-ageing attitudes or sentiments in your community?

8. Do you limit your physical or social activity because of age?

9. If you do, what is the main reason?

10. Do you have access to age-appropriate health care services that are?

Person-centered
Coordinated
Affordable?

11. Does your community offer options for long-term care?

12. If you need help, could you find a trained and affordable caregiver to provide assistance at home?

13. What do you think PAHO can do to better promote the Decade of Healthy Aging in your community?

Appendix 2. Responses to limitations to social and physical activity because of age

Avoid functions at night.

Enfermedad

Pocos ánimos

Dificultades para el desplazamiento de un lugar a otro

Inseguridad

Mi estado actual de salud

Risk of falling. I don´t go out without companion

Pain and disconford

SOME LIMITATIONS TO MOVE

Condición de daluf

movildad

Dolor en mis piernas.

Porque tengo menos agilidad para andar en las calles sola.

Problemas para caminar sin ayuda

Cansancio

Trato de manejarme dentro de las limitaciones que la edad me impone.

Falta de veredas en mi vecindario

Artritis

Existen deteeminadas actividades físicas que exigen una masa muscular que no posee un adulto mayor

Mobility. Using wheelchair. Need assistance.

Flexibility and inability to perform certain tasks

Old fractures and arthritis affect my mobility, plus some loss of balance

Being old

Get tired easily

Back Pain

I move slower and am losing balance so don’t want to fall.

cannot jump the same way as when I was 20

Due to lower energy level and not being able to actively participate

Mainly because I don't drive anymore

Not a youngster anymore

unable to do some exercises or walk as far

Do not like driving at night

Get tired easily.

Caring for husband

Health

Appendix 3. Responses to “What can PAHO do to better promote the Decade of Healthy Ageing in your community?”

Support the "University for the Elderly" programs, such as the one at the University of Cuenca, in Ecuador.

Support and encourage the training of professionals who can adequately care for the elderly populatiion

Awareness campaigns and information

Help retirees fill out Cigna company health insurance forms and shipping them which can only be done on the computer and when we mail it they don't receive it.

Awareness Campaign on the Rights of Older Adults

Concentrate in long term care

Raise awareness among

Continue to promote and disseminate self-care, group activities, exercise, and physical activity. To promote the decade of healthy ageing, comprehensive policies, continuous evaluation with the participation of young people are necessary

Continue to provide education on healthy aging.

DEVELOP PERMANENT SURVEY TO EVALUATE

Spread

Spreading Healthy Messages

Encourage exercise and mobility as well as socializing

Get long time care

Going completely Green not polluting anymore, especially in the poor area's.

Make arrangements with clinics for care and pay them directly 80% and the retiree only 20%. Include everything the doctor prescribes in the claim.

Have better access to healthcare. With Medicare you wait longer to get an appointments as with a private doctor and we get punished by being charged more for going to a private dr.

Help with long term care

How to eat healthy, how to exercise. and how to sleep well.

I believe that this subject is a personal one, not PAHO responsibility

ncorporate coverage for long term care in the SHI.

Increase awareness, highlight succesful initiatives

Inform senior retired staff of options available where you live.

Information on what we have for aging in the state/country

Reporting regularly with international guidelines

Information/advice on Alzheimer cases

Just by commenting in social nets

PAHO can further promote healthy aging.

List of senior housing health services doctors

Making Health a Policy in All Development Policies

Make long term care available. Provide assistance and remove hurdles and barriers to getting this assistance

Maintain up-to-date information for former officials on aspects of healthy aging. Improve health insurance in the coverage of problems typical of advanced age.

Keep informed of WHO's insurance rules on the subject

Keep us informed of all the latest news in health, care, treatments, therapies, etc.

best attention of local PR

My community is small and far from large urban centers. PAHO could offer community-level talks to the local Mayor's Office on the rights of older citizens and offer financial and technical resources for staff training on the subject

More media coverage, more advocacy with opinion leaders on the topic of healthy aging

More promotion, use of mailing lists of AFSM and social media.

Very difficult. There is no relationship with PAHO. Summoning Retirees

Not really sure PAHO could have any direct impact.

Nothinng it is an international and interubernmental organization

Organize face-to-face meetings

PAHO can link with the Ministry of Health - with input from the aging persons.

PAHO can put pressure on the concerned institutions to do more for the aging population

Present participatory activities on YouTube.

Promotion of cultural, physical and mental health activities

Promotion and individualized approach. Publish Webinar recordings.

Promote exercise and social activities

Promote healthy aging in America as aging is a normal process of life and aged people in good health shouldn't be a disqualification

Promote a career in Geriatrics. and Geriatrics Nurse Specialists

Promote the promotion and prevention prior to Healthy Aging.

Promote social life within the community of former officials.

Promote Public Policies for the Training and Employment of Special Caregivers of the Elderly

Provide resource information sources for seniors. An increase in the home care benefit for the elderly.

Raise awareness staying in your own home, if possible, is the best solution.

recommend supportive legislation

Stimulate the government to promote healthy aging at community level

STRENGHT THE MONITORING/RESEARCH ON AGING RELATED DISEASES

The health care in Paraguay is accessible to folks like me, with means. But the elderly in general here do not have access to much. PAHO could insist on better health care in Paraguay.

There is nothing that I can think of.

To send adequate studies to divulgue in the social nets and centers of reunion

Usar redes sociales con información pertinente

We need support with affordable care for the elderly. I have a 100 year-old-mother and would like to have someone to take care at home, in Guatemala, but I think the health insurance as it is, does not cover for a person who is not a certified nurse or ca1

Webinars on issues related to healthy aging. Many PAHO staff and retirees are also dealing with aging parents so I think it is important to include webinars and information both for ourselves as we age but also for us as caregivers (how to take care of on

Yes, PAHO does not have any visibility nor impact in my community