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## Original Research

# Physical activity among older people with sight loss: a qualitative research study to inform policy and practice

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## ABSTRACT

**Objectives:** To investigate the ways in which participation in physical activity is prevented or facilitated among older people with acquired sight loss later in life.

**Study design:** Qualitative research.

**Methods:** Interviews were conducted with 48 visually impaired adults age 60+ years, recruited from a range of settings including local sight loss organisations and via talking newspaper advertisements. Visual impairment was defined by self-report. Data was analysed using a thematic analysis. This research represents a first step toward the development of empirically based practical suggestions for decision-makers and health professionals in terms of supporting – when required – visually impaired older adults participation in physical activity.

**Results:** Six themes were identified that captured why physical activity was prevented or facilitated: disabling environments; organisational opportunities; transport; lack of information; confidence, fear and personal safety; and exercise as medicine.

**Conclusions:** Recommendations for policy change need to be focused at the societal level. This includes developing more accessible and inclusive environments and providing meaningful information about physical activity to older adults with a visual impairment, and visual impairment in older age to physical activity providers.

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## Introduction

Sight loss amongst people age 60+ years is a global and significant public health issue. For example, almost two million people in the UK are living with sight loss that has a major impact on their health and every day approximately 100 more people begin to lose their sight.<sup>1</sup> This phenomenon is increasingly linked to age, with one in nine people aged 60+ years in the UK currently living with sight loss. Visually impaired older adults, in general, have poorer general health than the sighted population.<sup>2</sup> They are also at significant risk of future costly medical complications.<sup>3</sup>

Being physically active can help improve health and well-being and prevent secondary medical conditions. For instance, physically active older adults are at lower risk of disease and have higher levels of physical and cognitive function, psychological well-being and independence than inactive older adults.<sup>4,5</sup> Despite such benefits, less than 10% of those over 55 years meet the minimum amounts of activity recommended for health (30 minutes of at least moderate physical activity on five or more days per week).<sup>4</sup> This is more pronounced for disabled people in general and visually impaired adults in particular. Disabled adults are less likely than non-disabled adults to participate in physical, leisure or sporting activities.<sup>6</sup> Participation in these activities for those with a sensory impairment (i.e. deaf and/or visually impaired) are 4% lower than amongst those adults with other impairments such as spinal cord injury (SCI).<sup>7</sup>

Within the fields of both gerontology and disability, research has highlighted numerous barriers that impact upon older people's ability and inclination to engage in physical activity.<sup>8–10</sup> For example, a recent meta-synthesis identified that for people disabled through SCI, barriers included depression, embarrassment, and a lack of knowledge and self-confidence.<sup>11</sup> What helped to facilitate a physically active lifestyle for this group included a sense of hope that exercise might enable them to be independent, sustain mental health, and walk again in the future. To that end, it has been noted that a more critically informed approach is needed when advocating a physically active lifestyle, particularly within certain groups such as those who are disabled and those in their older age (cognisant that these are not always separate). For instance, when promoting 'exercise as medicine' there is a danger that exercise is equated with a definition of and relation to the body to which it is not entirely akin.<sup>12</sup> Moreover, bodies can become at risk of being understood within the medical model or neo-liberal health role that locates the 'problem' of and 'solutions' to both disability and ageing within the individual as their own personal responsibility. In so doing, the social world that can oppress disabled and older people, subsequently restricting what they (perceive they) can do, can continue to be ignored.<sup>13,14</sup> There is a danger too, as has been identified with reference to ageing and physical activity, that various kinds of pleasure that can be experienced when being active are elided, thereby limiting health policy promotion.<sup>15</sup>

Although there is a growing prominence of evidence based policies, which advocate the need to improve health and well-

being in older age through increasing levels of physical activity,<sup>16–19</sup> there is a paucity of published research which might help inform health policy on why older adults who have late onset sight loss do not engage in physical activity and how their participation could be enabled. This is especially concerning given the aforementioned scenario of significant demographic change and increased prevalence of visual impairment in older adults.

It is important to fill this knowledge gap because public health practitioners and managers cannot assume that what is known about one population (e.g. older sighted people/young physically active/young visually impaired people) can simply be imported into recommendations for promoting physical activity for another (e.g. older adults with sight loss). As such, the purpose of this research was to investigate the ways in which participation in physical activity could be prevented or facilitated among older people with acquired sight loss later in life (i.e. people who lost their sight later in life, rather than were born with loss of sight). To meet this purpose, qualitative methods were used. Qualitative research plays an important role in contributing to the public health evidence base. Not only can it contribute to answering the 'why' questions, it can also produce rich and detailed answers that are grounded in the experiences of the end-users themselves (i.e. visually impaired older adults). This ensures that any public health recommendations that follow are meaningful and useful to this population.

## Methods

After gaining university ethical approval for the study, participants were recruited using a purposive sampling strategy that was informed by maximum variation sampling in order to capture a diverse range of views.<sup>20</sup> The inclusion criteria was (a) adults with acquired sight loss (i.e. non-congenital), and (b) aged 60+ years. Participants were recruited within England, from a range of settings by using local sight loss organisations and advertisements in talking newspapers. Upon expressing interest in the research, prospective participants were asked to fill out a biographical questionnaire (with assistance if required), wherein they confirmed their age and self-identified their current level of vision. Categories for these self-reports of visual impairment were drawn from the English Longitudinal Study of Ageing (ELSA) regarding visual impairment.<sup>21</sup> Recruitment of each participant group continued until data saturation was achieved and there were no more emergent patterns in the data.<sup>22</sup> Taking into account the notion of representativeness, in order to facilitate naturalistic generalisability and the transferability of findings, a sample was generated that included differences in sex, age, educational level, socio-economic status, and marital status.<sup>20</sup> The result was a recruited sample of 48 visually impaired older adults comprising of 24 males and 24 females who (via a self-report measure) identified a variety of activity levels – from being inactive to highly active (see [Table 1](#)).

In line with University ethical guidelines, interviews commenced only when the participants had provided informed consent either through written or recorded word

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