

Reasons why or why not older Australians participate in physical activity report ...

[Sociology](#)



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Adequate physical activity has been shown to benefit older adults by reducing the risks for age-related physical degeneration including osteoporosis, arthritis, cardiovascular disease, diabetes, cancer and a higher likelihood of falling (Tiedemann et al., 2011; Ewald et al., 2009). Exercise also helps alleviate depression (Lee et al., 2013). However, a sedentary lifestyle has increasingly become the norm among older adults. Inadequate physical activity is defined as engaging in moderate-intensity exercise for a duration that is less than the recommended 2.5 hours per week or failing to do moderate exercise for 30 minutes on most days of the week (Jancey et al., 2008; Sims et al., 2010). In Australia about 49-63% of older adults between 60 and 75 years old are sedentary with a third totally inactive (Ewald et al., 2009). Sedentary lifestyle accounts for 7.3-9.3% of the mortality burden among Australian adults and is magnified during older adulthood (Bird et al., 2009). What is also distressing is that only 40% of older Australians report the desire to increase their physical activity (Sims et

al., 2010). Clearly, there is an urgent need to promote a more active lifestyle in the older adult population.

Literature Review

Literature shows that individualised interventions and those that aim to overcome barriers are the most effective (Jancey et al., 2008; Bird et al., 2009). It was also found that physical and social environments are significant influences in the decision to exercise. For instance, geographical location, access to places where older adults can do physical activity and the quality of social interaction fostered by programmes in the community play a role in strengthening a personal commitment to become more active (Jancey et al., 2008; Bird et al., 2009). Thus, many of the interventions previously implemented were in a group setting and increased access to resources that enable greater physical activity with the end goal of maintaining the desired behaviors in the long term. Regarding the design of active lifestyle programmes, studies recommend that the teaching methods, communication styles and motivational strategies employed should fit the needs, circumstances and preferences of the older adult. Educational attainment, culture and socioeconomic status are other individual attributes that also affect behaviors related to exercise (Bird et al., 2009).

Addressing barriers requires studying the hindrances experienced by older Australians. Bird et al. (2009) conducted a survey of 363 older adults representing seven cultural minority groups and results showed that poor health status, bad weather, low energy levels, fatigue, fear of injury, lack of motivation, no time, no access to safe places for exercise, nobody to exercise together with, body image issues, and an aversion to exercise were

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the most common barriers. In a systematic review, health condition was a primary barrier and included shortness of breath, pain, muscle weakness, poor balance, and being overweight. Post-survey interviews also shed light on culturally-defined barriers such as gender roles, acceptable forms of exercise, and the social nature of physical activity (Bird et al., 2009). For immigrants, language is also a cultural barrier as they speak English as their second language (Horne & Tierney, 2012). Using a similar method as Bird et al., Macniven et al. (2013) investigated what 2, 225 older Australians perceived were barriers and enablers to greater physical activity. The study found that illness and having nobody to share activities with were significantly associated with the inability to meet physical activity recommendations (Macniven et al., 2013). This is while costs and time as enablers were linked with a higher probability of meeting recommendations. Besides knowing the barriers, effectively reducing the prevalence of sedentary lifestyles necessitates the use of research evidence. Sims et al. (2010) performed a review of literature on physical activity guidelines specifically developed for older adults, ranked the evidence and obtained expert opinion to generate five recommendations. First, all older adults regardless of health condition, weight, age and functional capacity must be encouraged to exercise as much as they are physically able. Second, they must be encouraged to be active on a daily basis through a variety of activities promoting balance, strength, fitness and flexibility (Sims et al., 2010). Third, the need to perform 30-minute activities of moderate intensity daily or on most days has to be emphasised. Fourth, for older adults who were previously sedentary or are trying out other types of activities, it is best

to start at an easy level and then progressively increase the duration, frequency and intensity. The last recommendation urges older adults to maintain their current level of activity for as long as they are able and applies to older adults who have always been physically active.

An example of an individualised and group-based intervention utilising guidelines was developed by Jancey et al. (2008). The overall goal was to increase and sustain physical activity among older Australians through a community-based walking programme. It aimed to address the older adult's beliefs and attitudes in order to engender participation in walking and related exercises. Increasing self-efficacy or the participant's self-confidence that he can successfully take part in the programme was also another objective. Building self-efficacy was validated as successful by Lee, Arthur & Avis (2008) in their study of a physical activity intervention. Based on a social cognitive model, the programme took into consideration predisposing factors or those that motivate the older adult to become active (Jancey et al., 2008). This included increasing the older adult's knowledge and shaping beliefs and attitudes through education. Meanwhile, enabling factors were those that helped produce the desired behavior and included skills, financial resources and access to programmes. A sample of 260 older adults 65 years and older were invited to join small walking groups at no cost for twice-a-week structured activities that lasted for 26 weeks (Jancey et al., 2008). Many of the barriers later validated by more recent studies were addressed by the programme. For instance, participant convenience, safety and preferences to the location of exercises were factored in decisions. The group setting facilitated social interaction, network-building and

reinforcement among members. Trained walk leaders provided education, assessed each participant's capacity for exercise, individualised plans to gradually increase the duration and intensity of activity as well as improve balance, endurance and flexibility (Jancey et al., 2008). Psychomotor skills were taught and walk leaders were empathic and supportive providing constant feedback and motivation to programme participants. Maintaining open communication was meant to address concerns, issues or problems. About 65% of the sample finished the programme, an acceptable rate compared to other studies. About 80% expressed the desire to continue exercising and those who were interested to become walk leaders were encouraged to do so (Jancey et al., 2008). Among those who finished, the average weekly duration of walking fulfilled recommendations.

In summary, the health needs of an increasing older adult population in Australia deserve adequate public health focus especially with the anticipated growth of this population. Statistics show a high prevalence of sedentary lifestyle among older Australians which has negative impacts on health. To reduce the burden of disease and improve quality of life, there is an urgent need to promote physical activity. The literature clearly points to selecting the most appropriate model to guide programme design while evidence-based recommendations should guide content. Implementation should be individualised to consider ability, needs, barriers, facilitators and other attributes associated with older adults. Knowing the reasons why or why not older adults exercise facilitates an individualised approach. The physical and social environment including culture should be factored in as well. It would also be helpful to know other programmes and models that

result in tangible outcomes from participation in physical activity. Knowing the types of interventions available and their strengths and weaknesses will increase the options especially when working with different subpopulations of older adults such as women, cultural minorities or the chronically ill who may have different needs.

Methodology

Having a sample permits inference of results to the entire population of older Australians without having to survey each member, a daunting task given that there are more than one million persons aged 65 years and older in the country (ABS, 2010). A sample is a section of this population. Purposive sampling was used in this study. The researcher focused on 15 older members of the community. The major advantage is that their responses would be relevant to community-based physical activity programmes targeting adults aged 65 years and older or those who have retired. Besides age, inclusion criteria included mobility and having sound mind. Older adults with these characteristics will benefit most from physical activity programmes. Conversely, exclusion criteria were confinement to bed or wheelchair and having dementia or Alzheimer's which affected the ability to understand and answer questions. The researcher used a door-to-door approach to the survey until the sample size was reached.

Prior to conducting the actual survey, the questionnaire and protocol were pilot-tested with two grandparents of friends. They provided feedback which helped improve and shorten the semi-structured tool so that it would be more understandable and less of an inconvenience to participants (Sharpe, 2010). A combination of open and closed questions was appropriate in

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obtaining the needed data. For each survey, a similar procedure or protocol was followed in accordance with ethical principles (ANHMRC, 2001). The researcher knocked on the door or rang the bell and respectfully greeted the person who answered it. This was followed by a short introduction explaining the purpose of the survey in order to establish trust (Ardzejewska, 2013).

They were then asked whether they or family members fit the inclusion criteria and if they had the time to answer questions.

Subsequently, they or their family members were requested to participate in the survey. If they refused, they were appreciated for taking the time to listen. If they consented, the researcher asked the participant questions from a clipboard and noted their responses on an answer sheet. Using the clipboard method allowed interaction between researcher and participant through face-to-face question and answer (Sharpe, 2010). It also saved the respondents the effort of writing down their answers. The surveys took between 15 to 30 minutes from start to finish. The researcher thanked each participant for their time. In all, 21 homes were visited. Two potential respondents refused to participate while no one fit the age criterion in four homes. One issue encountered was distrust as three participants insisted that the researcher will use the information to target who to sell home exercise machines to. This was dealt with by reiterating the purpose of the survey and stating that results of the survey will be communicated to them once available. There were no issues with language as there were no cultural minorities or immigrants among the respondents.

Results of Data Gathering

After the survey phase was concluded, the researcher collated the responses and created appropriate tables to better understand the data. Of the 15 respondents, 8 were female and 7 were male. More than half of the sample is between 65 and 69 years of age. The rest are older as shown in Table 1.

As shown in Table 2, only two of the respondents, both between 65 and 79 years of age, are currently in an exercise programme for older people and none of them perform other physical activities on their own. Of the 13 respondents who are not in an exercise programme only four are exercising on their own. All of them are also between 65-79 years old. The remaining nine are older and are neither part of a programme nor engage in physical activities on their own. Of the total respondents who are exercising, two are male and four are female. One male and one female were in exercise programmes.

For those who are in an exercise programme, one programme involved walking as a group, which progressed to jogging or cycling once it is determined that they are able to do so. The other programme was dancing. For those not in a programme but exercise on their own, their activities include gardening, walking, jogging, and housework. Regarding the reasons for participating in physical activity or exercise, presented in Table 3, the most common reason was to stay fit. One respondent reported having heard on television that exercise can help with diabetes which he is presently suffering from. Several respondents also stated feeling better after exercising. To have something to do is another reason why the older adults

exercise. Following retirement, they find nothing much to do at home and exercising helps pass the time. A minority stated that exercising means compliance with the recommendations of their physicians. Some also found group exercise programmes as ways of connecting with fellow older adults which eases their loneliness.

Among those who are not part of an exercise programme nor exercise on their own, the top reason was physical conditions. These include joint pain, low back pain, poor eyesight and hearing, easily getting tired, and feelings of being unwell. Another top reason is the lack of awareness of exercise programmes. They have not heard of such activities from others or seen it on television, nor have they read about any programmes in the community. Other reasons are listed in Table 4 and include costs. Three respondents cited not being able to afford gym membership, exercise equipment, or fees for classes. Another reason cited was that activities are not to be tailored to older people. They admit to not being able to do what younger people can do in the gym. They also feel insecure having to exercise with people who look young and physically capable. Further, there is also the inconvenience of location and the need to drive to get there or have somebody drive them. Only one reported not exercising because of fear of injury like losing her balance or twisting her ankle which can make it all the more difficult to live alone.

Discussion of the Results

The greater number of respondents aged 65 to 79 may be because of increased institutionalization of those who are older because of the inability

to live independently. If this is the case, it points to the urgent need to promote physical activity within the older adult population. Present concepts of active ageing advocate the idea that degeneration should not be associated with ageing (Stenner, McFarquhar & Bowling 2011). It is not an inevitable occurrence as one gets older. It only takes place because older adults become detached from society after retirement which renders them inactive (Lester et al. 2012). However, if older adults lead healthy lifestyles and continue to participate in society, thus remaining active, they can attain a better quality of life (Skelton & Dinan, 2007). Physical activity is one pillar of the concept of active ageing and is associated with reduced rates of disease, disability, and death (Kuh et al. 2012). However, the trend in decreasing physical exercise with increasing age may also be because of sampling bias since purposive sampling, and not random sampling, was employed.

The proportion of inactive or sedentary respondents is within the national estimate of 49-63% (Ewald et al., 2009), as 60% (9) report not being in an exercise programme or do physical exercises on their own. In contrast, the percentage of physically active females was slightly higher at 50% compared to the national average of 49%. On the other hand, the percentage of males performing physical activity was much lower at 29% compared to the national average of 63%. Again, these values may be influenced by the sampling method used. If not, then the data shows that more effort should be done to encourage older adult males to exercise.

Of those who choose to participate in physical activity, they are aware of the benefits in terms of physical fitness either from having learned about it in the

media or experiencing it themselves. They are also motivated by advice from health professionals. Moreover, they have other motives such as the need for social interaction and the desire to ease boredom. These reflect the social isolation and disconnectedness that many older adults experience (Lester et al. 2012). The selected physical activities are categorized as moderate intensity and aerobic which falls within physical activity guidelines (Sims et al., 2010), although it is not known whether the frequency and length of time of exercise are also within guidelines.

In the sample surveyed, there is low participation in exercise programmes and may be attributed to lack of awareness. Of those who are sedentary, many of the reasons stated for not exercising have been identified in literature, except for the lack of awareness, activities not developed with older adults in mind, and inconvenient locations. Otherwise, poor health, body image issues, costs, and fear of injury are consistent with literature (Bird et al., 2009). The fear of injury is actually a misconception. With individualised exercise plans that begin with the physical capacity of the older adult and progressively increase in terms of duration and intensity, injury can actually be prevented because of better balance and flexibility (Jancey et al., 2008). Although time was identified in literature as a factor (Macniven et al., 2013), it was not reported by survey respondents.

A limitation of the tool is its inability to measure the fragmented physical activities associated with performing simple activities of daily living such as fixing the house, carrying things up or down steps, or mowing the lawn (Hauer et al., 2011). These also count for physical activity. Thus, it may be inaccurate to assume that respondents who are not taking part in an

exercise programme or who state that they do not exercise on their own are inactive or sedentary. They may be active except that their physical activity and how long they perform it do not fit into established guidelines. Thus, older adults should be encouraged to remain as active and increase their level of activities by joining structured exercise programmes or devoting time for moderate-intensity exercise.

Conclusion

Older adults need physical activity for better health and quality of life. However, majority in the community do not exercise. It is important to consider the reasons behind this behavior. When designing physical activity programmes, it is important to keep in mind that building awareness should be part of the plan. Many older adults read the local paper and watch television. Utilising these media can communicate the existence of programmes they can participate in. It is also important to obtain physician recommendation prior to joining, especially when the desire to exercise is there but is hampered by joint and back pain. Physician advice is also a source of motivation. These symptoms should not become a hindrance to enjoying the psychological and physiological benefits of physical activity. The intensity and duration should be adapted to the older adult's physical capacity to allay fears of injury. It is also helpful to educate older adults that ageing does not preclude them from going to the gym or doing activities younger people do. The key is to develop and maintain physical capacity through sustained and progressive exercise. Programs should be designed exclusively for older adults to promote social interaction among peers and prevent body image issues. Further, costs and convenience must be

addressed to ensure access. While keeping with national exercise guidelines regarding type, duration, and frequency of activity, offering a variety of activities will interest as many older adults as possible.

Appendix A

Clipboard Survey Tool

Dear Respondent,

I am Andra Yousif, a student currently enrolled at the Australian College of Physical Education. As a requirement for my course, I am doing a survey to know the reasons why older adults, or persons aged 65 years and older, take part or do not take part in physical activities. Exercise has many health benefits for older adults. The knowledge gained from this survey will help me or others create future programs that encourage older people to exercise. To this end, your help in answering some questions is very much appreciated. I will be asking you questions from my clipboard and will be noting down your answers as well. You do not need to worry about your privacy as this survey does not include questions on your identity. The results of this survey will also be made known to you in the future.

1. What is your age? ____

2. What is your gender? Male __ Female __

3. Do you presently take part in an exercise programme for older people?

Yes __ No __

If you answered YES in Question #3, please answer the following:

4. What kind of exercises do you do?

5. Aside from joining exercise programmes, do you exercise on your own?

Yes ___ No ___

6. If yes, what are your activities?

7. What are your reasons for performing physical activities or exercising?

If you answered NO in Question #3, please answer the following questions:

8. Do you do physical exercises on your own? Yes ___ No ___

9. If yes, what are your activities?

10. What are your reasons for performing physical activities or exercising?

11. If no, what are your reasons for not performing physical activities or exercising?

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