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Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment of the requirements for the degree in Master of Science

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EXAMINING SOCIAL PARTICIPATION OF OLDER ADULTS TO HELP CREATE AN AGE FRIENDLY COMMUNITY

(Thesis format: Monograph)

by

Oksana Kubach

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Science

The School of Graduate and Postdoctoral Studies
The University of Western Ontario
London, Ontario, Canada

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Abstract

In 2010, London was the first Canadian city included in the World Health Organization's Global Network of Age Friendly Cities. In 2011, the City of London established the Age Friendly London (AFL) Task Force and created an Action Plan (AP) to improve the eight age friendly (AF) domains: Social Participation (SP), Respect and Social Inclusion, Outdoor Spaces and Buildings, Communication and Information, Community Support and Health Services, Civic Participation and Employment, Housing, and Transportation. One of the AP goals was to build a community centre in the Argyle district of London. The purpose of this project was to determine how lived experiences of older adults shape their needs for programs and services that can facilitate social participation in the community. A sequential explanatory mixed methods design was used, where findings from a baseline AF survey informed five questions asked in consecutive focus groups. Frequencies and domain score means were calculated, and inductive content analysis was used to analyze qualitative data. Survey results showed that Argyle SP domain had the second lowest score of 2.6/5. From focus group discussions' four distinct and one overarching themes emerged. Findings provided a holistic understanding of the community resources required to satisfy social participation needs of older adults. They also informed the potential to improve age friendliness of the community through multipurpose community centres.

Keywords: *age friendliness, age friendly cities, social participation, older adults, community centre, community, London, needs, programs and services, sequential explanatory mixed methods.*

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The sun sets on my journey through graduate school, illuminating the sky in brilliant colours with a reminder that new adventures await me. The past two years have been an exploration through both my personal and academic life. I could not have become the person I am today without the love, guidance and support from my family. I would also like to thank my furry family (Sammy and Juanold) for all their love and needed nuzzling distractions.

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Operational Definitions

The purpose of the operational definitions is to define the exact manner each variable is perceived in this study. The definitions are organized in sequence of appearance in text.

Older adult is an individual, 60 years if age or older (World Health Organization, 2014).

Population aging is an increase in older adult population in proportion to the total population (UN, 2013).

Urbanization is a consequence of industrialization, modernization and rationalization that influenced people to move to urban areas due to economic, technological, political and environmental advances (Kingsley, 2012).

Successful aging is the combination of the three criteria: 1. low probability of disease and disability; 2. high cognitive and physical functioning; and 3. active engagement with life (Rowe and Kahn, 1987).

Selective Optimization and Compensation (SOC) is a model of successful aging that is focused on dealing with negative changes brought about by aging. People select areas of their life to optimize by compensating for biological, psychological and socio-economic changes they experience (Bearon, 1996; Ouwehand, de Ridder & Bensing, 2007).

Structural lag is a "mismatch between the strengths and capacities of the increasing numbers of older people, and the inadequate opportunities in society to utilize, reward, and sustain these strengths" (Riley, 1994, p. 444).

Active aging is a "process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (World Health Organization, 2002)

Age Friendly City is a "social and physical environment that is guided by policies, services,

and structures in a community, collectively assisting older adults to actively age" (Public Health Agency of Canada, 2012).

Social participation is one of the three contributors to successful aging that involves not only sustaining relationships, but also participating in meaningful and purposeful activities (Rowe & Kahn, 1997).

Social isolation is identified by an individual's lack of contact with other people (Keefe, Andrew, Fancey & Hall, 2006).

Greatest Generation is a cohort of individuals born between the years of 1912 and 1927 (Brokaw, 2004).

Silent Generation is a cohort of individuals born between the years of 1928 and 1945 (Snook, 2011).

Baby Boomer Generation is a cohort of individuals born between the years of 1946 and 1964 (Statistics Canada, 2013).

Senior centre is a facility created in 1943 in North America dedicated strictly to older adults for the purpose of leisure and socialization (Wick, 2012).

Community centre is a facility that was establish in the 1800's in North America to encourage social participation of community members (Benson, Harkavy, Johanek & Puckett, 2009)

Phenomenology is a methodology that extracts deep issues, allowing individual's lived experiences to be heard (Lester, 1999) which are then described through the researcher's interpretations (Groenewald, 2004; Guba, 1990; Morse, 1991).

Themes:

Personal Responsibility is self-determination to find the meaning and purpose in the post-retirement phase of growth and development.

Uncertainty is a response to life's unpredictability.

Togetherness is the social support attained through community relationships.

Resentment is participant's negative emotions towards the lack of neighbourhood programs and services, community infrastructure, and public transportation that limits their social participation.

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Chapter 1 – Introduction

1.1 Population Aging and Urbanization

The world's population is aging rapidly (World Health Organization, 2007a). It is expected that the global proportion of individuals who are 60 years and older will double from 11% in 2007, to 22% by 2050. It is expected that by 2050, for the first time in human history, the number of individuals who are 60 years of age and older will exceed the number of children who are between infancy and the age of 14 years.

Simultaneous to the increase in global population aging, urbanization is also on the rise, resulting in an increased number of city dwelling older adults (World Health Organization, 2007a). Due to these trends, the World Health Organization (WHO) seized an opportunity to help make cities age friendly. An 'Age Friendly City' is defined by its "social and physical environments that are guided by policies, services, and structures in a community, which collectively assist older adults to age actively" (Public Health Agency of Canada, 2012; World Health Organization, 2007a). This was the main objective that the WHO had when the Active Aging Framework was created (World Health Organization, 2007a). The framework was intended to help cities create action plans to enable active aging in their communities. Active aging is defined as "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (World Health Organization, 2002). The active aging is based on six determinants that are influential to aging: Social Determinants, Physical Environment, Health and Social Services, Personal, Behavioural, and Economic

Determinants (World Health Organization, 2002). These determinants can have multiple effects on individuals' health as they correlate with one another.

1.2 Age Friendly Cities Movement

With the understanding that old people are a heterogeneous group, individuals will experience aging differently based on their community of residence (Lui, Everingham, Warburton, Cuthill & Bartlett, 2009; World Health Organization, 2007a). This notion informed WHO's Age Friendly Cities Project which aims to help communities understand what characteristics make a city age friendly and what barriers can prevent individuals from actively aging (Neal & DeLaTorre, 2009; World Health Organization, 2007a). The Age Friendly Cities project focused on eight domains of age friendliness: Civic Participation and Employment, Communication and Information, Community Support and Health Services, Housing, Outdoor Spaces and Buildings, Respect and Social Inclusion, Social Participation, and Transportation (World Health Organization, 2007a). In 2007, the WHO used the results from this project to create a document called *Global Age-Friendly Cities: A Guide.* It included a *Checklist of Essential Features of Age Friendly Cities*. Using the guide and checklist, cities around the world began assessing their own communities and identifying the areas that are in need of change.

In 2009, the City of London, Ontario established an Age Friendly City Working Group. The group engaged over 450 elderly community members in focus group discussions, to explore their outlook on life in London and the changes they wanted to see

in the future. In June 2010, the Working Group published *Age Friendly London: Report to the Community* (Age Friendly City Working Group, 2010). Based on results from this report, the City of London applied for membership in the WHO Global Network of Age Friendly Cities. In 2010, London was the first Canadian city to be accepted into the WHO Network.

In 2011, the City of London established the Age Friendly London (AFL) Task Force, comprised of over 150 community participants (City of London, 2013). Based on monthly consultations over a ten month period, the AFL Task Force created a Three-Year Action Plan that focused on recommendations to be implemented into the community. The plan was endorsed by London's City Council in November 2012.Six months later, in May 2013 the Age Friendly London Network was formed and given the responsibility of implementing the Action Plan.

1.3 The Age Friendly Domain of Social Participation

In this research project, the main focus will be on one of the eight domains of age friendliness, namely Social Participation. Social participation is beneficial to an individual's health and wellbeing and important for maintaining a positive quality of life (Findlay, 2003; MacKean & Abbott-Chapman, 2012; Richard, Gauvin, Gosselin & Laforest, 2008; Silverstein & Parker, 2002). Rowe and Kahn (1997) outlined that social participation involves not only sustaining relationships, but also engaging in meaningful and purposeful activities. It also influences individuals' health and quality of life (MacKean & Abbott-Chapman, 2012). According to Richard and colleagues (2008),

social participation tends to decrease with age for those with poor socio-economic status, such as income, education, and occupation whereas it can increase for individuals with better health and functional status. To experience high social participation, an individual needs access to appropriate resources (Richard et al., 2008). In an American study, Reichstadt, Gauvin, Gosselin and Laforest (2010) found that 95% of their study participants, who were 60 years of age or older, associated social participation to positive attitudes about their own aging. Encouraging and facilitating social participation in a community can influence a person's motivation to achieve and maintain activity as they age.

In North America, social participation was historically facilitated and encouraged within neighbourhood community centres. In the early 1900's the original community centres were hosted in local schools (Smith, 2002; Ward, 1913). The resourcefulness of schools fostered multiple programs that were catered to both children and adults. To this day, community centres provide gathering places for community members of all ages to access information, socialize, and participate in leisure and physical activity programs. This can help reverse feelings of loneliness by maintaining both physical and mental health through social participation (Aday, Kehoe & Farney, 2006; Fitzpatrick & McCabe, 2008; Malonebeach & Langeland, 2011; Turner, 2006).

Since 1943 senior centres were established exclusively for older adults with the goal to provide socialization and leisure programs (Fitzpatrick, Gitelson, Andereck & Mesbur, 2005; Fitzpatrick & McCabe, 2008; Miner, Logan & Spitze, 1993). A senior centre is a facility where older adults can come together for support, independence,

dignity, and engagement in programs and services that reflect their skills and needs (Miner et al., 1993). Studies conducted on the benefits of participation in senior centres found that older participants maintained their independence throughout retirement (Jett, 2006), experienced lower levels of depression (Aday, 2003; Florida Department of Elder Affairs, & Florida Association of Senior Centers, 2004), higher levels of life satisfaction (Jett, 2006; Malonebeach & Langeland, 2011), and a better quality of life (Pardasani & Thompson, 2012). However, new generations of older adults, namely the aging Baby Boomers perceive senior centres as unappealing as they segregate individuals based on age; they believe that being a senior entails frailty and inactivity and they do not want to be categorized into that group (Fitzpatrick & McCabe, 2008; Turner, 2004). With the changing needs and desires of aging adults, community centres need to incorporate innovative programs and services to help encourage social participation of all generations of older adults.

As the AFL initiative evolved, the City of London identified an acute need to help facilitate social participation in several city districts. One of the areas of interest, and the focus of this research project, was the Argyle district of London. The AFL Action Plan includes the initiative to develop plans and build a new community centre in the Argyle district by the year 2018. The purpose of the new community centre is to provide a gathering place for local residents, provide opportunities for physical, mental, and social participation, and contribute to improved quality of life in the aging population.

The focus of this research project was on Argyle district because of its’ recognized need for greater opportunities for social participation. However, the implications of this

research are transferable to other neighbourhoods and communities with similar needs. The purpose of this project was to determine how lived experiences of older adults shape their needs for programs and services that can facilitate social participation in the community.

Chapter 2 – Literature Review

2. Introduction

The goal of this literature review is to introduce a number of diverse but related concepts necessary to understand a gap in capacity of local communities to facilitate older adults' social participation needs. The chapter will begin with an overview of global population aging, and urbanization trends. Conceptual frameworks of successful aging, selective optimization and compensation and structural lag, that provide theoretical grounding for the study, will be introduced. Attention will then move to the WHO's Active Aging movement that preceded initiation of the Age Friendly Cities project and the establishment of Age Friendly Cities Network. Next, the discussion will shift to Canadian contributions to the Age Friendly movement, and local context of London, Ontario's efforts to become more age friendly. Moving on, the focus will shift to the Social Participation as a domain of age-friendliness of interest for this project. Here the reader will obtain an understanding of the three generations amalgamated into the current older adult population, and learn about historical roles of senior centres and community centres in North America. Finally, the purpose and research questions addressed in this study will be presented.

2.1 Population Aging

The United Nations define an older adult as an individual who is 60 years of age or older (World Health Organization, 2014). The world's population has been experiencing a demographic transition since the 1950s (UN, 2009). Fertility rates have

been decreasing while life expectancy from birth has been increasing, resulting in a shift in the distribution of the younger and older population (UN, 2009). Population aging occurs when there is an increase in older adult population in proportion to the total population (UN, 2013). The percentage of older adults over the age of 60 increased from 8% in 1950 to 11% in 2009 (UN 2009). By 2050, it is anticipated the world's older adult population will double to 22% (UN, 2009). In Canada older adults represent 14.8% of the total population, an increase of 1.1% from 2006 to 2011, while the proportion of children less than 14 years of age decreased by 1% (Statistics Canada, 2014).

Increased life expectancy has been on the rise in developed and developing countries in the last half century (World Health Organization, 2007a). Globally, women's life expectancy has risen from 48 to 70 years while male life expectancy has risen from 45 to 65 years (Hosseinpoor et al., 2012). It is estimated that in the next 50 years the world population's life expectancy at birth will rise by another decade (UN, 2009). In Canada, the life expectancy for women is estimated to be 83.3 years and 78.8 years for men (Human Resources and Skills Development Canada, 2014). Clearly, the world population is aging at an unprecedented pace and to an extraordinary level.

2.2 Urbanization

As the world is experiencing an increase in population aging a simultaneous trend of urbanization is evolving. Urbanization is a consequence of industrialization, modernization and rationalization. More people move to urban areas due to economic, technological, political and environmental advances (Kingsley, 2012). The 2014 revision

of the United Nations' report on *World Urbanization Prospects* states that today 54% of world's population is residing in urban areas, and projects that in 2050 the percentage of urban-dwellers worldwide will increase to 66% (UN, 2014). In 2010, 80% of older adults from developed countries already lived in urban areas (Beard & Petitot, 2010). The *Census of Population in Canada* reported that in 2006, 68% of Canadians lived in cities (Statistics Canada, 2008). With these rising numbers, municipal leaders are facing a challenge of adapting their cities to accommodate needs of elderly dwellers and allow them to age successfully (Nelson, 2009).

2.3 Successful Aging, Selective Optimization and Compensation, and Structural Lag

Today's aging population is superseding their ancestor's life expectancy. However, additional years of life may not always equate to a good quality of life (Baltes & Baltes, 1990). Scientific literature offers a number definitions and criteria that describe successful aging (Menec, 2002; Riley & Riley, 1989). Three conceptual frameworks, described here, are of particular relevance for the present study: a model of Successful Aging, a model of Selective Optimization and Compensation and the concept of Structural Lag.

A dominant model used to describe successful aging was proposed by Rowe and Kahn in 1987. They described successful aging as the combination of the three criteria: 1. low probability of disease and disability; 2. high cognitive and physical functioning; and 3. active engagement with life. Considerable research, supported by the MacArthur Foundation Research Network on Successful Aging, has been conducted to determine

predictors of successful aging (Baker et al., 2009). In Canadian context, a longitudinal study on Aging in Manitoba measured older adult's activity levels, physical and cognitive function, wellbeing based on life satisfaction and happiness, and mortality. Through increased activity levels mortality was reduced, physical and cognitive functioning improved and happiness and life satisfaction increased (Menec, 2002). The most relevant recommendation from conceptual and empiric research on successful aging for the present study is the need for sustained engagement in social and productive activities (Rowe and Kahn, 1997).

In addition to the criteria set forth by Rowe and Kahn, Baltes and Baltes (1990) developed an idea that success is a balance between the gains and losses of aging. The Selective Optimization and Compensation (SOC) model of successful aging focuses on dealing with negative changes brought about by aging, and strategies individuals use to cope with loses (Bearon, 1996; Ouwehand, de Ridder & Bensing, 2007). Baltes and Baltes (1990) expressed that aging is a heterogeneous process that can result in various pathways and outcomes. People choose areas in their lives that are of importance to them, optimize resources to allow them to fulfill their needs, and compensate for biological, psychological and socio-economic changes they experience (Ouwehand, de Ridder & Bensing, 2007). With age, stressors may become more predominant, whereas the abundance of resources may decline; this is where SOC is of importance to maintain a balance between loses and gains (Baltes & Baltes, 2002).

Structural lag was proposed in mid 1990s to explain the revolutionary changes in society (Bengtson, Silverstein, Putney & Gans, 2009). People were living longer and

healthier due to the advances in public health and medicine (Bengtson et al., 2009). Due to a rapid demographic shift, social environments tend to have a delay in providing older adults with the adequate roles to match their capabilities. These two related social structures change at different rates and get out of sync with each other (Riley & Riley, 1989). Behavioural patterns of older adults change quicker than community opportunities (Peine & Neven, 2011). Matilda White Riley (1994) defines structural lag as a "mismatch between the strengths and capacities of the increasing numbers of older people, and the inadequate opportunities in society to utilize, reward, and sustain these strengths." (p. 444). She reinforces that "as people grow older in new ways, the surrounding social structures have lagged behind." (p. 445). Structural lag is mutually shaped by individuals' behaviours and societal opportunities (Riley & Riley, 1989). Therefore, communities need to address this lag with new policies, norms and social institutions to provide older adults with adequate resources to support their strengths and capabilities and facilitate successful aging.

2.4 The Active Aging Movement

To accommodate the growing aging population, the WHO recognized the need to promote healthy and active aging around the world. In April 2002, *Active Aging: A Policy Framework* was presented at the Second United Nations World Assembly on Aging (World Health Organization, 2002). This framework was created by the WHO's Aging and Life Course Programme with the intention of promoting the need to discuss and develop action plans to help communities actively age. Active aging is defined as a

"process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (World Health Organization, 2002; World Health Organization, 2007a).

Active aging goes beyond chronological age classifications. It is a lifelong process (Plouffe & Kalache, 2010) that is applicable for all age groups (Kwok & Tsang, 2012). Individuals with varying functional capacities can age actively (Plouffe & Kalache, 2010) through their continual involvement in social, economic, civic, cultural, and spiritual activities (World Health Organization, 2002). As people age, there is a stigma towards the notion of disengagement from work and social roles in the community (Kwok & Tsang, 2012). The Active Aging Framework encourages cities to design policies and programs to promote active aging through supportive environments to encourage continual community engagement (Plouffe & Kalache, 2011). Through supportive environments, people can remain active, improving their health and overall quality of life (Kwok & Tsang, 2012).

In the *Active Aging: A Policy Framework*, the WHO outlines six fundamental determinants of active aging that interact together, creating a unique individualistic experience (World Health Organization, 2002). They are: Social Determinants, Physical Environment, Health and Social Services, Personal, Behavioral, and Economic Determinants (World Health Organization, 2002; World Health Organization, 2007a). In addition to these six determinants, an individual's culture and gender play an important role. Through these determinants, differences in life expectancy, health status, and social wellbeing among individuals from different countries can be understood (Plouffe &

Kalache, 2010). Clearly urban communities need to address these determinants in order to provide supportive environments for their aging population.

2.5 The Age Friendly Cities Project

To account for the simultaneous increase in global aging and urbanization, in June 2005, the WHO created an Age Friendly Cities Project at the World Congress of Gerontology and Geriatrics in Rio de Janeiro, Brazil (Neal & DeLaTorre, 2009; World Health Organization, 2007a). Statistical predictions mentioned earlier portrayed an influx of the aging population in the future, making it imperative for cities to address their age friendliness (Lui et al., 2009; World Health Organization, 2007a). The WHO defines an Age Friendly City as a "social and physical environment that is guided by policies, services, and structures in a community, collectively assisting older adults to actively age" (Public Health Agency of Canada, 2012).

In 2006, the WHO and the Ministry of Health in British Columbia collaborated with 33 cities, from 22 countries around the world to create a research protocol called The Vancouver Protocol to help communities assess their age-friendliness (Neal & DeLaTorre, 2009; World Health Organization, 2007a). The Vancouver Protocol was based on the WHO Active Aging approach and intended to be used as a research script and qualitative data analysis guide (World Health Organization, 2007b).

The 33 cities that participated in the original project represented urban settings in developed and developing countries (Plouffe & Kalache, 2010). Participating countries included: Argentina, Australia, Brazil, Canada, China, Costa Rica, Germany, India,

Ireland, Italy, Jamaica, Japan, Jordan, Kenya, Lebanon, Mexico, Pakistan, Puerto Rico, Russian Federation, Switzerland, Turkey, United Kingdom, and United States of America. The data collection involved 158 focus groups with adults 60 years and older from low to middle-income class. Additional focus groups were conducted with caregivers, and service providers in the private, public, and voluntary divisions for aging adults (Plouffe & Kalache, 2010; World Health Organization, 2007a). In the focus groups, eight domains of a city's age friendliness were discussed (World Health Organization, 2007a):

1. Civic Participation and Employment,
2. Communication and Information,
3. Community Support and Health Services,
4. Housing,
5. Outdoor Spaces and Buildings,
6. Respect and Social Inclusion,
7. Social Participation, and
8. Transportation.

Insightful information pertaining to (i) what makes an age friendly city; (ii) the barriers that people encounter; and, (iii) how cities can enhance a community's health, participation, and security were established from focus group discussions (Neal & DeLaTorre, 2009).

No major differences in themes were noticed between developed and developing countries; but, developed countries had more positive results of age friendliness. Some of

the important ideas focused on physical accessibility, proximity, security, affordability and inclusiveness (Plouffe & Kalache, 2010). On October 1st, 2007, the results from this project were presented simultaneously in London, England, and Geneva at the United Nations' International Day of Older Persons (Neal & DeLaTorre, 2009). The results helped create a WHO document called *Global Age Friendly Cities: A Guide* that incorporated a *Checklist of Essential Features of Age Friendly Cities*. This document helps cities around the world identify barriers that may be hindering their age friendliness and helps them advocate for change and monitor progress (Neal & DeLaTorre, 2009; World Health Organization, 2007a).

2.5.1 The WHO Global Network of Age Friendly Cities

The WHO continued to expand the age friendly cities initiative by creating the WHO Global Network of Age Friendly Cities, run by the WHO Aging and Life Course Department (Plouffe & Kalache, 2010). The Network's main goal is to foster connections between participating cities, create supportive partnerships and share strategies and solutions (Plouffe & Kalache, 2011; World Health Organization, 2009; World Health Organization, 2012). Furthermore, this global Network provides guidance on assessing a city's age friendliness and helps incorporate age friendliness into a city's design. Participants in this global platform share a desire to improve their city's physical and social environment to encourage active aging within their communities (World Health Organization, 2012).

2.5.2 Canada's Contribution to Age Friendliness

Today, many countries around the world are participating in the age friendly city movement, including Canada (Plouffe & Kalache, 2010). Canada's role began in 2006 when the federal, provincial and territorial governments identified a need for supportive environments (Public Health Agency of Canada (PHAC), 2012). As the WHO initiated the Age Friendly Cities Project around the world, four of the thirty-three participating cities were Canadian: Saanich, British Columbia; Portage la Prairie, Manitoba; Sherbrooke, Quebec; and Halifax, Nova Scotia. Canada's initiative in helping communities become age friendly includes both urban and rural areas (Plouffe & Kalache, 2010).

Since the WHO research focused on urban areas, the Federal, Provincial and Territorial Age Friendly Rural and Remote Communities Initiative conducted a similar study in 2007, looking specifically at rural communities (PHAC, 2012; Plouffe & Kalache, 2011). The initiative followed the Vancouver Protocol and included 10 communities with populations of less than 5,000 from eight provinces: British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Newfoundland, Prince Edward Island, and Nova Scotia. At the end of the project Canada created an *Age Friendly Rural and Remote Communities: A Guide*, reporting findings from rural communities (PHAC, 2012; Plouffe & Kalache, 2010; Plouffe & Kalache, 2011). By 2008, the PHAC organized a national Age Friendly Community Forum, helping to promote and implement the Age Friendly Community initiative in local communities. From 2007 until 2010, a total of 560

Canadian communities, in eight provinces participated in the initiative to become age friendly (Plouffe & Kalache, 2011).

2.5.3 Age Friendly London, Ontario

In 2008, the Creative Cities Committee established a London Age Friendly City Working Group (Age Friendly City Working Group, 2010; Age Friendly Communities, 2010). The group included community volunteers from various organizations and city departments. The purpose of the Working Group was to evaluate London's age friendliness. The initiative of the Working Group was grounded in the WHO's eight domains of age friendly cities, using the *Checklist of Essential Features of Age Friendly Cities* to explore Londoners' outlook on living in London. In 2009, the Working Group conducted focus groups with over 450 older adult participants. In June 2010, the *Age Friendly London: Report to the Community* was published, incorporating participants' responses and recognizing the priorities set forth by the residents. With this report, the City of London applied to be part of the WHO Global Network of Age Friendly Cities.

In 2010, London, Ontario was the first Canadian city accepted into the WHO's Global Network of Age Friendly Cities (City of London, 2013). In 2011, the City of London established the Age Friendly London Task Force, comprised of over 150 older adult residents, service providers, caregivers, community members, and staff from various municipal departments. The Task Force members met on a monthly basis, from September 2011 to June 2012. During this time the Task Force reviewed current initiatives, as well as best practices implemented in North America, and developed a

vision for Age Friendly London. The Age Friendly London vision statement is: *"A diverse, vibrant, caring, and healthy community which empowers all individuals to age well and have opportunities to achieve their full potential"* (City of London, 2013).

The Task Force developed strategies to achieve this vision under the eight key focus areas of age friendliness (City of London, 2013). Over 500 Londoners reviewed the strategies and feasibility of their implementation. Feedback was considered and finalized in a Three Year Action Plan produced by the Task Force. The Action Plan focused not only on initiatives that were already being implemented in London, but also on recommendations for new initiatives to be integrated into specific neighbourhoods or city districts. The plan was endorsed by London's City Council in November 2012. In May 2013 the AFL Network was formed and given the responsibility of implementing the AFL Action Plan.

2.6 Social Participation among Older Adults

With a growing population of older adults, social isolation is becoming one of the major issues affecting their health and wellbeing (Findlay, 2003). As older adults retire from paid work, they may experience negative stereotypes based on their socio-demographic characteristics and socio-economic status (MacKean & Abbott-Chapman, 2012). Individuals may turn to their social networks for support, but with advanced age they may have a smaller social circle primarily due to the death of peers (World Health Organization, 2002). With a decreased number of social relationships, social isolation

from community resources, neighbourhoods and civic activities is increasingly common (Ashida & Heaney, 2008; Hawton et al., 2010; Lai & Tong, 2012; Lang & Baltes, 1997).

Social isolation has numerous definitions in literature (Findlay, 2003; Hawton et al., 2010; Nicholson, 2012), but the one accepted for this study is an individual's lack of contact with other people (Keefe, Andrew, Fancey & Hall, 2006; Hawton et al., 2010). Social isolation encompasses emotional, social, physical and psychological dimensions and can be experienced on an individual and societal level (Keefe et al., 2006). The effects of social isolation has grave consequences to an individual's physiological, psychological, and behavioural health, thus cities are trying to encourage social participation among their older adult population (Keefe et al., 2006; Nicholson, 2012).

Social isolation has also been known to increase the likelihood of mortality (Bower, 1997; Findlay, 2003; Nicholson, 2012; Silverstein & Parker, 2002; Thomas, 2012), dementia, risk for re-hospitalization and increase in the prevalence of falls (Nicholson, 2012). It can be influenced by mental illness, poor health, geographic location, lack of communication, caregiving, poor finances, living alone, and transportation difficulties (Findlay, 2003; Gilmour, 2012; Keefe et al., 2006). With so many contributing factors, social isolation is difficult to control.

In Canada, health restrictions are the most common limitation for social participation, accounting for 33% among men and 35% among women (Gilmour, 2012). As a result, women are more dependent on others to participate in community programs (Gilmour, 2012). On the other hand, men are less reluctant to participate in activities on their own, but are limited by their busy work schedules (Gilmour, 2012). Aging men have

higher rates of loneliness in comparison to women due to their small social support networks (World Health Organization, 2002). In order to maintain a healthy lifestyle both men and women need to preserve their social connections (Bower, 1997; Findlay, 2003; World Health Organization, 2002) and their access to sources of emotional support (Richard et al., 2008) throughout late life.

Community social engagement of older adults is important to help prevent social isolation (Silverstein & Parker, 2002). As Rowe and Kahn (1997) outline, social participation involves not only sustaining relationships, but also participating in meaningful and purposeful activities and thus, they contend that social participation is a contributor to successful aging. Older adult's successful aging is provisional on the dynamics of structural modifications (Kahn, 1994). Creating services and programs to match the needs of the older adult users will motivate them to become socially engaged.

Numerous studies have found that social participation is beneficial for older adults' health and wellbeing, and important for maintaining a positive quality of life (Findlay, 2003; MacKean & Abbott-Chapman, 2012; Richard et al., 2008; Silverstein & Parker, 2002). Improvement in an older adult's wellbeing can be attributed to their sense of purpose (MacKean & Abbott-Chapman, 2012), physiological improvements and enhanced social relationships through activity (Silverstein & Parker, 2002).

Social participation is based on the structural and functional characteristics of social network systems. Structural characteristics pertain to geographic distance, size of the network, and similarity of the members; whereas functional characteristics pertain to social supports, social influences and social connectedness (Ashida & Heaney, 2008). For

individuals to increase their level of participation, the community needs to provide a variety of social resources and a welcoming neighbourhood design (Richard et al., 2008). For example, Richard and colleagues (2008) have shown that pedestrian oriented neighbourhoods generate higher rates of participation in comparison to suburban neighbourhoods.

Another important factor to consider is the socio-economic status of the population of interest. In North America, socio-economic characteristics can pertain to a population's level of education, occupation, level of income, and social class (Richard et al., 2008). A community may be well equipped with resources, but if individuals do not have financial security they will not be able to participate (Richard et al., 2008). Social participation tends to decrease with age for those with poor socio-economic status (World Health Organization, 2002) and increase with age for individuals with better health and functional status (Richard et al., 2008). A study conducted by Reichstadt et al. (2010) found that 95% of participants related their social participation to their positive attitudes about aging. Social isolation can be prevented through a positive urban atmosphere that embraces societal needs and provides equal access to its community members (Findlay, 2003; Mahmood et al., 2012).

2.6.1 The Three Generations that Comprise the Current Older Adult Population

To plan adequate resources to enhance older adult's social participation levels, consideration needs to be given to the various generations that are amalgamated together.

The current population of older adults is made up of three generations: the Greatest Generation, the Silent Generation, and the Baby Boomer Generation.

The Greatest Generation, or G.I. Generation, was born between 1912 and 1927 (Brokaw, 2004). This generation grew up between the Great Depression and the Second World War (Williams, 2007). Their experience with poverty and war made them hard workers that helped form their resiliency to hardship (O'Donnell, 2005). Their sense of community allowed them to work together and honor their country, attaining a sense of purpose (O'Donnell, 2005). Majority of this generation are war veterans who helped rebuild their countries during the post-war era (Williams, 2007). Their lives were filled with hard work, loyalty, and self-reliance (The Intergenerational Center, 2008). As this generation aged they took on a traditional role of retirement, where they focused on rest and leisure, populating retirement communities (Brokaw, 2004).

In 1928 and 1945 the Silent Generation was born (Snook, 2011). This cohort grew up during the economic growth after the war (The Intergenerational Center, 2008). Women in this generation were predominantly at home, but desired to have both a career and a family. Women who went out into the workforce were predominantly teachers, nurses, or secretaries (Snook, 2011). In addition, the Silent Generation was becoming more educated then then the Greatest Generation. Johnson, Butrica, and Mommaerts (2010) found that 12.9% of men born between 1933 and 1937 failed to complete high school, in comparison to the 47.1% of men born between 1913 and 1917. In addition, half of the working women attended college, doubling from the previous generation.

Within the Silent Generation there was a divide between the older and younger aged individuals (Snook, 2011; The Intergenerational Center, 2008). As the older members of this generation reached adulthood, they experienced an era of conformity that made people disciplined and cautious, valuing stability (The Intergenerational Center, 2008). On the other hand, the younger members were exposed to the revolution of rock music, making them question their society and way of life (Snook, 2011). The younger members wanted to break free from conformity and became the leaders of the civil rights movement (Snook, 2011). This population empowered feminism, popularized divorce, and increased the interest in outreach and missionary work (Snook, 2011). As this generation aged, older individuals embraced traditional views of retirement, while the younger population saw retirement as a new found sense of freedom (Snook, 2011; The Intergenerational Center, 2008). They took on an active retirement, participating in recreational activities, traveling, and learning new things (Snook, 2011). The tail end of Silent Generation influenced the changes brought on by the next generation called the Baby Boomers (Snook, 2011).

The Baby Boomer generation refers to a cohort of individuals born between 1946 and 1964 (Statistics Canada, 2013). As the Baby Boomer generation grew, they encouraged many changes in the infrastructure of North America. There was an influx of schools and businesses built, and a growth in the demand for a luxury market of goods and services (Malonebeach & Langeland, 2011). With these socio-historical changes, the Baby Boomers had the opportunity to become better educated than generations before them (Malonebeach & Langeland, 2011; Winston & Barnes, 2007). These opportunities

drove the Baby Boomers towards success in their careers, allowing them to become more involved in their communities (Frey, 2010). The value system of this generation is characterized by three streams: agelessness, independence and goal-oriented (Kane, 2014; Rojas, 2009). Ultimately, these individuals have forged on a new model of retirement, leading in the direction of greater self-fulfillment (Winston & Barnes, 2007).

The oldest Baby Boomers began to reach retirement age of 65 in 2011 and the last of the Baby Boomers will reach this milestone by 2029 (Frey, 2010). These retirees will be more educated and more women will be leaving the workforce (Malonebeach & Langeland, 2011). The Baby Boomer generation had significantly higher divorce and separation rates, and lower rates of marriage compared to previous cohorts, resulting in a greater number of people living alone (Frey, 2010), increasing their chances of isolation in later years. Their lifestyle is different from preceding generations and they have great expectations for their retirement. Their main goal is to remain active through travelling, physical activity, engaging within professional environments and sustaining a volunteering role (Winston & Barnes, 2007). It has been estimated that Baby Boomers will live for at least 20 years post-retirement (Nelson, 2009). Recognizing this path of longevity, cities need to plan effectively to provide adequate resources to keep this generation socially engaged into their later years.

In summary, urban communities face a challenge to affectively address the needs of three different generations of older adults. Community leaders need to understand and cater to very different value systems and variety of lifestyles. As the Baby Boomers enter retirement, they will become the dominating older adult population for which forward

thinking about policies that will shape future community facilities, programs and services will be needed.

2.6.2 Senior Centres: The Facilitators of Social Participation

In the past, social participation in urban areas has been embraced by older adults through meaningful use of senior centres in North America. The first senior centre, the William Hodson Community Centre, was created in New York City in 1943 (Wick, 2012). The main purpose of this community centre was to give retired older adults a place to gather and continue their social participation, protecting them from social isolation (Wick, 2012). From that point on, many senior centres began opening in cities around North America, and by 1950, 218 senior centres were operating (Fitzpatrick et al., 2005; Wick, 2012). Later, in 1965, The Older Americans Act secured the funding for an additional 6,000 centres (Wick, 2012). According to the act, the role of the seniors centre was to be a focal point for adults aged 60 years and older to receive a variety of programs and services to better their self-fulfillment (Pardasani & Thompson, 2012; Wick, 2012).

When senior centres were designed, they followed the voluntary organization model (Fitzpatrick & McCabe, 2008). This model advocates for socialization and leisure as the focus of all programs (Fitzpatrick et al., 2005; Fitzpatrick & McCabe, 2008; Miner et al., 1993). Seniors centres became, and remain to this day, a source for education, socialization, and empowerment for the older adults (Fitzpatrick et al., 2005; Fitzpatrick & McCabe, 2008). Research shows that senior centre participants are largely women who live alone, have lower income and few difficulties with activities of daily living, and

exhibit high social interaction (Aday, 2003, Farone, Fitzpatrick & Tran, 2005; Miner et al., 1993; Turner, 2004). The use of senior centres is dominated by individuals aged 70 years and older (Aday, 2003; Krout, 1988; Pardasani & Thompson, 2012; Wacker & Roberto, 2008). Studies conducted on the benefits of participation in senior centres found participants who maintain independence throughout retirement (Aday, 2003; Jett, 2006; Pardasani & Thompson, 2012; Florida Department of Elder Affairs, & Forida Association of Senior Centers, 2004) have higher levels of life satisfaction and a better quality of life (Malonebeach & Langeland, 2011). Interactions within the centre foster close friendships, create a sense of security, and protect people from loneliness and depression (Aday, 2003; Aday et al., 2006; Farone et al., 2005; Pardasani & Thompson, 2012).

According to the voluntary organization model, socialization is a primary function of senior centres (Fitzpatrick & McCabe, 2008; Miner et al., 1993). Some of the most commonly used amenities offered in senior centres are meals, blood pressure screenings, games, and day-trips (Turner, 2004). These programs provide benefits and new learning opportunities for participants.

However, the Baby Boomer generation does not identify with the traditional user of senior centres, therefore, cannot reap the benefits of participation identified in the literature (Turner, 2004). For them, a senior centre is a stereotypical gathering place for the old, frail and inactive (Fitzpatrick & McCabe, 2008). Baby Boomers view themselves as energetic individuals who will not age until very late in life (Fitzpatrick & McCabe, 2008). Decreasing senior centre attendance is a signal that innovative approaches are

needed to encourage social participation and active aging of the Baby Boomer generation.

2.6.3 Community Centres

With the changing interests of the Baby Boomer generation, communities are turning to community centres as an option to improve activities and social engagement. Senior centres encouraged social participation by providing comfort and security through an exclusive environment for older adults; however, this is not preferred by the Baby Boomers (Fitzpatrick & McCabe, 2008; Turner, 2004). Community centres can become fresh enablers of social participation for the new generation of older adults, as they have had a prominent place in encouraging social participation since the late 1800s (Benson, Harkavy, Johanek & Puckett, 2009; Ward, 1913). For over a hundred years, community centres have been called a variety of names, including ‘settlements’ and ‘social centres’, and were officially given the name ‘community centre’ in 1915 (Benson et al., 2009; Fronc, 2009; Ward, 1913).

In 1889 Jane Addams, a settlement house reformer, established one of the first settlements in North America called the Hull House Settlement (Fronc, 2009). The purpose of this settlement was to provide educational, recreational, and social services to the immigrants in the poorest area in Chicago, Illinois, the Nineteenth Ward (Shpak-Lisak, 1989). With the success of Hull House, settlements became a popular institution in North America, but, finding locations to house these settlements became a barrier to their development (Benson et al., 2009). In 1902, John Dewey recognized the need to expand

these institutions and had an idea of creating school based 'social centres' (Benson et al., 2009; Fronc, 2009; Ward, 1913). With Dewey's model, schools were used during the day as educational institutions for children, and in the evenings they were transformed into a centre that promoted recreational, educational, political, industrial, and medical programs and services for adults.

Between 1907 and 1930, community centres experienced four historical movements that will be further discussed below: community development, professional planning, mobilization, and community service (Ward, 1913). The first community centre movement focused on community development between 1907 and 1914 (Ward, 1913). Community development was to provide a bottom-up approach for community centres. Residents would manage the facility while upper-class groups would fund it (Ward, 1913). The goal of community development was to foster self-expression through the collaboration of citizen participation in working for the community as much as working for oneself (Bushnell, 1920). The bottom-up approach did not last and instead social welfare professionals took over the advisory roles sidelining community involvement (Ward, 1913). With this shift in power, community centre leaders maintained the concept of the facilities in schools to preserve a unity of power between residents and decision makers (Bushnell, 1920; Ward, 1913).

From 1915 until 1917 the second community centre movement focused on professional planning (Ward, 1913). With the collapse of the bottom-up approach, a National Community Centre Association was established, regulating the decisions that were being made (Fronc, 2009; Ward, 1913). The association's main aim was to focus on

social services and improve the communication between the centre and its participants. The third movement, from 1918 until 1919, focused on mobilization of the community centres (Ward, 1913). America had entered the First World War, and communities were coming together to join forces to get involved. Neighbourhood recreational needs were overlooked and community centres became facilities for the Red Cross relief, Liberty Loan drives, food and nutritional programs and any other programs or services that were rendered important (Benson et al., 2009; Ward, 1913).

In a decade after the First World War, 1920 until 1930, community centres experienced their last movement (Ward, 1913). They became the city`s responsibility, decreasing the influence of private organizations through greater governmental control. With this last movement, the community centre model was solidified and is still used to this day. With an understanding of the history of community centres, their evolution, and the significance of their role within the community, one can appreciate the importance for an inclusive environment for older adults. The multipurpose use of community centres can welcome people from various socio-economic backgrounds, encouraging social participation that can lead towards healthy and active aging for all.

2.7 The Present Study

The current older adult population is superseding the life expectancy of their ancestors. With increase to the number of years of life, people want to age successfully, but in order to do so society needs to provide adequate resources to meet their needs. With the rise of urbanization, government officials are motivated to adapt their cities to

handle the upcoming changes. With the help of the WHO's Age Friendly Cities initiative, cities now have guidelines that they can follow to address the eight domains of age friendliness. The age friendly initiative is globally accepted and is underway in Canadian cities, such as in London, Ontario. The collaborative union between city officials, service providers and community members helped drive the initiative forward, fulfilling necessary city changes. The main focus of this research project is on the domain of Social Participation in North American context.

Chapter 3 – Methods

3. Introduction

This study followed a sequential explanatory mixed methods design with a qualitative approach grounded in phenomenology. In this chapter, the suitability for a sequential mixed method design is discussed, as well as the methodological approach of this study. Following this, the study design, including recruitment, data collection, data analysis and trustworthiness are all discussed.

3.1 Mixed Methods

Mixed methods are a procedural combination of quantitative and qualitative research data (Creswell, 2014; Ivankova, Creswell & Stick, 2006; Tashakkori, 2003). Both data sets are analyzed, and can either be integrated, merged, connected or embedded within one another based on the selected mixed methods design (Ivankova et al., 2006; Klassen, Creswell, Clark, Smith & Meisser, 2012). There are four types of mixed method research designs: convergent parallel design, sequential explanatory design, sequential exploratory design, and the embedded design (Creswell & Clark, 2011; Tashakkori, 2003). A researcher's rationale for selecting mixed methods is that neither quantitative nor qualitative methods could solely determine the depth of the information pertaining to the research question (Klassen et al., 2012; Mayoh, Bond, & Todres, 2012; Tashakkori, 2003). When using a mixed method design, rigorous attention needs to be attributed towards the priority of the research data; the sequence of the data collection; the level of interaction each data set has with the other; the timing when the data will be collected;

and the decision of how the data will be mixed together (Creswell, 2014). Using mixed methods helps explore the intricacy of a phenomenon through measurement and interpretation (Sale, Lohfeld & Brazil, 2002).

Since the twentieth century, mixed methods were predominantly used by cultural anthropologists and field work sociologists who believed their research questions would be best answered by mixing of quantitative and qualitative methods (Johnson, Onwuegbuzie, & Turner, 2007). However, this methodology has been frequently questioned as an attempt to combine two fundamentally different paradigms (Johnson et al., 2007; Sale et al., 2002).

Each paradigm has its own ontological and epistemological position that looks at solving a phenomenon through different perspectives (Mayoh et al., 2012; Sale et al., 2002). Quantitative research focuses on the positivist paradigm, proposing there is one truth and objective reality (Mayoh et al., 2012). The researcher maintains objectivity by being a separate entity to the phenomenon, with no personal influences affecting the research (Mayoh et al., 2012). On the other hand, qualitative research focuses on the interpretivist and constructivist paradigm, proposing that there are multiple realities constructed by the participants and the researcher (Mayoh et al., 2012; Sale et al., 2002). The researcher is positioned within the phenomenon because reality is not separate from individual minds, but rather created through the researcher's exposure (Mayoh et al., 2012). With these differences, arguments have been made to disprove the credibility of mixed methods, stating mixed method researchers cannot have two research philosophies.

In the past 60 years, the mixed methods popularity has begun to rise within the social, behavioural, and human sciences, where this methodology has proven to be very effective (Johnson et al., 2007). Sale et al. (2002) suggested that a situation can arise when two paradigms come together, complementing one another. In this research project, specific attention was put towards appropriately mixing paradigmatic strategies through the methodological belief of complementarity. Complementarity is the combination of two approaches that study the same phenomenon through different perspectives (Sale et al., 2002). The quantitative approach measured the numerical values, while the qualitative approach interpreted the underlying meaning of the contextual responses. Combining the two results provided distinctive outcomes that followed their respective paradigm and methods, yet helped explore the same phenomenon (Sale et al., 2002; Mayoh et al., 2012).

3.1.1 Sequential Explanatory Mixed Methods

In this research project, a sequential explanatory mixed methods design was chosen to comprehensively and completely explore the research questions. A sequential explanatory mixed methods design was composed of two-phases, where the collection of quantitative data preceded the collection of qualitative data (Creswell, 2013; Ivankova et al., 2006; Klassen et al., 2012). Once the quantitative data was analyzed, a new research question was created that built off of the quantitative results. In this study, a heavier focus was put on the qualitative data. Once qualitative data was collected and analyzed, results from both methodologies were integrated together. Their interaction helped gain an

interpretive understanding of the phenomenon of social participation. Figure 1 provides a visual representation of this research design. Arrows in the figure indicate the sequence of the study design. The uppercase letters of ‘QUALITAITVE’ indicate that this was the primary method, whereas the lowercase letters of ‘quantitative’ indicate that this was the secondary method (Creswell & Clark, 2011).

Figure 1. A visual representation of a sequential explanatory mixed methods research design.

3.2 Phenomenology

The qualitative part of this study was grounded in phenomenology that explored lived experiences of older adults that shaped their needs for programs and services that could facilitate social participation. Phenomenology is an approach that extracts deep issues, allowing individual voices to be heard (Lester, 1999), which are then described through the researcher’s interpretations (Groenewald, 2004; Guba, 1990; Morse, 1991). The researcher experienced an inter-subject reality, controlling for preconceived assumptions and personal biases (Groenewald, 2004; Robbins & Yandree, 2009). In this study, informants were selected to explore personal experiences on social participation within their neighbourhood (Groenewald, 2004; Guba, 1990; Lester, 1999).

3.2.1 Hermeneutic Phenomenology

Hermeneutic phenomenology informed by Max van Manen, was the chosen qualitative methodology for this study. It focused on examining subjective human experiences through interpretation (Laverty, 2003; van Manen, 2007). The goal of hermeneutics was to achieve a sense of understanding by unearthing hidden meanings (Ness, Fried, & Gill, 2011; Wilcke, 2002). These meanings were uncovered through the use of rich descriptive language, such as written work, speech, or art (Van Hesteren, 1986; van Manen, 2007).

An important concept to the hermeneutical methodology is the hermeneutic circle, which is an ongoing reflexive process, helping individuals develop an understanding of a phenomenon (Wilding & Whiteford, 2005; Wilcke, 2002). Van Manen believed that by continually reflecting on the collected data through writing, it would help a researcher gain better interpretations of the findings (Laverty, 2003). This process occurred in a circular fashion within the study, the researcher submersed herself in the text, moving from portions of the experiences to its entirety (Laverty, 2003; van Manen, 1995). The role of a researcher was to pay attention to the information taken for granted, from contextual omissions, silences, and assumptions (Laverty, 2003; Wilcke, 2002). The circle concludes itself once a sensible meaning was established without any contradictions from the information collected (van Manen, 1995; Wilding & Whiteford, 2005).

This methodology embodied this research project as it revealed lived experiences, exposing individuals' needs for social participation. The researcher engaged with the

participants, exploring participants' experiences, and interpreting the information based on theoretical and personal knowledge (Ajjawi & Higgs, 2007). This allowed the researcher to interpret the information as a whole, focusing on the information provided, as well as the experience behind the verbalized data.

In summary, this research project was anchored in a quantitative methodology followed by deeper qualitative explorations. In the following section, the study procedure describes participant eligibility and recruitment, data collection, and data analysis for quantitative and qualitative parts of the study.

3.3 Research Setting

The City of London is comprised of 42 planning districts, which are dispersed within four quadrants of the city: North East, North West, South East, and South West London. Argyle is one of the planning districts of London and is located in South East London. The borderlines of this neighbourhood are Veterans Memorial Parkway, Oxford Street, Highbury Avenue, Kiwanis Park, and the CN tracks (London Strengthening Neighbourhoods Strategy, 2014). Argyle's population was compared to all of London to show the educational and economic differences between the groups. The purpose of illustrating these measurable differences was to show that Argyle's population was not the typical voice heard when age friendliness of London was examined as a whole.

According to the 2006 census, the Argyle planning district had 7.9% of London's total population of 352,359; which was more than any other planning district in London (City of London, 2012). This was another reason why Argyle was the focus of this

research project. With an anticipated increase in the aging population, it was vital for neighbourhoods such as Argyle to increase the availability of resources to help increase social participation and decrease social isolation as people age.

When comparing Argyle's demographics to the rest of London, educational levels and social economic status attracted special attention. Education is an important social determinant of health that can influence an individual's lifestyle factors, career paths and financial stability (Marmot & Wilkinson, 2005). Table 1 shows the discrepancy in education and income between residents in Argyle and the rest of London, Ontario. These differences can negatively influence experiences of social participation in later life if community resources do not coincide with what the people need.

Table 1

Selected Statistics from 2006 Census Comparing Argyle to London, Ontario

	Argyle	London
Total Population	27,785	352,359
Education Level Obtained (20 to 64 years old)	%	
No certificate, degree or diploma	19.3	12.2
Apprentices/trade	11.7	7.6
University Degree	9.4	27.7
Income	Dollar Value	
Average income (all people age 15+)	$30,684	$36,549
Average family income	$67,071	$84,593

3.4 Study Procedure

This research project was conducted in two phases. The first phase encompassed a quantitative approach (survey), followed by a qualitative phase (focus groups). This chapter describes the data collection and analysis in the order they were conducted. The research team was comprised of five individuals: the researcher, the researcher's supervisor, the researcher's two advisory committee members, and a research assistant who helped with qualitative data collection. Ethics approval for this study was obtained from the University of Western Ontario's Health Sciences Research Ethics Board (Appendix A).

3.5 Quantitative Approach: Survey

3.5.1 Data Collection

In the summer of 2013, a separate research project, led by a group of researchers from Western University in partnership with the Council for London Seniors and the City of London, administered a survey called "Assessing Baseline Age Friendliness of London, Ontario". The survey was a modified version of the Community Assessment Survey for Older Adults (CASOA) (Dellamora, 2013; National Research Centre, 2010). CASOA was a needs assessment instrument that was valid, reliable, and sensitive to change. CASOA had been previously used for baseline and follow-up assessments in communities in the United States, assessing the needs of older adults.

Although comprehensive, the overall question breakdown of CASOA did not adequately represent all eight WHO domains of age friendliness. Outdoor Spaces and Buildings (N=2), Housing (N=6), Transportation (N=5), and Communication and

Information (N=7) had limited questions (Dellamora, 2013). Therefore, nine multi-item questions were added at the end of CASOA to enhance the four domains, creating at least ten questions per domain. The additional questions were generated from other age friendly surveys and were created in consultation with the London Age Friendly Task Force representative. Minor adjustments were made to CASOA to make the survey more applicable to Canadian context (e.g., having adequate information for dealing with public programs such as Canadian Pension Plan). The Modified CASOA (M-CASOA) had three main sections: i) community assessment survey of older adults; ii) demographic questions; and iii) additional age friendliness questions. Questions were answered using a Likert Scale and responses were rated either on a four, five, or six point scale. In addition, some questions were descriptive; for example, participants were asked to indicate how information on programs and services were obtained (e.g., advertisement at community centre or library bulletin board, church newsletter or bulletins, and community associations). Dellamora (2013) describes the identification, modification, and administration of the survey in more detail.

A random sample was recruited by mailing out 3,000 surveys to targeted postal codes in all districts of London, Ontario with high concentrations of older adult residents. An additional 3,000 surveys were distributed for a snowball sample to members of the London Age Friendly Task Force and various community organizations, whose representatives participated in the Task Force. Some of these surveys were distributed at six senior community housing locations in London and during the annual Age Friendly Cities conference.

A subset of 76 surveys, from two postal codes in the Argyle district, was extracted from Dellamora's (2013) study dataset. An additional 100 surveys were distributed through a snowball sample in the Argyle neighbourhood, between October and December 2013, and 21 were returned. Connections were made with Argyle neighbourhood gatekeepers, allowing access to the East Public London Library, the Argyle Seniors' Satellite, the Argyle Senior Neighbourhood Advisory Committee (SNACs) Group, and the Richard Memorial United Church. Interested individuals in these organizations helped distribute surveys to other colleagues and friends within the community. All participants met the following criteria: 55 years of age or older, fluent in English, and proficient in reading, understanding and answering survey questions.

To ensure anonymity, respondents were asked to mail the surveys in a self-addressed postage-paid envelope included with the survey, or drop them off at two drop-boxes located at the local senior centres: Hamilton Road House Senior Centre or Kiwanis Senior Centre. The only partial identifier in the survey was the first three digits of the participant's postal code. This information allowed a sub-analysis of the participant's area of residency, such as the Argyle planning district.

3.5.2 Data Analysis

Survey data collection continued in Argyle until a week before the first focus group. Data analysis began with the calculation of frequencies and percentages of responses for each survey question, using SSPS statistical software version 21 (Muijs, 2004). Question items were divided into the eight WHO domains of age friendliness. The

mean was calculated for each question item, and then combined to calculate a domain score. To maintain consistency, questions with four and six point scales were re-scaled into a five point scale using a formula designed by Preston and Coleman (2000) (Dawes, 2008): (mean of question – 1) / (number of response categories -1) x 5. The purpose of the score was to rank the eight domains from most to least age friendly, thus identifying areas that would require immediate attention. Based on the design of the survey, the best responses were represented by smaller numbers. Three multi-item questions in the survey had an opposite response scale where the best responses were represented by larger numbers: (1) *In the last 12 months, about how many times, if ever, have you participated in or done each of the following?*; (2) *During a typical week, how many hours, if any, do you spend doing the following?*; (3) *During a typical week, how many hours do you spend providing care for one or more individuals with whom you have significant personal relationship, whether or not they live with you?* These questions were reverse coded, prior to item score calculations, to maintain consistency with the other responses. On the request of the Age Friendly Task Force, final scores were reversed so that the greater number (closest to five) reflected a domain's success.

3.6 Qualitative Approach: Focus Groups

3.6.1 Data Collection

The second phase of this study drew on the survey results from the Argyle planning district and focused on the specific domain of Social Participation. To explain and probe results from the surveys, pertaining to Social Participation, five focus groups

were held with Argyle participants, 50 years of age or older, who were recruited through purposeful sampling. Bradbury-Jones, Sambrook & Irvine (2008) proposed "that group interviews in phenomenology are actually beneficial because they stimulate discussion and open up new perspectives" and that "the use of focus groups can provide a greater understanding of the phenomenon under study" (p. 663). Their view was reiterated by Breakwell, Smith & Wright (2012) who sad that "people find it easier to talk openly about their personal perceptions and experiences in a context in which these experiences can be shared with similar others" (p. 431). A maximum of six participants were recruited per focus group. According to Simon (1999), six participants provide sufficient discussion and are easily manageable.

Prior to a focus group meeting, each participant received the "Assessing Baseline Age Friendliness of London, Ontario" survey to complete; if they had not done so previously. Connections were established with leaders in various Argyle community organizations, including the Argyle Community Association, the Argyle Seniors' Satellite, the Argyle SNAC Group and the East London Public Library. The community leaders helped identify potential focus group participants. These individuals were given a flyer that described time slots for various focus groups, the researcher's contact number, and the purpose of the study. Additionally, posters were distributed at public establishments in Argyle, such as Walmart, Canadian Tire, Tim Hortons, Shoppers Drug Mart, Metro and a variety of hair salons and dry cleaners.

Snowball sampling was used to further recruit participants, as needed, until data saturation was achieved. Data saturation occurred when the same information was

collected repeatedly; allowing the researcher to anticipate that no new knowledge would be gained (Onwuegbuzie, Dickinson, Leech & Zoran, 2009). The focus group participants were asked to recommend additional eligible individuals (their friends, neighbors, etc.) and provide them with contact information for the researcher. Each participant received a brief overview of the study, and had an opportunity to ask questions. When their questions were answered, they were then registered for a focus group meeting. The inclusion criteria for the focus groups were that participants had to be 50 years of age or older, live in Argyle, speak English and be capable of actively engaging in a focus group discussion with their peers.

The survey results helped formulate five open-ended questions for focus group discussions; please refer to Appendix E for focus group questions. The goal of focus group discussions was to gain a deeper understanding of participants' lived experiences on how community programs and services could facilitate meaningful social participation within their district. The researcher decided to divide participants into age groups; younger individuals may have different perspectives and needs for social participation compared to older generations. Smaller age groups had a potential to reveal any difference or similarities between groups. This assured that each age group provided information pertaining to their point of view, allowing their voices to be heard and not overshadowed by other age groups. A total of four age groups were created to cover two age generations: the Baby Boomer generation (50 to 57, and 58 to 67 years of age), and the current older adult generation (68 to 78, and 79 years of age or older). A total of five focus groups were conducted; each age group had one focus group whereas one

additional focus group was added to the 79 years of age or older group to attain a larger sample size.

The East London Public Library hosted four of the five focus groups, with the fifth group meeting at Richard's Memorial apartment complex. All of the focus groups lasted approximately 90 minutes (Appendix E). The focus groups began with a welcoming from the researcher, introducing the research assistant, explaining of the study's background and purpose, and how the discussion would be tape-recorded. Each participant received a portfolio from the research assistant that included the study's letter of information, informed consent form, (Appendix D) and a demographic questionnaire (Appendix E). Participants were given time at the beginning of the focus groups to read over the letter of information and decide if they were still interested in participating and would consent to being tape-recorded. If they wanted to continue with the focus group, participants signed their consent form and kept a copy of the letter of information for their own records. Finally, the consenting participants filled out a short demographic questionnaire.

Once all the paperwork was completed, the researcher described the focus group protocol, outlined rules, explained confidentiality and the responsibility of the individuals to maintain confidentiality about other participants. When everyone was settled and his or her questions were answered, the researcher turned on the three digital tape-recorders. Each discussion question was initially allocated twelve minutes; however, if discussion took on a natural flow and diverted into the next question the researcher allowed the participants to continue talking. The last ten minutes of the focus group discussion were

dedicated to member- checking. The research assistant kept notes of major themes and ideas that were mentioned by the participants during discussion and then proceeded to write them on large pieces of paper for everyone to see. Major topics were reviewed and summarized, allowing participants to make corrections and contribute additional comments. Once all the participants were satisfied with the major themes, the focus group came to a conclusion. After participants were thanked for their time and information, the tape-recorders were turned off. All focus groups were tape-recorded using the same three digital audio recorders that allowed for future transcription.

3.6.2 Data Analysis

The researcher transcribed the audio recordings of the focus group discussions and used inductive content analysis to achieve abstraction. Transcription and content analysis occurred simultaneously with data collection to assure that saturation was achieved (Onwuegbuzie et al., 2009). All personal identifiers, such as names, were removed and replaced with identification codes during the transcription process. Each participant was assigned a particular code. In addition, participants were assigned an alias name for descriptive purposes in the results chapter.

The researcher organized transcripts in Nvivo 10, and used this software for open coding (Ajjawi & Higgs, 2007). The researcher read through the full transcripts multiple times to gain a holistic understanding of what was discussed. As the researcher submersed herself into the data, she continually reflected on the information she read, taking note of specific details and their influence on the story told by the participants,

through the hermeneutic circle. Interpretations were formed by combining the researcher's understandings about the community's social engagement with those of the participants, creating new perspectives (Elo & Kyngas, 2007). The researcher used the circular path to establish codes that connected to each transcript. After submersing herself in multiple readings of the transcripts, and in collaboration with three other coders on the research team, the researcher created sub-codes and codes that categorized the data into distinct units (Appendix F). Figure 2 describes this process visually. Once the codes were accepted the researcher coded all transcripts in Nvivo 10 (Goble, Austin, Larsen, Kreitzer, & Brintnell, 2012). Each code was made into a node, and once all the transcripts were fully coded, the researcher engaged in abstraction.

Each code was reviewed separately. Through continual examinations of the codes, the researcher established emerging themes. The themes encompassed a collection of codes coming together, to explain one aspect of the phenomenon. The researcher met with her research team to discuss findings, consolidate ideas and make connections. After the revisions, the results were finalized.

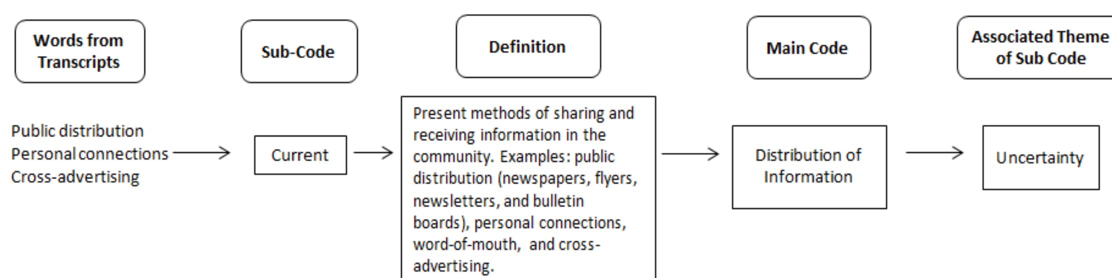

Figure 2. A visual example of the systematic steps taken to create codes.

3.6.3 Establishing Trustworthiness

When conducting a qualitative study, trustworthiness needs to be established through credibility, dependability, confirmability, and transferability (Cojocaru, 2010; Koch, 1994; Lincoln & Guba, 1985). Trustworthiness represents experiences of participants that have reliably been embodied by the researcher through rigor (Koch, 1994; Morrow, 2005). Rigor assures a clear representation of the study participants' responses, and a strong study protocol (Koch, 1994; Morrow, 2005).

***Credibility*.** Credibility was recognized by how data was collected, analyzed and represented by the researcher (Graneheim & Lundman, 2003). The main goal of credibility was to ensure that participants recognize that the findings are a reflection of their own experiences provided during data collection (Koch, 1994). To maintain credibility in this study, member checking was conducted at the end of each focus group (Lincoln & Guba, 1985). The researcher summarized the discussed information, using the research assistant's notes. Participants had an opportunity to agree or disagree with the researcher's clarifications, providing additional explanations to further their views. This endorsed accuracy in the data collected, allowing participants' responses to be properly understood and interpreted in data analysis.

***Dependability*.** Dependability determines how well a study can be repeated (Lincoln & Guba, 1985). This was achieved through auditability, where the research process and protocol, from beginning to end, were reported in detail. By maintaining an audit trail, other researchers have the ability to replicate this study. Rich documentation

was created that supported decisions on the research design, data collection, data analysis, and data interpretation.

Confirmability. Confirmability aims to prove that the results were supported by data and not molded by the researcher's bias, preconceptions, or influence (Lincoln & Guba, 1985). Confirmability was maintained within this study through reflexivity and the assistance of the researcher's supervisor and advisory committee (Irwin, He, Bouck, Tucker, & Pollett, 2005; Lincoln & Guba, 1985). Reflexivity is a researcher's intention to reveal personal assumptions and biases she had towards the research questions (Guba, 1981). In this study, the researcher continuously kept field notes and a reflective journal that captured preconceived conception of the participants' responses. This helped the researcher to contain bias from prior knowledge or a specific culture. By continually reflecting on oneself and the experiences of conducting the study, the researcher was fully present in the study, understanding her impact on the interpretation of the findings (Goodley, Lawthorn, Clough & Moore, 2004). Weekly de-briefing sessions with the supervisor and bi-monthly meetings with the advisory committee were arranged to minimize personal bias. In addition to personal opinions and thoughts, the researcher also reflected on the study setting. By understanding the environment, the researcher was able to extract a deeper understanding and value from the information provided by the participants (Morse, 2006). Prior to each focus group, the researcher reviewed her field notes to remind herself to enter the discussion with a clear mind, open to being immersed in the participants' lived experiences. During data analysis, the researcher's advisory committee assisted with the inductive content analysis. Transcripts were coded

independently by the researcher, the researcher's supervisor, and two of the advisory committee members. Additional reviews were conducted to consolidate information and come to an agreement on how certain transcripts would be coded.

Transferability. Transferability describes how applicable the findings are from this study to other contexts (Graneheim & Lundman, 2003; Lincoln & Guba, 1985; McGloin, 2008). The researcher was fully aware that the context of location, culture, and socio-economic reality of the study setting (Argyle, the district of London) limited transferability of findings. However, the process of obtaining the information essential for future planning of Age Friendly improvements is transferable to any comparable neighbourhood. Hence, the researcher assured that the protocol was described in sufficient detail to allow other Age Friendly City Network members to follow and gain useful knowledge in their local context.

Chapter 4 – Findings

In this chapter the findings from both the quantitative and qualitative phases of this study are reported. These results are presented in the order the data was collected. Survey results will precede the explanation of themes that emerged from focus groups discussions.

4.1 Quantitative Approach: Survey

4.1.1 Participants

A total of 97 participants completed the survey, 70% were female, 28% males, and 2% did not disclose their gender. All participants resided in the Argyle neighbourhood. The majority of participants (25%) were between the 75 to 79 years of age; while the oldest respondents (1%) were in the 90 to 94 years age group. The sample was predominantly female (70%), overwhelmingly of white ethnicity (91%), fully retired (71%), with an annual household income between \$25,000 and \$50,000, and more than half (60%) owned their home with a paid off mortgage. A table with the full set of the demographic variables collected in the survey available in Appendix B.

4.1.2 Age Friendly Domain Scores

The survey questions were divided into the eight domains of age friendliness. Table 2 shows the summary of all eight domain scores in a hierarchal order. Further, question item scores for Social Participation are shown in Table 3, while question items scores for the other seven domains can be found in Appendix C.

4.1.2.1 Overall Domain Scores

The M-COSOA survey questions were not organized per age friendly domains. Therefore, to calculate domain scores, all questions/question items that pertained to one of the eight domains were grouped together. Once domain scores were calculated, they were presented on a five point scale. A high score represented a higher level of age friendliness. For the purpose of this study, a score of three or more was interpreted as a good level of age friendliness; while scores below three were interpreted as having fair or poor age friendliness that needed further attention.

As shown in Table 2, there was a clear divide that separated domains in two groups. The first four domains – Community Support and Health Services, Respect and Social Inclusion, Communication and Information, and Transportation – had a score above three points, with a 0.5 range between the highest and lowest score. These domains were considered age friendly. On the other hand, the last four domains – Outdoor Spaces and Buildings, Housing, Civic Participation and Employment, and Social Participation – had a score below three points with only a 0.2 range between the highest and lowest score. These domains cannot be considered age friendly and would need further attention. The separation between the two groups of domains was 0.4. This divide was significant as it represented the urgent need to implement changes that would help the lower scored domains become more age friendly. Overall, survey results showed that the Argyle community was meeting community needs for Community Support and Health Services, Respect and Social Inclusion, Communication and Information, and Transportation, but still needed changes to help improve age friendliness of the other four domains.

Table 2

Summary of Age Friendly Argyle Domain Scores in Hierarchical Order

Domains	Domain Scores[1]
Community Support and Health Services	3.5
Respect and Social Inclusion	3.2
Communication and Information	3.1
Transportation	3.0
Civic Participation and Employment	2.6
Social Participation	2.6
Housing	2.4
Outdoor Spaces and Buildings	2.4

Note. [1]Score on a five point scale where 5/5 is the best score.

4.1.2.2 Social Participation

Social Participation had the second lowest score of 2.6/5 among the eight domains. The interest in this domain was of relevance due to its connection to the health and wellbeing of older adults after retirement. Table 3 displays the Social Participation question items alongside the score on a five point scale. The fourteen items were also interpreted as contributing to good or poor age friendliness. Two responses demonstrated an abundance of opportunities in Argyle, they were: *Finding productive or meaningful activities to do* and *Having interesting recreational or cultural activities to attend*. Participants reported that they rarely felt bored but also that their actual participation in social programs were low. The lowest responses pertained to *Using a recreation center in your community* and *Participating in a club, religious or spiritual activities with others*. The frequency responses to each survey question are available in Appendix B. Overall, the domain of Social Participation had great potential for improvement of age friendliness once the lack of participation was explained.

Table 3

Scores for Individual Question Items in the Social Participation Domain

Questions	Item Score
Finding productive or meaningful activities to do	4.2
[1] Feeling bored	3.9
Having interesting recreational or cultural activities to attend	3.9
[1] Having interesting social events or activities to attend	3.8
Opportunities to attend religious or spiritual activities	3.6
Recreation opportunities (including games, arts, and library services, etc.)	3.3
Opportunities to attend social events or activities	2.9
Communicating/visiting with friends and/or family	2.2
Used a public library in your community	1.8
Used a senior center in your community	1.5
Participating in a recreation program or group activity	1.5
Used a recreation center in your community	1.3
Participating in a club (including book, dance, game and other social)	1.3
Participating in religious or spiritual activities with others	1.1
Domain Score	2.6

Note. Item score refers to item responses on a five point scale where 5/5 is the best score. Domain score refers to the average of all item scores out of five, where 5/5 is the best score. [1]These question items are negatively worded because they asked respondents to rate each item as ‘Not a problem’, ‘Minor problem’, ‘Moderate problem’, or ‘Major problem’ versus the standard ‘Excellent’, ‘Good’, ‘Fair’, or ‘Poor’ selections.

4.2 Qualitative Approach: Focus Groups

4.2.1 Participants

A total of 23 participants took part in focus groups. Twenty were females and three were males. The average age of participants in each of the four age groups was: 55 years, 64 years, 74 years, and 82 years. All participants resided in the Argyle neighbourhood and could understand and speak English. Table 4 provides a summary of demographic information of these participants.

In addition to the demographic questions, participants were asked two descriptive questions, about their access to transportation and information (Table 5). Participants were allowed to choose more than one answer, where applicable to them. The responses are presented in percentages to reflect the total response rate. More than half of the participants had access to a vehicle and were able to drive, while 19% relied on public transportation. When participants were asked how they attained public information about programs and services in Argyle, the most frequent responses were: the free newspaper; word-of-mouth through friends, neighbours, or family members; and through advertisements on the bulletin board at the East London Public Library.

Table 4

Summary of Demographic Information for Focus Group Participants (N=23)

Demographic Information		N
Highest Level of Education	Grade 8 or less	2
	Grade 12 or less	3
	High School Diploma	9
	College Degree	8
	University Degree	1
Current Occupational Status	Fully Retired	21
	Working Full-Time for Pay	1
	Working Part-Time for Pay	1
Current Marital Status	Married	11
	Widowed	7
	Divorced	3
	Single	2
Do you volunteer in the community?	Yes	19
	No	4

Table 5

Responses to Two Descriptive Questions for Transportation Information Collection for Focus Group Participants'

Descriptive Questions		%
Which of the following transportation options do you use on a regular basis?	Car – I drive myself	53
	Car – Someone else drives me	13
	London Transit Commission (LTC)	19
	Para-Transit	9
	Taxi	6
How do you currently get information on programs and services in Argyle?	Free newspaper	16
	Friend, neighbour, or family member	15
	Advertisement at the library bulletin board	13
	Community associations	12
	London Free Press	11
	Church newsletters or bulletins	10
	Internet on personal computer	10
	Email newsletters	5
	Internet on a public computer	2
	Yellow Pages	2
	211 Phone Line	2
	Senior's Helpline	1
	Other	1

4.2.2 Emergent Themes

This study gained a deeper understanding of participants lived experiences on how community programs and services could facilitate meaningful social engagement in community. Four distinct themes emerged: Personal Responsibility, Uncertainty, Togetherness, and Resentment. Below is an in-depth explanation of each theme, supported by relevant codes and examples of quotes from the focus group discussions. Appendix F has the complete list of codes with their operational definitions, and relations to emerging themes.

4.2.2.1 Theme 1: Personal Responsibility

Personal Responsibility was a prevalent theme that arose in all focus group discussions. It included the following six codes and sub-codes: Current Informal Activities Enabling Social Engagement, Current Private Locations for Social Engagement, Obligation and Necessity as Personal Motivators for social engagement, Civic Engagement, and Participation Frequency. Participants in all age groups talked about how important it was for them to continue doing informal leisure activities in their spare time. As they aged they continued to engage in these activities, not letting physical or psychological restrictions keep them away from being active. In words of Jane (80 years old): *"Walking [at Kiwanis Park] was always high on our list, so even though my husband has some mobility issues we still go out after supper in the summer months"*.

This theme could be conceptually defined as self-determination to find the meaning and purpose in the post-retirement phase of growth and development. Personal

Responsibility emerged from descriptions of current informal activities, such as hobbies, caregiving, reading or gardening, that were predominantly performed in private locations, such as a home, garden or garage. The informants used the feelings of obligation and necessity as motivators for social engagement. They described their obligation to continue pre-retirement activities, try new things, progressively increase participation and develop resilience. They felt necessity to fulfill roles of family members that were at a distance, to develop trust and comfort with others, to have a reason to get up in the morning and accomplish something each day. Personal Responsibility also emerged from stories about participants' engagement in lobbying for policy change and regular participation in voting during elections.

Continuous participation helped individuals transition from working full-time to retirement. The transition of having to go to work every day to becoming a free agent with more free time influenced individuals to become self-reflective. They often took a step back and realized that their time was theirs and now they could relax and do what they liked.

> *I'm just retired not quite about nine months, so I'm still kind of finding ways to keep active. I know I'm not getting enough exercise because I worked a physical job all my life [participant was a mail carrier], so I'm doing a lot less than I used to. I can tell I need to do more* (Angie, 61 years old).

However, once the novelty of freedom wore off, they realized that they were not satisfied and had a choice to improve their routine by progressively participating more in the community. This was seen through Grace's (66 years old) comment: *"I think when you*

first retire you just want to take a big breath. Once you have been retired for a while you're like 'this is boring,' so you have to get out there and do something."

For participants who had been fully retired for many years, social participation was a necessity. They viewed their social schedule as a reason *"to get up in the morning"* (Jane, 80 years old). As participants explained the importance of continually keeping busy, many of the older respondents linked their busy schedules to the fact that their families were not local. Participants tried to remain physically and mentally strong so that they were better able to spend time with their grandchildren when they came to town. They did this by maintaining active through community participation and not withering away from boredom:

> *I keep busy in the winter so that in the summer I am busy with my family. My family lives out of London and I am busy with them. I have a little great grandson so I have to chase him around, but they don't live in the city so that's the hardest part* (George, 83 years old).

An interesting positive aspect of personal responsibility was observed in the focus groups with the oldest age group of 79 years or older. Reaching their late eighties, those participants had experienced wars, diseases, ailments, and heartache. However, they still managed to keep moving forward with positivity. They viewed life as a gift that would not be thrown away. They were not able to participate in the community as much as they wanted to, but they still made a personal commitment to keep moving forward while staying connected to the rest of the world the best way they could.

> *There is no poor me in this. You are either going to make it or just lay down and die. I've had a couple of people who said to me, "what the hell are you so happy about"? I'm alive! I can walk! There's so much to be grateful for* (Rachel, 79 years old).

> *You have to think positively. I get up in the morning and say "I am here!" I read the obituaries every day and when I don't see my name in there, I get up and keep going. You got to think positively. I have problems too, you know. I've been in the hospital and opened up about eight times. But you just need to think positively! It's positive thinking that gets you through. Some people become seniors and think this is the end of my life. Or they become a widow and think it's the end of their life. But you know what I mean; you just can't sit back and give up* (Ruth, 81 years old).

This sense of positivity was not illuminated through everyone. Participants also discussed their experiences with people who were isolated or as they called it, "shut-in" from the neighbourhood. They perceived that isolation was based on either personal choice or harmful circumstances that had impacted the isolated person's comfort level and trust with the community. Participants discussed how coming out to participate in a community relied heavily on an individual's personality and motivation. The group talked about individuals who had habitually been in specific routines their whole life and did not want to change because they were comfortable being separate from the community. Patty (54 years old) commented: *"My one neighbour has a routine down*

packed and my other neighbour you barely ever see, until she opens her garage door and you're just like, 'oh ... okay ... you're still kicking'" (Patty, 54 years old).

When people experienced a traumatic event that isolated them from the community, it was hard to gain the courage to step back into a social circle. Participants believed that people needed to gain self-confidence and once they trusted themselves and the community, they had to find an organization because they would *"get them involved"* (Paul, 65 years old). Some participants explained how they joined a program to experience something new, which led them to initially feel exposed and hesitant about their decision. However, once they started participating and learning new things, they gained *"a sense of accomplishment"* (Betty, 78 years old) and validation for their courage.

Throughout the focus group discussions it became clear that everyone's lived experiences were different. Participants experienced the world through different lenses which could not be compared to others, but every person felt accountable for themselves. Social participation began with the internal motivation to help empower one's life, followed closely by reaching out for support from other people and community organizations.

4.2.2.2 Theme 2: Uncertainty

As participants described their experiences or recalled anecdotes about their friends and family, a key theme of Uncertainty developed. The theme emerged from two codes: Personal Barriers to Social Engagement, and Current Distribution of Information.

This theme could be conceptually defined as a response to life's unpredictability. Rich stories of personal experiences with health issues, changing mobility abilities, periods of social isolation due to widowhood, varying desire to engage, reliance on others and feelings of being a burden to others were described as barriers to social engagement. Also, current methods of information sharing were identified as insufficient, which contributed to the uncertainty.

Participants identified that at any time everything they had known and expected in life could quickly change. Maybe they suffered a stroke, their spouse passed away, or they suddenly lost their vision. Influential factors like those changed people's routines and life's expectations at any moment. With these uncertainties, participants still lived their lives to their fullest. This whole theme of uncertainty was captured wonderfully by Veronica (55 years old):

> *We don't know where our life is going to be in 20 years, whether we will be mobile; whether we will have our sight; whether we will have our health; or whether or not we are going to even be here. [We do not know if] what we are stating now is going to be reality.*

The most influential source of uncertainty was the ambiguity of one's health status. As people age, the probability that one's health would decline became more prominent. Unexpected diagnoses, surgeries, and the natural wear-and-tear of the human body frequently occurred with increasing age. Many participants voiced their experiences of living with unexpected health outcomes. As a result of unforeseeable health conditions, participants explained how their social participation began to regress and how

they needed to adapt to their new lifestyle: "*prior to the operation on my leg I used to do a lot of volunteer work. Now since the operation I try, but in the winter time it's hard to walk around"* (George, 83 years old).

Participants' stories revealed another dimension of the unpredictability: the unpredictability of a partner's health. Being married or in a relationship, meant that one person needed to support and encourage their significant other. Both partners were affected when either spouse suffered from an unexpected health concern. Becoming a caregiver modified the person's lifestyle and participation levels to match that of their significant other.

> *When he retired I had my programs and he had his. His were totally what he wanted to do. We had two cars, we didn't have to conflict with one another. My week was filled up and his week was filled up with different activities. Now [after his knee operation] we are more dependent on going to the same places at the same time, it's not easy to get somewhere different* (Jane, 80 years old).

The support provided by a significant other, a family member, or friends was very beneficial for an individual who wanted to participate in the community. Dependence on others was not restricted to people with health needs; it could also affect able-bodied individuals who had lived their lives in co-dependence with their partner. Participants expressed how the uncertainty of not knowing what to do or how to do something on their own was very prominent when they retired before their partner, or when their partner passed away. The reliance on someone else caused limitations in participation, which isolated some participants from the world due to their emotional and mental

constraints. Julia (68 years old) described her experience: *"I've been widowed for fourteen years now and you just can't let that stop you. You just have to go. You're not doing anything if you just wait"*.

Uncertainty caused by relying on other people for transportation was also discussed. Many participants expressed their fortune for the ability to drive and stated how they frequently assisted their immobile friends to get around to different programs and events. The participation of people without their own transportation method was, for the most part, dependent on the participation of their friends. If the driver did not go to the event, the dependent friend could not go either. Beth (82 years old) explained *"there's a lot going on for seniors ... but it's hard for people to get to them. Even in our Argyle group at the church, I know two or three ladies who don't have rides."*

Lastly, difficulties in attaining community information added to a person's level of uncertainty. Information was distributed through many facets as described by the participants: bulletin boards, newsletters, advertisements in the paper, online postings, and word-of-mouth. However, not all information was distributed through the variety of methods that were available; for example, library programs may only be advertised on a bulletin board in the library, restricting their exposure. If people had physical restrictions, such as limited sight, or did not have the knowledge in using technology to get connected, then they would become *"very dependent on the information coming to [them]"* (Lucy, 68 years old). For some participants, attaining information was simple. They had learned how to use technology and knew where to go to find the information about programs and services. Others expressed their concerns:

> *As much as you don't like it [technology], you have to be able to [use] it in order to stay connected. You open yourself up to so many more people sharing information. Just a lot of people don't look at [the information] if they don't have [the internet] and don't get out. I mean if they can't get out, they might as well learn how to use a computer and then they can be in the loop* (Angie, 61 years old).

Through the exploration of the lived experiences of the participants, the notion of life's uncertainty revealed that at no age was anyone safe from change. Younger participants expressed their roles as caregivers to their parents, while older participants expressed their newfound reliability on others. The message participants conveyed was that at this time of life situations could and do change quickly, and although uncertain, people should keep moving forward.

4.2.2.3 Theme 3: Togetherness

To be more socially engaged, people were participating in activities and events with other individuals in the community. The camaraderie formed through common interests and goals created a sense of community that supported and encouraged its people. Many of the points mentioned in the focus group discussions that centered on participation included the notion of doing things with other people. Friendships were seen to be strong; people made sure they were there to support their friends when in need and help them continue moving forward within the capabilities that they still had. The theme of Togetherness emerged from 11 codes: current participation in Formal Activities and

Formal Clubs, use of Public Locations for Social Engagement, motivation by Friendships and Multigenerational Activities, descriptions of desired ways to Distribute Information, accounts of Creative and Stimulating Recreational Programs and Services, and availability of Para-transit services.

This theme could be conceptually defined as the social support attained through community relationships. Through lived experiences, participants explained the strength of participating in activities with their friends, and how it helped and encouraged them to come out and partake in community clubs. Togetherness also emerged in participants' desires for improved information distribution, creation of new opportunities for engagement and improvement of longstanding services, such as para-transit.

When participants were asked how they stayed active, almost every answer involved taking part in a group activity. The most popular responses were activities that engaged the participants in physical activity, such as: aqua-fit, 'sit-to-be-fit', and yoga. However, individuals with limited capabilities had creative ways of socially participating and using the functional abilities they still had, as expressed by Jane (80 years old):

> *We play scrabble at home. We have an ongoing game every day; it's a lot of fun. We go to a maximum of 5,000 points, which takes about 20 games. You don't win or lose in one day. You can over take or you can drop back. We've been doing it for quite a few years. There's always a joke, the winner has to take the other for lunch ... so usually to the kitchen to cook* (Jane, 80 years old).

As well, socialization was an important activity that was done either through group classes, organized events, or during personal time, such as during trivia night,

coffee dates, and shuffleboard. People with similar needs and interests seemed to naturally gather together, finding a common ground that strengthened their connections. No matter what age the participants were, the importance of *"doing it together"* (Stacey, 70 years old) resonated as something that kept them motivated and looking forward to their next gathering.

> *A lot of people have their circle of friends. Like, I have different groups, like the retired, and we call ourselves the 'Golden Girls'. We don't know who is who, we haven't figured that out. We all retired at the same time and meet up once a month to have lunch and play cards* (Beth, 82 years old).

The importance of friendship and 'doing it together' was strengthened by the support and encouragement that was given to one another. George (83 years old) expressed that without his wife's support through his surgery and recovery, he would not be able to be as active as he was. A poignant point Lucy (68 years old) brought up reflected on the mutual relationship of marriage or friendship was that support was given to all, *"there are givers and takers [in the community] and we need both."* Everyone had different needs and in order to keep the wheel of social participation moving one needed to support and encourage those around them in any way they could. As well, Anne (61 years old) stated that *"it's important to encourage people to use the facilities that we have"* to get people out into the community. By looking out for others, the morale of the community would increase someone's confidence and comfort in participating while also decreasing the possibility of social isolation as they aged.

> *One thing I learned from the creative writing group is supporting people. People say they don't know how to write, but everyone knows how to write a letter, just make your letter a bit more interesting. I think that giving them support to be able to do things that they don't think they can do is important. I think [these are] the things we most need as older people* (Lucy, 68 years old).

Through the support that individuals provided one another, a process of learning new things occurred. Nicolas (85 years old) expressed his curiosity towards expanding his knowledge of history through personal experiences of others: "*When you come down to coffee hour and listen to people's histories, I am surprised to hear how people come from different walks of life, it's interesting."* The interest of continually learning new things was met by people's interest in teaching others their skills. The reciprocal process of working together to further one another's abilities was seen through participants' passionate expressions of their own experiences. The following is an example of one of those participants:

> *I used to be a writer for a newspaper in Toronto. For 20 years I didn't do any of that. I unfortunately had to learn to make a living and survive outside of my passion for writing. But now I teach creative writing. I would love to see something like this in this area [Argyle] to encourage these people who have got 60 years of information in their minds and get it down on paper. I have watched some very timid people find their own voice and be able to speak out and write about who they are and where they came from* (Lucy, 68 years old).

A strong sense of community emerged as participants discussed their reciprocal relationships and the support and encouragement they provided to one another. The resonating idea was that no matter who it was, people were accommodating and accepting of bringing new individuals into their community circle. A younger participant, Veronica (55 years old), expressed how she wanted to promote opportunities at a seniors club for older adults in Argyle and was embraced with open arms. After being accepted into the new community, she soon became *"a senior in training"*. There was no discrimination, *"people are very accommodating and always pleased to see you. There's camaraderie there"* (Jane, 80 years old). Participants expressed their strong preference for participating socially with individuals of different ages. The sense of community did not appear to exclude younger generations. The combination of younger generations joined together with older generations created an empowered youthful environment. Julia (68 years old) expressed this need well by saying, *"I don't think old people just want to be with old people. It makes you feel older."*

Getting involved in the community brought out new opportunities through the togetherness of participating in activities and events with other individuals. The power of this theme was best displayed through the enthusiasm participants showed when discussing their friendships and the support they provided or received through these friendships.

4.2.2.4 Theme 4: Resentment

The theme of Resentment was described through lived experiences in two distinct ways. The first included codes that described the current Financial, Social, and Structural barriers for social engagement; and the second described the codes about desired changes for Community Centre, Facility Improvements, Desired ways of Financing Social Engagement and wanting Everything other city district already have. This theme can be conceptually defined as participant's negative emotions towards the lack of neighbourhood programs and services, community infrastructure, and public transportation that limits their social participation. A lot of participants expressed their frustration and anger towards the way their community was treated by the City leaders. They felt as if the needs of the people in their community were not considered by the City and that many resources were located in other neighbourhoods. Participants expressed desires to have what other neighbourhoods already had, and petitioned for a new community centre to be the central location for social participation, welcoming to all individuals regardless of their functional abilities or financial needs.

Many participants discussed their concerns the same as Veronica (55 years old): *"this [Argyle] is a very unfunded and un-resourced community."* As participants had no knowledge of how money was currently spent in their community, they proceeded to discuss their concerns and anguish of what they experienced on a daily basis. A considerable concern was that *"there are no real designated areas for the seniors"* (Veronica, 55 years old) to congregate. They had programs at various organizations that were housed by secondary sources, such as the East London Public Library and local

churches, and these programs were only offered on specific days of the week. At the time of this study, older adults living in Argyle did not have one location in their district where they could engage in programs and services at any time during the week. Many participants explained how they participated in Hamilton Road Seniors' Centre or at the Kiwanis Seniors' Centre (located in other city districts) to meet their needs. However, these sites were quite far away and not everyone was capable of attending programs outside of their neighbourhood.

> *We have to go outside our own area to Hamilton or Kiwanis. But you still have to get there and a lot of people maybe don't have their own vehicles to get there. So a big concern for a lot of people in the area is transportation to get outside of their area* (Lucy, 68 years old).

The revelation that the Argyle neighbourhood was lacking facilities for social engagement was voiced clearly. Participants resented that the senior population in their community was not cared for as much as it was in surrounding districts. Their current social participation was based on their ability to travel to other districts and access programs offered there. If the City did not provide the resources and programs were *"not accessible nearby, then people will not [participate]"* (Angie, 61 years old). Beth (82 years old) mentioned that entertainment options were also limited or non-existent in their community; the simple act of going to the movies required at least thirty minutes of travel. Transportation options within the community were inadequate, infrequent, and expensive for older adults. Participants mentioned that if older adults needed to take the bus to come to the library, there were no bus stops conveniently located in the Library's

vicinity. Older adults would have to walk to the nearest set of lights in order to cross the street to get to the library. It was extremely difficult for older adults who had to take two or more busses as bus schedules did not coincide with one another. This made older adults reluctant to travel far to attend desired programs and services. During the winter season, older adults did not have a safe, dry, and covered location to walk as a form of physical activity. The one location they used in the past was the *Argyle Mall*, until it was torn down and renovated into a walk-unfriendly open concept *Smart Centre*. The structural hindrances of the community planning combined with weather and personal constraints, limited community members' opportunities to actively participate and remain social.

These negative influences also drew up comments on how seniors responded to this situation which clearly bothered the study participants. Many individuals discussed how *"some seniors are like kids ... [who say] 'there's nothing to do'"* (Beth, 82 years old). Their motivation to find available resources was hindered by their irritation of the structural layout of their community. Participants explained that there are individuals who were boycotting their social participation to make a point that their community deserved a gathering place dedicated to older adults: *"we have people who will sit there and do nothing until they get their community centre"* (Anne, 61 years old).

However, further discussion revealed that there were some programs currently offered through various clubs and organizations in the community, such as: the Argyle Seniors' Satellite, the SNAC group, and the YMCA. Unfortunately, almost all of these establishments charge a fee to participate. As described in the Methods chapter, Argyle

district had a lower social economic status than the city overall and this fact became highly evident in all focus group discussions. Participants who did not have financial security expressed their concern about not being able to afford the programs they needed and wanted to participate in. Anne (61 years old) expressed that *"being poor is expensive. You're retired, you're on more of a limited income, and it's expensive. Yeah you know you want to be involved, but you need to watch where the [funds] go"*. Participants were concerned about membership fees, transportation costs, and the commitment of paying for a program ahead of time.

When participants were asked what they would like to see in their neighbourhood to boost their social participation, they unanimously said, *"EVERYTHING!"* When participants were asked to elaborate on what "Everything" included, they were lost for words. They couldn't fathom the idea that their community could have all the conveniences they desired. They came to a conclusion that "Everything" meant that they want what other communities have: a main location for seniors to attend. *"I think we need a big centre now because look at all the people coming out and more people keep joining [the Argyle Seniors' Satellite]. I think it's just amazing"* (Stacey, 70 years old).

As mentioned in the first chapter, the City has plans to build a new community centre in Argyle district by the year 2018. This appeared to be well known by every study participant. The anticipation of a community centre located in their own community elated them. However, some participants were worried that the City would not consider the needs of the people in the community because of their negative past experiences with the City's delayed plans. Participants explained a past circumstance relating to the design

of the East London Public Library. The library was supposed to function as a community centre, but once built it was overruled for other purposes. Because of this negative past experience, participants had concerns that a similar situation would befall them once again. Their sense of trust with the City seem to have been broken and they were worried about what would come. *"Hopefully they ask us what we want in a community centre, instead of putting up a big square box"* (Beth, 82 years old).

As participants further divulged into the creation of the potential community centre, suggestions were made that could help improve community members' perspectives of their neighbourhood. The most common ideas were: accessibility, adequate parking, flexibility of programs and services, good crosswalks, and user-friendliness.

The theme of Resentment was closely related to fairness. Participants expressed how all they wanted was equal access to opportunities that other individuals in the City had. Opportunities for social participation should be available to people who never learned to drive, or for individuals who spent most of their money on medications. Resentment seemed to be perpetrated by a lack of clear and timely communication. The participants wanted to be able to better shape their neighbourhood to meet their current needs and the future needs of older adults.

4.3 Summary

In summary, the results of this study revealed that the age friendliness of Argyle was a mixture of strong and poor levels of age friendliness, depending on the domain.

Low scoring domain of Social Participation clearly needed further exploration. The qualitative results defined four themes: Personal Responsibility, Uncertainty, Togetherness, and Resentment. Personal Responsibility entailed an individual's obligation for social participation in the community. Uncertainty focused on the unknown factors that influenced individual's daily lives and changed their form of social participation; Togetherness included the social aspect of support and encouragement community members received and gave each other to stay involved in their community; and Resentment involved the negative feelings community members had towards the City leaders, based on the lack of facilities that would improve opportunities for participation in their neighbourhood.

Chapter 5 – Discussion

The discussion chapter will explain the relationship between the quantitative and qualitative results and how they connect to the concept of Age Friendly Cities. The interconnection of four themes will be described, to summarize a story of participants' lived experiences. The findings will then be linked to conceptual frameworks of successful aging, structural lag and selective optimization and compensation, to explain how social engagement is influenced by the opportunities available in the community. Findings from the literature will be used to help place this study in the larger context of current knowledge. At the end of the chapter, the study's limitations and strengths will be outlined, followed by implications and recommendations for the future service delivery, policy making and research,.

5.1 Similarities and Differences between Argyle, the District of London, and the City of London, Ontario

This study benefited greatly from the use of a sequential explanatory mixed methods design. The quantitative aspect provided an overview of eight domains of age friendliness for Argyle district. Results from the administered survey, "Assessing Baseline Age Friendliness of London, Ontario", from the Argyle neighbourhood answered the study's first research question: *How age friendly is the Argyle district of London currently in the domain of Social Participation?* As documented in the Findings, Social Participation was found to be the second least age friendly domain. With this information Argyle was then compared to the overall results for the City of London

available from Dellamora's (2013) study. Both Argyle and London needed improvements in the domains of Outdoor Spaces and Buildings, Housing, Civic Participation and Employment, and Social Participation (Table 54 in Appendix C). Although Argyle district had different education and income demographic than London, those difference did not appear to have influence on the survey results.

Social Participation was further examined because of its interconnectedness with other domains of age friendliness. For example: social participation levels can be low because of poor access to organizations and facilities, which can be impacted by the domains of Outdoor Spaces and Buildings, and Transportation. Social participation can have positive impact on individual's health and wellbeing, and is important for maintaining a quality of life (Findlay, 2003; MacKean & Abbott-Chapman, 2012; Richard et al., 2008; Silverstein & Parker, 2002).

The Social Participation domain was examined for trends by comparing scores for each question item (Table 55 in Appendix C) between Argyle and London. Question items related to participation opportunities were given scores whereas question items that pertained to actual participation were ranked lower. Four question items scored higher and two scored lower in Argyle than in London. The question items that scored lower were: *recreation opportunities* and *opportunities to attend social events or activities*. Four of the scores that reflected a favourable experience of Argyle residents were: *used a senior center in your community*; *participating in a recreation program or group activity*; *participating in a club*; and *participating in religious or spiritual activities with others*. Cumulatively, quantitative results provided rationale for a follow-up qualitative study.

Exploring participants lived experience helped identify possible interventions for improvement of social participation.

5.1.1 Interconnectedness for Social Participation

As reported in Findings, four distinct themes emerged from qualitative part of this study: Personal Responsibility, Uncertainty, Togetherness, and Resentment. Each theme was grounded in participants' lived experiences. Themes were also interconnected.

Social participation was not a binary phenomenon that was either happening or not. Rather, it evolved over time, and was continually subjected to personal, social, or environmental influences. Motivators and barriers to social participation worked together in a positive or negative ways. For example, a person who experienced loss of independent mobility may decrease their social participation, but through carpooling with friends, this individual reinstates their community involvement. Older adult had to have the inner willpower to actually step outside of their home as well as social support to fully embrace the social opportunities in their community. By understanding the benefits of participating and having a reason to get up in the morning, older adults took one step closer to achieving their participation goals.

Due to life's unpredictability, negative influences do occur, occasionally rendering older adults socially isolated. In that case, support and encouragement from friends and family can help older adults find the strength and determination to get back up and re-engage. This connection can help people break through resentment and actively lobby for change. Through the bonds of togetherness, multiple possibilities can develop,

such as the creation of localized resident-based programs. According to the study informants, every discouragement can be countered by the optimistic and progressive attitudes of community members. Participants expressed great resilience and eagerness for their community to be graced by a community centre of their own. Through their passion, it was clear that new opportunities will help increase social participation.

5.2 Social Participation Findings through Lenses of Conceptual Frameworks

Conceptual frameworks of successful aging, selective optimization and compensation and structural lag, provided theoretical grounding for the study. Social participation was one of the three key criteria for successfully ageing. It includes both nourishing personal relationships, and engaging in productive and meaningful activities (Rowe & Kahn, 1997). While, there are no predictors that can determine if an individual will either participate or socially isolate themselves, the literature suggests that older adults can increase their social participation based on structural dynamics of a community (Kahn, 1994). Creating opportunities that satisfy older adults' capabilities can help increase societies health and functioning, enabling individuals to successfully age (Riley &Riley, 1989).

Riley and Riley (1989) described structural lag as "the imbalance or mismatch between the strengths and capacities of the number of long-lived people and the lack of role opportunities in society to utilize and reward these strengths" (p. 15). From participant's testimonials, it was clear their desires superseded their community's capabilities, and they were pressing for more favourable structures. Ironically, when

participants had an opportunity to describe the resources they would like to see in their community, a unanimous ‘EVERYTHING’ was shout out, as they were baffled for a moment to think of the resources their community could possibly benefit from. Once they collected their thoughts, a long list of ideas for productive social activities stated to emerge. Participants in this study expressed that limited opportunities for social participation were available in churches and the local library. These locations offered programs and services for older adults only a few times a week. The lack of appropriate facilities clearly identified a structural lag for social participation in this community. Individuals able to drive travelled to other districts to socially engage. Overall, elderly members in the Argyle community perceived that facilities were more readily available elsewhere in the city, in comparison to their district.

Participants expressed great resiliency achieved by optimizing available opportunities and compensating for what the community was lacking. In spite of identified structural lag participants described tenacity and resourcefulness, as strategies for optimization and compensation. The selective optimization and compensation model recognizes that aging is a heterogeneous process with many different pathways (Ouwehand, de Ridder & Bensing, 2007). However, according to the model creators, Baltes and Baltes (1990), the supportive environments, both social and physical, are necessary for sustained and successful lifelong development. The Argyle residents demonstrated strong desire to manage their aging decline, by actively developing themselves, participating in physical activities, learning new technologies and supporting each other along the way.

5.3 Study Findings in Contexts of Current Literature

The findings of this study, parallel those reported by Mahmood et al. (2012). Mahmood and colleagues (2012) conducted a photovoice study which looked at physical activity levels of 66 older adults in relationship to physical and social environments in eight neighbourhoods in Vancouver, British Columbia, Canada and Greater Portland, Oregon, USA. Authors concluded that the universal determinant for participation was accessibility of resources. Safety and the comfort of getting to the programs and services were also important factors. Social interactions were essential for encouragement to participate in physical activities. The integration of physical and social environments helped enable individuals to participate. The physical and social pillars identified by Mahmood et al. (2012) paralleled well with Ashida and Heaney's (2008) classification of structural and functional characteristics of social participation. Through the literature (Ashida & Heaney, 2008), trends that manipulated social participation based on structural and functional characteristics were also seen in the social network systems in the Argyle community. The two characteristics have a shared role for participant's social participation. If one characteristic was lacking, for example structural (geographic distance of program), and the other characteristic, for example functional (social support and social influence), was abundantly stronger, social participation could transpire.

In addition, when social support and accessibility were combined, the social participation in a community increased. A stronger sense of community resulted in better teamwork and social inclusion of older adults (Moody & Phinney, 2012). Lang and Bates (1997) reported that older adults benefited greatly from increased social interaction on a

daily basis. They concluded that the more exposure individuals had to a society, the greater was their life satisfaction. This parallels the results from the present study as they all accent the importance of participating with other people in the community.

Social connections allow for knowledge exchange about community activities and events, as was evident in this study. Older adults must be able to find information about opportunities available in a community that are beneficial for their health and quality of life. This knowledge allows older adults to actively age, by adjusting activity levels to their functional capabilities and assuring continuity of social participation (Plouffe & Kalache, 2010). Silverstein and Parker (2002) looked at how older adults maintain their leisure activities as they age. They found that older adults substituted new activities that met their capabilities in order to continue being active as they got older. Many older adults in their study took on walking as a new aerobic activity, which facilitated both exercise and social participation. A transition from familiar to new activities also appears to be a part of the story told by participants in this study.

The district of interest for this study (the Argyle neighbourhood), had lower social economic status than the City of London overall. With less disposable income, it was more difficult for Argyle residents to get involved when facilities were located outside of their community. The costs for transportation and participation fees were repeatedly mentioned. According to Richard et al. (2008), the resources that are available and accessible help translate into greater social participation. Kwok and Tsang (2012) add that individuals that are exposed to resources appropriate to their needs strive to attain a better quality of life.

Increase in community resources can have a chain reaction in having more satisfied and healthier residents. However, to properly channel new resources, community officials need to consult individuals living in the community, those who will be using the new facilities. Participants in this study expressed high hopes that when the anticipated new community centre is built, they will have an impact on what it will contain and how it will be structured. Findlay (2003) explained that in order to reduce social isolation and increase participation, older adults need to be involved in the planning, implementation, and evaluation phases of new facilities.

Argyle residents' desires for facilities and programs are no different from what older adults in other districts already have. They want the same opportunities for social participation, but cheaper and closer to home. They acknowledged the successes of current programs, such as the Argyle Seniors' Satellite, and wanted these organizations to have a centralized facility that can accommodate more participants and offer programs more frequently throughout the week. As Findlay (2003) suggested, success of new interventions occurs by expanding off of existing resources that work.

5.4 Study Limitations

This study had several limitations. First, 78% of all participants in both parts of the study were female (70% of survey participants and 87% of focus group participants), therefore, the results reflect a predominantly female perspective. This could partly be explained by recognized difficulties men have when asked to share their lived experiences and feelings (Park, Knapp, Shin, & Kinslow, 2009). The second limitation

was that all the focus group participants were in some way already engaged in their community. Participant recruitment involved connections with community organizations and snowball sampling. Due to limited time and resources, recruitment of less engaged or isolated individuals was not possible. Third, representation of participants in the youngest age category of 50 to 57 year olds (younger half of Baby Boomers) was low (N=2). This age group was more likely to be in the workforce and was more concerned about issues related to work and family, rather than social participation in late life. Recruitment for this focus group was long and exceptionally difficult. More than 17 of eligible participants that were approached by the researcher could not find the time to attend the focus group session. Therefore, only limited perspective of the trail end of the Baby Boom generation was captured. Fourth limitation of this study was its scope. The study focused on one neighbourhood, in a city that has 42 neighbourhoods, thus limiting generalizability even in a local context. Nonetheless, the process of measuring age friendliness using a Modified-CASOA survey and exploring lived experiences that can facilitate or impede social participation of older adults through focus groups can be of interest to any community engaged in the Age Friendly Cities movement.

5.5 Study Strengths

This research project provided an innovative approach to measurement of age friendliness that might be of interest to the members of WHO Age Friendly Cities Network. A sequential explanatory mixed method design helped locate and further explore Social Participation in a larger context of other Age Friendly domains. Including

participants of 50 years of age and older, this study captured diverse and rich lived experiences of three generations of older adults. The focus on one city district could be of use for rural communities interested in identifying their age friendliness, or in process of planning new communal facilities. Lastly, this study provided evidence that could be used to inform policy makers and influence service delivery in Argyle district and the City of London, Ontario.

5.6 Study Implications and Recommendations for Next Steps

There are three main implications of this study: implications for infrastructure changes and service delivery; implications for policy making, and implications for future research. First, the key implication for all involved in the Age Friendly Cities movement would be to solicit and take into consideration the needs of local residents when planning new facilities, programs, and services. As the City of London prepares to build the new community centre in the Argyle district by 2018, officials have an opportunity to include findings of this study in the planning process. Several influential factors identified in this study both positively (e.g., personal responsibility and togetherness) and negatively (e.g., uncertainty and resentment) impacted social participation of older adults. These findings offer a good platform for building of a social dialog between community leaders in Argyle and the City officials. The Argyle community can present their challenges and build on their successes to create innovative ideas for improvement of infrastructure, services and programs in their district. Through an active symbiotic relationship, the local community can advocate for allocation of resources necessary to increase social

participation in later life. Collaboration between the City and local residents will help reduce community resentment and help recreate a trusting relationship.

Study participants provided numerous ideas for what, they believed, would ensure a new community centre would be used to its capacity. Their suggestions included: an arena, central information hub, classrooms and computer lab, gathering space, a gym, an indoor pool, an indoor walking space, a medic clinic, meeting rooms, multipurpose activity rooms, and a yoga studio. In addition, study participants strongly called for the implementation of a community bus. This bus could take multiple routes to areas where clusters of older adults reside, and the new community centre should be the start/end point, making it a central hub for everyone in the district. By providing a stable form of transportation that is user-friendly for older adults, would result in greater accessibility and increased social participation.

Second, findings of this study could be used to influence policy. When municipalities better understand arising issues, they can put in place appropriate policies to solve them. Taking into consideration community's voice can help create policies that will meet community needs and strengthen social participation. As this study confirmed, older people perceive life as unpredictable and this affects their capability to participate. City officials should consider creating policies that will help facilitate availability, affordability and access to social programs and services for individuals who experience unexpected hardships. New policies should address protection, and reintegration of isolated and vulnerable older adults.

This project offered a number of opportunities for further research. The M-CASOA survey dataset for Argyle offers opportunities for additional gender- or age-specific analysis, or detailed analysis of other age-friendly domains. For example, safety and security from crime were identified by 10% of the survey respondents as a problem, warrantying further exploration. Now that baseline data (i.e., prior to construction of the new community centre) of age-friendliness are available, a follow-up studies can be conducted at 3, 5 or 10 years to follow change over time. In addition, a follow-up study on changes in residents' social participation levels, after the community centre is fully functional, would be interesting. Participation levels and the access to programs and services could be measured. This would provide municipal leaders with clear evidence for future planning. Finally, results from focus group discussions could be used for construction of a new survey; where a large number of district residents could inform whether the needs expressed by participants in this project are reflected by the community as a whole.

5.7 Conclusion

By combining both the quantitative and qualitative results in the context of Age Friendly Cities, a holistic understanding of social participation of older adults in Argyle, the planning district of London emerged. In this study, the quantitative research question was answered through the use of an anonymous age friendly survey that revealed Social Participation as the second least age friendly domain in Argyle, with a score of 2.6/5. From those results, qualitative focus group discussions further uncovered the lived

experiences that shaped older adults' needs for programs and services to facilitate social participation.

In Argyle, it was found that elderly residents expressed strong intention to socially participate. There was ample positive reinforcement, support and encouragement for seniors to step outside of their comfort zones and engage. However, once these individuals got into the community, they found few facilities and limited resources to sustain their interest for social engagement. The majority of their needs could only be met in other city districts.

In summary, the combination of survey results with lived experiences helped determine underlying issues caused by structural lag. This determined the importance of social (i.e., support systems) and physical (i.e., community accessibility) contributing factors in a community that help individuals successfully age. Undoubtedly, a community with great passion, resilience, togetherness and desire to participate deserves the opportunity to attain resources that will help enhance their social participation in later life.

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APPENDIX A

Approved Ethics Review Form

Research Ethics

Use of Human Participants - Initial Ethics Approval Notice

Principal Investigator: Dr. Aleksandra Zecevic
File Number: 104632
Review Level: Delegated
Protocol Title: Social inclusion through social engagement in a multipurpose center of the future.
Department & Institution: Health Sciences\Faculty of Health Sciences,Western University
Sponsor:
Ethics Approval Date: December 13, 2013 **Expiry Date:** December 31, 2018
Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Instruments	Demographic questionnaire.	
Recruitment Items	A script for recruitment over the telephone.	
Instruments	FG protocol and questions	
Advertisement	Revised poster.	
Letter of Information & Consent	Revised LOI and consent.	2013/12/06
Response to Board Recommendations	Response to HSREB recommendations	2013/12/06

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines; and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the University of Western Ontario Updated Approval Request Form.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

The Chair of the HSREB is Dr. Joseph Gilbert. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Ethics Officer to Contact for Further Information

___ Erika Basile (ebasile@uwo.ca)	✓ Grace Kelly (grace.kelly@uwo.ca)	___ Mina Mekhail (mmekhail@uwo.ca)	___ Vikki Tran (vikki.tran@uwo.ca)

This is an official document. Please retain the original in your files.

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APPENDIX B

Master Copy of All “Assessing Baseline Age Friendliness of London, Ontario” Survey Results for Argyle, the District of London

Table 6

Frequency Scores for Individual Question Items in Survey Question 1

Please circle the number that comes closest to your opinion for each of the following questions.	Excellent	%	Good	%	Fair	%	Poor	%	Don't know	%	N
How do you rate London as a place to live?	19	20	50	52	14	14	2	2	0	0	85
How do you rate London as a place to retire?	18	19	46	47	21	22	2	2	0	0	87

Note. N varies because of missing responses from participants.

Table 7

Frequency Scores for Individual Question Items in Survey Question 2

Please rate each of the following characteristics as they relate to adults age 55 or over in London:	Excellent	%	Good	%	Fair	%	Poor	%	Don't know	%	N
Opportunities to volunteer	37	38	43	44	7	7	0	0	10	10	97
Employment opportunities	0	0	9	9	29	30	37	38	14	14	89
Opportunities to enroll in skill-building or personal enrichment classes	8	8	41	42	24	25	3	3	19	20	95
Recreation opportunities (including games, arts, and library services, etc.)	27	28	45	46	17	18	5	5	3	3	97

Fitness opportunities (including exercise classes and paths or trails, etc.)	26	27	39	40	25	26	3	3	1	1	94
Opportunities to attend social events or activities	14	14	44	45	26	27	4	4	8	8	96
Opportunities to attend religious or spiritual activities	28	29	48	50	12	12	1	1	8	8	97
Opportunities to attend or participate in meetings about local government or community matters	6	6	30	31	35	36	12	12	13	13	96
Availability of affordable quality housing	2	2	13	13	26	27	39	40	15	16	95
Variety of housing options	2	2	23	25	29	31	24	26	13	14	91
Availability of information about resources for older adults	6	6	31	32	39	40	17	18	4	4	97
Availability of financial or legal planning services	2	2	33	34	25	26	12	12	25	26	97
Availability of affordable quality physical health care	11	11	32	33	21	22	25	26	5	5	94
Availability of affordable quality mental health care	5	5	13	13	23	24	29	30	24	25	94
Availability of preventive health services (e.g., health screenings, flu shots, educational workshops)	11	11	48	50	29	30	4	4	3	3	95

Availability of affordable quality food	19	20	36	37	27	28	13	13	1	1	96
Sense of community	8	8	35	36	37	38	11	11	3	3	94
Openness and acceptance of the community towards older residents of diverse backgrounds	3	3	27	28	38	39	13	13	16	17	97
Ease of bus travel in London	4	4	22	23	30	31	16	17	25	26	97
Ease of car travel in London	1	1	42	43	32	33	15	16	7	7	97
Ease of walking in London	11	11	47	49	27	28	10	10	0	0	95
Ease of getting to the places you usually have to visit (e.g. grocery store, doctor's office, pharmacy)	15	16	53	55	23	24	6	6	0	0	97
Overall feeling of safety in London	4	4	48	50	35	37	9	9	0	0	97
Valuing older residents in London	2	2	38	39	28	39	11	11	6	6	95
Neighborliness of London	5	5	40	41	36	37	11	11	3	3	95

Note. N varies because of missing responses from participants.

Table 8

Frequency Score for Survey Question 3

How would you rate the overall services provided to older adults in London?		N	%
Excellent		3	3
Good		42	43
Fair		40	41
Poor		9	10
Don't know		3	3
	Total	97	

Note. N varies because of missing responses from participants.

Table 9

Frequency Scores for Survey Question 4

In general, how informed or uninformed do you feel about services and activities available to older adults in London?	N	%
Very informed	8	8
Somewhat informed	56	58
Somewhat uninformed	29	30
Very uninformed	4	4
Total	97	

Note. N varies because of missing responses from participants.

Table 10

Frequency Scores for Individual Question Items in Survey Question 5

Please circle the number that comes closest to your opinion for each of the following questions.	Excellent	%	Good	%	Fair	%	Poor	%	N
How do you rate your overall physical health?	17	18	55	57	21	22	4	4	97
How do you rate your overall mental health/emotional well-being?	22	23	56	58	15	16	3	3	97
How do you rate your overall quality of life?	21	22	54	56	18	19	4	4	97

Note. N varies because of missing responses from participants.

Table 11

Frequency Scores for Individual Question Items in Survey Question 6a [1]

The following questions list a number of problems that older adults may or may not face. Thinking back over the last 12 months, how much of a problem, if at all, has each of the following been for you?	Not a problem	%	Minor problem	%	Moderate problem	%	Major problem	%	Don't know	%	N
Having housing to suit your needs	77	79	8	8	8	8	4	4	0	0	97
Your physical health	43	44	29	30	16	17	8	8	0	0	96
Performing regular activities, including walking, eating and preparing meals	68	70	14	14	9	9	5	5	0	0	96
Having enough food to eat	84	87	6	6	4	4	2	2	1	1	97
Doing heavy or intense housework	37	38	26	27	18	19	16	17	0	0	97
Having safe and affordable transportation available	70	72	10	10	8	8	6	6	3	3	97
No longer being able to drive	66	68	4	4	2	2	7	7	13	13	92
Feeling depressed	54	56	29	30	9	9	3	3	0	0	95
Experiencing confusion or forgetfulness	57	59	31	32	6	6	2	2	0	0	96

Maintaining your home	55	57	25	26	12	12	4	4	0	0	97
Maintaining your yard	44	45	22	23	15	16	7	7	6	6	94
Finding productive or meaningful activities to do	62	64	22	23	7	7	2	2	1	1	94
Having friends or family you can rely on	65	67	17	18	8	8	4	4	0	0	94
Falling or injuring yourself in your home	69	71	15	16	6	6	2	2	2	2	94
Finding affordable health insurance	50	52	12	12	10	10	14	14	10	10	96
Getting the health care you need	53	55	25	26	12	12	4	4	2	2	96
Affording the medications you need	62	64	18	19	5	5	9	9	2	2	96
Getting the oral health care you need	58	60	19	20	7	7	9	9	4	4	97
Having tooth or mouth problems	51	53	30	31	7	7	6	6	2	2	96
Having enough money to meet daily expenses	57	59	22	23	10	10	5	5	2	2	96
Having enough money to pay your property taxes	63	65	10	10	6	6	6	6	10	10	95

Note. N varies because of missing responses from participants. [1] These question items may be negatively worded because they asked respondents to rate each item as ‘Not a problem’, ‘Minor problem’, ‘Moderate problem’, or ‘Major problem’ versus the standard ‘Excellent’, ‘Good’, ‘Fair’, or ‘Poor’ selections.

Table 12

Frequency Scores for Individual Question Items in Survey Question 6b [1]

The following questions list a number of problems that older adults may or may not face. Thinking back over the last 12 months, how much of a problem, if at all, has each of the following been for you?	Not a problem	%	Minor problem	%	Moderate problem	%	Major problem	%	Don't know	%	N
Staying physically fit	44	45	28	29	16	17	8	8	0	0	96
Maintaining a healthy diet	50	52	24	25	18	19	4	4	0	0	96
Having interesting recreational or cultural activities to attend	52	54	23	24	12	12	4	4	5	5	96
Having interesting social events or activities to attend	50	52	23	24	16	17	4	4	3	3	96
Feeling bored	52	54	26	27	13	13	4	4	2	2	97
Feeling like your voice is heard in the community	24	25	22	23	13	13	16	17	21	22	96
Finding meaningful volunteer work	64	66	8	8	2	2	4	4	19	20	97
Providing care for another person	51	53	12	12	7	7	5	5	21	22	96
Dealing with legal issues	56	58	16	17	6	6	8	8	10	10	96

Having adequate information for dealing with public programs such as Canadian Pension Plan	58	60	20	21	9	9	6	6	3	3	96
Finding work in retirement	34	35	6	6	6	6	9	9	36	37	91
Building skills for paid or unpaid work	36	37	8	8	4	4	5	5	37	38	90
Not knowing what services are available to older adults in London	30	31	20	21	17	18	17	18	12	12	96
Feeling lonely or isolated	55	57	24	25	12	12	5	5	1	1	97
Dealing with the loss of a close family member or friend	46	47	23	24	9	9	8	8	8	8	94
Being a victim of crime	64	66	6	6	5	5	4	4	15	16	94
Being a victim of fraud or a scam	65	67	9	9	3	3	2	2	15	16	94
Being physically or emotionally abused	76	78	7	7	1	1	3	3	10	10	97
Dealing with financial planning issues	60	62	15	16	12	12	5	5	5	5	97

Note. N varies because of missing responses from participants. [1] These question items may be negatively worded because they asked respondents to rate each item as ‘Not a problem’, ‘Minor problem’, ‘Moderate problem’, or ‘Major problem’ versus the standard ‘Excellent’, ‘Good’, ‘Fair’, or ‘Poor’ selections.

Table 13

Frequency Scores for Individual Question Items in Survey Question 7 [1]

Thinking back over the past 12 months, how many days did you spend …	No days (zero)	%	One to two days	%	Three to five days	%	Six or more days	%	N
As a patient in a hospital?	77	79	8	8	6	6	4	4	95
In a nursing home or in-patient rehabilitation facility?	87	90	2	2	0	0	0	0	89

Note. N varies because of missing responses from participants. [1] These question items may be negatively worded because they asked respondents to rate each item as ‘No days’, ‘One to two days’, ‘Three to five days’, or ‘Six or more days’ versus the standard ‘Excellent’, ‘Good’, ‘Fair’, or ‘Poor’ selections.

Table 14

Frequency Score for Survey Question 8

Thinking back over the past 12 months, how many times have you fallen and injured yourself? Was it…	N	%
Never	58	60
Once or twice	31	32
Three to five times	3	4
More than five times	3	4
Total	95	

Note. N varies because of missing responses from participants. [1] These question items may be negatively worded because they asked respondents to rate each item as ‘Never’, ‘Once or twice’, ‘Three to five times’, or ‘More than five times’ versus the standard ‘Excellent’, ‘Good’, ‘Fair’, or ‘Poor’ selections.

Table 15

Frequency Score for Survey Question 9

How likely or unlikely are you to recommend living in London to older adults?	N	%
Very likely	33	34
Somewhat likely	38	39
Somewhat unlikely	6	6
Very unlikely	9	9
Don't know	9	9
Total	91	

Note. N varies because of missing responses from participants.

Table 16

Frequency Scores for Survey Question 10

How likely or unlikely are you to remain in London throughout your retirement?	N	%
Very likely	71	73
Somewhat likely	14	14
Somewhat unlikely	5	5
Very unlikely	2	2
Don't know	2	2
Total	91	

Note. N varies because of missing responses from participants.

Table 17

Frequency Scores for Individual Question Items in Survey Question 11 [1]

In the last 12 months, about how many times, if ever, have you participated in or done each of the following?	Never	%	Once or twice	%	3 to 12 times	%	13 to 26 times	%	More than 26 times	%	N
Used a senior center in your community	47	49	6	6	10	10	14	14	19	20	96
Used a recreation center in your community	44	45	18	19	8	8	7	7	16	17	93
Used a public library in your community	29	30	10	10	18	19	17	18	16	17	90
Attended a meeting of your community's local elected officials or other local public meeting	53	55	29	30	11	11	0	0	2	2.1	95
Watched a meeting of your community's local elected officials or other public meeting on cable television, the Internet or other media	50	52	26	27	17	18	2	2	1	1	96
Used public transit (e.g., bus) within your community	54	56	12	12	10	10	8	8	12	12	96
Visited a neighborhood park	14	14	26	27	27	28	19	20	9	9	95

Note. N varies because of missing responses from participants. [1] Question item frequencies were reverse coded to calculate question item scores.

Table 18

Frequency Scores for Individual Question Items in Survey Question 12 [1]

During a typical week, how many hours, if any, do you spend doing the following?	Never (no hours)	%	1 to 3 hours	%	4 to 5 hours	%	6 to 10 hours	%	11 or more hours	%	Don't know	%	N
Participating in a club (including book, dance, game and other social)	40	41	20	21	10	10	14	14	10	10	0	0	94
Participating in a civic group (including Kinsmen, Lions, Over 55, etc.)	74	76	11	11	3	3	2	2	4	4	1	1	95
Communicating/visiting with friends and/or family	6	6	26	27	27	28	13	13	22	23	1	1	95
Participating in religious or spiritual activities with others	37	38	29	30	11	11	3	3	10	10	3	3	93
Participating in a recreation program or group activity	28	29	31	32	11	11	8	8	15	16	2	2	95
Providing help to friends or relatives	9	9	48	50	18	19	5	5	12	12	4	4	96
Volunteering your time to some group/activity in London	46	47	23	24	9	9	7	7	8	8	2	2	95

Note. N varies because of missing responses from participants. [1] Question item frequencies were reverse coded to calculate question item scores.

Table 19

Frequency Scores for Individual Question Items in Survey Question 13 [1]

During a typical week, how many hours do you spend providing care for one or more individuals with whom you have a significant relationship (such as spouse, other relative, partner, friend, neighbor or child), whether or not they live with you?	Never (no hours)	%	1 to 3 hours	%	4 to 5 hours	%	6 to 10 hours	%	11 to 20 hours	%	20 or more hours	%	Don't know	%	N
One or more individuals age 60 or older	48	50	17	18	9	9	7	7	1	1	9	9	1	1	92
One or more individuals age 18 to 59	58	60	13	13	6	6	1	1	0	0	5	5	1	1	84
One or more individuals under age 18	62	64	7	7	7	7	5	5	2	2	2	2	1	1	86

Note. N varies because of missing responses from participants. [1] Question item frequencies were reverse coded to calculate question item scores.

Table 20

Frequency Score for Survey Question 14

Whether or not they live with you, does someone provide assistance to you almost every day?	N	%
Yes	83	86
No	13	13
Total	96	

Note. N varies because of missing responses from participants.

Table 21

Frequency Scores for Survey Question 15

Are you registered to vote in municipal elections?		N	%
Yes		96	100
No		0	0
Ineligible to vote		0	0
Don't know		0	0
	Total	96	

Note. N varies because of missing responses from participants.

Table 22

Frequency Scores for Survey Question 16

Many people don't have time to vote in elections. Did you vote in the last municipal, OR provincial, OR federal election?		N	%
Yes		90	95
No		5	5
Ineligible to vote		0	0
Don't know		0	0
	Total	95	

Note. N varies because of missing responses from participants.

Table 23

Frequency Scores for Individual Question Items in Survey Question 17

Please rate each of the following characteristics:	Excellent	%	Good	%	Fair	%	Poor	%	Don't know	%	N
Accessibility of public buildings	17	18	47	49	23	24	3	3	4	4	94
Accessibility of businesses	17	18	44	45	26	27	4	4	3	3	94
Places to sit or rest in the parks	15	16	35	36	23	24	16	17	4	4	93
Places to sir or rest downtown	5	5	16	17	25	26	26	27	19	20	91
Availability of public washrooms	2	2	18	19	31	32	28	29	15	16	94
Ease of entering or exiting public buildings	9	9	41	42	32	33	6	6	7	7	95
Accessibility of public buildings for people with disabilities	6	6	20	21	24	25	15	16	29	30	94
Ease of walking on sidewalks and in public places	8	8	33	34	39	40	14	14	1	1	95

Note. N varies because of missing responses from participants.

Table 24

Frequency Scores for Survey Question 18

Are you aware of transportation options available to Londoners other than the London Transit Commission buses?		N	%
Very aware		15	16
Somewhat aware		49	51
Somewhat unaware		15	16
Very unaware		16	17
	Total	95	

Note. N varies because of missing responses from participants.

Table 25

Frequency Scores for Survey Question 19

Please indicate which of the following transportation options you use on a regular basis. Check all that apply	N	%
Car - I drive myself	76	34
Car - Someone else drives me	20	9
London Transit Bus	28	12
ParaTransit	5	2
Taxi	7	3
Volunteer transportation services	0	0
Other	91	40
Total [1]	227	

Note. [1] Total does not represent how many participants responded, rather the total amount of options selected.

Table 26

Frequency Scores for Survey Question 20

How affordable is London public transit for you personally?		N	%
Very affordable		15	16
Somewhat affordable		21	22
Somewhat unaffordable		5	6
Very unaffordable		4	4
Don't know		6	7
I don't use public transit		44	45
	Total	95	

Note. N varies because of missing responses from participants.

Table 27

Frequency Scores for Individual Question Items in Survey Question 21

Do you agree or disagree with the following statements?	Strongly agree	%	Somewhat agree	%	Somewhat disagree	%	Strongly disagree	%	Don't know	%	N
All city areas and services are accessible by public transport	6	6	31	32	38	39	16	17	4	4	95
Information for bus routes and schedules is available and easily accessible	22	23	36	37	29	30	7	7	2	2	96
Buses are accessible to people with disabilities	12	12	38	39	38	39	6	6	1	1	95
Bus drivers are courteous to older people	13	13	29	30	48	50	5	5	1	1	96

Note. N varies because of missing responses from participants.

Table 28

Frequency Scores for Individual Question Items in Survey Question 22

Please rate each of the following characteristics as they relate to adults age 55 or older in London:	Excellent	%	Good	%	Fair	%	Poor	%	Don't know	%	N
Availability of affordable housing	2	2	12	12	21	22	28	29	33	34	96
Variety of housing options for older people	3	3	10	10	24	25	26	27	32	33	95
Availability of housing for low income seniors	2	2	5	5	16	17	37	38	35	36	95
Housing options that are safe and accessible	2	2	9	9	23	24	17	18	44	45	95

Note. N varies because of missing responses from participants.

Table 29

Frequency Scores for Survey Question 23

How do you currently get information on programs and services for older adults in London? Check all that apply.	N	%
Advertisement at community centre or library bulletin board	43	13
Church newsletters or bulletins	30	9
Community associations	23	7
Email newsletters	12	4
Free newspapers	64	20
Friend, neighbour, or family member	42	13
Internet on a personal computer	26	8
Internet on a public computer	7	2
London Free Press	47	15
Senior's Helpline	2	1
Yellow pages or phone book	19	6
211 phone line	3	1
Other	2	1
Total [1]	320	

Note. [1] Total does not represent how many participants responded, rather the total amount of options selected.

Table 30

Frequency Scores for Individual Question Items in Survey Question 24

Please circle the number that comes closest to your opinion for each of the following statements:	Strongly agree	%	Somewhat agree	%	Somewhat disagree	%	Strongly disagree	%	Don't know	%	N
Information in public areas (e.g. posters, brochures) is available in a format that I can take home with me	11	11	50	52	26	27	8	8	2	2	97
Information from public areas is clear and readable	16	17	42	43	24	25	9	9	2	2	93
I am well-informed about community events in London	11	11	54	56	7	7	18	19	7	7	97
I am well-informed about public services available to me in London	10	10	52	54	12	12	15	16	8	8	97

Note. N varies because of missing responses from participants.

Table 31

Frequency Scores for Survey Demographic Question 1

How many years have you lived in London?	%
Less than 1 year	0
1-5 years	3
6-10 years	2
11-20 years	4
More than 20 years	91

Table 32

Frequency Scores for Survey Demographic Question 2

Which best describes the building you live in?	%
Single family home	75
Townhouse, condominium, duplex or apartment	0
Mobile home	0
Assisted living residence	19
Nursing home	2
Other	3

Table 33

Frequency Scores for Survey Demographic Question 3

Do you currently rent or own your home?	%
Rent	24
Own (with a mortgage payment)	16
Own (free and clear; no mortgage)	60

Table 34

Frequency Scores for Survey Demographic Question 4

About how much is your monthly housing cost for the place you live (including rent, mortgage payment, property tax, property insurance and homeowners' fees)?	%
Less than $300 per month	8
$300 to $599 per month	26
$600 to $999 per month	8
$1,000 to $1,499 per month	33
$1,500 to $2,499 per month	16
$2,500 or more per month	1

Table 35

Frequency Scores for Survey Demographic Question 5

How many people, including yourself, live in your household?	%
1 person (live alone)	42
2 people	44
3 people	6
4 or more people	4

Table 36

Frequency Scores for Survey Demographic Question 6

How many of these people, including yourself, are 55 or older?	%
1 person (live alone)	50
2 people	45

Table 37

Frequency Scores for Survey Demographic Question 7

What is your employment status?	%
Fully retired	71
Working full time for pay	7
Working part time for pay	11
Unemployed, looking for paid work	0
Other	7

Table 38

Frequency Scores for Survey Demographic Question 8

[If not yet fully retired] At what age do you expect to retire completely and not work for pay at all?	%
60 to 64	8
65 to 69	32
70 to 74	16
75 or older	12
Never	28
Don't know	4

Table 39

Frequency Scores for Survey Demographic Question 9

How much do you anticipate your household's total income before taxes will be for the current year? (Please include in your total income money from all sources for all persons living in your household.)	%
Less than $15,000	7
$15,000 to $24,999	21
$25,000 to $49,999	33
$50,000 to $74,999	13
$75,000 to $99,999	8
$100,000 or more	1
Choose not to answer	17

Table 40

Frequency Scores for Survey Demographic Question 10

Are you French Canadian?	%
Yes	4
No	96

Table 41

Frequency Scores for Survey Demographic Question 11

What is your ethnic origin?	%
Arab	0
Black	1
Chinese	0
Filipino	1
Japanese	0
Korean	0
Latin American	0
South Asian	0
Southeast Asian	0
Status Indian	0
West Asian	0
White	91
Other	7

Table 42

Frequency Scores for Survey Demographic Question 12

In which category is your age?	%
55-59 years	12
60-64 years	17
65-69 years	20
70-74 years	14
75-79 years	25
80 -84 years	7
85-89 years	4
90-94 years	1
95 years and older	0

Table 43

Frequency Scores for Survey Demographic Question 13

What is your gender?	%
Female	72
Male	28

Table 44

Frequency Scores for Survey Demographic Question 14

What is your sexual orientation	%
Heterosexual	85
Lesbian	4
Gay	0
Bi-sexual	0
Prefer not to answer	11

APPENDIX C

Age Friendly Argyle Domain Tables with Domain Scores and Comparison Scores between Argyle and London

Table 45

Scores for Individual Question Items in the Community Support and Health Services Domain

Question	Item Score
Being physically or emotionally abused[1]	4.6
Providing care for another person[1]	4.1
Experiencing confusion or forgetfulness[1]	4.1
Dealing with legal issues[1]	4.0
Feeling depressed[1]	4.0
Affording the medications you need	4.0
Having tooth or mouth problems[1]	3.9
Feeling lonely or isolated[1]	3.9
Getting the health care you need	3.9
Getting the oral health care you need	3.9
Maintaining a healthy diet	3.7
Finding affordable health insurance	3.6
Staying physically fit	3.5
Fitness opportunities (including exercise classes and paths or trails, etc.)	3.2
Availability of affordable quality food	2.9
Availability of preventive health services (e.g., health screenings, flu shots, educational workshops)	2.9
Not knowing what services are available to older adults in London[1]	2.9
Availability of affordable quality physical health care	2.2
Availability of affordable quality mental health care	1.5
Domain Score	3.5

Note. Item score refers to item responses on a five point scale where 5/5 is the best score. Domain score refers to the average of all item scores out of five, where 5/5 is the best score. [1] Question items may be negatively worded, because they do not have the standard ‘Excellent’, ‘Good’, ‘Fair’, or ‘Poor’ selections, but rather ‘Not a problem’, ‘Minor problem’, ‘Moderate problem’, or ‘Minor problem’.

Table 46

Scores for Individual Question Items in the Respect and Social Inclusion Domain

Question	Item Score
Being a victim of fraud or a scam[1]	4.5
Being a victim of crime[1]	4.4
Having friends or family you can rely on	4.2
Dealing with the loss of a close family member or friend	3.7
Feeling like your voice is heard in the community	2.9
Valuing older residents in London	2.8
Overall feeling of safety in London	2.5
Neighborliness of London	2.4
Sense of community	2.4
Openness and acceptance of the community towards older residents of diverse backgrounds	2.1
Domain Score	3.2

Note. Item score refers to item responses on a five point scale where 5/5 is the best score. Domain score refers to the average of all item scores out of five, where 5/5 is the best score. [1] Question items may be negatively worded, because they do not have the standard ‘Excellent’, ‘Good’, ‘Fair’, or ‘Poor’ selections, but rather ‘Not a problem’, ‘Minor problem’, ‘Moderate problem’, or ‘Minor problem’.

Table 47

Scores for Individual Question Items in the Communication and Information Domain

Question	Item Score
Having adequate information for dealing with public programs such as Canadian Pension Plan	4.0
Dealing with financial planning issues[1]	4.0
Building skills for paid or unpaid work	4.0
Finding work in retirement	3.6
Not knowing what services are available to older adults in London[1]	2.9
Information in public areas (e.g. posters, brochures) is available in a format that I can take home with me	2.8
In general, how informed or uninformed do you feel about services and activities available to older adults in London?	2.8
Information from public areas is clear and readable	2.8
I am well-informed about community events in London	2.7
I am well-informed about public services available to me in London	2.7
Availability of information about resources for older adults	2.1
Domain Score	3.1

Note. Item score refers to item responses on a five point scale where 5/5 is the best score. Domain score refers to the average of all item scores out of five, where 5/5 is the best score. [1] Question items may be negatively worded, because they do not have the standard ‘Excellent’, ‘Good’, ‘Fair’, or ‘Poor’ selections, but rather ‘Not a problem’, ‘Minor problem’, ‘Moderate problem’, or ‘Minor problem’.

Table 48

Scores for Individual Question Items in the Transportation Domain

Question	Item Score
No longer being able to drive[1]	4.4
Having safe and affordable transportation available	4.2
How affordable is London public transit for you personally?	3.4
Information for bus routes and schedules is available and easily accessible	3.0
Ease of getting to the places you usually have to visit (e.g. grocery store, doctor's office, pharmacy)	3.0
Are you aware of transportation options available to Londoners other than the London Transit Commission buses?	2.8
Buses are accessible to people with disabilities	2.7
Bus drivers are courteous to older people	2.5
All city areas and services are accessible by public transport	2.2
Ease of car travel in London	2.2
Ease of bus travel in London	2.0
Domain Score	3.0

Note. Item score refers to item responses on a five point scale where 5/5 is the best score. Domain score refers to the average of all item scores out of five, where 5/5 is the best score. [1] Question items may be negatively worded, because they do not have the standard 'Excellent', 'Good', 'Fair', or 'Poor' selections, but rather 'Not a problem', 'Minor problem', 'Moderate problem', or 'Minor problem'.

Table 49

Scores for Individual Question Items in the Civic Participation and Employment Domain

Question	Item Score
Finding meaningful volunteer work [1]	4.5
Having enough money to pay your property taxes [1]	4.2
Having enough money to meet daily expenses [1]	4.0
Dealing with legal issues [1]	4.0
Building skills for paid or unpaid work [1]	4.0
Opportunities to volunteer	3.9
Finding work in retirement [1]	3.6
Opportunities to enroll in skill-building or personal enrichment classes	2.8
Opportunities to attend or participate in meetings about local government or community matters	2.3
Availability of financial or legal planning services	2.2
Employment opportunities	1.0
Volunteering your time to some group/activity in London	1.0
Watched a meeting of your community's local elected officials or other public meeting on cable television, the Internet or other media [2]	0.7
Attended a meeting of your community's local elected officials or other local public meeting [2]	0.6
Participating in a civic group (including Kinsmen, Lions, Over 55, etc.) [2]	0.4
Domain Score	2.6

Note. Item score refers to item responses on a five point scale where 5/5 is the best score. Domain score refers to the average of all item scores out of five, where 5/5 is the best score. [1] Question items may be negatively worded, because they do not have the standard 'Excellent', 'Good', 'Fair', or 'Poor' selections, but rather 'Not a problem', 'Minor problem', 'Moderate problem', or 'Minor problem'. [2] Question items were reverse coded before their item score were calculated.

Table 50

Scores for Individual Question Items in the Housing Domain

Question		Item Score
Having housing to suit your needs [1]		4.4
Falling or injuring yourself in your home [1]		4.4
Maintaining your home [1]		3.9
Maintaining your yard [1]		3.6
Variety of housing options		1.7
Housing options that are safe and accessible [1]		1.5
Variety of housing options for older people		1.4
Availability of affordable housing		1.3
Availability of affordable quality housing		1.2
Availability of housing for low income seniors		0.9
	Domain Score	2.4

Note. Item score refers to item responses on a five point scale where 5/5 is the best score. Domain score refers to the average of all item scores out of five, where 5/5 is the best score. [1] Question items may be negatively worded, because they do not have the standard ‘Excellent’, ‘Good’, ‘Fair’, or ‘Poor’ selections, but rather ‘Not a problem’, ‘Minor problem’, ‘Moderate problem’, or ‘Minor problem’.

Table 51

Scores for Individual Question Items in the Outdoor Spaces and Buildings Domain

Question	Item Score
Accessibility of public buildings	3.1
Accessibility of businesses	3.0
Ease of entering or exiting public buildings	2.7
Ease of walking in London	2.7
Places to sit or rest in the parks	2.6
Ease of walking on sidewalks and in public places	2.3
Visited a neighborhood park [2]	2.2
Accessibility of public buildings for people with disabilities [1]	2.1
Places to sir or rest downtown	1.7
Availability of public washrooms	1.5
Domain Score	2.4

Note. Item score refers to item responses on a five point scale where 5/5 is the best score. Domain score refers to the average of all item scores out of five, where 5/5 is the best score. [1] Question items may be negatively worded, because they do not have the standard ‘Excellent’, ‘Good’, ‘Fair’, or ‘Poor’ selections, but rather ‘Not a problem’, ‘Minor problem’, ‘Moderate problem’, or ‘Minor problem’. [2] Question items were reverse coded before their item score were calculated.

Table 52

Comparison of AFC Domain Scores for Argyle, the District of London and the City of London, Ontario in Hierarchical Order

Domains	Domain Scores for Argyle[1]	Domain Scores for London[1]
Community Support and Health Services	3.5	3.6
Respect and Social Inclusion	3.2	3.2
Communication and Information	3.1	3.2
Transportation	3.0	3.3
Civic Participation and Employment	2.6	2.6
Social Participation	2.6	2.6
Housing	2.4	2.7
Outdoor Spaces and Buildings	2.4	2.6
Total Score for Age Friendliness	2.9	3.0

Note. [1]Score on a five point scale where 5/5 is the best score.

Table 53

Comparison of Social Participation Question Items Score for Argyle and London

Questions	Argyle's Item Scores[1]	London's Item Scores[1]
Finding productive or meaningful activities to do	4.2	4.1
Feeling bored	3.9	3.8
Having interesting recreational or cultural activities to attend	3.9	3.9
Having interesting social events or activities to attend	3.8	3.9
Opportunities to attend religious or spiritual activities	3.6	3.6
Recreation opportunities (including games, arts, and library services, etc.) [2]	3.3	3.5
Opportunities to attend social events or activities[2]	2.9	3.1
Communicating/visiting with friends and/or family	2.2	2.3
Used a public library in your community	1.8	1.9
Used a senior center in your community[2]	1.5	1.2
Participating in a recreation program or group activity[2]	1.5	1.2
Used a recreation center in your community	1.3	1.3
Participating in a club (including book, dance, game and other social) [2]	1.3	1.1
Participating in religious or spiritual activities with others[2]	1.1	0.9
Domain Score	2.6	2.6

Note. [1]Score on a five point scale where 5/5 is the best score. [2]Question items with a 0.2 point score difference between Argyle and London.

APPENDIX D

Letter of Information and Consent Form

Social inclusion through social engagement in older adults of the future

Principle Investigator: Aleksandra Zecevic, PhD, School of Health Studies, Western University, Faculty of Health Sciences

Co-investigator: Oksana Kubach, MSc candidate, Health and Rehabilitation Sciences Graduate Program, Western University

Letter of Information

Dear [participant]:

You are being invited to participate in a research project that will examine social inclusion and social engagement of adults in Argyle. To participate in this study you need to be 50 years of age and older, be able to read this letter, be able to participate in a group discussion, and have your permanent residence in Argyle district. The purpose of this letter is to provide you with enough information to help you make an informed decision of whether or not to participate in this research study.

In the summer of 2013 Western University, in partnership with the Council for London Seniors and the City of London, administered a survey called "Assessing Baseline Age-Friendliness of London, Ontario". To further this work, we came to your neighbourhood to learn about ways you socially engage in your community today and what would help you socially engage more in the future.

If you agree to participate, information you provide will be audio recorded, reviewed, transcribed and analyzed. All personal features, such as your name, address or names of

people you mention during the discussion, will be removed and unique code name will be used for each participant. Participants are advised to maintain privacy and confidentiality. Please do not repeat what is discussed in the focus groups to others. The researcher will take every precaution possible to maintain confidentiality; the nature of the focus groups prevents guaranteeing confidentiality. All data (with personal identifiers removed) and consent forms will be kept confidential and stored at a secure location at the Western University for up to seven years. You do not waive any legal rights by signing the consent form.

You will not be compensated and you may not directly benefit from participating in this study. Information you provide will inform creation of future programs and services for adults in Argyle district and London, Ontario.

There are no known risks to your participation in this study. Participation is voluntary. You may refuse to participate, or refuse to answer any questions. If you wish to stop participation, just let the investigator know.

If the results of the research are published or presented at scientific meetings, your name will not be used and no information that discloses your identity will be released or published without your explicit consent.

Representatives of The Western University Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of the research. If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Western University Office of Research Ethics. If you have any specific questions about the research project you may contact, Dr. Aleksandra Zecevic.

This letter is for you to keep.

Sincerely,

Aleksandra Zecevic, PhD	Oksana Kubach, MSc (c)	Donna Baxter, MSc
Western University	Western University	City of London

Social inclusion through social engagement in older adults of the future

Principle Investigator: Aleksandra Zecevic, PhD, School of Health Studies, Western University, Faculty of Health Sciences

Co-investigator: Oksana Kubach, MSc candidate, Health and Rehabilitation Sciences Graduate Program, Western University

Consent Form

I have read the Letter of Information and have had the nature of this study explained to me. I am eligible to participate in this study. I allow my discussion in focus group to be audio recorded. All questions have been answered to my satisfaction.

____

Name of participant (Print)

__________________________________ _________________

Signature of participant Date

____

Name of person obtaining consent (Print)

__________________________________ _________________

Signature of person obtaining consent Date

APPENDIX E

Focus Group Protocol, Focus Group Discussion Questions and Demographic Questionnaire

Table 54

Detailed Focus Group Protocol Outlining Estimated Time per Task for the Performer

Time	Task	Task Performer
Before the focus group begins	Welcome the participants as they arrive and check them off the list, making sure the people who signed up arrived to the focus group.	Focus Group (FG) Moderator
	Draw their attention to the table with refreshments and show them where the nearest restrooms are located.	FG Moderator
	Provide a folder with: a copy of the Letter of Information, Consent Form, and Demographic Questionnaire to each individual.	Assistant
7 min	Once everyone is settled and has their refreshments, introduce the researcher and assistant.	FG Moderator
	Provide an overview of the study and state the main purpose.	
	Go through the Letter of Information, Consent Form, and Demographic Questionnaire.	
8 min	Participants will read the Letter of Information, ask questions, sign Consent Forms, and fill-in Demographic Questionnaire.	FG Moderator and Assistant
	Double check all of the forms are signed and completed. Assistant will collect each participant's forms. The Letter of Information is the participant`s copy to keep.	Assistant
2 min	Introduce guidelines about the focus group process.	FG Moderator

12 min / question	*Guidelines:* Five open-ended questions will be administered. The assistant will keep track of time. Once the timer goes off, the discussion will come to a close and the group will move on to the next question. However, this is an estimate of time per question. The researcher will be flexible with the discussions flow.	FG Moderator and Assistant
3 min	Remind the participants that three digital audio recorders will be placed at either ends of the tables to tape the discussion. Explain that the audio data will be transcribed and analyzed. Explain how identity of each participant will be concealed by using pseudonyms and that results will be combined for the whole group.	FG Moderator
	Ask if there are any questions.	FG Moderator
Discussion begins: 12 min / question	*Begin the audio recording* and start with the first discussion question	FG Moderator
	Field notes will be kept to document dominant themes and ideas expressed by the participants on a white board.	Assistant
	The survey responses will be used to probe. For example: “Survey data from Argyle showed that ..., is this everyone opinion? Why or why not?”	FG Moderator
10 min	At the end of the focus group member checking will be conducted. An overview of all the major themes and idea`s that were recorded by the research assistant will be summarized, allowing any additional comments from participants. This will allow the participants to review their ideas and provide final remarks.	FG Moderator
End of the focus group	Thank the participants for their time and input into the research project. Reiterate their contribution to improvement of social inclusion through future programs and services in multipurpose community centre.	FG Moderator
	Total: 90 min	

Discussion Questions

1. How do you stay active in Argyle?

2. What types of services and programs do you use in Argyle?

3. What types of programs and services would you like available in Argyle?

4. Do you experience any barriers that prevent you from being active in Argyle?

5. How to you access information about programs and services available in Argyle?

Demographic Questionnaire

ID Number: _____________

Time and Date of focus group: ____

Year of Birth: ____________

Gender:

- ☐ Female
- ☐ Male

Occupation:

- ☐ Fully retired
- ☐ Working full-time for pay
- ☐ Working part-time for pay
- ☐ Unemployed
- ☐ Other ___________________________

Education:

- ☐ Grade 12 or less
- ☐ High school diploma
- ☐ University Degree
- ☐ College Degree
- ☐ Professional School (i.e. Medicine, Dentistry, Law etc.)
- ☐ Other ___________________________

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow
- ☐ Common-law

Do you volunteer in your community?

- ☐ Yes
- ☐ No

Please indicate which of the following transportation options you use on a regular basis. *Check all that apply.*

- ☐ Car – I drive myself
- ☐ Car – Someone else drives me
- ☐ London Transit Bus
- ☐ Para-Transit
- ☐ Taxi
- ☐ Volunteer transportation services (e.g. Boys' and Girls' Club of London, Seniors' Transit etc.)
- ☐ None of the above
- ☐ Other ___________________________

How do you currently get information on programs and services in Argyle? *Check all that apply.*

- ☐ Advertisement at library bulletin board
- ☐ Church newsletters or bulletins
- ☐ Community associations
- ☐ Email newsletters
- ☐ Free newspapers (Londoner, Community News, Metro)
- ☐ Friend, neighbour, or family member
- ☐ Internet on a personal computer
- ☐ Internet on a public computer
- ☐ London Free Press
- ☐ Senior's Helpline
- ☐ Yellow Pages or phone book
- ☐ 211 Phone Line

Other ___________________________

APPENDIX F

Code Table with Corresponding Definitions and Themes

Table 55

Established Codes and Sub-Codes with Definitions and Relations with Themes

#	Code	Sub-Code	Definition	Theme
1.	Current Activities Enabling Social Engagement	1.1 Formal Activities	Structured physical, mental or social activities for group or individual participation. Examples: physical activity (walking, Spectrum courses, Tai Chi, yoga, swimming in another districts pool, aqua-fit, Sit to be Fit, skating, riding a bike, seated exercises, and any other physical activity); volunteering; research projects; organized meals; games (cards games, board games, darts, shuffleboard, trivia night and any other game).	Togetherness
		1.2 Formal Clubs	Any organizations offering programs and services. Examples: Optimist Club, Senior Learning and Retirement, Student Outreach for Seniors, Argyle Seniors' Satellite, Argyle Community Associations, Community Employment Services, Argyle Strengthening Committee, Unions, Huff and Puffs, Boys and Girls Clubs, SNAC, Lunch Brunch, and any other organization.	Togetherness
		1.3 Informal	Activities performed by an individual at their leisure not offered by a community organization. Examples: caregiving, hobbies, reading, gardening, computer-use, movies, working any other.	Personal Responsibility
2.	Current Locations for Social Engagement	2.1 Private	Locations without public access. Examples: home and garage.	Personal Responsibility

		2.2 Public	Specific locations in the community. Examples: YMCA, Churches, Food Courts, Kiwanis Park, parks, Kiwanis Senior Center, Hamilton Road Senior Center, Curling Heights Swimming Pool, Library, BMO Soccer Center, Malls, Boyle Seniors Center, and any other locations.	Togetherness
3.	Personal Motivators for Social Engagement	3.1 Obligation	A sense of responsibility to remain socially engaged. Examples: post retirement, prior participation, progressively increasing participation, trying new things, resilience and activity level.	Personal Responsibility
		3.2 Necessity	A need to be socially engaged. Examples: personality, comfort level, trust, reason to get up in the morning, accomplishment, family at a distance.	Personal Responsibility
		3.3 Friendship	Personal connections that are used to benefit one another. Examples: carpooling, making contacts, social gatherings, doing it together, building confidence and fun.	Togetherness
		3.4 Multigenerational Activities	Activities with participants of various ages. Examples: family involvement, participation with grandchildren and great grandchildren, participation in programs open to all generations.	Togetherness
4.	Barriers to Social Engagement	4.1 Financial	Pre-set fees limiting participation. Examples: bus ticket fee, membership fee, pay services, and parking costs.	Resentment
		4.2 Personal	Personal limitations and experiences. Examples: no desire, reliance on others, social isolation, widowhood, lack of social interaction, perceived burden, unpredictability of health, mobility issues, lack of commitment and technology use (user versus non-users, influence due to availability and age).	Uncertainty

		4.3 Social	Lack of community cohesion. Examples: unheard voices, sustainability of programs (inconsistent member participation, lack of leadership initiation and lack of male attendance), uninformed, timing (time of day and season), inequality, and unequal access.	Resentment
		4.4 Structural	Lack of participation due to the built environment (indoor/outdoor, downtown, lack of benches, walkability, distance, limited parking), public transport (bus routes and frequency), resentment, and police checks.	Resentment
5.	Distribution of Information	5.1 Current	Present methods of sharing and receiving information in the community. Examples: public distribution (newspapers, flyers, newsletters, and bulletin boards), personal connections, word-of-mouth, and cross-advertising.	Uncertainty
		5.2 Desired	Requests for future information distribution. Examples: central communication hub (staff, information desk), variety of online and hard copy information, and online engagement.	Togetherness
6.	Desired Programs	6.1 Creative	Programs encouraging the use of imagination/talent. Examples: arts and crafts, creative writing.	Togetherness
		6.2 Recreational	Pastime activities performed for personal enjoyment through relaxation, outings or physical activity. Examples: desired physical activity, group activity (hockey, aqua-fit, dancing, skating, walking groups, and any other group activity) and bus excursions.	Togetherness
		6.3 Stimulating	Programs encouraging mental activity and neuroplasticity. Examples: desired games, mind activities, educational activities, and movie theater.	Togetherness

7.	Desired Services		Supportive services providing help or assistance to individuals with needs. Examples: peer support groups, community bus, buddy system, health services (massage, physiotherapy, chiropractor, CCAC, VON, and multi-service facilities) and services for isolated seniors (friendly phone calls, and volunteer visitation).	Togetherness
8.	Desired Facilities	8.1 Community Centre	A central building in the community that people can go to for social, recreational, or educational activities. Examples: multipurpose activity rooms, meeting rooms, gathering space, gym, indoor pool, arena, indoor walking space, classrooms, computer lab, yoga studio, medic clinic, and any other amenities in a community center.	Resentment
		8.2 Facility Improvements	To improve current and create future establishments to promote participation. Examples: user-friendliness, accessible, good crosswalks, adequate parking and flexibility.	Resentment
9.	Desired Finances		The ability of an individual to pay for a program or service that is within their financial means. Examples: free, lower fees, no expiration on payment, pay as you go, and punch card.	Resentment
10.	Desiring Everything		Wanting everything other communities have not knowing the details.	Resentment
11.	Other	11.1 Civic Engagement	Lobbying for policy change, including voting.	Personal Responsibility
		11.2 Para-transit	Availability of transportation service for individuals with disability.	Togetherness

11.3	Participation Frequency	How often an individual currently participates in a program or service. Examples: weekly, monthly, and annually.	Personal Responsibility
11.4	Other	Any text that does not fit into any other code or sub-code.	

APPENDIX G

Curriculum Vitae

Curriculum Vitae

Name:	Oksana Kubach
Post-secondary Education and Degrees:	Western University London, Ontario, Canada 2008-2012 B.HSc. (Hons.)
	Western University London, Ontario, Canada 2012-2014 M.Sc.
Honours and Awards:	The Queen Elizabeth Award Scholarship (2008)
	Western University Faculty of Health Science's Scholarship (2008)
	Annual Health and Rehabilitation Sciences Graduate Research Forum Presentation Winner (2014)
Related Work Experience:	Teaching Assistant Western University 2012-2014
	Health and Rehabilitation Sciences (HRS) Graduate Student Society Social Vice President 2013-2014
	HRS Graduate Research Forum Coordinator 2013-2014
	Student Organized Graduate Society (SOGS) of Western University Councilor Representative for HRS 2013-2014
Presentations:	Faculty of Health Sciences (FHS) Symposium - Poster Presentation *Research to Action: Technology, Innovation, and Health* (2013)
	FHS Research Day - Poster Presentation (2013)
	The Annual Ontario Gerontology Association Conference - Poster Presentation (2013)
	Annual HRS Graduate Research Forum - Oral Presentation *Bringing your Creativity to Life: Capture, Focus, Develop* (2014)