



UNIVERSITY OF  
LIVERPOOL

**Promoting respect and social inclusion for healthy  
ageing in the urban setting: a juxtaposition of  
research evidence, stakeholder perspectives and  
the views of older people.**

Thesis submitted in accordance with the requirements of the  
University of Liverpool for the degree of Doctor in Philosophy

By

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# **AUTHOR'S DECLARATION**

I, Sara Ronzi confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

*“Tamdiu discendum est, quamdiu vivas” \**

(Seneca Philosophus, Ep. LXXVI 76,3)

\* Translation: We should learn as long as we may live (We live and learn).

# LIST OF PUBLICATIONS FROM THIS THESIS

## – Journal articles

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## – Reports

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– **Other contributions (photographic display)**

Ronzi, S., Pope, D., Orton, L., Bruce, N. (2015). *‘Thinking about what is important to me as an older person’: using Photovoice to explore Older People’s Perceptions of Respect and Social Inclusion in Liverpool City*. International Visual Methods, 16-18 September, Brighton.

[A selection of photographs and stories which reflect what older residents in Liverpool like and dislike about their local community in relation to respect and social inclusion were on display at Brighton Town Hall on 16-18 September 2015.]

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<sup>1</sup> Phaedrus, 4.2: "*Non semper ea sunt quae videntur: decipit frons prima multos*". Translation: "Things are not always what they seem: the first appearance deceives many people".

<sup>2</sup> Ovidio Epistulae ex Ponto (3, 5, 18). "*Gratius ex ipso fonte bibuntur aquae*". Translation: "Water is best drunk at the source". It means that *true* knowledge comes from accurate sources (clear water versus turbid water).

# ABSTRACT

Sara Ronzi

**Title:** Promoting respect and social inclusion for healthy ageing in the urban setting: a juxtaposition of research evidence, stakeholder perspectives and the views of older people.

**Introduction:** Population ageing and increasing urbanisation present challenges for public health policy and practice. Creating a supportive environment – as promoted by the WHO Age-Friendly Cities (AFCs) Initiative – is especially important for older people’s health. This thesis examines how views on strengthening respect and social inclusion in the urban setting differ among older people and city stakeholders, the extent to which their priorities are supported by evidence for health benefits, and the implications for public health policy.

**Methods:** A systematic review was conducted of quantitative and qualitative evidence for the impact on health and wellbeing of interventions fostering respect and social inclusion in community-resident older adults. Photovoice was used to explore respect and social inclusion among 26 older people aged 60+ from four contrasting areas of Liverpool (UK). Perspectives on respect and social inclusion among 23 local policy makers and service providers were explored at interview. A photo-exhibition was then organised to generate meaningful discussions between the two groups. Synthesis compared findings for older people and city stakeholders, and assessed the extent to which priorities of both groups were supported by evidence from the systematic review.

**Results:** Thirty-four quantitative evaluations included in the systematic review suggest that interventions on respect and social inclusion, particularly intergenerational and music and singing initiatives, may have an impact on psychological outcomes, wellbeing, subjective and physical health of older people. Fourteen qualitative studies identified some of the factors in the pathways to improved health outcomes (*e.g.* improved self-esteem and social relationships). Through photovoice methods, older people identified a wide range of enablers, barriers and potential solutions spanning services, the environment and city facilities. City stakeholders identified similar issues as older people, but were additionally concerned by impacts of budget cuts on provision and planning of respect and social inclusion. While some older people’s and city stakeholders’ priorities were supported by evidence (*e.g.* art and culture initiatives), there were no evaluations of the health/wellbeing impact of other important aspects for respect and social inclusion identified by older people and/or city stakeholders (*e.g.* attempts to promote affordability and accessibility of transportation).

**Discussion and Conclusions:** Although city stakeholders appeared to understand many of the views of older people and vice versa, the former’s views were driven more by their need to address budgets constraints. Photovoice can be an effective tool to (i) engage older people, and (ii) incorporate their views into city planning. However, participants’ concerns about photographing difficult topics and producing ‘expected’ images need to be addressed. Future research should address previously neglected priorities identified by older people and city stakeholders. Systems thinking would help structure more inclusive evaluation of health impacts of AFC initiatives.

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## ABBREVIATIONS AND DEFINITIONS

<b>Abbreviation</b>	<b>Definition</b>
AFC	Age-friendly City
Area	Geographical area/electoral ward
CBPR	Community-based participatory research
City stakeholders	Local policy makers, representatives from clinical commission groups, and service providers with an interest in older people
ICT	Information and communication technology
IT	Information technology
Older people	People aged 60 and more
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
RCT	Randomised controlled trial
RoB	Risk of bias
WHO	World Health Organization
60+	Aged 60 and more

# **Chapter 1 INTRODUCTION**

## **1.1 Introduction to the chapter**

New opportunities for public health research and action are particularly critical today. As researchers, advocates, and leaders, we face profound challenges. These include addressing the increasing ageing of population and urbanisation. Despite these challenges, with the right policies and services in place, an ageing population can be perceived as a unique opportunity for the whole society (World Health Organization 2015; Government Office for Science 2016; Beard & Bloom 2015). In fact, urban settings bring together the whole range of services, human activities and environmental conditions, and have the potential for well-coordinated governance to meet their population's needs.

In this chapter, I present a brief overview of the public health challenges and opportunities associated with an increasing ageing population and urbanisation. I then go on to explain some of the approaches developed to create cities which better support healthy ageing (in particular, the Age-Friendly Cities Initiative), and I give a description of the specific focus of this thesis and the reasons for selecting this domain: respect and social inclusion. This is followed by a discussion about the concept of age-friendliness and how this links with the literature of evaluation of complex public health interventions. I conclude this chapter with the aim and study objectives and an outline of the thesis.

For the purpose of this research, older people are defined as those aged 60 and over (World Health Organization 2007). While the term 'ageing' is referred to

here as an on-going process of physical, cognitive and social change and adaptation arising as an individual grows old (Hansen-Kyle 2005), 'healthy ageing' refers to the process enabling the individual to adapt and compensate "in order to optimally function and participate in all areas of one's life", despite the slowing down of the body (Hansen-Kyle, 2005 p.52).

There are various definitions of community in the literature (Cornish & Ghosh 2007; Marková 2003; Milton et al. 2012). For instance, community is often defined as a group of individuals who share some characteristics, such as the same location (*e.g.* the physical characteristics of the local environment where people live) (Heller 1989). Community is also defined as a group of individuals who cultivate similar interests or a set of circumstances (Vaandrager & Kennedy 2016). The notion of community, based on similarities between members, has been challenged by Wiesenfeld (1996), who argued the need to consider variation and diversity in the definition of community. Cornish & Ghosh (2007) have suggested to adopt a systemic perspective, wherein individuals are held together not only because they live in the same location or have the same interests, but "they are part of an interdependent system in which their actions have effects on each other by virtue of their participation in a joint activity" (Van Vlaenderen 2001 cited in Cornish & Ghosh 2007, p. 5).

The definition of community has also been related to the experience of being connected to each other and to the physical environment where people live – the so called 'sense of community' - which contributes to the communities collective cohesion and wellbeing (Chavis & Wandersman 1990; David 2005). Moreover,

the concept of community has been referred to collective or community action (Vaandrager & Kennedy 2016). If related to collective action, community refers to the capacity of individuals and community to deal with difficulties (Morton & Lurie 2013). Community action aims to bring individuals with a shared interest or vision together, and to encourage them to influence the decision processes within their cities/neighbourhoods (Minkler 2005).

In this research, I adopted the definition expressed by Cornish & Ghosh (2007) and Wiesenfeld (1996), wherein community refers to a group of individuals who share a similar location (Liverpool City) and interests (*e.g.* respect and social inclusion), but it also acknowledges the members' unique characteristics, contrasting views, and dynamics (Vaandrager & Kennedy 2016). As argued by Wiesenfeld (1996 p.339), "such differences are the result of the dynamic nature of the relations and processes its members construct over time". Community refers to the individuals that I was researching and who took part in shaping the project as well as those with whom I interacted and engaged with (Cornish & Ghosh 2007; Van Vlaenderen 2001), specifically: older people, volunteers, policy makers, and service providers with an interest in older people in Liverpool City.

## **1.2 Why are ageing population and urbanisation important for public health? Challenges and opportunities**

According to the World Health Organization (WHO) (2016), many people now have fewer children and live longer lives than ever before. Furthermore, with

advancing age, people are subject to numerous physiological changes, and the risk of chronic disease and disability rises (Beard & Bloom 2015; WHO 2016). The combination of these factors has profound implications for public health and health systems, the workforce, and projected spending/economy; and this has captured attention in health and political debates (WHO 2016; Rechel et al. 2013; House of Lords 2013). As highlighted by the *World Report on Ageing and Health* (WHO 2016b):

“The extent of these human and social resources, and the opportunities available to each of us as we age, will be heavily dependent on one key characteristic: our health. If people are experiencing these extra years in good health, their ability to do the things they value will have few limits. If these added years are dominated by declines in physical and mental capacities, the implications for older people and for society may be much more negative.”

As Dr Margaret Chan – Director General of the WHO – has emphasised (WHO 2016, no page), there is a need to develop a public health action which takes a societal approach to population ageing. This includes developing health systems that are based on an older-person-centred and integrated care model, which aims to maximise the opportunities for older people to live independently for longer (WHO 2016b; Bowling & Dieppe 2005; The Swedish National Institute of Public Health 2006).

Since the majority of the population now lives in cities, a connected phenomenon to the ageing population is increasing urbanisation (WHO 2016b). Cities have

become important settings for efforts to promote healthy ageing (WHO 2016b; Beard & Bloom 2015; Yen et al. 2009). As older people tend to spend more time in their homes and local neighbourhoods, the features of that neighbourhood (*e.g.* corner shops and transports) can have a great influence on their day to day living, health and wellbeing, particularly for those with limited mobility. This can also impact upon their social inclusion or exclusion in that setting (Phillipson & Kendig 2014; Mahmood & Keating 2012).

With advancing age, older people are more likely to be isolated and disconnected from their community (Phillipson 2007; Mahmood & Keating 2012). They are less likely to experience the health benefits of those living in socially inclusive environments providing social support and connectivity (Marmot 2010; Whitehead 2007). This risk is greater for older people with low socio-economic status, with pre-existing chronic health conditions and/or forms of disability, and who live in socially disadvantaged communities (Marmot 2010; Scharf & Keating 2012; Scharf et al. 2005; Buffel et al. 2012).

Among the priorities identified by the *Future of an Ageing Population* report (Government Office for Science 2016), there is the need (i) to develop a supportive physical, social and virtual (*i.e.* represented by increased use of technology and digital interactions) environment; (ii) to address barriers to technology use; and (iii) to consider the transport needs of different age groups. Cities have the potential to contribute to older people's wellbeing in various ways. For instance, by providing access to facilities and resources that enable older people to interact with others, to cultivate interests, cultural, learning, and social opportunities (*e.g.* libraries, museums, green spaces) (Buffel 2015;

Mahmood & Keating 2012). Moreover, cities can provide new assistive devices such as access to Internet and technology that may enable older people to cultivate learning opportunities and social relationships, despite the limitations in their mobility (WHO 2016b; Government Office for Science 2016; Menec et al. 2011).

### 1.3 Towards an Age-Friendly City

To respond to the opportunities and challenges of an ageing population and increasing urbanisation, in 2002 the WHO (2007) launched the Age Friendly City (AFC) Initiative, proposing a set of eight interconnected domains that influence the extent to which individuals age healthily (Figure 1).

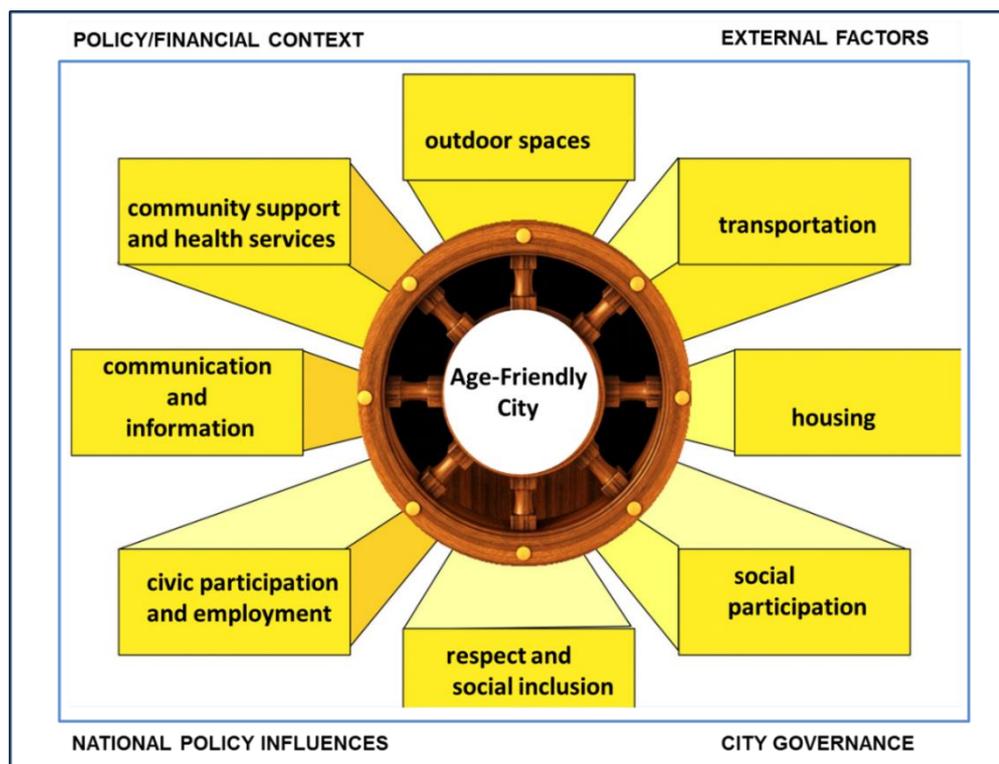


Figure 1 Eight features of an Age-Friendly City. Adapted from WHO (2007)

The *Global Age-friendly Cities* guide (WHO, 2007) provides a helpful framework for developing initiatives that can create age-friendly

cities/neighbourhoods, which can be adapted to the local context. Furthermore, in 2010 the WHO created the *Global Network of Age-friendly Cities and Communities* with the aim to exchange experiences and to link cities that are committed to these principles. In this context, an AFC is a community – formed by its wide-ranging category of individuals, neighbourhoods, policies, services, and buildings – which creates a physical and social environment that optimises the opportunities for health, and supports older people to live independently, and to contribute to various aspects of community life (WHO 2007). An AFC is a society inclusive of all ages, as it promotes “the physical and psychosocial wellbeing of community members throughout the life cycle” (Scharlach 2009 p.9). An AFC is not isolated, but it is integrated and influenced by national and local policies, external factors, the financial context, and city governance (Figure 1).

To create AFCs, the development of initiatives from national to local government level need to directly involve older people in the planning and decision making processes within their cities, and this is also an essential criterion to becoming a member of the WHO Global Network of AFCs (WHO 2014). Various researchers, policy makers, and practitioners have highlighted the importance of this approach, which is now widely recognised (Moulaert & Garon 2016; Buffel 2015; Garon et al. 2013; Public Health Agency of Canada 2013; McGarry & Morris 2011; Buffel, McGarry, et al. 2013).

Moreover, AFC initiatives need to consider the diversity of experiences and health inequities in older age, and to tackle negative perceptions and stereotypes towards older people and ageing (WHO 2016).

## **1.4 Focus of this research: respect and social inclusion**

In this research, I have focused on the domain of respect and social inclusion, as it is cross-cutting, and of fundamental importance to policy for healthy ageing, and because it has been identified “as a basis for a society for all ages” (Ogg & Renaut 2012 para 1).

Recent years have seen a focus on strategies to improve aspects of the physical environment of cities including housing, green spaces, and transportation (Finlay et al. 2015; Belon, Nieuwendyk, et al. 2014; Plane & Klodawsky 2013; Broome et al. 2013; Broome et al. 2013; Wigglesworth et al. 2016). With regard to the social environment, research and political debates have often focused on social isolation and loneliness in older people as a priority, adopting a disease-based curative model (HM Government 2012; Pennycook 2016; Henderson 2013), while there is little research about how to promote respect and social inclusion (Mahmood & Keating 2012). By contrast, the AFC Initiative (WHO 2007), advocates an approach to healthy ageing based on a *salutogenic* model to health (Eriksson et al. 2016), which contrasts a diseased-based curative model and focuses on ‘What makes people healthy?’. In this research, I followed the latter approach by focusing on the strategies that can improve respect and social inclusion in the urban setting.

Menec *et al.* (2011) have considered respect and social inclusion as an underlying value of the overall AFC Initiative (WHO 2007), rather than as a distinct domain. One of the reasons for not being regarded as a distinct domain is it is highly interconnected with other domains of an AFC, including social participation, communication and information, outdoor spaces, transportation

and housing (WHO 2007; Liddle et al. 2013; Mahmood & Keating 2012; Scharlach & Lehning 2012). For instance, access to public transports is likely to contribute to social inclusion by allowing older adults to reach places, services and/or people who are distant from their homes and this, in turn, is likely to facilitate social participation of older people in the community (Mahmood & Keating 2012).

– **Definitions of respect and social inclusion**

In this study, respect and social inclusion are seen as a process rather than a state, and refer to enhancing the opportunities for older people to cultivate social relationships, have access to resources and support, and feel valued and part of their community (Scharlach & Lehning 2012; Scharlach 2009).

According to Scharf & Keating (2012), despite the definition of social exclusion having been conceptualised – as the “exclusionary mechanisms of society, its potential breakdown, disorder, or incoherence” (Daly & Silver 2008 p.551), the concept of social inclusion remains rather unexplored. The term social inclusion has explicit links with other concepts “such as equality, rights and social cohesion, and draws attention to barriers or inequalities that prevent individuals or groups from taking a full role in society” (Warburton et al. 2012 p.4).. Hence, social inclusion adopts a more positive approach, by focusing on goals rather than problems (Cass et al. 2005; Eriksson et al. 2016). Instead of being considered merely the implied opposite of exclusion, social inclusion refers to the opportunities for individuals to participate in the society/communities where they live (Cass et al. 2005; Daly & Silver 2008). Promoting inclusion in the built

environment can enable older people to participate more fully to their community (Mahmood & Keating 2012).

In this context, social inclusion is “relative to a given society (place and time); multidimensional (whether those dimensions are conceived in terms of rights or key activities); dynamic (because inclusion is a process rather than a state); and multi-layered (in the sense that its causes operate at individual, familial, communal, societal and even global levels)” (Huxley et al. 2012 p.3).

Respect refers to “the attitudes, behaviour and messages of other people and of the community as a whole towards older people”(WHO 2007 p.9). Living in a culture which values and respects older people is likely to improve their empowerment and self-esteem. The concept of respect also refers to the activities and policies that promote intergenerational solidarity (Ogg & Renaut 2012).

- **Negative stereotypes of ageing**

Despite the important social and economic contribution that older people make in our societies – for example, through voluntary work and the raising of future generations (Age UK London 2012; Angus & Reeve 2006; House of Lords 2013) – older people are often described as frail, dependent, and burdens on public spending. In this discourse, extra years to live are merely perceived as an extension of the period of retirement, with connotations of dependency and being a drain on society’s resources (WHO 2015; Menec et al. 2011; Officer et al. 2016; Pickard 2014).

The belief that older people have qualities and attitudes which differ from younger people is included in the concept of stereotypes of ageing. This is based

on the existence of age categories, which tend to differentiate people according to their ages and assume that features amongst different age groups are not common and also that people of the same age group have the same characteristics (Bytheway 2005; Twigg 2012; Pickard 2014). A main issue with considering elderly people as a homogenous group, is that it does not reflect properly the reality, in which, despite individuals being of the same age and possessing other common features, each older person is different from another (House of Lords 2013; Mahmood & Keating 2012).

Various explanations have been suggested regarding how individuals acquire knowledge of ageing. For instance, individuals develop knowledge of ageing through relationships with older people and personal experience of growing old (Williams et al. 2010). Some authors (Wurtele 2009; Garstka et al. 2005; Grefe 2010; Williams et al. 2010) have suggested that negative perceptions toward ageing are in part associated with lack of social interactions between young and old people, which contributes to reinforcing negative perceptions toward elderly people (Grefe 2010). On the other hand, individuals with greater inter-group relationships with older people, as a result of a more accurate knowledge of the elderly, are more likely to hold more positive views toward ageing (Gluth et al. 2010).

In a study concerning how older people were portrayed in the magazine 'the Globe & Mail', Rozanova (2006) has pointed out how health and ageing are often related to each other. In particular, young people were often associated with healthy, vigorous bodies that are more resistant to diseases, in comparison with older people who were associated with physical and mental decline

(Rozanova, 2006). This, along with the influence of TV shows and films, and the fashion industry, have an important impact on the development of stereotypes toward older people as well as the construction of self-stereotypes by older people themselves (Williams et al. 2010; Uotila et al. 2010; Beard et al. 2011; Ylanne et al. 2009; Twigg 2012; Pickard 2014).

– **Impact of negative stereotypes on ageing**

Persistent disrespectful attitudes, and misconceptions about older people and growing old have been identified among the most significant barriers to the development of good public health policies on ageing (WHO 2016b; Officer et al. 2016). These barriers, have consequences for the way we perceive ageing (*e.g.* by restricting our perspectives and by offering a distorted view of older people by disregarding the contribution that they make in our societies), and may negatively impact on the health and wellbeing of older people (Nelson 2005; Angus & Reeve 2006).

For instance, as a result of being exposed to negative stereotypes, older people may internalise these into unconscious self-stereotypes, with a consequent decrease in their self-esteem and lowering of their contribution within society (Ory et al. 2003; Horton et al. 2007; Handler 2014b). The effect of exposure to negative stereotypes of ageing and health outcomes includes increased risk of cardiovascular events (Levy et al. 2009) and poorer recovery from disability (Levy et al. 2012).

As previously mentioned, several attempts have been made to tackle negative attitudes and perceptions towards older people and ageing. One important

strategy is to actively involve older people in planning and decision making processes within their neighbourhoods – which is at the core of the development of AFCs (Buffel et al. 2012). This action can be complemented by strategies that foster intergenerational connections between young and older people (Grefe 2010; Ory et al. 2003; Martens et al. 2005; The Intergenerational Center Temple University 2012). This, in turn, may allow young people to gain a more positive understanding of the ageing process (Wurtele & Maruyama 2012; Wurtele 2009). This need to foster intergenerational solidarity has also been pointed out by the United Nations (2013). Communication campaigns that focus on the contributions to development made by older people can also be helpful to improve our understanding of ageing. Tackling negative perceptions and attitudes towards older people presents a key opportunity for achieving more effective policy for healthy ageing, but it “will require building and embedding in the thinking of all generations, a new understanding of ageing” (WHO 2016b p.218).

### **1.5 What is age-friendliness? How might it be assessed?**

An extensive range of papers has been published on how to develop AFCs, and on examples of best practice on AFCs around the world (Garon et al. 2013; Plouffe & Kalache 2011; Buffel 2015; Buffel, McGarry, et al. 2014; Goldman et al. 2016; Scharlach 2011; Lui et al. 2009; Handler 2014b; Phillipson & Kendig 2014). Despite the importance behind the creation of AFCs, authors have started questioning the health impact of AFC initiatives, and have highlighted the need to ensure that these initiatives are evidence-based and evaluated (Buckner et al. 2016; Handler 2014b; WHO 2016a). Beard & Bloom (2015) and Scharlach

(2016) have called for more evaluation research that can fill the knowledge gaps about understanding the effects of initiatives to create AFCs.

To address some of the challenges, the WHO (2016a) has developed a framework consisting of indicators that (i) can be adapted to the local context and to the typology of intervention; and (ii) can help policy makers to evaluate their progress in improving the ‘age-friendliness’ of their cities. This framework is based on scientific literature and contributions received through expert consultations. Other evaluation frameworks have also been developed to complement the WHO framework (Buckner et al. 2016; Phillipson, White & Faheem Aftab 2013; Handler 2014a; Kihl et al. 2005; Goldman et al. 2016).

In this context, ‘age-friendliness’ refers to the extent to which a city is age-friendly in one or more domains of the physical and social environment (Figure 1). According to a review of literature (Lui et al. 2009), there is a variety of terminologies which are used to define an AFC (*e.g.* elderly-friendly city), which may reflect different approaches on how to make environments more age-friendly. As with AFC, there is no consensus on the concept of age-friendliness. Other terms include elder-friendliness, defined as supporting the wellbeing of older people (Scharlach 2016).

Due to the close link between the concepts of AFC and age-friendliness, the latter is often defined and assessed as a combination of elements (*e.g.* green spaces) and/or domains (*e.g.* outdoor spaces) which would contribute to create an AFC (Novek & Menec 2013; De Donder et al. 2012; Plouffe & Kalache 2011; Phillipson, White & Aftab 2013). In this discourse, the eight domains that contribute to an AFC (Figure 1), are likely to become the domains that improve

the age-friendliness of a city (Zur & Rudman 2013). However, this concept which sees age-friendliness as a ‘checklist of elements’, has been challenged by Liddle *et al.*, (2013 p.6), who argue the need to consider age-friendliness as an on-going process “of improvement rather than maintaining a focus on specific approaches or features”. Moreover, age-friendliness is context-specific, and it applies within particular community’s needs, circumstances and priorities (Alberta Health 2012; Liddle et al. 2013; Keating et al. 2013). Buffel *et al.* (2012 p.601), in particular, recommend that older people themselves should identify the “actual opportunities and constraints in cities for maintaining quality of life as people age” (for a more exhaustive analysis of AFCs and age-friendliness see Biggs & Carr 2016).

With no consensus on a common definition of age-friendliness, questions remain as to how best to assess the impacts of AFC initiatives (Buffel, McGarry, et al. 2013; Liddle et al. 2013), and how its meaning varies in different contexts (Menec et al. 2011). Despite some significant developments on measuring the impact on AFC initiatives on tangible aspects, for example showing that the use of bus passes led to improved satisfaction with the bus system (Broome et al. 2013), less work has been done to measure health and wellbeing outcomes (Buckner et al. 2016; Goldman et al. 2016).

## **1.6 Evaluating complex public health interventions**

One of the reasons for the limited assessment of the impact of AFC initiatives on health outcomes, owes to complexity. In the next paragraph I explore the rationale for considering AFC initiatives as complex interventions – defined as

initiatives/projects/policies with several interacting components (Craig et al. 2008) – embedded within complex systems (Sautkina et al. 2014).

In this context, complexity “arises from a system’s interconnected parts” (De Savigny & Adam 2009 p.40). With regard to AFCs, one challenge is that the system – defined as the city operating within a national/international policy context, and external factors (Figure 1) – is undoubtedly complex. Moreover, the interventions to create an AFC may consist of relatively well-defined actions within that complex system (*e.g.* the creation of accessible pedestrian paths), or the interventions may themselves be a much more complex set of actions driven by policy.

A key concept within the WHO approach to healthy ageing (2007) is that the AFC domains need to be interpreted by recognising the diversity of older people (Handler 2014a; Menec et al. 2011). Moreover, AFC initiatives are characterised by non-linear pathways linking the intervention and its outcomes (Craig et al. 2008). It is likely that the same intervention may have different impacts in different cities and even within the city itself, as (i) its implementation is context-specific and (ii) the context adapts to its environment (de Vlaming et al. 2010; Menec et al. 2011; Naaldenberg 2011; Wong 2013). The combination of these aspects translates thereby in challenges in evaluation (Australian Public Service 2007; Ogilvie et al. 2011; Pawson et al. 2004; Koelen 2001).

As noted previously, all the AFC domains are interconnected, and a change in one is likely to impact on one or more domains. In such context, adopting a systems perspective may help to better understand the interrelationships between domains and the interactions with the wider context. Hence, to understand and

assess AFC initiatives we need to use a holistic and integrated approach (system thinking) – rather than linear thinking, which can take into account the various interactions between the wide-range of components involved in the intervention and its context, and the diversity within the older people group (Wong 2013; WHO 2016a; De Savigny & Adam 2009; Petticrew 2015).

In this research, I sought to adopt a system thinking approach by (i) drawing on the methods/techniques of evaluation of complex interventions, including use of logic models to understand aspects of the system in which AFC initiatives operate, and (ii) by highlighting pathways for enhancing respect and social inclusion that are not well represented in the more linear approach to the intervention research literature.

## **1.7 Aim and objectives of this research**

This research addresses two main knowledge gaps: (i) the need to better involve older people in the planning processes within their cities, and to bring their views to the attention of city stakeholders; and (ii) the lack of evaluation research exploring the health impacts of AFC initiatives. To address the former knowledge gap, I employed a Community-Based Participatory Research (CBPR) approach consisting of a photovoice study with older people and city stakeholder interviews to explore the concepts of respect and social inclusion in the urban setting, and to bring the views of older people to the attention of stakeholders in Liverpool City. To address the limited assessment of the impact of AFC initiatives on health outcomes and to identify where the gaps remain, I

developed a systematic review of the literature exploring the health impact of initiatives promoting respect and social inclusion in older people.

Aim: within the WHO framework of AFCs (2007) to examine how perspectives on strengthening respect and social inclusion in the urban setting differ among older people and city stakeholders, the extent to which their respective priorities are supported by evidence for health benefits, and the implications for public health policy.

The specific objectives of this PhD research are the following:

1. To explore the concept of age-friendliness in terms of respect and social inclusion, including how its meaning may vary in different contexts, and how it may be assessed.
2. To assess if interventions and initiatives that aim to promote respect and social inclusion in older people have been shown to have an impact on health and wellbeing, and how this impact has been measured.
3. To clarify the relationships and pathways by which factors in the domain of respect and social inclusion either promote or impair health and wellbeing in older adults in the context of age-friendly cities.
4. To explore perspectives of older people on aspects that promote and inhibit respect and social inclusion in Liverpool City, and what may be required to strengthen this.
5. To explore the factors which influence the ability of policy makers and service providers to promote respect and social inclusion for older people in Liverpool City.

6. To assess the strengths and limitations of photovoice methods to (i) effectively explore features of an urban setting that promote or inhibit older people's perceptions of respect and social inclusion, and (ii) stimulate constructive dialogue between participants and city stakeholders.
7. To compare the perspectives of city stakeholders and older people on key priorities for promoting respect and social inclusion – and thereby health and wellbeing of older people – in the context of current research evidence.

Figure 2 connects the chapters within this thesis to the objectives.

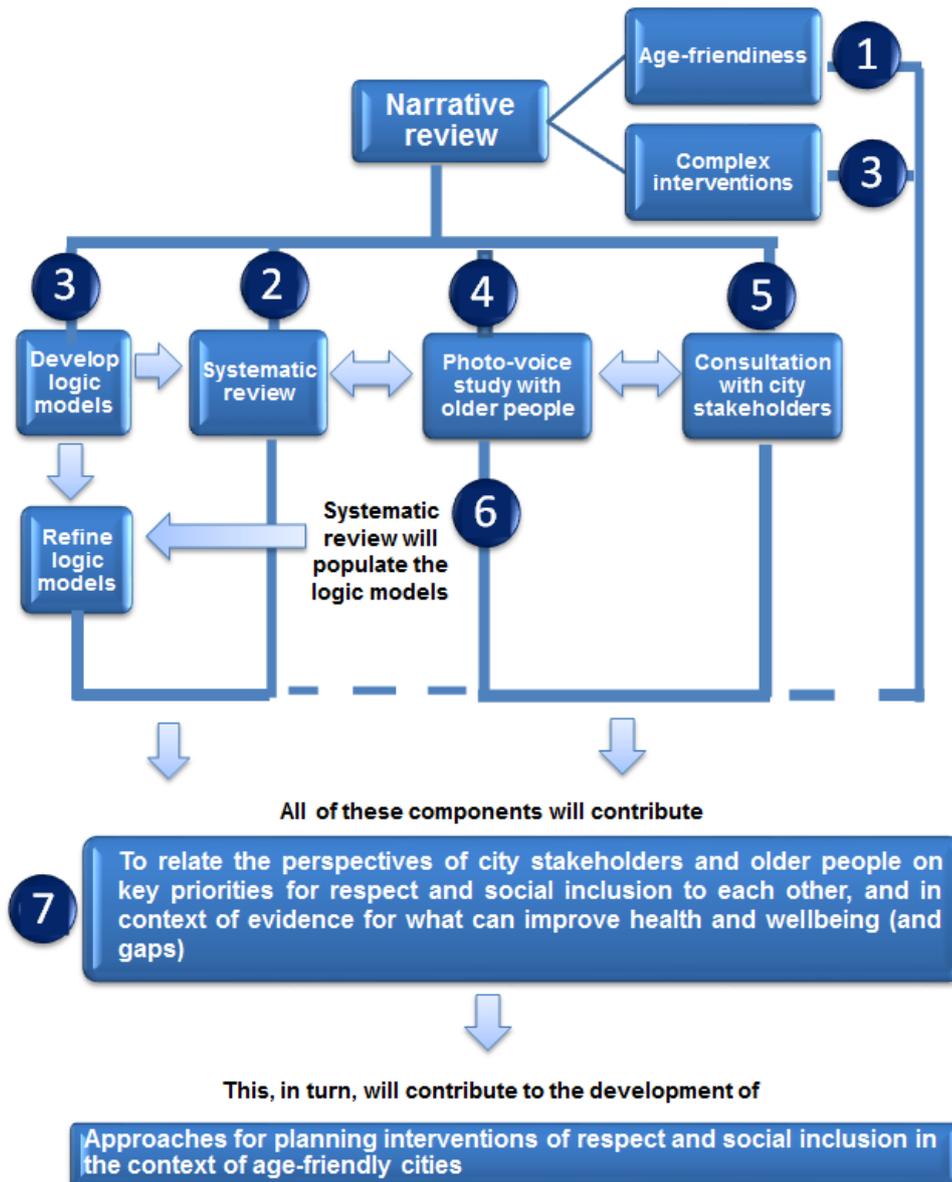


Figure 2 Overview of the methods and structure for this PhD research. The numbers refer to the study objectives.

## **1.8 Organisation of the thesis**

The thesis is divided into seven chapters (Table 1). Chapter 1, the introduction, has set the context and rationale for this research, including the aim and study objectives. Chapter 2, presents a narrative synthesis of interventions on respect and social inclusion in older people and their impact on health and wellbeing, including the possible pathways to health outcomes. Chapter 3, the methodology, describes the philosophical and methodological considerations that underpin the studies with older people and city stakeholders. This chapter illustrates the approaches that I used to enhance methodological quality, my positionality and ethical implications. The section on the methods, describes the research setting, sampling recruitment, procedures, and my approach to data analysis to the studies with older people and city stakeholders.

Chapter 4 contains the research findings related to enablers, barriers and solutions to promote respect and social inclusion in Liverpool City, according to older people. Chapter 5 presents the city stakeholders' findings related to enablers, barriers and solutions to respect and social inclusion in Liverpool City. Chapter 6 provides an assessment of the strengths and limitations of photovoice methods to (i) effectively explore features of an urban setting that promote or inhibit older people's perceptions of respect and social inclusion, and (ii) stimulate constructive dialogue between participants and city stakeholders. Chapter 7, the discussion, synthesises the results of the qualitative studies and the systematic review, and presents a summary of the findings in relation to the PhD study objectives. This is followed by (i) an analysis of the strengths and limitations of the overall thesis, (ii) a discussion of the main opportunities,

challenges and solutions of using photovoice methods, and (iii) a presentation of the findings in relation to the literature on AFCs and public health interventions. The last sections of Chapter 7 highlight the implications for public health policy and practice, and for the research. Also, the main conclusions are drawn.

<b>Objective (s)</b>	<b>Study design(s)</b>	<b>Chapter(s)</b>
Objectives 1, 4 and 5	Photovoice study with older people Study with city stakeholders	Chapter 1: Introduction Chapter 3: Methodology Chapter 5: Results
Objectives 2 and 3	Systematic review	Chapter 2: Systematic review
Objective 4	Photovoice study with older people	Chapter 3: Methodology Chapter 4: Results
Objective 5	Study with city stakeholders	Chapter 3: Methodology Chapter 5: Results
Objective 6	Photovoice study with older people	Chapter 3: Methodology Chapter 6: Results
Objective 7	Photovoice study with older people Study with city stakeholders Systematic review	Chapter 7: Discussion

Table 1 Overview of the objectives and how I addressed these in the chapters that follow.

# **Chapter 2 SYSTEMATIC REVIEW OF INTERVENTIONS FOR RESPECT/SOCIAL INCLUSION AND HEALTH IN OLDER PEOPLE**

## **2.1 Introduction**

The previous chapter served to introduce this doctoral research and the importance to public health of addressing the challenges of an ageing population, with regard to respect and social inclusion. It also highlighted that limited research has assessed the health and wellbeing outcomes of Age-Friendly City (AFC) initiatives, and that more evaluative research is needed.

To address this challenge, Chapter 2 describes a systematic review investigating how interventions and initiatives designed to promote respect and social inclusion of older people impact on health and wellbeing. In reporting the findings of the systematic review, the chapter addresses the objective of identifying whether, and to what extent, interventions and initiatives which promote respect and social inclusion in older people have been shown to have an impact on health and wellbeing, including how this impact has been measured. The chapter adopts the structure of an extended journal article. I will discuss the implications for research and policy of this review in the main conclusions of this thesis (Chapter 7, Sections 7.6 and 7.7).

### **2.1.1 Structured Summary**

#### **Background**

Diminished respect and social inclusion may negatively impact on older people's health in the urban setting. Although many interventions designed to include promotion of respect and social inclusion for older people have been developed, the evidence of their impacts on health is unclear. This systematic review aimed at summarising the current evidence base for the impact of such interventions on the health and wellbeing of older people.

#### **Methods**

Eligible studies were identified by (i) searching six bibliographic databases using a pre-piloted strategy, (ii) screening reference lists of retrieved items, and (iii) searching relevant organisational websites. Searches were conducted over a 25-year period from January 1990 to January 2015. The study inclusion criteria were (i) community-resident people aged 60 years and over, and (ii) measurement of the impact of an intervention to promote respect and social inclusion on physical/mental health. Only articles published in English were included. All study designs were eligible.

Titles, abstracts, and full texts were screened for eligibility by one reviewer, with a second reviewer independently screening 10 percent of randomly selected samples at each stage. One reviewer extracted data onto standardised forms, and assessed the methodological quality and risk of bias for selected studies. A second reviewer independently duplicated data extraction and quality appraisal in a 14.5 percent sample, where the first reviewer was not certain about the relevance for inclusion. Methodological quality and risk of bias were assessed

using the Liverpool Quality Assessment Tools (LQAT) (Pope 2014) for quantitative studies, and an adapted version of a tool developed by Harden *et al.* (2009) and May & Pope (2000) for qualitative studies. Narrative synthesis and harvest plots were used to summarise the study findings; meta-analysis was not possible due to the extensive heterogeneity between studies (interventions, outcomes, designs and methods).

## **Results**

Of 27,354 records retrieved, 40 studies (23 quantitative, 6 qualitative, 11 mixed methods) met the inclusion criteria. A broad range of interventions were identified, including (i) mentoring, (ii) intergenerational initiatives, (iii) dancing, (iv) music and singing, (v) art and culture, (vi) information and communication technology, and (vii) multi-activity programmes. Most studies had moderate risk of bias, particularly regarding the representativeness of the study sample. Positive and negative impacts were reported on a range of health outcomes including psychological outcomes (depressive symptoms, perceived stress, and mental health), physical health and subjective health, quality of life and wellbeing, chronic pain and falls.

Among the broad range of interventions, there is some indication that intergenerational initiatives and those based on music and singing may have a positive impact on psychological outcomes, wellbeing, subjective and physical health of older people. However, the evidence for other types of intervention – mentoring, dancing, information and communication technology, art and culture, and multi-activity initiatives – was more limited and inconclusive.

Standard outcome measures (*e.g.* physical health scales) often failed to capture the effects of interventions (studies reporting no significant effect). Hence, qualitative studies helped to enhance understanding of some of the factors reported by older people to be important in the pathways to improved health outcomes (*e.g.* improved self-esteem and social relationships). Qualitative evidence was found to be useful to help fill in the gaps about potential casual pathways which subsequently would need to be elicited.

### **Conclusion**

Whilst this review suggested that intergenerational, music and singing interventions that aim to respect and social inclusion may positively impact on the health and wellbeing of older people, the evidence was based on studies with heterogeneous methodologies and, for many, high and moderate risks for bias (*e.g.* selective outcome reporting). Future investigations are required to understand how such interventions impact on health (i) using randomised controlled trial designs with larger samples, longer follow-up and overall length of the programmes and/or (ii) taking advantage of natural policy experiments fostering respect and social inclusion. In addition, in-depth qualitative studies would contribute to better understand the context and the possible mediating factors between the intervention(s) and the health outcomes.

## **2.2 Definitions, current state of knowledge, and its limitations**

Although many interventions and strategies promoting respect and social inclusion have been developed in recent years, the evidence of their impacts on health and wellbeing is unclear. The importance of promoting respect and social inclusion in the urban setting as a public health priority has been highlighted on a number of occasions (WHO 2015; Buffel et al. 2012). However, for those wishing to improve population health, it is important to establish what is known about the impacts of interventions in terms of benefits for the health and wellbeing of older people.

In this systematic review, I have focused on two social aspects of ageing in the city: respect and social inclusion. This review is situated within the context of the Age-Friendly City (AFC) field (WHO 2007), wherein the concepts of social inclusion and respect mainly refer to the feelings experienced by individuals as a result of interaction(s) with both their community members and their urban setting. Specifically, respect refers to positive attitudes and behaviours towards older people, and where older people feel accepted, valued, and appreciated by the community regardless of age (WHO 2015). Social inclusion is defined as enhancing the opportunities for older people to cultivate social relationships, have access to resources and feel part of the community (Warburton et al. 2012; Scharlach & Lehning 2012). However, there is a lack of consensus in the literature in terms of an accepted definition of social inclusion (Scharf & Keating 2012; Wright & Stickley 2013). It is usually defined broadly, and a range of similar terms (*e.g.* social isolation) are also used to refer to the same concept

(Curran et al., 2007; Huxley et al., 2006; Coombs et al., 2013; Wright & Stickley, 2013).

The Centre for Reviews and Dissemination (CRD) (2014) has identified and provided a summary of several systematic reviews of interventions addressing social isolation and loneliness in older people (Dickens, A.; Richards, S.; Greaves, C. & Campbell 2011; Cattan 2005; Medical Advisory Secretariat. 2008; Findlay 2003; Hagan et al. 2014; Choi et al. 2012). In Table 2 I provide a brief overview of these previous reviews, including their aims, focus, interventions, and key outcomes with commentary on how the current review builds on this existing evidence.

Although social isolation and loneliness are related to the social aspects of ageing, the current review did not look specifically at interventions designed to address social isolation and loneliness, as they can be seen as the converse of social inclusion. In fact, social isolation refers to the quantity and quality of social support or contact received by others. The same applies for loneliness, which is defined as “a subjective concept resulting from a perceived absence or loss of companionship” (Dickens, A.; Richards, S.; Greaves, C. & Campbell 2011 p. 2).

Moreover, previous reviews have examined specific types of interventions, including music, dancing, reminiscence, and gender-based interventions (Choi et al. 2012; Heaven et al. 2013; Pinquart & Forstmeier 2012; Westerhof et al. 2010; Milligan et al. 2015; Keogh et al. 2009; Lötze et al. 2015; Clift et al. 2008). Reviews on social inclusion within the mental health field, have focused on scales used to assess social inclusion in specific populations, for instance,

people with mental health disorders (Huxley et al. 2006; Coombs et al. 2013; Baumgartner & Burns 2014; Curran et al. 2007), or on definitions of social inclusion and exclusion (Wright & Stickley 2013). Only six studies included in these reviews were directly concerned with the definition of respect and social inclusion adopted in the current review (Table 2).

<b>Authors</b>	<b>Focus of the review and key features</b>	<b>Comments/considerations</b>
Dickens, A.; Richards, S.; Greaves, C. & Campbell (2011)	<p>Aim: to assess the effectiveness of interventions designed to alleviate social isolation and loneliness in older people.</p> <p>One-to-one and group interventions. RCTs and quasi-experimental studies with a control group. Community and health care settings. Studies published before May 2009.</p>	<p>Outcomes: loneliness, social isolation, and social support. Secondary outcomes: health benefits.</p> <p>Fujiwara <i>et al.</i> (2009) was included in the current review.</p>
Cattan (2005)	<p>Interventions aimed to prevent or alleviate social isolation and loneliness.</p> <p>Group, one-to-one, service provision, and community development interventions. Experimental, quasi-experimental and before-and-after study designs. Community setting. Studies published between 1970 and 2002.</p>	<p>Outcomes: loneliness.</p>
Medical Advisory Secretariat (2008)	<p>Aim: to assess interventions aimed at preventing or reducing social isolation and loneliness in community-dwelling older people.</p> <p>Studies that included a control or a comparative group. Single-focused interventions directed to or evaluating social isolation or loneliness (<i>e.g.</i> telephone-based interventions). Community setting. Studies published between 1980 and 2008.</p>	<p>Outcomes: loneliness and social isolation.</p>
Findlay (2003)	<p>Interventions to reduce social isolation in older people.</p> <p>One-to-one and group interventions (<i>e.g.</i> telephone support services and support groups).</p> <p>RCTs, non RCTs, quasi experimental, cross-sectional surveys, before and after intervention studies, observations and interviews. Community and health care settings. Studies published between 1982 and 2002.</p>	<p>Outcomes: social support, social isolation, loneliness, mortality, and social interactions.</p>

<p>Hagan <i>et al.</i> (2014)</p>	<p>Social therapeutic interventions aimed at reducing loneliness in older people.</p> <p>Interventions using new technologies (mindfulness programme and Nintendo — Wii activities) and group interventions.</p> <p>Experimental, quasi-experimental and before-and-after study designs. Community and health care settings. Studies published between 2000 and 2012.</p>	<p>This review focused on a specific type of intervention (social therapeutic programmes) and the benefits on older people.</p> <p>Outcome: loneliness.</p> <p>Greaves <i>et al.</i> 2006 was included in the current review.</p>
<p>Choi <i>et al.</i> (2012)</p>	<p>Computer and Internet training interventions to reduce loneliness and depression.</p> <p>Group interventions (<i>e.g.</i> educational programme for Internet use). Experimental design or studies with a control group. Community and health care settings. Studies published between 2001 and 2012.</p>	<p>This review focused on a specific type of intervention (computer and Internet training programmes) and the benefits on older people.</p> <p>Outcomes: loneliness and depression.</p> <p>Woodward 2011 and Slegers 2008 were included in the current review.</p>
<p>Heaven <i>et al.</i> (2013)</p>	<p>Interventions aimed to create meaningful and socially engaging activities for people during their transition to retirement (social roles interventions).</p> <p>Aims: to identify what kinds of interventions have been developed to promote social roles in the retirement transition; if these interventions increased satisfaction with, or quantity of, the participants' roles; and to assess if these interventions improved the participants' health and wellbeing.</p> <p>All study designs were eligible. Group interventions (<i>e.g.</i> volunteering). Community setting. Studies published between 2010 and 2011.</p>	<p>Outcomes: related to the participants' perception of their social roles and health or wellbeing.</p> <p>Fujiwara <i>et al.</i> 2009 (Japan) was included in the current review.</p>
<p>Pinquart &amp; Forstmeier (2012)</p>	<p>Aim: to assess the effects of (simple) reminiscence, life-review, or life-review therapy.</p> <p>Controlled trials. Community and health care settings. Studies published until 2012.</p>	<p>This review focused on a specific type of intervention (reminiscence programmes) and the benefits on older people.</p> <p>Outcomes: depression, anxiety, positive psychological wellbeing, ego-integrity, purpose in life, mastery, cognitive performance, social integration, and preparation for death.</p>

Westerhof <i>et al.</i> (2010)	Aim: to report recent progress in theory, research and practical applications of reminiscence.	This review focused on a specific type of intervention (reminiscence interventions, including simple reminiscence; life review; and life-review therapy) in older people.
(Milligan <i>et al.</i> 2015))	Aim: to assess evidence for the effects of <i>Men's Sheds</i> and other gendered social activities on the health and wellbeing of older men, and to consider their effective components and theoretical frameworks.  Group interventions ( <i>e.g.</i> people working together). All study designs were eligible. Community setting. Studies published between 1990 and 2013.	The review focused on a specific type of intervention ( <i>Men's Sheds</i> ) promoting social inclusion in older men. In <i>Men's Sheds</i> interventions, the aim is to meet, socialise, learn new skills and voluntarily take part in practical activities with other men.  Outcomes: physical and mental health, and wellbeing.
Keogh <i>et al.</i> (2009)	Aim: to assess the physical benefits of dancing for healthy older people.  Studies had to compare a group of older dancers with an age-matched group of no dancers or involve an exercise intervention that was primarily dance based and lasted at least 8 weeks. Group interventions ( <i>e.g.</i> dance classes). Community setting. Studies published until 2009.	This review focused on a specific type of intervention (dance exercise programmes) and the physical benefits on older people.  Outcomes: muscle endurance and strength, falls, balance, agility, aerobic power, flexibility, gait speed, and risk of cardiovascular disease.
Lötzke <i>et al.</i> (2015)	Aim: to summarise the current research results on the effectiveness of Argentinian tango for individuals with Parkinson's disease on physical functioning and health-related quality of life.  Group interventions ( <i>e.g.</i> dance classes). All study designs were eligible. Community setting. Studies published until 2015.	This review focused on a specific on a specific type of intervention (Argentinian tango) and the health benefits on older people with Parkinson's disease.  Outcomes: motor symptoms, balance, gait, falls, cognitive measures, health-related quality of life, depression and fatigue, activity participation, and treatment satisfaction.  Hackney <i>et al.</i> 2007 was included in the current review.
Clift (2008)	Aim: to identify research on singing, wellbeing and health; to map this research in terms of the forms of singing	This review focused on a specific type of intervention

	<p>investigated, designs and methods employed and participants involved; to synthesise findings to draw general conclusions about the possible benefits of singing for health.</p> <p>Group interventions (<i>e.g.</i> amateur singers or professional singers). All study designs were eligible. Community and health care settings. Studies published until 2008.</p>	<p>(singing) and the physical health benefits.</p> <p>Only two studies looked at older people.</p> <p>Outcomes: subjective health, physical and mental health, and wellbeing.</p> <p>Cohen <i>et al.</i> 2006 was included in the current review.</p>
Huxley <i>et al.</i> (2006)	<p>This review looked at scales used to assess social inclusion in specific populations (<i>e.g.</i> people with mental health disorders).</p> <p>Studies published between 1948 and 2007.</p>	<p>This review has examined the question of which other concepts or constructs overlap with social inclusion, and from which concepts it helpfully can be distinguished (<i>e.g.</i> social capital).</p>
Coombs <i>et al.</i> (2013)	<p>This review looked at scales used to assess social inclusion currently used in public sector mental health services.</p> <p>Studies published between 2010 and 2012.</p>	
Curran <i>et al.</i> (2007)	<p>This review looked at the relationships between mental health problems and social exclusion.</p> <p>Studies published between 1948 and 2003.</p>	<p>Outcomes: mental health and/or social exclusion.</p>
Wright & Stickley (2013)	<p>This review explored the literature relating social inclusion/exclusion and mental health, particularly the definition of social inclusion and exclusion.</p> <p>Studies published between 2000 and 2010.</p>	

Table 2 Previous reviews developed in the field of ageing, and interventions related to social isolation and inclusion.

### 2.3 Review question and objectives

In light of the current limitations of this evidence base, this systematic review has focused on interventions fostering respect and social inclusion in older people that covered all typologies of interventions, in all countries, and assessed their impacts on health and wellbeing. The aim of this review was to identify and understand the effects of interventions promoting respect and social inclusion on the health and wellbeing of older people. The stated research question for the

review was: **“What is the empirical evidence of the impact on health and wellbeing of interventions which foster respect and social inclusion in older adults?”**

## **2.4 Methods**

### **2.4.1 Approach of this review and protocol**

The approach that I took in this systematic review was informed by Medical Research Council (MRC) guidance on the development and evaluation of complex interventions (Craig et al. 2008) and by literature addressing issues related to evidence synthesis of complex interventions (Anderson et al. 2011; Petticrew et al. 2012; Ogilvie et al. 2008; Petticrew 2011; Datta & Petticrew 2013; Wong 2013; Petticrew, Rehfuss, et al. 2013). I also sought to follow the Centre for Reviews and Dissemination’s Guidance (CRD) for undertaking reviews in healthcare (Tacconelli 2009), and recommended best practice (Moher et al. 2015). The protocol was registered with the International Prospective Register of Systematic Reviews (registration number: CRD42014010107) (Ronzi et al. 2014).

The review approach included the creation of diagrams representing logic models developed prior to the review, which evolved and were adapted throughout the review process. The initial construction of the logic model helped me to visualise the complexity of the interventions on respect and social inclusion, and to conceptualise my assumptions on how such interventions could impact on the health and wellbeing of older people (Anderson et al. 2011; Anderson et al. 2013; Squires et al. 2013). As suggested by Petticrew *et al.* (2013), when dealing with different types of interventions (in this case, diversity

of approaches used to address respect and social inclusion), it is important to look at specific/simple aspects of complexity. The logic models helped me to understand that, in this review, the key sources of complexity related to the multiple types of interventions and outcomes assessed. They also helped to visualise the multiple, interacting pathways by which the interventions could induce their effects. By contrast, the population (older people) and setting (community) remained fixed.

In the current review, I tried to be relatively open in my approach to defining health outcomes – including a wide variety of outcomes of interest to a diverse range of different stakeholders (Petticrew 2015). In addition to the outcomes, I was moderately open in my approach to defining the interventions – to include the wide range of interventions on respect and social inclusion, thereby minimising any risk of missing potentially relevant interventions.

In Figure 3 I present the initial logic model of an intervention promoting respect and social inclusion. The model shows the possible mediating factors that I highlighted in the pathways to improved health and wellbeing, based on assumptions derived from reviewing the literature on ageing and social inclusion. I chose intergenerational initiatives as an example of such interventions because they have been included as a key strategy to tackle age-stereotypes, and in turn, to improve the respect and social inclusion in older people (Officer et al. 2016; Government Office for Science 2016; WHO 2016b). With these interventions, older people are usually encouraged to interact with children in various ways (*e.g.* assisting with maths problems) and settings (*e.g.* in schools). At the end of the review, I was able to assess if the hypothesised

links in the pathways from the intervention to the outcomes were supported by evidence.

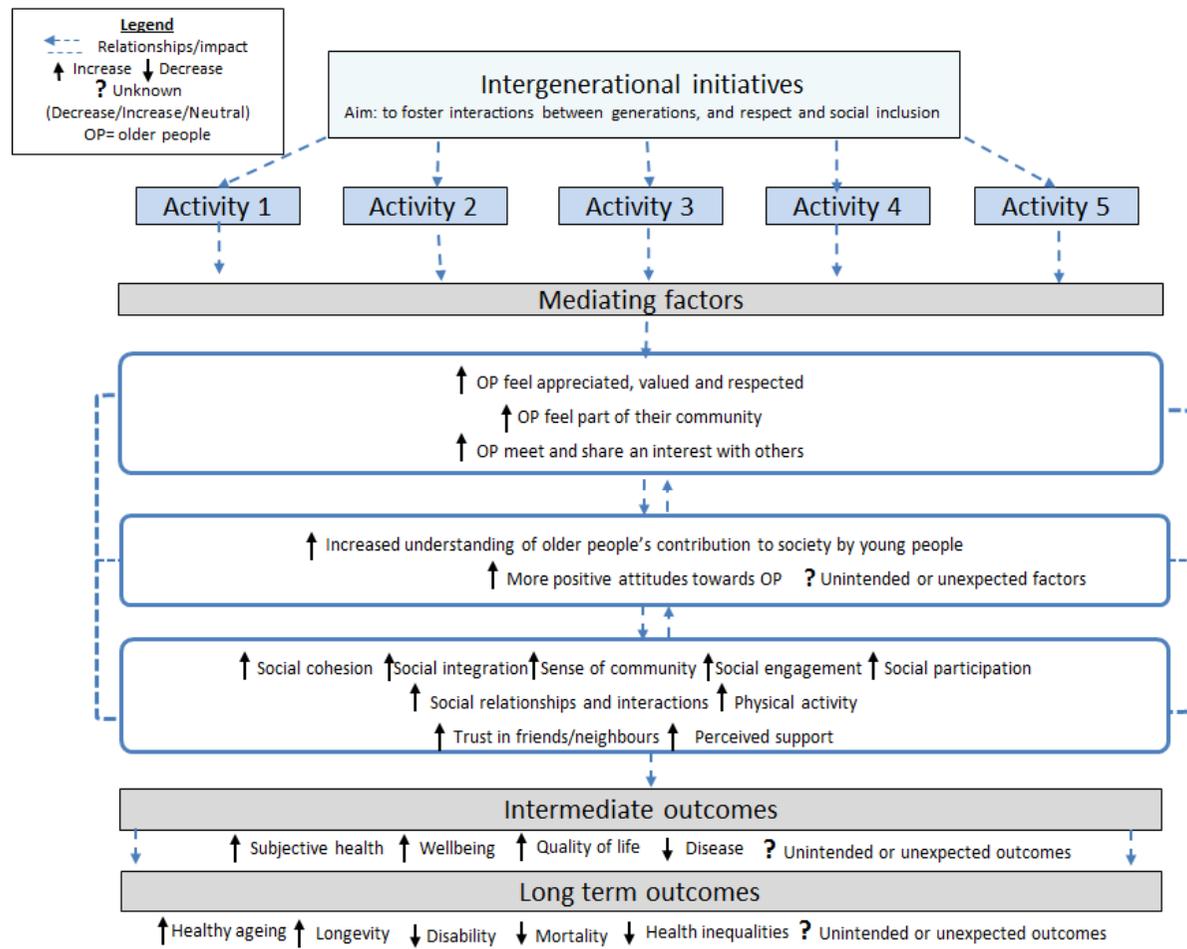


Figure 3 Example of a logic model for intergenerational initiatives created at the start of the review.

#### 2.4.2 Inclusion criteria

**Types of study:** eligible studies were those reporting quantitative empirical data (randomised and non-randomised control studies, before and after studies), mixed methods and qualitative studies. Systematic reviews were retrieved and titles of individual studies were checked to see if they met the inclusion criteria. Case studies were defined as “the study of a social phenomenon in one, or only a few, of its manifestations; in its natural surroundings; during a certain period; that focuses on detailed descriptions, interpretations and explanations that several categories of participants in the system attach to the social process; that exploits several sources of data (informants, documents, observations, etc.)” (Swanborn 2010 p.13). Case studies were included if sufficient description was provided for sampling techniques used, data collection methods, and results/analysis of the health impact of a defined project.

**Participants/population:** studies were included if they involved any older adults aged 60+ years, with at least 50% of the participants being this age (these studies were only included if the data on older people (60+ years) could be disaggregated (*e.g.* intergenerational programme with young and old people); and where the mean, modal or median age was 60 and above).

**Interventions:** any intervention or project aiming to improve respect and social inclusion in older people was eligible (*e.g.* community centre opened in the community; dancing, arts, singing groups and related activities; learning activities, intergenerational and mentoring programmes). The concept of respect and social inclusion could have been implied – given the confusion over definitions, described previously. However, to be included in the review, the

purpose of the intervention had to be to improve social participation, sense of belonging, access to resources, learning, cultural, social opportunities, and social relationships. As I was interested in interventions focusing on making people valued and part of the community, and based on the definitions given in Section 2.2, only group-based interventions were included (*e.g.* individual based interventions such as telephone befriending were excluded).

**Comparator/Control:** where comparison groups were included, these were (i) groups of people not exposed to the interventions on respect and social inclusion being investigated, (ii) groups of people exposed to other forms of interventions included as 'usual practice' and (iii) groups of people exposed to interventions comparing one or more new variants.

**Setting:** studies conducted in community settings were eligible. Studies which included groups recruited both from a community setting and from a health and social care, and institutionalised setting (*e.g.* nursing homes) were included, as long as the data on people recruited from/living in the community was disaggregated.

**Health outcomes:** relevant health outcomes included any measure of physical and mental health of participants. Health-related quality of life and measures of wellbeing were considered only if they included outcomes specifically related to health, and/or if those outcomes were measured using published and standardised tools (*e.g.* the Warwick-Edinburgh Mental Wellbeing Scale). Standardised outcome measures were defined as those supported by an academic reference and evidence of their psychometric properties. Non-standardised outcome measures for health outcomes were defined as those developed by the

authors for the purposes of the study. For this review, outcomes related to cognitive function were not included as health outcomes. Outcomes related to autonomy and physical activity (*e.g.* posture, balance, muscle strength, stability, and walking speed) were not included as health outcomes, as these were likely to be primarily the result of physical activity and exercise *per se* (*e.g.* dancing) rather than of the intervention on respect and social inclusion.

### **2.4.3 Rationale and steps to identify the search terms**

Given the complexity of the review topic, I developed the search strategy using an inclusive approach and I refined it after piloting to be able to capture the highest quality evidence available (Table 5). As noted in Section 2.4.1, I developed some logic models that helped to clarify the aim of the review and to refine the search strategy. Below I present an explanation and rationale on how I developed and refined the search terms according to the study inclusion criteria.

**Social inclusion:** as highlighted previously, the variety of definitions of social inclusion adopted within the literature, led to developing a comprehensive list of terms to identify all the relevant papers published on this field. Some terms adopted in the review (Table 3) were used in previous systematic reviews on social inclusion measures (Curran et al. 2007; Huxley et al. 2006; Coombs et al. 2013; Wright & Stickley 2013). Others were identified by reviewing the literature on social inclusion and on AFCs (*e.g.* “social participation”, “social engagement”, “civic engagement” and “community engagement”, “social divide”, “information and communication technology”).

Previous reviews First author and year	Search terms used in this systematic review
Huxley (2006)	"social inclusion", "social exclusion", "social capital", "social cohesion", "social engagement", "social interaction*", "social integration", "social responsabilit*"
Curran (2007)	"social inclusion", "social exclusion", "social capital", "social cohesion", "social engagement", "social interaction*", "social integration", "social responsabilit", "social involvement", "social networks", "age* stereotyp*", "community participation", "access services"; "health", "disorder*", "illness", "psychological"
Wright (2013)	"social inclusion", "social exclusion"; "health", "illness"
Coombs (2013)	"social inclusion", "community participation", "social capital"; "mental health"

Table 3 Search terms that were selected from previous systematic reviews on respect and social inclusion.

**Health outcomes:** I used a combination of (i) general terms related to health (*e.g.* health, disease), (ii) specific health conditions identified as significant for older people in terms of the UK burden of disease (Murray et al. 2013) (*e.g.* stroke) and (iii) additional health conditions experienced in old age (Figure 4). This combination was felt to represent the most inclusive approach to identify relevant papers on health of older people.

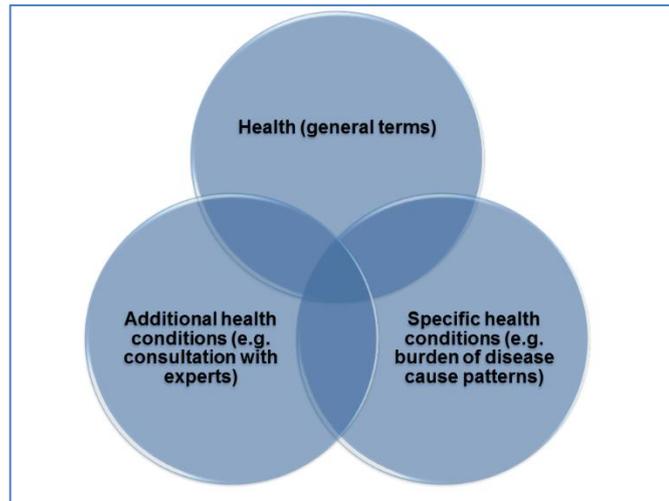


Figure 4 Diagram representing the main sources of terms used to develop the search strategy for health outcomes.

The term ‘health’ was used to represent studies with both mental and physical health outcomes. Health was used with truncation (\*) to include other health-related terms including healthy (ageing). Synonyms of health and disease and general health outcomes were included: “illness\*”, “disorder\*”. The terms “psychological” and “psychosocial” were included as those are usually in the keywords and abstracts of papers which report health outcomes. Based on the work conducted by Murray *et al.* (2013) on the UK burden of disease (the Global Burden of Disease Study 2010) and the Institute for Health Metrics and Evaluation (2013), specific health conditions were added to the more general terms. Considering the UK top causes of Disability-Adjusted Life-Years (DALYs) and Years of Life Lost (YLLs) in older people aged 60-64 years to 80+ years for both sexes, the following health conditions and synonyms/abbreviations were included in the search strategy: "ischaemic heart disease", "lung cancer", "stroke", "COPD", “low back and neck pain”, "falls", "colorectal cancer", "breast cancer", “falls” and "Alzheimer's disease". Amongst

these conditions, I included only those terms that were considered as potentially clarifying the underlying mechanisms between interventions on respect and social inclusion, and an impact on health (*e.g.* dementia, ischaemic heart disease, stroke, falls, and Alzheimer's disease). I included further terms such as “depressi\*” (depression or depressive symptoms), “dementia”, and “mobility”, as they are often reported in studies of social aspects in older people (Milligan et al. 2013; Dickens, A.; Richards, S.; Greaves, C. & Campbell 2011) – these were also identified as important through discussion with academic colleagues who were consulted on the comprehensiveness of the search terms proposed in this systematic review.

**Population/participants:** I included various terms to retrieve all relevant papers which comprised older people. Some of the terms adopted in the current systematic review ("old\*", "elder", "aged", "senior\*", "pensioner\*" “aging” and "ageing") were used by other previous systematic reviews within the field of ageing (Milligan et al. 2013; Gillespie et al. 2010). For the full electronic strategy used to search MEDLINE, see Appendix L.

#### 2.4.4 Summary of search terms

##### Search strategies 1, 2 and 3 combined with AND

<b>Intervention</b>	("social inclusion" or "community inclusion" or "e-inclusion" or "digital inclusion" or "social cohesion" or "community cohesion" or "neighbo* cohesion" or "social involvement" or "community involvement" or "social integration" or "community integration" or "social engagement" or "civic engagement" or "community engagement" or "intergeneration*" or "social recognition" or ("information and communication technolog*") or "social exclusion" or "neighbo* inclusion" or "neighbo* exclusion" or "community participation" or "social participation" or "age* stereotyp*" or "age* discrimination" or "digital divide" or "social interaction*" or “social
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	responsabilit*" or "social capital" or "social networks" or "access services" or "access information" or "access opportunit*" or "access facilities" or "access volunteer*" or "access learning" or "social exchange" or "ageism" or "agism" or "solidarity")
<b>Participants</b>	("old*" or "elder" or "aged" or "senior*" or "pensioner*" or "aging" or "ageing")
<b>Physical and mental health outcomes</b>	("health*" or "disorder*" or "disease*" or "illness*" or "mortality" or "morbidity" or "disability" or "depressi*" or "dementia" or "mobility" or "ischaemic heart*" or "stroke" or "cerebrovascular accident*" or "falls" or "Alzheimer's*" or "Parkinson's" or "psychological distress" or "psychological disorder*" or "psychological symptoms")

Table 4 Search terms used in the search strategy for the current systematic review.

### 2.4.5 Information sources and search strategy

I identified eligible studies by searching six bibliographic databases using a pre-piloted strategy, screening reference lists of retrieved items and searching organisational websites. Searches comprised a combination of subject terms selected from the controlled vocabulary or thesaurus for the relevant databases (MEDLINE, CINAHL, and PSYCINFO) with a wide range of free-text terms. Searches were restricted to the dates January 1990 to January 2015, where possible, English language, and search categories included title-abstract-key words. Letters and editorials were excluded. The search strategy included the following components:

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#### **Six electronic databases:**

Scopus, MEDLINE, PsycINFO, CINAHL, and Web of Science Core Collection: Citation Indexes (Social Science Citation Index, Science Citation Index, Book Citation Index–Science, Book Citation Index - Social Sciences & Humanities); The Cochrane Library: Cochrane Reviews (Reviews and Protocols) and Other Reviews and Trials.

**Sources of grey literature** to uncover unpublished papers including thesis, working and policy papers, and government reports.

Web of Science Core Collection: Citation Indexes (Conference Proceedings Citation Index-Science, Conference Proceedings Citation Index - Social Science & Humanities); ProQuest Dissertations & Thesis

**Specialist websites and key electronic journals on ageing** as part of a targeted approach:

The Joseph Rowntree Foundation (<http://www.jrf.org.uk/>); Age of Creativity (<http://www.ageofcreativity.co.uk/>); Age UK (<http://www.ageuk.org.uk/>); Alzheimer's association (<http://www.alzheimers.org.uk/>); Intergen (<http://www.intergen.org.uk/>); Beth Johnson Foundation (<http://www.bjf.org.uk/>); Manchester Institute for Collaborative Research on Ageing (<http://www.micra.manchester.ac.uk/>).

**Consultation with experts in the field** to gather any potential references that may be missing from the literature search.

**Retrieval of references of potential relevant papers.**

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Table 5 Search strategy adopted in the current systematic review.

#### **2.4.6 Study selection and data extraction process**

- **Titles and abstract screening of papers**

I imported references identified from the database searches, grey literature, and consultation with experts into EPPI-REVIEWER 4 software (Eppi Centre 2015) and removed duplicates. I screened titles and abstracts for eligibility using a pre-designed and piloted tool based on the inclusion criteria (Section 2.4.2). A second reviewer independently screened a 10 percent random sample of titles and abstracts. The software EPPI-REVIEWER 4 produced a reconciliation report showing that there were 51 disagreements out of 2736 papers independently coded by the reviewers (less than 2% disagreement). These discrepancies were resolved through discussion, and 10 additional studies were included in the full text screening phase.

- **Full text screening**

I screened 259 papers for eligibility. The supervisory team (NB, DP, LO) screened 35 papers out of the 259 papers (14.5%), for which I was not certain about the relevance for inclusion. Any discrepancies were resolved through discussion, and decisions for exclusion were documented in a table. For seven papers the full text was not available. For these, I contacted the authors to ask for the full text; two papers were retrieved from these contacts. For the remaining five papers, I searched for information from related publications from the same authors to inform my decision for inclusion. The flow of study selection at each stage of the search strategy is presented as a PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) flow diagram in Section 2.5.1.

- **Data extraction**

I conducted data extraction for included studies using pre-piloted forms, checked by the supervisory team (NB, DP, LO) during synthesis. Key findings and characteristics of studies were reported in summary tables (Table 7 and Table 8). I used separate data extraction forms to extract the quantitative and qualitative evidence from included studies. When I was not sure of the relevance of a paper during data extraction, these were resolved by discussion with the supervisory team (NB, DP, LO).

The data extraction forms for quantitative and mixed-methods (quantitative) studies included: bibliographic information (study authors, year and country of publication); study design (study aims, design, sample size, sampling technique, length of follow-up, drop-out rates, setting); study participants (inclusion criteria, number, age, sex, with or without pre-existing health conditions); details

of control group(s); study aim and key features of the intervention; outcomes and outcome measures; study results relevant for the review; main conclusions of the review; and key methodological issues.

The data extraction form for qualitative and mixed-methods (qualitative) studies included: bibliographic information (study authors, year and country of publication); study design (study aims, design, sample size, sampling technique, length of follow-up, drop-out rates, setting); study participants (inclusion criteria, number, age, sex, with or without pre-existing health conditions); study aim and key features of the intervention; outcomes and outcome measures; study results relevant for the review; mediating factors; main conclusions of the review; and key methodological details.

Where the results of a specific study had been published more than once, I extracted information from the duplicate publication on to separate data extraction form, because sometimes information about the study characteristics differed between papers. For these studies, in the synthesis phase, I gave priority to information gathered from the higher quality paper, that incorporated more recent information about findings, methods and analysis as sometimes information about the study characteristics differed between papers. However, I used the ‘duplicate’ study to update the information taken from the main paper if additional information was reported.

- **Assessment of methodological quality and risk of bias (RoB)**

I used tools that assessed both the methodological quality – which refers to the extent to which “study authors conducted their research to the highest possible standards” (Higgins et al. 2011 no page) – and the risk of bias – defined as “a

systematic error, or deviation from the truth, in results or inferences” (Higgins et al. 2011 no page). In this thesis, I incorporated the overall assessment of quality in the term RoB, particularly when referring to the Harvest Plots, which will be presented in the following section. Hence, this thesis uses RoB as preferred terminology (Viswanathan et al. 2012)

For case studies, I assessed the methodological quality and RoB using an adapted version of the tool developed by Atkins and Sampson (2002) (Puzzolo et al. 2013; Rehfuss et al. 2014) (Appendix O).

I conducted assessment of methodological quality and RoB for all other quantitative studies using the Liverpool Quality Assessment Tools (LQATs) (Pope 2014) (Appendix M). Quantitative elements of mixed method studies were also assessed using these tools. The LQATs forms assess RoB across all quantitative study designs. They also include space for the researcher to annotate comments. The forms represent various aspects of methodological quality including (i) selection procedures, (ii) baseline assessment, (iii) outcome assessment, (iv) analysis/confounding and (v) contribution of evidence towards the review question) that are rated as ‘Strong, Moderate or Weak’.

With the LQATs it is possible to allocate an overall assessment of quality based on the individual components, and it is this assessment that was used to estimate the overall RoB for each study. In addition to the global assessment of RoB, I commented on the major source of bias for quantitative studies in a narrative summary.

I assessed the methodological quality and RoB of qualitative studies using an adapted version of Harden *et al.* (2009) (in Puzzolo *et al.*, 2013; Rehfuess *et al.*, 2014) and Mays & Pope (2000) (Appendix N). Qualitative elements of mixed methods studies were also assessed using this tool. The form is divided into sections (context of the study, methodology, use of strategies to increase reliability and validity, and extent to which findings reflected participant perspectives and experiences). A global assessment of RoB was made on the basis of whether aspects of the study were clear, adequate or explicit using the scale. The form includes a space for the researcher to annotate comments.

The assessments for methodological quality and RoB for the quantitative and qualitative evidence were checked by the supervisory team (NB, DP, LO) during synthesis, and discrepancies were resolved by discussion. When presenting the data in the summary tables (Table 7 and Table 8) I ranked studies based on a 'summary score' (from lower to higher RoB) in each intervention category. In the reporting of the results, RoB was explained as a narrative summary (Katikireddi *et al.* 2015) and included as a component of quantitative synthesis through harvest plots. Because of the substantial heterogeneity between interventions, outcomes and designs precluded meta-analysis, I was not able to perform a sensitivity analysis based on study quality and RoB.

- **Data synthesis**

Given the broad topic and complexity of interventions fostering respect and social inclusion included in the current review, I anticipated heterogeneity between studies in terms of study design, methods and outcomes (Ronzi *et al.* 2014). I addressed the issue of heterogeneity between studies by looking at

similarities in study designs, populations, methods, and measures to assess outcomes, interventions, and definitions. I conducted a narrative synthesis following the framework recommended by the narrative synthesis frameworks of the Centre for Reviews and Dissemination (Tacconelli 2009) and of Popay *et al.* (2006). For an adapted version of the framework see Figure 5. This section offers an overview of the synthesis approach that I used in this review.

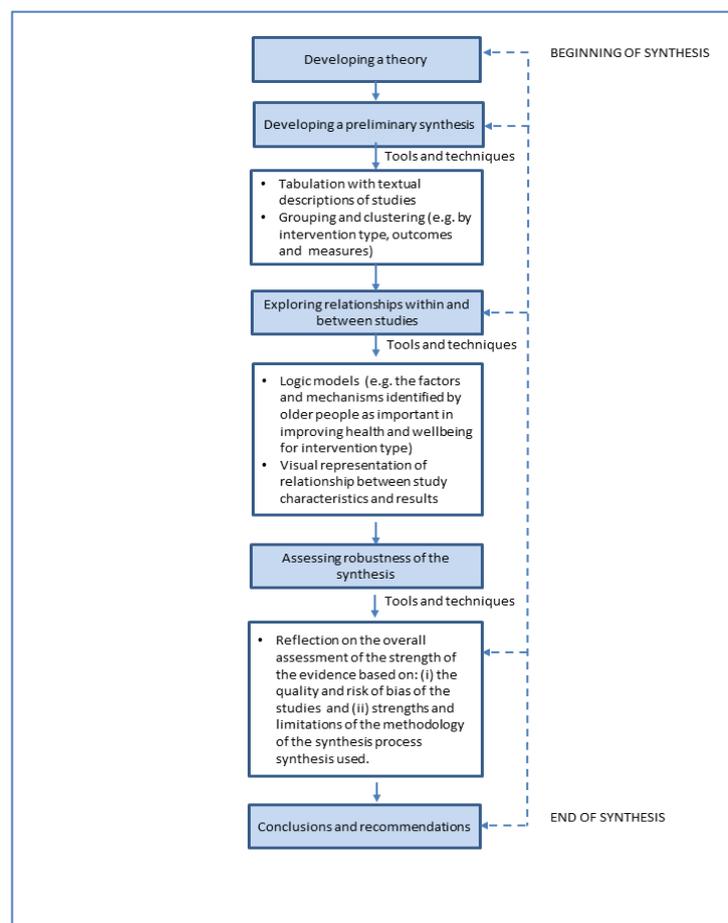


Figure 5 Narrative synthesis framework for the current systematic review adapted by Tacconelli (2010) and Popay *et al.* 2006.

**Preliminary synthesis:** As first step, I summarised together studies considered sufficiently comparable using a tabular synthesis, with summary tables organised by intervention category, which helped to organise the findings from

different studies (Table 7 and Table 8). Table 6 shows the characteristic of the summary tables of included quantitative studies. Studies were then stratified by outcomes (*e.g.* depressive symptoms) and measures and scales used (*e.g.* Geriatric Depression Scale) (Appendix A).

<b>Quantitative evidence</b>	First author, year published, study type, participants and recruitment, comparison group(s), study aim relevant for this review and key features, outcome measures, scales interventions, quality and risk of bias.
<b>Qualitative evidence</b>	Same characteristics as quantitative studies + mediating factors or mechanisms identified by older people as important in improving health and wellbeing.

Table 6 Characteristic of the summary tables used in the current review.

**Exploring relationships between and within studies:** I used the harvest plots to summarise quantitative and qualitative findings visually. Harvest plots provide an effective way of synthesising evidence from different data sources to assess (i) amount of evidence, (ii) direction of evidence, (iii) quality of evidence and (iv) outcomes measured for different constructs (Ogilvie et al. 2008). All data, not just statistical outputs, can be included in this way as they can be judged in terms of whether they tend to support a particular hypothesis or not.

Harvest plots were constructed to summarise evidence from studies included in the systematic review by subgroups of the outcomes (*e.g.* psychological outcomes) including RoB information for each category of intervention. As shown in Figure 6, the harvest plots had five rows (one for each category of outcome) and three columns (representing the intervention effect (positive, no effect, negative)). For quantitative studies, the ability of the study design to provide more definitive evidence is indicated by the height of the bar, according

to study design. RoB is represented by the symbols ++ low/low-moderate risk of bias; + moderate risk of bias; - moderate-high/high risk of bias.

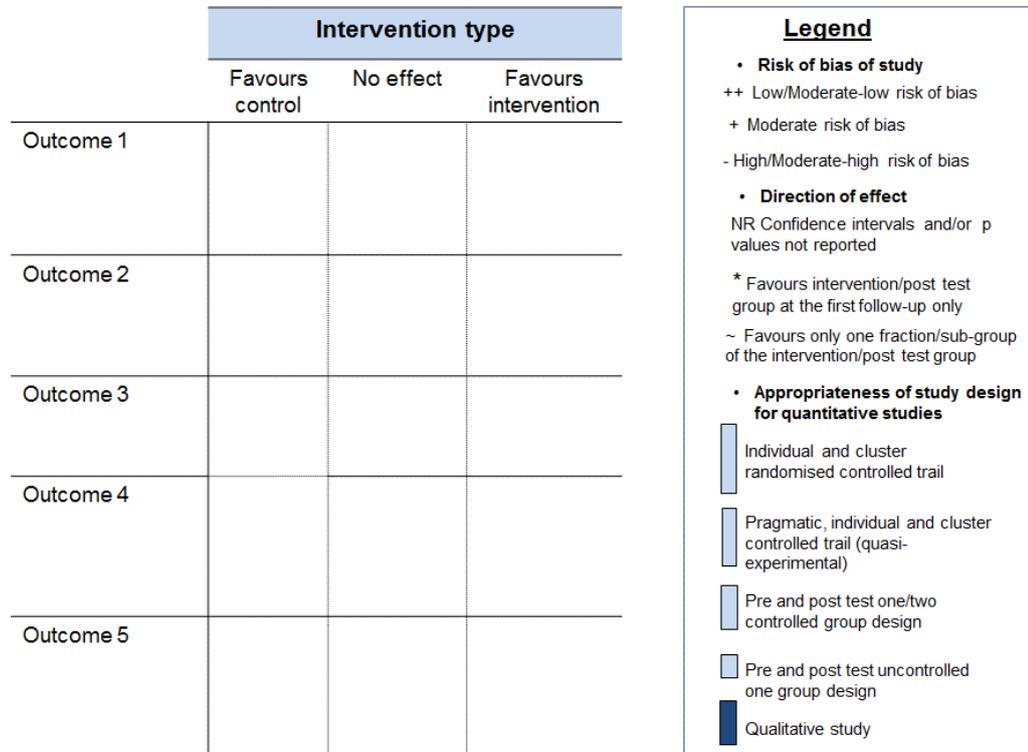


Figure 6 Structure of harvest plots adopted in the current review.

**Developing a theory:** As highlighted by Petticrew (2015 p.2), looking at complex interventions “purely in terms of whether they ‘work’ or ‘do not work’ can be simplistic and misleading”. In the current review, the effectiveness of the interventions (“what works?”) was informed by the quantitative evidence. This showed if interventions on respect and social inclusion had a quantifiable health impact, and how this impact had been measured. The qualitative data was linked to and complemented the quantitative evidence, providing information on how interventions on respect and social inclusion might work, and what were the

mediating factors reported by older people involved in the process to improve their health and wellbeing (*e.g.* feeling valued, and improved social interactions).

One way to deal with heterogeneity of complex interventions (Pigott & Shepperd 2013) includes development of logic models mapping mediating factors linked to health impacts reported in the qualitative and quantitative studies. In the current review, I incorporated the information about the mediating factors into logic models stratified by intervention category (for an example, see Figure 7). The logic model included the list of outcomes identified primarily by the quantitative studies, and highlighted in red/green/blue those outcomes relevant for the specific intervention. The red colour represents the outcomes that are supported by the quantitative evidence. The blue colour represents the outcomes that are supported by the qualitative evidence. The green colour represents the outcomes supported by both qualitative and quantitative evidence. It is important to note that the green and red colours are not intended to suggest that there is evidence of an effect, which is covered in the harvest plots. The colours are for an illustrative purpose, representing only if the study measured a specific outcome (irrespective of an effect or no effect).

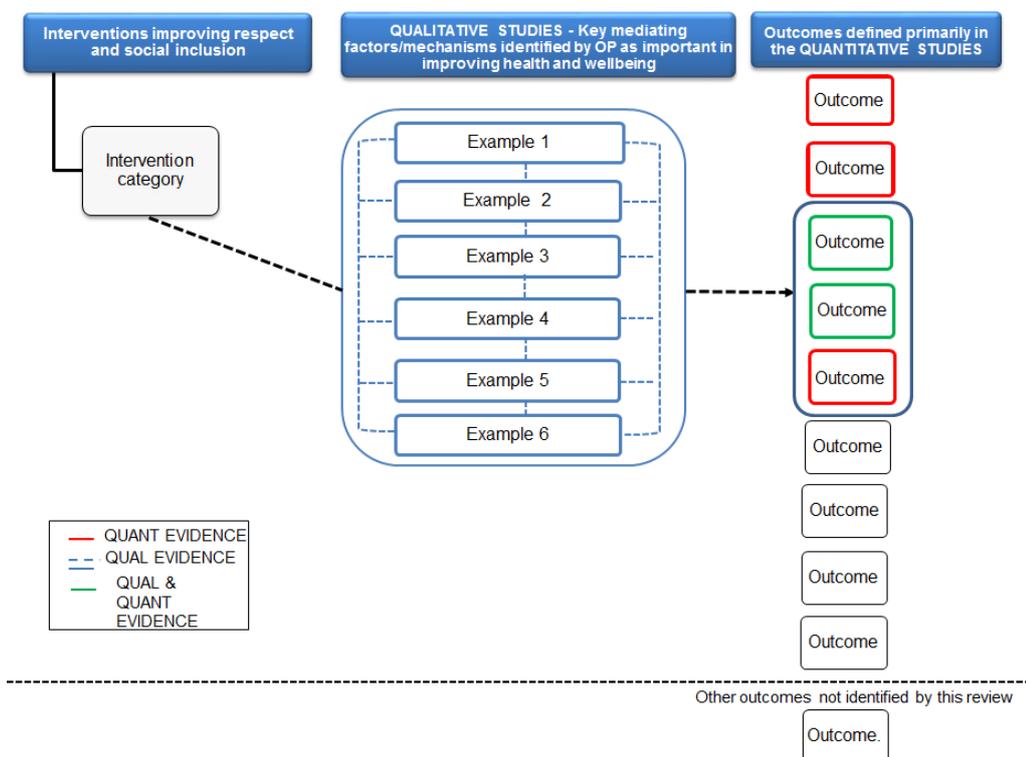


Figure 7 Logic model summarising the range of reported outcomes of interventions and the possible mechanisms for these effects as suggested by the qualitative evidence.

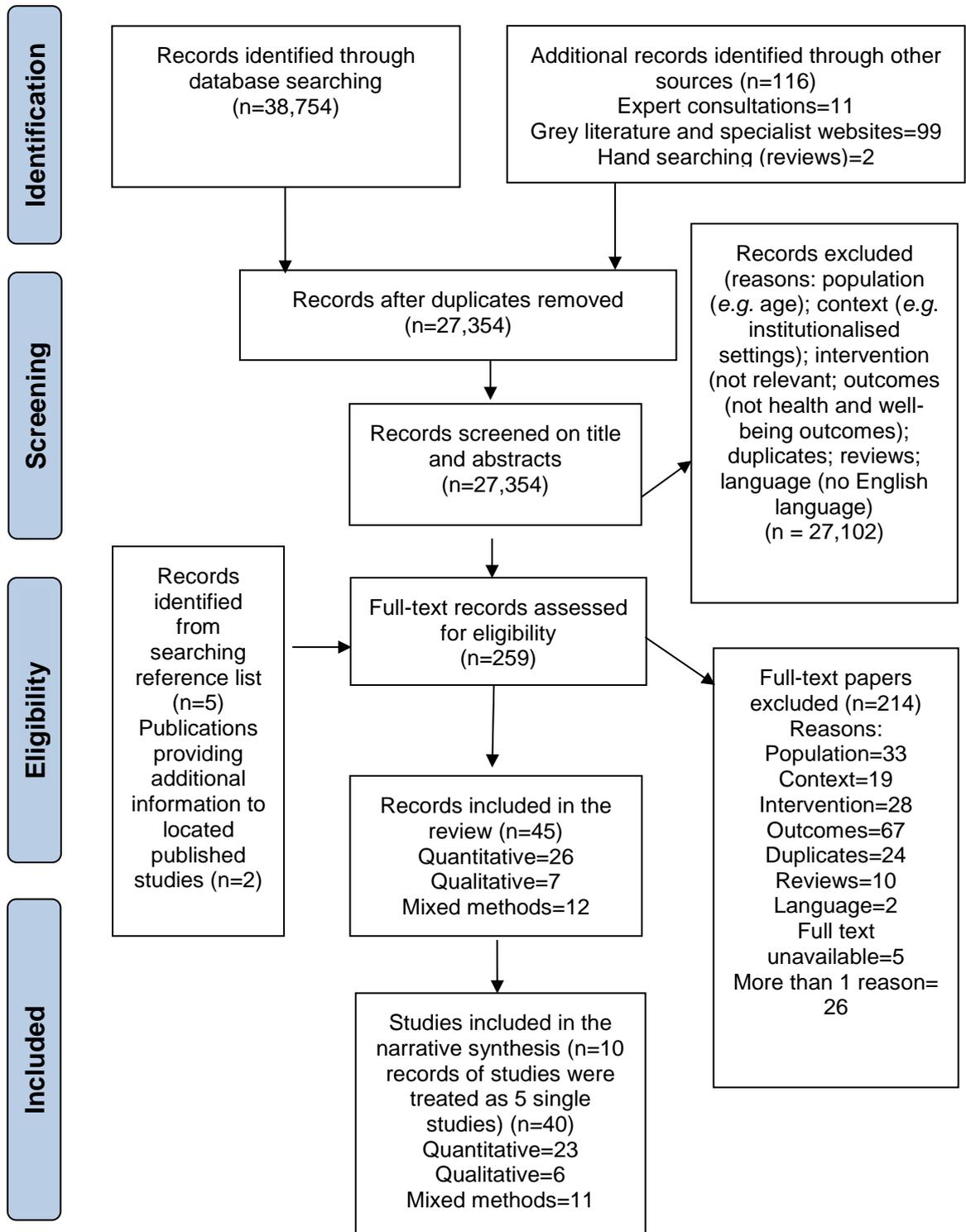
During the creation of harvest plots and logic models, I summarised the results as a narrative summary. In each intervention category, I grouped findings that were similar empirically and/or theoretically (Popay et al. 2006). For instance, I grouped the studies that measured the same health outcome (*e.g.* depressive symptoms), and/or where the qualitative evidence showed similar links in the pathways to improve health outcomes (*e.g.* improved self-esteem). I subsequently incorporated this information into the logic models for each intervention category. In addition, I examined possible relationships across the wide range of interventions, by grouping the studies that measured the same outcomes, or/and had the same intervention contact frequency.

## **2.5 Results**

### **2.5.1 Study selection**

Of 27,354 records retrieved, 45 records – covering 40 studies (23 quantitative, 6 qualitative, 11 mixed methods) – were included in the review (Figure 7a – PRISMA flow chart). During the screening of titles and abstracts of studies, 27,102 records were excluded as not meeting the inclusion criteria due to population (*e.g.* age < 60 years), context (*e.g.* institutionalised settings), intervention (not relevant to respect and social inclusion), outcomes (not related to health and wellbeing outcomes), duplication, reviews and not individual studies and language (not English language). The remaining 259 full-text records were assessed for eligibility, and 214 records were excluded due to: outcomes not relevant (n=67), age < 60 years (n=33), intervention not clear (n=28), non-community setting (n=19), reviews (n=10), non-English language (n=2), full text unavailable (n=5), duplicates (n=24) and more than one reason (n=26).

Figure 7a - PRISMA flow diagram of the study selection process.



### 2.5.2 Study characteristics

Table 7 and Table 8 summarise the characteristics of the studies providing quantitative and qualitative evidence stratified by intervention category. Studies are ranked by assessment of RoB (from low to high RoB) (Katikireddi et al. 2015). Figure 8 shows the included studies stratified by intervention category (n=40).

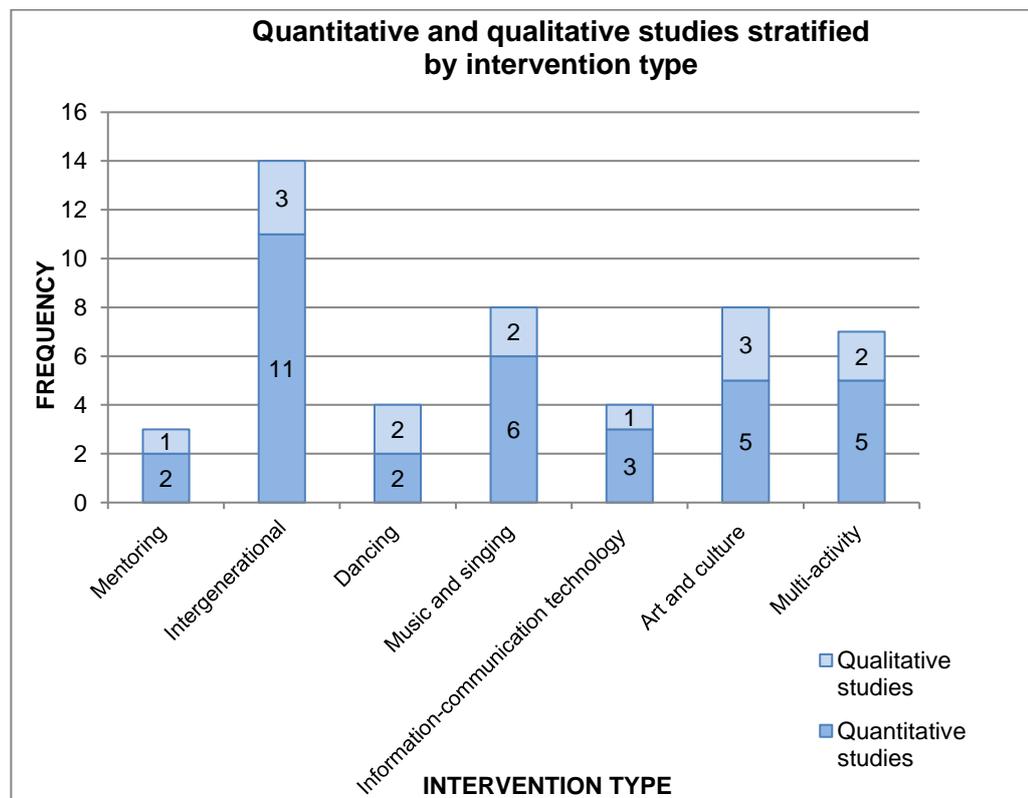


Figure 8 Quantitative and qualitative studies stratified by intervention type.

Studies using mixed methods designs contributed to the numbers of both quantitative and qualitative studies in these summaries. Therefore, 34 studies formed the quantitative evidence base, and 14 studies formed the qualitative evidence base (Ellis 2004 contributed to both the mentoring and

intergenerational interventions; and Cohen & Perlstein 2006 contributed to both singing and art and culture interventions).

- **Study design**

Of the 32 studies reporting quantitative evidence, seven were individual or cluster randomised controlled trials (RCT) with the rest using quasi-experimental designs. Four were controlled before and after studies, seven cluster or individual controlled studies and 15 were uncontrolled before and after studies. Studies reported a range of comparison/control groups including: other interventions (n=2), usual care (n=2), other activities (*e.g.* hobbies) (n=5) and waiting lists (n=2). One study used multiple comparison groups including no intervention, and participants with no interest in computer training (Slegers et al. 2008). One study recruited the control group through matching individuals participating in a national survey (Hong & Morrow-Howell 2010). One study followed over time a comparable group living in the same metropolitan area (Ruffing-Rahal 1994). In one study, the control group was a specific subsample of an ongoing study (Cohen & Perlstein 2006). In one study, the control group was selected from the participants who participated in a former study (Woodward et al. 2012). Two studies did not report how the control group was selected (Fried et al. 2004; Houston & McGill 2015).

Most studies had only one follow-up conducted between two weeks and eight months. The shortest follow-up included assessment conducted immediately after the programme (Gaggioli et al. 2014), while the longest follow-ups were two years (Hong & Morrow-Howell 2010), and three years after the baseline assessment (Phinney et al. 2014). The remaining six studies consisted of multiple

follow-up points, which had between two and three follow-up points covering periods of between two weeks and 12 months (Houston & McGill 2015; Coulton et al. 2015a; Slegers et al. 2008; Woodward et al. 2012; Phinney et al. 2014; Saito et al. 2012).

- **Setting**

All studies were conducted in high and upper middle income countries. 13 were from the UK, 13 from the United States, three from Japan, two from each of the Netherlands, Australia, Canada and Brazil and one from each of Spain, Italy and China.

- **Intervention types**

A broad range of interventions were identified, broadly including (i) mentoring, (ii) intergenerational programmes, (iii) dancing, (iv) music and singing, (v) art and culture (vi) information-communication technology and (vii) multi-activity programmes (*e.g.* health promotion).

In terms of delivery of the interventions, four studies included interventions delivered by peers (Dickens et al. 2011; Woodward et al. 2012; Kocken & Voorham 1998; Schlag 2011), eight were led by study participants themselves (Ellis 2004; De Souza & Grundy 2007; Hong & Morrow-Howell 2010; Fujiwara et al. 2009a; Murayama et al. 2014; Fried et al. 2004; Ellis 2003; De Souza 2003), one study involved both professionals and students (Hernandez & Gonzalez 2008), four studies were led by study participants themselves with some support from helpdesk and community centres (Slegers et al. 2008; Gonyea & Burnes 2013; Weintraub & Killian 2007; Buijs et al. 2003) and 19 studies

were led by professionals (Gaggioli et al. 2014; Houston & McGill 2015; Hackney et al. 2007; Coulton et al. 2015a; Davidson & Fedele 2011; Clift & Morrison 2011; Creech et al. 2013; Davidson et al. 2014; Woodward et al. 2011; Phinney et al. 2014; Cohen & Perlstein 2006; Camic et al. 2014; Yuen et al. 2011; Vogelpoel & Jarrold 2014; Saito et al. 2012; Greaves 2006; Ruffing-Rahal 1994; Houston & McGill 2011; VarVarigou et al. 2012; Skingley & Bungay 2010). Only one study did not report who delivered the intervention (Mendis 1993).

The frequency of contact with participants varied, with the majority of interventions being delivered on a weekly or other periodic basis (*e.g.* every two weeks). Most interventions lasted between three and 12 weeks, with a few lasting 26 (Ruffing-Rahal 1994) and 30 weeks (Cohen & Perlstein 2006), and one spanning three years (Phinney et al. 2014). In one study, the duration of the intervention was not clear (Ellis 2003).

- **Populations**

The majority of studies included healthy older people aged between 60 and 95 years, with the exception of two studies that included older people with dementia (Chung 2009; Davidson & Fedele 2011), and three studies that included older people with Parkinson's disease (Houston & McGill 2015; Hackney et al. 2007; Houston & McGill 2011).

Among the studies that reported a breakdown by gender of the sample, the majority reported comprising mostly women, with only one study reporting a balance between women and men (Ellis 2004), and one study including only

women (Ruffing-Rahal 1994). In the majority of the studies, study participants were either volunteers currently involved with/interested in the programme or those recruited through fliers, letters, and room visit invitations. Study participants were also referred by general practices (Vogelpoel & Jarrold 2014), or recruited from day centres (Chung 2009) and community centres/groups (Gaggioli et al. 2014; Fried et al. 2004).

- **Outcomes**

Impacts were reported on a varied range of health outcomes including (i) depression, (ii) subjective health, (iii) mental health, (iv) wellbeing, (v) physical health, (vi) quality of life, (vii) falls, (viii) perceived stress and anxiety, and (ix) chronic pain. Quantitative data on depression was provided by 20 studies, perceived stress and/or anxiety was assessed by three studies and mental health by four studies. Subjective health and physical health were assessed by seven studies each. Seven studies measured quality of life, and eight measured wellbeing. Only one study assessed chronic pain. Appendix A shows an overview of the scales used for the quantitative studies in measuring outcome. Most of the included studies used standardised scales, with only a few studies using non-standardised measures for subjective and health (Hong & Morrow-Howell 2010; Fujiwara et al. 2009b; Kocken & Voorham 1998; Cohen & Perlstein 2006), falls (Fried et al. 2004; Houston & McGill 2015), and quality of life outcomes (Woodward et al. 2012; Woodward et al. 2011). Figure 9 summarises the outcomes assessed in each intervention category.

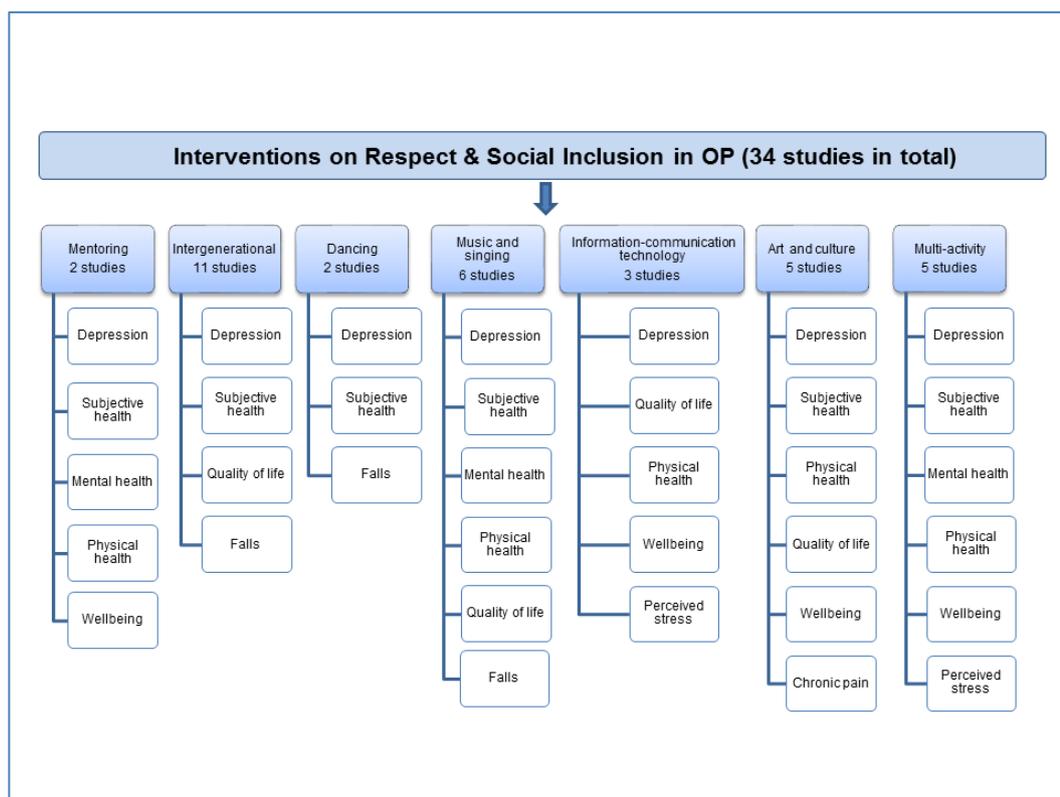


Figure 9 List of outcomes stratified by intervention category (quantitative evidence). OP= older people.

- **Risk of bias (RoB)**

Overall, 12 studies were rated as high RoB, 12 studies were judged to be at moderate RoB, and 21 at low or low-moderate RoB. The main RoB issues with these studies included small sample size, poor selection of participants, differences observed between intervention and control group participants at baseline, and poor reporting.

### 2.5.3 Results by intervention category

In the following section I present study data according to the category of intervention referring to summary tables (Table 7 and Table 8) and harvest plots. Harvest plots and summary tables were two complementary aspects of the synthesis process, with the harvest plots giving an overall summary of the

amount, direction and quality of the evidence and the tables providing detailed information on the results. For each intervention category I give information about the number, type and RoB (as an indicator of overall methodological quality) of included studies and a summary of the findings from the quantitative and qualitative evidence. Whilst many studies reported a breakdown by socio-economic status, education, gender at baseline, the majority did not report sub-analysis of how any impacts of the interventions may vary by age, ethnic, education or socio-economic status of older people.

- **Intervention group 1: Mentoring**

As shown in Figure 10, Table 7 and Table 8 the amount of available evidence is limited with only three studies (two quantitative and one qualitative) on this topic. The quantitative studies included an individual RCT of a community-based mentoring service programme rated as low-moderate RoB (Dickens et al. 2011); and an uncontrolled before and after study of a mentoring programme rated as high RoB (Ellis 2004). The main RoB issues with these studies included: differences observed between intervention and control group participants at baseline (Dickens et al. 2011), small sample size, and poor reporting on analysis (Ellis 2004), making it difficult interpret the results.

Neither quantitative study found an effect on depressive symptoms or on improvements in general mental health and subjective health (Ellis 2004; Dickens et al. 2011). Based on only one study (high RoB), there was no observed effect of mentoring on quality of life (Ellis 2004). Neither study measured the impact on falls and chronic pain.

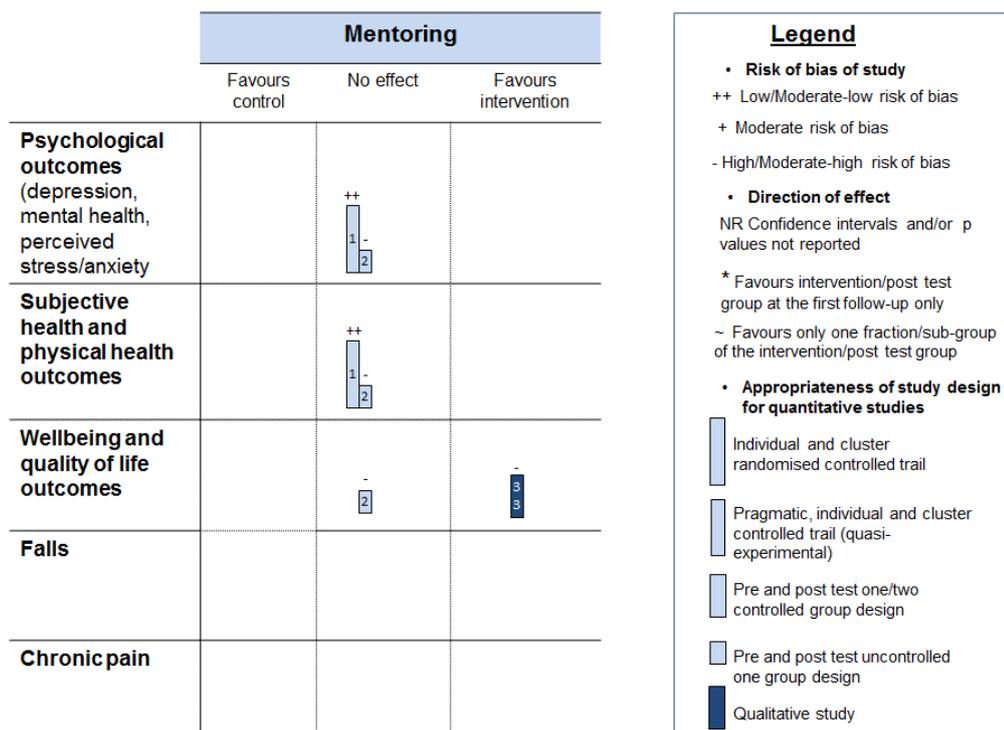


Figure 10 Harvest plot for mentoring interventions. Studies are numbered based on those used in Summary Table 7 and Table 8.

The one qualitative study concerned a mentoring programme adopting an intergenerational approach (Ellis 2003). It was rated as moderate-high RoB, due to poor reporting of analysis, sampling, and results. From the older people's narratives, mentoring children was reported to help participants going through difficult times in their lives, and to enhance their physical and mental wellbeing. As shown in Figure 11, the possible factors that might lead to an improvement in wellbeing reported by older people were: improved self-esteem, satisfaction, confidence, interactions and relationships, and feeling valued.

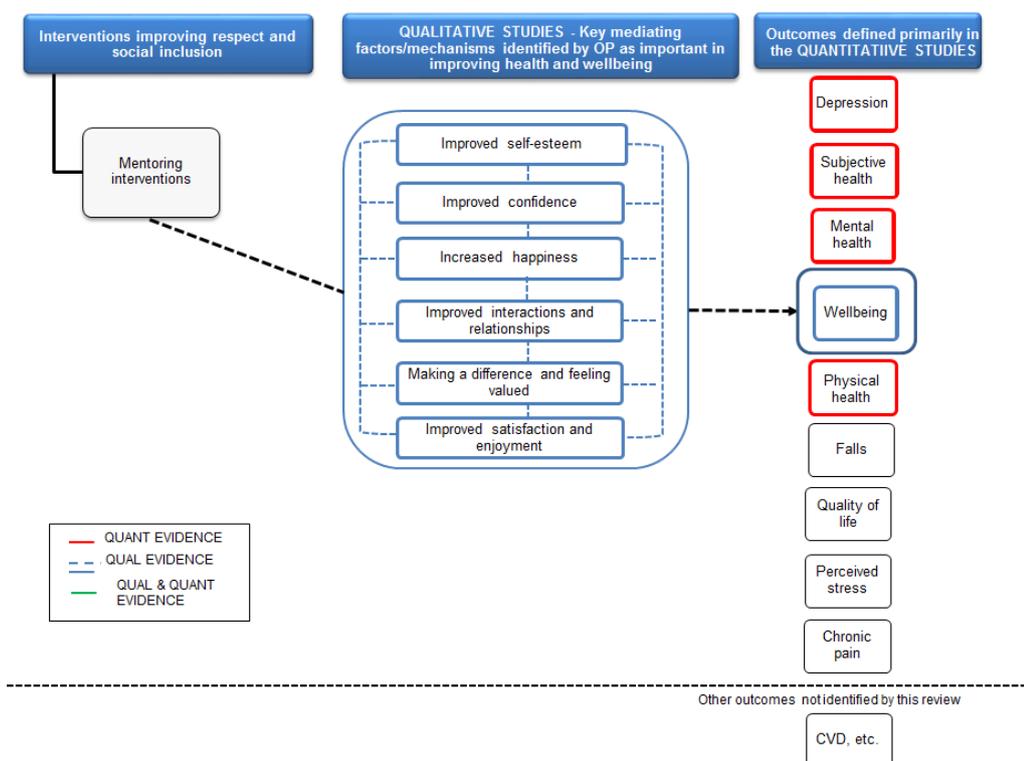


Figure 11 Diagram for mentoring interventions (QUANT signifies quantitative; QUAL signifies qualitative). The blue borders represent the outcomes that are supported by the qualitative evidence; the red borders represent the outcomes that are supported by the quantitative evidence; and the green borders indicate that there is quantitative and qualitative evidence which has measured a specific outcome; this notation is not intended to signify the strength or direction of any effect, which are illustrated in the harvest plot.

- **Intervention group 2: Intergenerational initiatives**

As shown in Figure 12, Table 7 and Table 8, there was more evidence available for intergenerational initiatives (11 quantitative and three qualitative studies). Among the quantitative studies, two were cluster controlled trails (Fujiwara et al. 2009a; Murayama et al. 2014), one was a cluster RCT (De Souza & Grundy 2007) and one individual RCT (Fried et al. 2004), two were controlled before and after studies (Hernandez & Gonzalez 2008; Hong & Morrow-Howell 2010), and five were uncontrolled before and after studies (Chung 2009; Gaggioli et al. 2014; Newman et al. 1995; Mendis 1993; Ellis 2004).

Among the 11 quantitative studies, seven were judged as low-moderate RoB, with four being moderate-high RoB (Newman et al. 1995; Mendis 1993; Fried et al. 2004; Ellis 2004). The main weaknesses of these studies were small sample size (n=2) (Mendis 1993; Newman et al. 1995), no control group (n=2) (Mendis 1993; Newman et al. 1995), and poor reporting on analysis (n=3) (Ellis 2004; Fried et al. 2004; Newman et al. 1995), making it difficult interpret the results.

Intergenerational studies included (i) mentoring initiatives (Chung 2009; De Souza & Grundy 2007; Ellis 2004), (ii) initiatives based on service-learning pedagogy (Hernandez & Gonzalez 2008), (iii) school initiatives (Hong & Morrow-Howell 2010; Fried et al. 2004; Newman et al. 1995), (iv) reading initiatives (Fujiwara et al. 2009a; Murayama et al. 2014), (v) reminiscence initiatives (Gaggioli et al. 2014), and (vi) initiatives involving reading and drawings (Mendis 1993).

As shown in Figure 12, five studies found an effect on depressive symptoms (Mean Difference between scores (MD)=1.86; 95% CI=0.92, 2.80; Chung 2009; MD=3.53 p<.001: Hernandez & Gonzalez 2008; p=.001: Murayama et al. 2014; reduction of 16.64%: Newman 1995), and an improvement in general mental health. In contrast, two studies did not find an effect on mental health (Ellis 2004), and on depressive symptoms (Mendis 1993).

With regard to subjective health, one study showed a favourable effect (p< 0.01; Fujiwara et al. 2009), while two studies did not find an effect (De Souza & Grundy 2007; Ellis 2004). For wellbeing and quality of life, however, there appeared some indication of an effect (p=<.05: Gaggioli et al. 2014) and (Chung

2009: MD= -1.91; 95% CI = -3.18, -0.64) respectively. One study did not find an effect on falls (Fried et al. 2004).

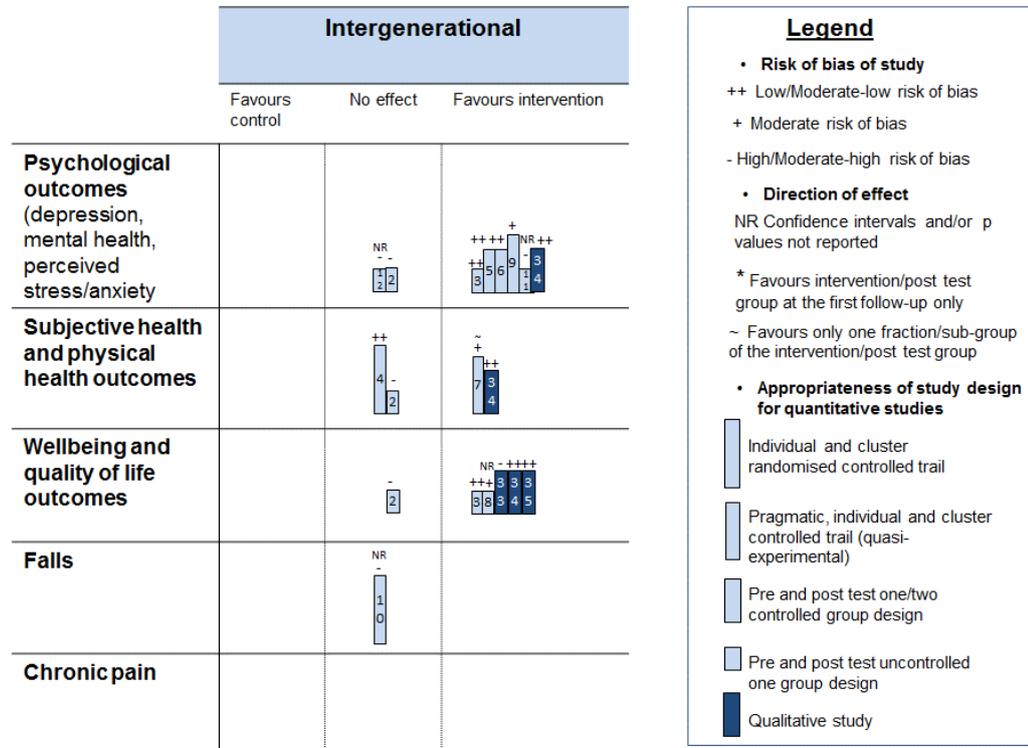


Figure 12 Harvest plot for intergenerational interventions. Studies are numbered based on those used in Summary Table 7 and Table 8.

As shown in Figure 13, three low-moderate RoB qualitative studies assessed this intervention identifying some of the mediating factors reported by study participants involved in improving their wellbeing and subjective health, and in reducing depressive mood (Weintraub & Killian 2007; De Souza 2003; Ellis 2003). These factors were: improved self-esteem and confidence, enjoyment and satisfaction, and happiness; improved interactions and relationships with others; feeling valued, and positive perceptions towards ageing and children. Older people’s narratives reported a perceived enhanced emotional and physical wellbeing and subjective health (Weintraub & Killian 2007; De Souza 2003;

Ellis 2003). In De Souza (2003) the female group of older people reported that the project helped them to alleviate their depressive moods and to improve their overall wellbeing and humour.

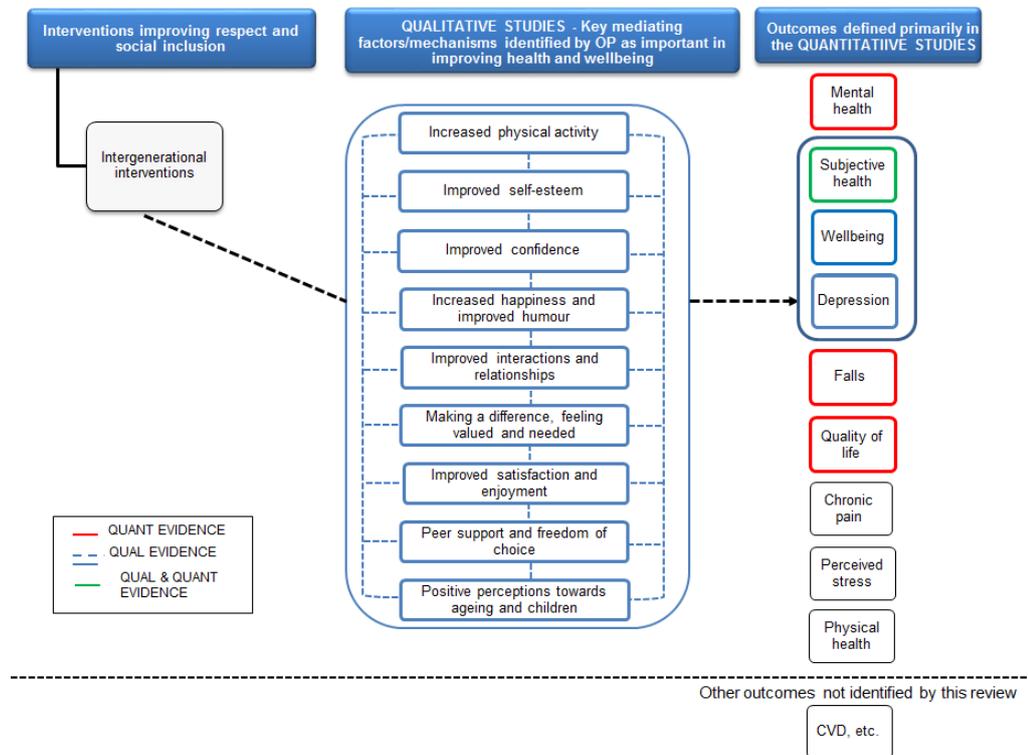


Figure 13 Diagram for intergenerational interventions (QUANT signifies quantitative; QUAL signifies qualitative).

- **Intervention group 3: Dancing**

As shown in Figure 14, Table 7, and Table 8, the available evidence for dancing as an intervention is limited (two quantitative studies and one qualitative study). The quantitative studies included an individual controlled trial (Houston & McGill 2015) and an individual RCT (Hackney et al. 2007). Both were rated as high and moderate RoB (Hackney et al. 2007; Houston & McGill 2015) due to differences between control and intervention groups in the depression levels at the outset of the study (Hackney et al. 2007), and small samples and poor

reporting on analysis (Hackney et al. 2007; Houston & McGill 2015), making it difficult interpret the results.

One study showed a significant effect on depressive symptoms (p=0.001: Hackney et al. 2007). Neither study found an effect on wellbeing and subjective health (Houston & McGill 2015). Findings were mixed for falls, with one study showing evidence of an effect (Hackney et al. 2007), and the other no effect (Houston & McGill 2015). There were no studies reporting on chronic pain.

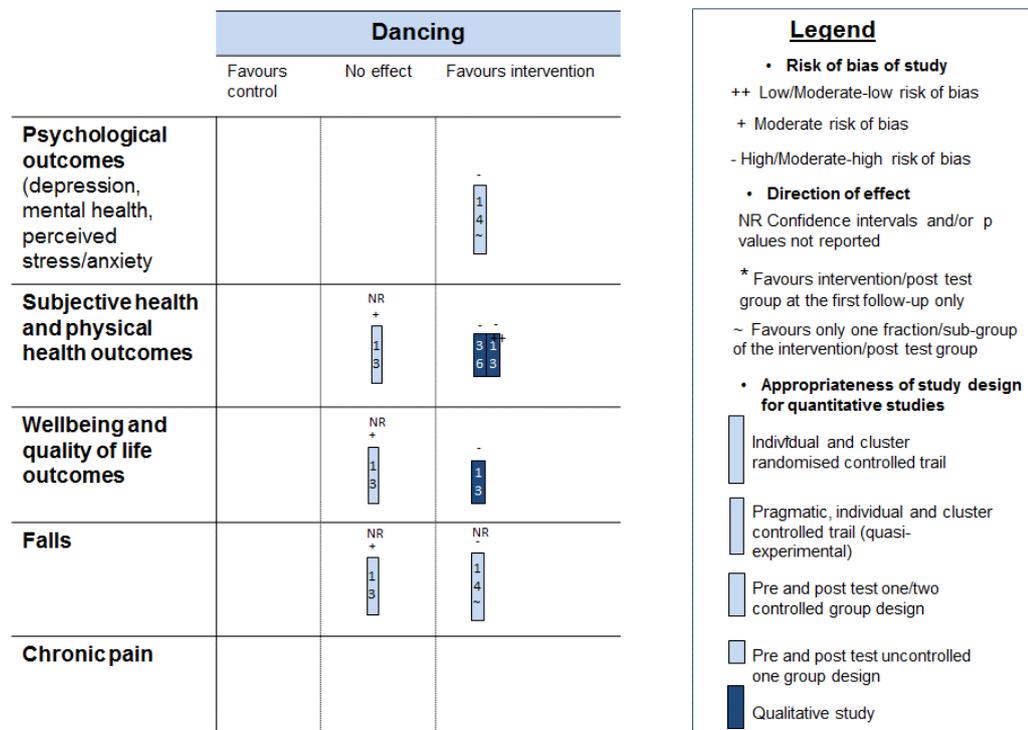


Figure 14 Harvest plot for dancing interventions. Studies are numbered based on those used in Summary Table 7 and Table 8.

Two qualitative studies rated as moderate-high RoB provided context to the relationship between dancing and subjective and physical health, and wellbeing (Houston & McGill 2011; Houston & McGill 2015). The RoB issues included poor reporting of sampling, analysis and results.

As shown in Figure 15, mediating factors included: improved satisfaction, enjoyment, confidence; improved fluency, dynamics of movement and mobility; improved social interactions, and feeling valued. Older people talked about how the programme made them ‘feel better’, giving them a sense of wellbeing (Houston and McGill 2011), and made them feel good and capable despite some health difficulties (Houston & McGill 2015).

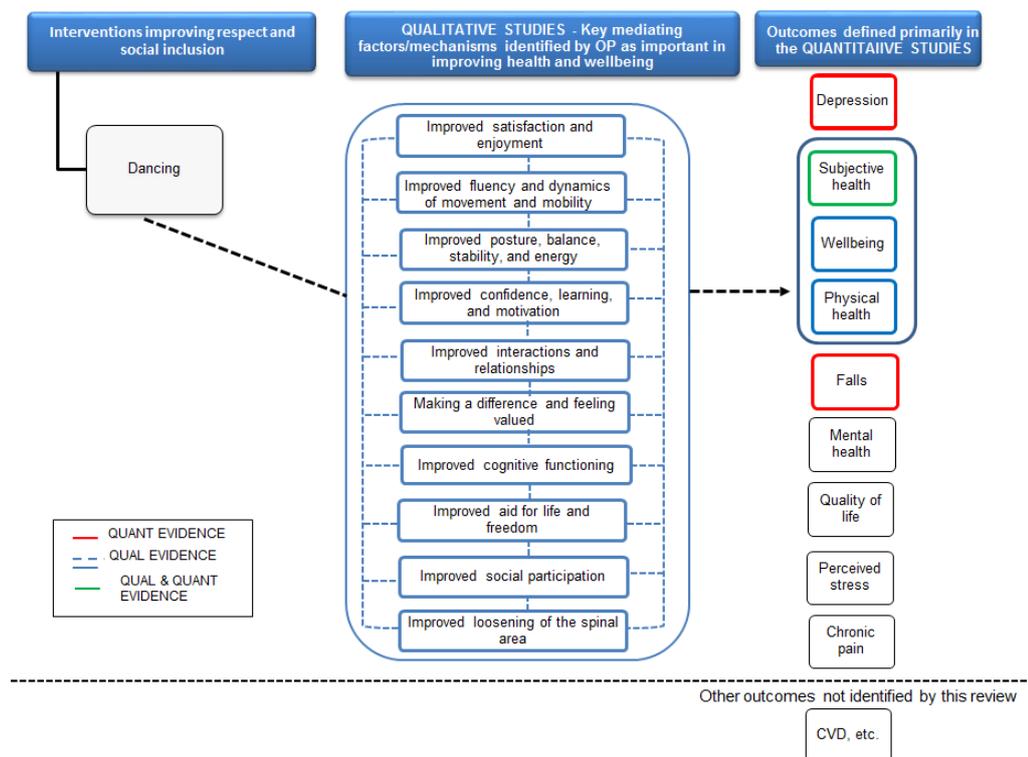


Figure 15 Diagram for dancing interventions (QUANT signifies quantitative; QUAL signifies qualitative).

- **Intervention group 4: Music and singing initiatives**

As shown in Figure 16, Table 7, and Table 8, there are six quantitative and two qualitative studies for music (Creech et al. 2013; VarVarigou et al. 2012) and singing initiatives (Coulton et al. 2015a; Skingley et al. 2011; Davidson et al.

2014; Davidson & Fedele 2011; Skingley & Bungay 2010; Cohen & Perlstein 2006).

Among the six quantitative studies, one was an individual RCT (Cohen & Perlstein 2006), one was a cluster RCT (Coulton et al. 2015b), one was a controlled before and after study (Creech et al. 2013), and three were before and after uncontrolled studies (Clift & Morrison 2011; Davidson et al. 2014; Davidson & Fedele 2011).

Three studies were judged as low-moderate RoB (Coulton et al. 2015b; Clift & Morrison 2011; Cohen & Perlstein 2006), two as moderate RoB (Davidson et al. 2014; Creech et al. 2013) and one as high RoB (Davidson & Fedele 2011). The main RoB issues were short follow-up (Davidson et al. 2014; Davidson & Fedele 2011), small sample size (Davidson et al. 2014; Davidson & Fedele 2011), poor reporting on analysis (Davidson & Fedele 2011; Davidson et al. 2014), and no/poor adjustment for confounders (Creech et al. 2013), making it difficult interpret the results.

As shown in Figure 16, four quantitative studies found a significant effect on depressive symptoms (MD= -1.52,  $p < 0.01$  at first follow-up; Coulton et al. 2015; MD= -0.2; Davidson et al. 2014), perceived stress (MD= 2.58,  $p < 0.001$ : Clift & Morrison 2011), and anxiety (MD: -1.78,  $p < 0.01$  at first follow-up; Coulton et al. 2015). Two studies suggested an improvement in mental health quality of life (MD=10,  $p = 0.03$ : Davidson et al. 2014;  $p < 0.01$  at first follow-up;  $p = 0.05$  at second follow-up: Coulton et al. 2015). One study reported a reduction in perceived anxiety (MD=-0.57,  $p = 0.13$ : Coulton et al. 2015) and depression (MD= -0.53,  $p = 0.14$ : Coulton et al. 2015); and a reduction in perceived stress

(MD=0.37, p<0.001: Clift & Morrison 2011). Two studies found an effect on physical health (p=0.03: Davidson et al. 2014; MD= 0.72, p<0.01: Cohen et al. 2006).

For singing and music initiatives findings were mixed – one study found an improvement in wellbeing and quality of life outcomes (p=.0001: Creech et al. 2013), and the other found no effect (Davidson & Fedele 2011). Two studies, however, reported improvements in two out of four components of the quality of life scale (Creech et al. 2013), and in one subscale of physical and mental health (Davidson et al. 2014). One study showed an effect on falls rates (p<.05: Cohen & Perlstein 2006). There were no studies reporting on chronic pain.

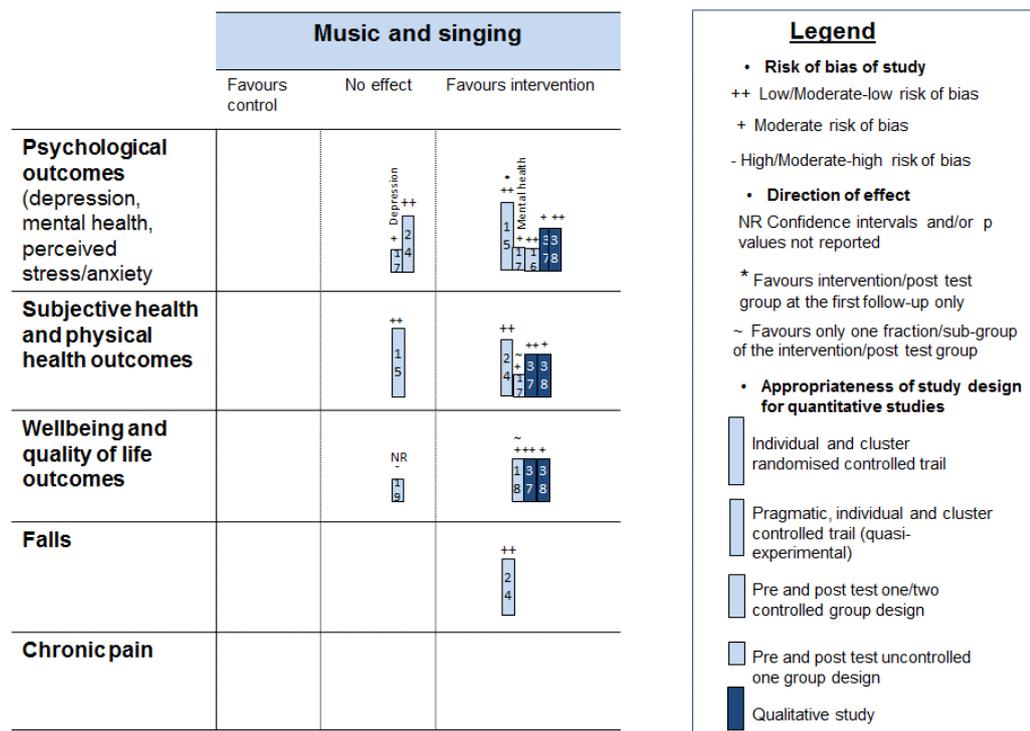


Figure 16 Harvest plot for music and singing interventions. Studies are numbered based on those used in Table 7 and Table 8.

Two qualitative studies rated as low-moderate RoB gave context to the relationship between singing and music initiatives and the health outcomes

(Varvarigou et al. 2011; Skingley & Bungay 2010). As shown Figure 17, mediating factors for this relationship included improved confidence, concentration and memory, and sense of achievement, and improved interactions with others and feeling valued. With regard to music making activities, older people’s narratives suggested a perceived enhanced quality of life, and mental health benefits (*e.g.* ability to cope effectively with stress) and physical health (*e.g.* good for asthma and breathing) (Varvarigou et al. 2011). Older people’s narratives revealed that singing enhanced their perceived mental health, wellbeing, and physical health (Skingley & Bungay 2010).

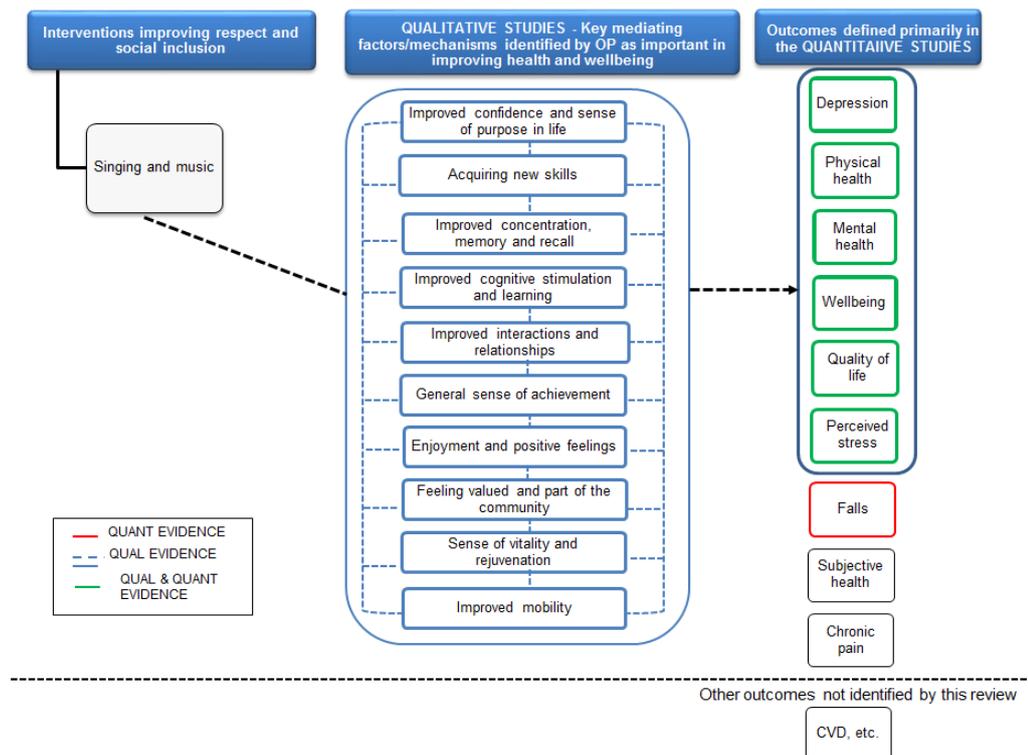


Figure 17 Diagram for music and singing interventions (QUANT signifies quantitative; QUAL signifies qualitative).

- **Intervention group 5: Information-communication technology**

As shown in Figure 18, Table 7 and Table 8, there were three quantitative studies and one qualitative study. Among the quantitative studies, two were individual

RCTs (Slegers et al. 2008; Woodward et al. 2011) rated as low and moderate RoB, and one was a controlled before and after study rated as moderate-high RoB (Woodward et al. 2012) – the RoB issue relating to a small sample and poor selection of participants.

Three studies found a non-significant effect on depressive symptoms (Slegers et al. 2008; Woodward et al. 2011; Woodward et al. 2012), anxiety (Slegers et al. 2008), and mental health (Slegers et al. 2008). One study did not find an effect on physical health (Slegers et al. 2008). Findings were mixed for the two studies looking at quality of life outcomes with one intervention showing an improvement ( $p < .05$ : Woodward et al. 2011), and the other showing no effect (Woodward et al. 2012). There were no studies reporting on falls and chronic pain.

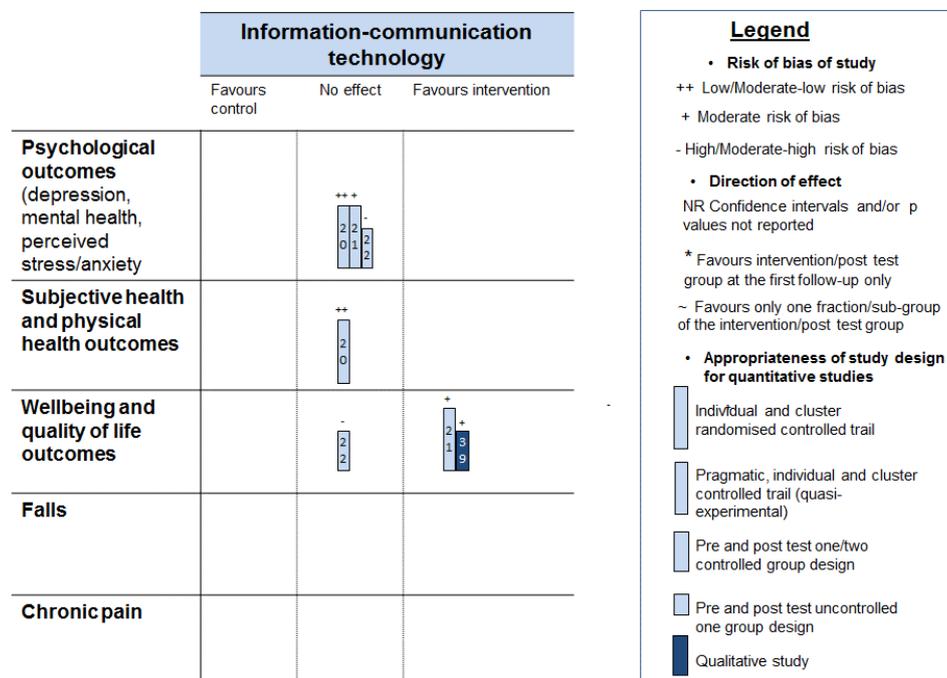


Figure 18 Harvest plot for ICT interventions. Studies are numbered based on those used in Summary Table 7 and Table 8.

One qualitative study of an ICT programme reported a perceived improvement in wellbeing. This study was rated as moderate RoB (Schlag 2011) due to poor reporting of analysis.

Study participants related their enhanced sense of wellbeing acquired from ICT use to an increased sense of purpose, and enjoyment to their lives. Some older people reported the programme served as a medium for strengthening existing relationships. Others mentioned that having ICT as a common interest brought them closer to family members. As shown in Figure 19, other possible mediating factors for an improvement in wellbeing included improved health maintenance, sense of purpose, satisfaction, civic engagement, and feeling valued.

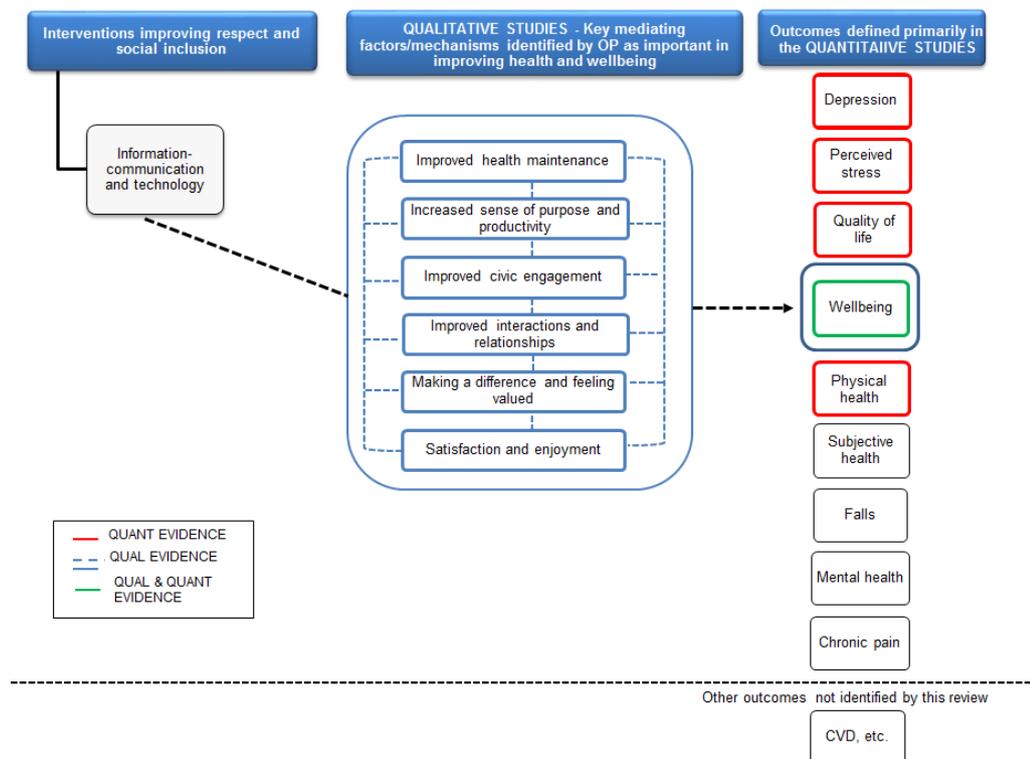


Figure 19 Diagram for ICT interventions (QUANT signifies quantitative; QUAL signifies qualitative).

- **Intervention group 6: Art and culture**

As shown in Figure 20, Table 7, and Table 8 there were three quantitative studies and one qualitative study for art and culture interventions. Among the quantitative studies, one was an individual controlled trial (Cohen & Perlstein 2006), and three were three before and after uncontrolled studies (Camic et al. 2013; Phinney et al. 2014; Yuen et al. 2011).

Two studies were rated as low-moderate RoB (Phinney et al. 2014; Cohen & Perlstein 2006) and two were rated as moderate RoB (Yuen et al. 2011; Camic et al. 2014) – one study (counted twice as providing both quantitative and qualitative evidence) was rated as high-moderate RoB (Vogelpoel & Jarrold 2014). The main weakness of the moderate-high RoB study included small sample size and poor reporting of results and methods, making it difficult to interpret the results.

Two studies showed an effect on depressive symptoms (Phinney et al. 2014), and mental health (Yuen et al. 2011). One study found a significant effect on physical health ( $p=.03$ : Yuen et al. 2011) and two studies found a significant effect on subjective health ( $p<.10$ : Phinney et al. 2014;  $p<.01$ : Cohen & Perlstein 2006).

In terms of wellbeing, one study found a significant effect ( $p=.002$ : Yuen et al. 2011), and one found no effect (Vogelpoel & Jarrold 2014). One study did not find an effect on health related quality of life (Camic et al. 2014). With regard to falls and chronic pain, two studies, which were judged as low RoB, showed a

significant effect on both falls ( $p < .05$ ; Cohen & Perlstein 2006) and chronic pain ( $p < .05$ ; Phinney et al. 2014).

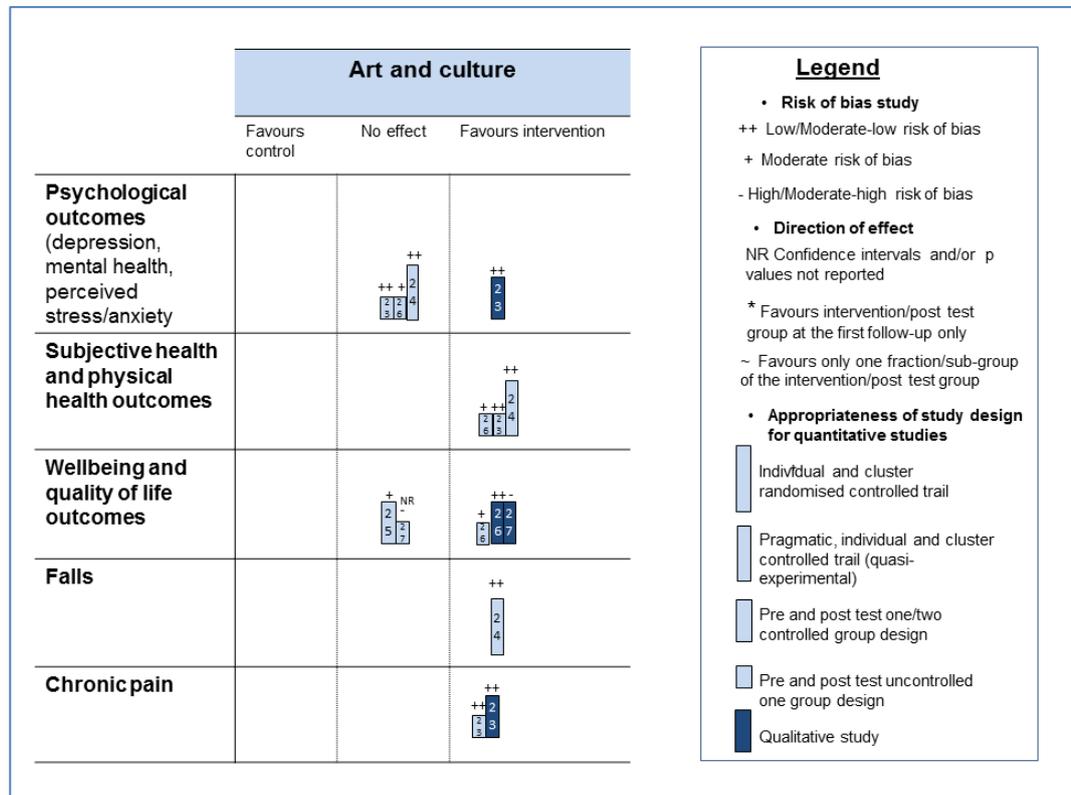


Figure 20 Harvest plot for art and culture interventions. Studies are numbered based on those used in the Summary Table 7 and Table 8.

Three qualitative studies provided context to the association of art and culture interventions with reductions in depression and chronic pain, and in improving physical health (Phinney et al. 2014), wellbeing (Vogelpoel & Jarrold 2014; Yuen et al. 2011) and health related quality of life (Yuen et al. 2011). Two were rated as low-moderate RoB, and one as high RoB (Vogelpoel & Jarrold 2014) particularly due to poor reporting of sampling and analysis.

Older people described how creative work helped them to reduce their perceived feelings of stress and anxiety, and to overcome some health limitations (e.g. depression) (Phinney et al. 2014; Yen et al. 2009). Furthermore, they reported

feeling more socially and physically active, and feeling more relaxed (Phinney et al. 2014). As shown in Figure 21, mediating factors reported by older people included reduced social isolation, increased self-confidence and social connectedness, improved interactions and social interactions, and feeling valued.

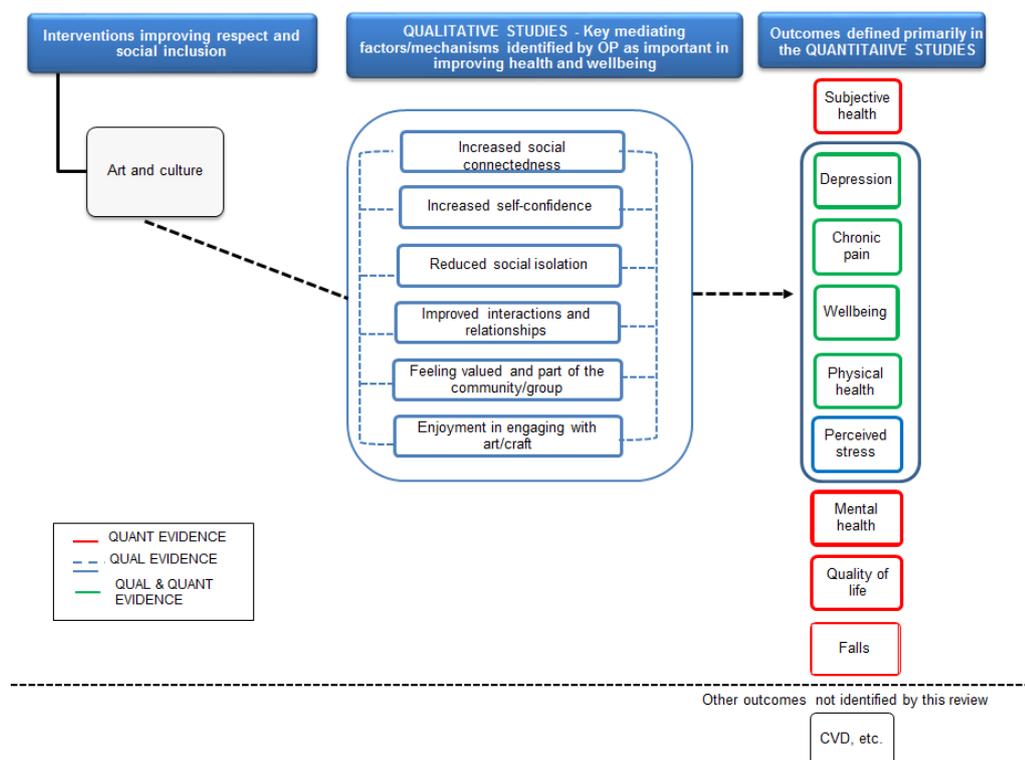


Figure 21 Diagram for art and culture interventions (QUANT signifies quantitative; QUAL signifies qualitative).

- **Intervention group 7: Multi-activity initiatives**

As shown in Figure 22, Table 7, and Table 8, there were five quantitative studies and two qualitative studies. Among the quantitative studies, one was an individual RCT (Saito et al. 2012), two were individual controlled trials (Kocken & Voorham 1998; Ruffing-Rahal 1994), and two were before and after uncontrolled studies (Greaves 2006; Gonyea & Burnes 2013).

Three studies were rated as low to moderate RoB (Saito et al. 2012; Gonyea & Burnes 2013; Kocken & Voorham 1998), one study as moderate RoB (Greaves 2006) and one as moderate-high RoB (Ruffing-Rahal 1994) – due to small sample size, no random allocation of the intervention or control group, and poor reporting of results and convenience sampling methods.

Multi-activity interventions included: activities to encourage older people to participate in various activities organised in the city (Saito et al. 2012), creative exercise and/or cultural activities wherein older people were guided by peers (Greaves 2006), regular gatherings in neighbours' homes and interactions with others (Gonyea & Burnes 2013), social clubs and exercise programmes (Kocken & Voorham 1998; Buijs et al. 2003), and regular meetings to discuss health information and self-care topics including older people's feelings and health (Ruffing-Rahal 1994).

Findings for psychological outcomes were mixed. One study found a significant effect on depressive symptoms at first follow-up only ( $p < 0.02$ : Greaves 2006) and two studies did not find an effect (Saito et al. 2012; Gonyea & Burnes 2013). One study showed a significant effect on mental health ( $p < 0.005$ : Greaves 2006) but at the first follow-up only. One study found a significant effect on perceived stress ( $p < 0.001$ : Gonyea & Burnes 2013).

Two studies appeared to have a positive effect on subjective health ( $p < 0.01$ : Kocken & Voorham 1998) and ( $p = 0.06$ : Greaves 2006). One study found an effect on wellbeing ( $p = 0.039$ : Saito et al. 2012), and two studies did not find an effect (Ruffing-Rahal 1994; Kocken & Voorham 1998). There were no studies reporting on falls and chronic pain.

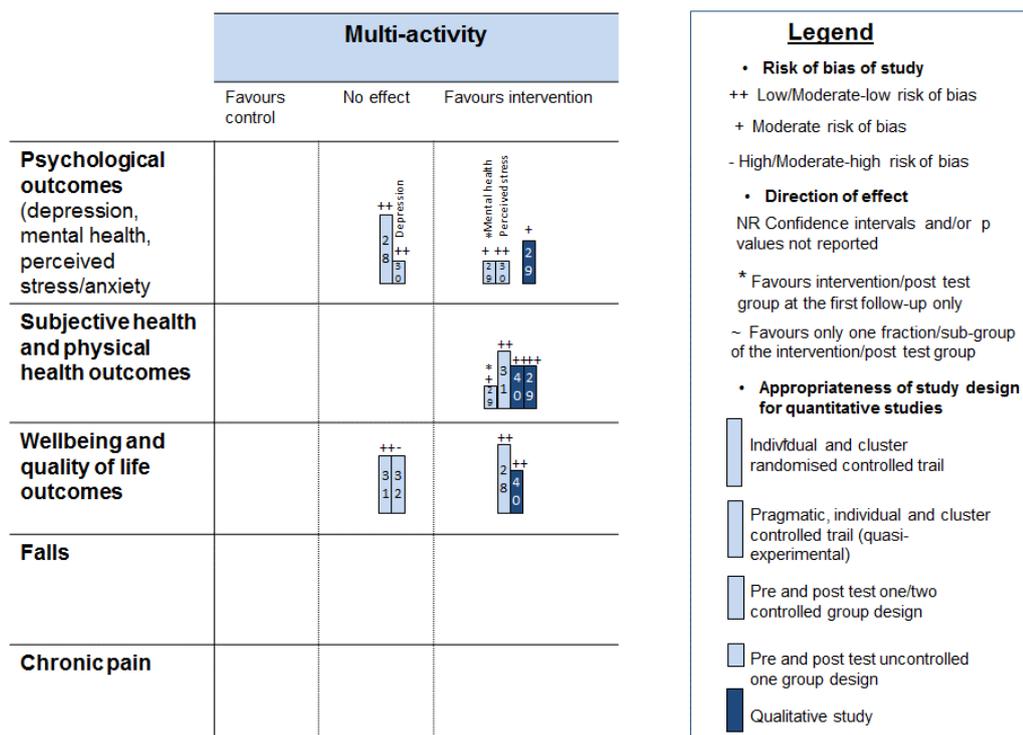


Figure 22 Harvest plot for multi-activity interventions. Studies are numbered based on those used in the Summary Table 7 and Table 8.

As shown in Figure 23, two qualitative studies rated as low-moderate RoB gave insight on some mediating factors reported by older people as important in reducing depression (Greaves 2006) and in improving physical health (Greaves 2006; Buijs et al. 2003). These included (i) improved attention to self-care, self-worth, enjoyment, (ii) improved interactions and social interactions and (iii) and feeling valued. Older people reported perceived psychological and physical health benefits including ‘feel better’, increased flexibility and strength.

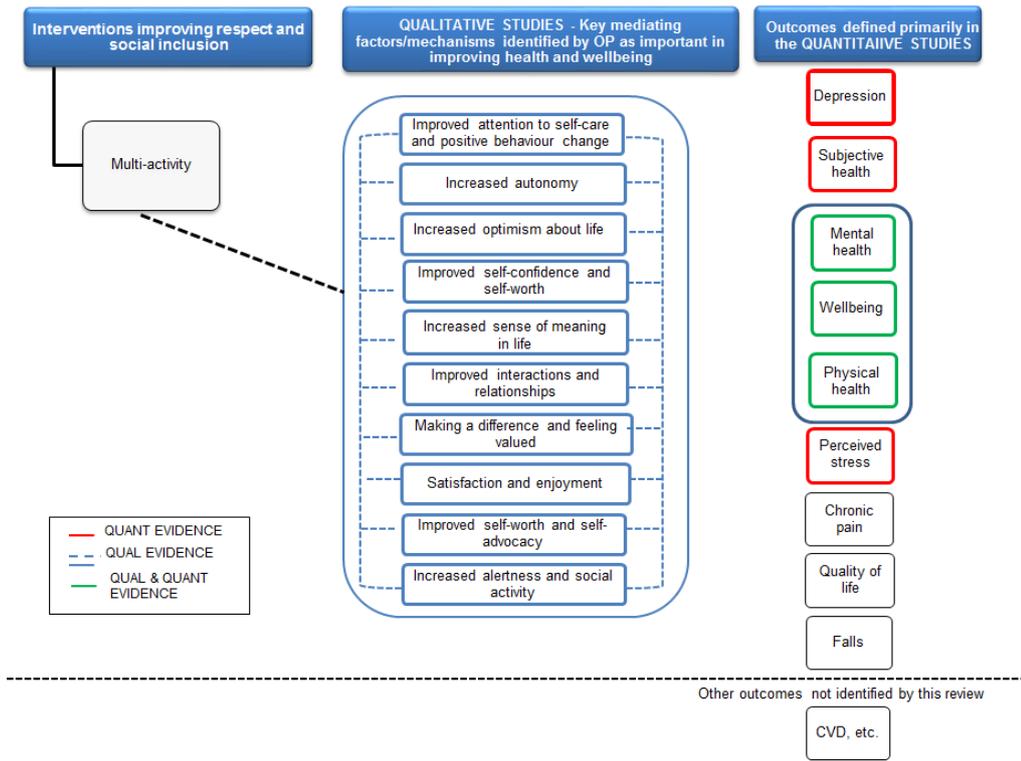


Figure 23 Diagram for multi-activity interventions (QUANT signifies quantitative; QUAL signifies qualitative).

**Table 7 Characteristics of included studies - Summary of the quantitative evidence of the included studies stratified by intervention type**

NA= not applicable; NS= non-standardised; NR= not reported; OP= older people (aged 60+ or where the age mean/mode/median is 60+); CI= confidence interval; N= number; Risk of bias: H= high; M= medium; L= low; QUANT= quantitative; MIXED= mixed methods; MD= mean difference; M= mean; <sup>1</sup> Liverpool Quality Assessment Tools (Pope, 2014)

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>		<b>Scales</b>			
<b>GROUP N 1: Mentoring interventions</b>								
1	Dickens 2011, QUANT	UK Individual controlled trial	Intervention group: N=200 OP Mean Age: 71.8 years F>M  Study participants identified from a population of individuals who were in receipt of the intervention	Control group: N=195 OP Mean Age: 69.8 years F>M  Study participants were receiving usual care through routinely available health, social and voluntary care services  Study participants	To examine the effectiveness of a mentoring programme on the mental health, and physical health of socially isolated OP  Key features: Study participants were assigned a mentor who worked with them for up to 12 weeks; in rare cases the support was offered for	Mental health status, physical health, health status, depression  SF-12 mental health component score (SF-12MCS); SF-12 physical health component score (SF-12PCS), health status (EQ-5D), Geriatric Depression Scale (GDS-10)	OP mentoring (intervention group) experienced non-significant improvement in <u>mental health</u> (MD= 0.8; 95% CI -1.5 to 3.2; p = 0.48); physical health (MD= 0.1; p = 0.90); and reduction in depression (MD=0.2; p = 0.29) at 6 months. In the intervention group, <u>subjective health</u> improved (MD= -0.09; p < 0.01) over 6 months. However, intervention group participants reported significantly less improvement in	L-M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
				recruited through 3 general practices	longer. The aim was to build OP's self-confidence and engage them in social activities.		subjective health than controls (MD= -0.1; 95% CI -0.1 to -0.03; p < 0.01).	
2	Ellis 2004, MIXED (this study is included in the intergenerational interventions as well)  (only QUANT part reported; QUAL excluded for no info on data and analysis)	UK Before and after one group design	In 2003 N=64 OP F=M in 2004 N=39 OP Almost F=M Mean age: NR  Study participants were taking part in the mentoring programme	Subjects acted as own controls	To assess the impact of an intergenerational mentoring programme on health and wellbeing of the  Key features: OP mentored younger (Y4-6) and older (Y9-11) children by providing learning support (e.g. areas of mathematics), or by taking part in various intergenerational activities	Wellbeing  Short Form 12 Health Survey (SF12)	OP reported non-significant improvement in the <u>physical health</u> questions, mental health scores and in quality of life between the responses for 2002/3 and those recorded for 2003/4 [numbers, CIs and p-values NR]	H

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			Recruitment			Scales		
<b>GROUP N 2: Intergenerational interventions (including Ellis 2004)</b>								
3	Chung 2009, QUANT	China Before and after one group design	N= 49 OP with early dementia Mean age: 79 years F>M  Study participants recruited from eight-day care centre (convenience sampling)  N=117 youth participants aged between 16 and 25 years	Subjects acted as own controls	To examine the impact of a reminiscence programme, adopting an intergenerational approach, on OP with early dementia and youth volunteers.  Key features: Each OP was assigned to two youth participants	Quality of life, depression, orientation, mental health, aspects of physical health  Quality of Life- Alzheimer's Disease (QoL-AD)  Chinese version of Geriatric Depression (CGDS)	OP taking part in the intergenerational programme reported an improvement in <u>quality of life</u> (MD= -1.91; 95% CI = -3.18, -0.64) and a reduction in <u>depressive symptoms</u> (MD = 1.86; 95% CI = 0.92, 2.80) within 2 weeks after the completion of the programme.	L
4	De Souza 2007, QUANT	Brazil Cluster randomised control trial	Intervention group: N=149 OP Mean age= 69.5 years F>M	Control group: N= 117 OP Mean age= 69.5 years F>M	To see whether participants in an intergenerational reminiscence programme had better scores on self-rated health	Self-rated health  Questions taken from the Brazilian Old Age Scale	OP taking part in the intergenerational programme (intervention group) experienced non-significant improvement in the <u>self-rated health</u>	L

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
			(only 32 attended the intervention activities) Follow-up interviews: 134 OP	Follow-up interviews: 103 OP  5 classes randomly allocated to the control group	at the end of the intervention Key features: intergenerational activities in which OP shared their memories with the students. The intervention was based on the use of reminiscence to promote joint activities		(p=0.554; OR 1.133: 95% IC 0.749–1.716) at 4 months' follow-up.	
5	Hernandez 2008, QUANT	Spain Before and after design with two control groups	Students: Intervention group N=100  OP: slightly depressed older people Group 1: N=36 (treatment with students) Mean age: 74 years F>M	Students: Control group N=79.  Group 3: N=32 (they attended the recreational activities organised in the centre) Mean age: 75 years F>M	To analyse the effect of an intergenerational programme on OP's wellbeing  Key features: 32 interactive sessions between students and OP based on service-learning pedagogy. In group 1 the	Depressive symptoms  The Yesavage Depression Scale (YDS)	Group 1 of OP showed a reduction of <u>depressive symptoms</u> scores obtained in the post-treatment evaluation (MD= 3.53 p < .001). Group 2 showed significant a reduction in <u>depressive symptoms</u> scores obtained in the post-treatment evaluation (MD= 1.11 p < .008). However, this	L

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
			Group 2: N=35 (treatment with professional) Mean age: 75 years F>M	Study participants took part in weekly recreational activities	session was led by students; in group 2 by professionals		improvement is worse than that shown by Group 1. For Group 3 (control) an increase of the scores obtained in the post treatment evaluation, revealed an increase of <u>depressive symptoms</u> (MD= -2.72 p < .001).	
6	Hong 2010, QUANT	USA Quasi-experimental two-group pre-post-test design	Intervention group: N=167 OP Mean age: 64.78 years F>M  Study participants were new volunteers taking part in the programme	Control group: N=167 OP Mean age: 65.14 years F>M  The control group was established through matching individuals participating in the Health and	To evaluate the effects of an intergenerational school programme on OP's health outcomes over a two-year period  Key features: OP interacted with students in the classroom on a regular basis.	Self-rated health; depression;  Self-rated health: NS 9 items from the Centre for Epidemiologic Studies Depression Scale (CES-D)	OP taking part in the intergenerational programme (intervention group) experienced a decrease in <u>depressive symptoms</u> at 2 years' follow-up (MD=0.94 5.08-4.14 p<.001). OP in the intervention group reported non-significant improvement in <u>self-rated health</u> at 2 years' follow-up. When adjusting for pre-test	L

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
				Retirement Study (a biennial survey of a large nationally-representative sample of adults over the age of 50)	Activities include support students to improve academic achievement		health status, socioeconomic status, volunteer history, and boosted propensity scores, the intervention group experienced greater reduction in <u>depressive symptoms</u> (p < .001) at 2 years' follow-up. OP in the intervention group experienced greater improvement in <u>self-rated health</u> that were marginally significant (p = .09) at 2 years' follow-up. The effect sizes associated with programme participation were 0.73 for depressive symptoms for the intervention group.	
7	Fujiwara 2009, QUANT	Japan	Intervention group: N=67 OP	Control group: N=74 OP	To assess the impact of an	Self-rated health;	OP taking part in the intergenerational	M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
	(same study as Murayama 2014, QUANT)	Cluster controlled trial	(After 12 months n=39 'intensive volunteers' and n=17 'volunteers with low frequency') Mean age: 68.2 years F>M  3 cities were selected and study participants were recruited through newspapers or newsletters  Children recruited from 6 schools, 3 kindergartens, and six child care centres	Mean age: 68.7 years F>M  Study participants recruited from various social activity clubs (e.g. hobby clubs)	intergenerational programme on health and depressive symptoms of the participants.  Key features: OP were engaged in reading picture books to children	depressive symptoms  NS scale; the short version of Geriatric Depression Scale Version Japanese (GDS-S-J)	programme (intervention group) experienced an improvement in <u>self-rated health</u> that was greater among the 'intensive' participants of the intervention group (n=37) than the control group (n=60) at 21 months (p < 0.01). OP (intervention group) experienced a non-significant improvement in <u>self-rated health</u> at 9 months (MD=0.2. 1.9-2.1) when compared to the control group (MD= 0.1. 2.1-2.0) [Depressive symptoms results reported in Murayama 2014]	
8	Gaggioli 2014, QUANT	Italy	N=32 OP	Subjects acted as own controls	To test if an intergenerational	Perceived quality of life	OP taking part in the intergenerational	M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
		Before and after one group design	Mean age: 67.5 years F/M= NR  Study participants were recruited from different social senior centres  N=114 students recruited from primary schools located in the same area of OP		remembrance programme could benefit perceived quality of life in OP  Key features: OP were assigned to 16 groups, each including two OP and six to eight students. A psychologist facilitated the 3 weekly meetings of reminiscing activities (e.g. local traditions, jobs and professions of the past, and historical events)	The adapted Italian version of the World Health Organization Quality of Life Scale for Older People (WHOQOL)	programme experienced an improvement in perceived <u>quality of life</u> immediately after the completion of the 3-week programme (p<.05). [further details NR]	
9	Murayama 2014, QUANT	Japan Cluster controlled trial	Intervention group: N=67 OP (N=26 OP	Control group: N= 82	To examine whether participation in	Depressive mood	OP taking part in the intergenerational programme	M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
	(same study as Fujiwara 2009 QUANT)		<p>included in the analysis) Mean age: 68.8 years F&gt;M</p> <p>Study participants recruited through newspapers or newsletters</p> <p>Study participants who took part in the seminars constituted the intervention group</p>	<p>(N=54 OP included in the analysis) Mean age: 69.3 years F&gt;M</p> <p>Study participants were recruited from hobby clubs, volunteering for adults, etc., but none of them were allowed to engage themselves in intergenerational programs with children</p>	<p>the intergenerational programme affected OP's depressive mood by strengthening their sense of coherence</p> <p>Key features: OP were engaged in reading picture books to children</p>	<p>Geriatric Depression Scale-Short Version-Japanese</p>	<p>(intervention group) experienced an improved sense of meaningfulness which was positively correlated with <u>depressive mood</u> (p=.001); When controlling for sense of meaningfulness, the overall direct effect of programme participation was reduced (p &lt; .05). Multiple mediation analysis revealed that participation in the programme was associated with a sense of manageability which was also significantly related to depressive mood.</p>	
10	Fried 2004, QUANT	USA Pilot individual randomised controlled trial	Intervention group: N=70 OP Mean age: 69 years	Control group N= 58 Mean age: 69	To assess if an intergenerational school programme leads	Falls (fallen in the last 12 months)	OP taking part in the intergenerational programme (intervention group)	M-H

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
	(same study as Rebok 2011 QUANT)		<p>F&gt;M</p> <p>Study participants were recruited through community groups and church in the neighbourhoods around the chosen schools, etc. They were randomly assigned to the intervention or control group.</p> <p>6 public elementary schools recruited</p>	F>M	<p>Sampling method for the control group NR</p> <p>Key features: OP worked 15 hours per week. Activities included support literacy development for children, etc.</p>	NS	<p>experienced a non-significant decrease of more than 50% in <u>falls</u> rates (from 15% to 7%) at 4-8 months' follow-up (p= 0.17) if compared with the controls, wherein <u>falls</u> rate increased from 10% to 13% among the OP. [CIs and p-values NR]</p>	
11	Newman 1995, QUANT	USA Before and after one group design	N=26 OP Mean age: NR F>M	Subjects acted as own controls	To assess the effect of the programme on perceived depression	Perceived depression	OP taking part in the intergenerational programme experienced a reduction in perceived <u>depression</u> of 16.64% at	H

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b> Convenience sampling		(secondary outcome) in relation to age and educational level (descriptive analysis)  Key features: OP interacted with students in the classroom. OP assisted students in some activities including maths problems, and science experiments.	<b>Scales</b>	6-8 weeks' post-test. Effects by Education level: OP in the lower education group (high school) experienced an increase of in perceived <u>depression</u> 1.61% at 6-8 weeks' post-test; the higher education group (college) reported a decrease of 26.42% in perceived <u>depression</u> at 6-8 weeks' post-test. Effects by Age: the older group (70 and over) experienced a decreased in perceived <u>depression</u> of 24.27% at 6-8 weeks' post-test, while the younger group (60 and over) reported an increase in perceived <u>depression</u> of 4.77% at 6-8 weeks' post-test. [CIs and p-values NR]	

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
12	Mendis 1993, QUANT	USA Non-concurrent multiple baseline design/ before and after one group design	N=20 OP Mean age: 83.7 years M/F= NR  Study participants were recruited from a residential facility. OP were randomly assigned to children  N= children: NR	Subjects acted as own controls	To explore the effect that participation in an intergenerational programme may have on the psychological wellbeing of OP  Key features: older people were involved with pre-school children in various activities such as drawings, reading from children's books decorating a cup etc.	Psychological wellbeing; depression  Centre for Epidemiological Studies- Depression Scale (CES-D)	OP taking part in the intergenerational programme experienced a non-significant reduction in <u>depression</u> scores at 8-weeks' follow-up (p=0.3). [Findings for psychological wellbeing NR]	M-H
2	Ellis 2004, MIXED (this study is included in the intergenerational	UK Before and after one group design	In 2003 N=64 OP F=M in 2004 N=39 OP Almost F=M	Subjects acted as own controls	To assess the impact of an intergenerational mentoring programme on	Wellbeing  Short Form 12 Health Survey (SF12)	OP reported non-significant an improvement in the <u>physical health</u> questions, <u>mental health</u> scores and in <u>quality of</u>	H

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
	interventions as well)  (only QUANT part reported; QUAL reported in Table8)		<b>Recruitment</b>  Study participants were taking part in the mentoring programme		health and wellbeing of OP  OP mentored younger (Y4-6) and older (Y9-11) children by providing learning support (e.g. areas of mathematics), or took part in various intergenerational activities	<b>Scales</b>	<u>life</u> between the responses for 2002/3 and those recorded for 2003/4. [CIs and p-values NR]	

### GROUP N 3: Dancing interventions

<b>13</b>	Houston 2015, MIXED (grey literature)  (only QUANT part reported; QUAL reported in Table 8)	UK Individual controlled study	Intervention group: N=24 OP with PD of which the majority was 60 years M/F= NR  Study participants were volunteers	Control group: N=15 OP with PD  Sampling method for the control group NR	To examine the effects of a dancing programme for OP with Parkinson's disease on their health, quality of life, and falls	Health; quality of life, falls  Dance for Parkinson's' questionnaire (including questions from SF-36, UPDRS, Centre for	OP taking part in the dancing programme (intervention group) experience non-significant improvements in <u>subjective health</u> (including change in medication), <u>quality of life</u> , and <u>falls</u> scores between 2 weeks and 6-	M
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Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
			taking part in the programme		Key features: OP took part in several dancing sessions led by professionals	Epidemiologic Studies Depression Scale)	8 months' follow-up. [CIs and p-values NR]	
14	Hackney 2007, QUANT	USA Individual Randomised controlled trial	Intervention group (tango): N=9 OP with PD N=9 without PD of which the majority was 60 years M/F= NR  Study participants with PD were recruited from the University School of Medicine's Movement Disorders Center and the community, and were randomly assigned to one of two groups:	Control group (traditional exercise); N=10 with PD N=10 without PD of which the majority was 60 years	To compare the effects of a 13 weeks' intervention (tango) to those of traditional exercise on depression and falls in OP with and without Parkinson's Disease (PD)  Key features: OP took part in several dancing sessions led by professionals	Depression; falls (more confidence in their ability not to fall during daily activities)  The modified Falls Efficacy Scale; The 17-item Philadelphia Geriatric Centre Morale Scale	OP with PD taking part in the tango dancing programme (intervention group) experienced little overall reduction in <u>depression</u> scores (MD= 3.31, p = 0.001) at 10-week follow-up when compared with controls. OP with PD taking part in the tango dancing programme (intervention group) experienced improvements in the measures of <u>falls</u> (functional reach and one leg stance) at 10-week follow-up if compared to the control group. [CIs and p-values NR for falls]	M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
			tango or traditional exercise.					
<b>GROUP N 4: Music and singing interventions</b>								
15	Coulton 2015, QUANT (same study as Clift 2012, grey literature QUANT)	UK Pragmatic randomised controlled trial	Intervention group (singing group): N=127 OP Mean age= 69 years F>M  Study participants were recruited from day centres and through local advertisements and were randomly assigned to the intervention or control group	Control group (non-singing group): N=131 OP Mean age= 69 years F>M  Participants of the control group continued with their normal activities	To assess the effectiveness for OP of an engagement in community singing on measures of physical and mental health  Key features: OP come together to sing with the support of professional musicians	Health-related quality of life; physical health-related components of quality of life; depression and anxiety  York SF-12 mental health component; SF12 – Physical health component: Hospital Anxiety and Depression Scale (HADS)	OP taking part in the singing programme (intervention group) experienced an improvement in <u>mental health-related quality of life</u> at 6 months' follow-up (MD=2.35 p=0.05). However, OP taking part in the singing programme (intervention group) experienced non-significant improvements in the <u>physical health related quality of life</u> (MD 0.26 p=0.73), <u>anxiety</u> (MD= -0.57 p=0.13) and <u>depression</u> (MD= -0.53 p=0.14) at 6 months' follow-up. At 3 months, OP taking part in the singing programme	L

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>	(intervention group) experienced improvements in <u>mental health-related quality of life</u> (MD= 4.77 p <0.01), a reduction in <u>anxiety</u> (MD= -1.78 p <0.01) and <u>depression</u> (MD=-1.52 p <0.01).	
24	Cohen 2006, QUANT	USA Individual controlled trial	Intervention group (chorale singing) N=90 OP F>M Mean age: 79 years  Study participants were recruited through notices requesting volunteers  Study participants were assigned to either an	Comparison group: N=76 OP Age mean: 79.9 years  The control group was a specific subsample of a longitudinal study	To measure the impact of community-based cultural programmes on the physical health, and mental health of OP  Key features: The cultural programmes comprised participatory art programmes, ranging from painting, writing, to music in the	Overall perceived health; falls; depression  Self-reported assessments of general physical health; Geriatric Depression Scale-Short Form (GDS)	OP taking part in the participatory cultural programme experienced improvements in <u>perceived health</u> (MD= 0.72; p <.01), and a decrease in <u>falls</u> to an average of 0.23 <u>falls</u> per person (P < .05) and fewer other health problems (MD= -0.15 p< .10) than the comparison group at 12 month-follow-up. However, OP taking part in the participatory cultural programme experienced non-significant	L

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
			intervention (chorale) or comparison (usual activity) group.		form of singing in chorales.  The intervention consisted of participating in a professionally conducted chorale in which there were weekly singing rehearsals for 30 weeks as well as public performances		improvements in <u>depression</u> (MD= -0.7) than the comparison group at 12 month-follow-up.	
16	Clift 2011, QUANT	UK A before and after one group design (longitudinal, observational design)	N=137 OP (N=42 provided sufficiently data on the CORE questionnaire) Mean age: 59.6 years F>M  Study participants	Subjects acted as own controls	To describe the development and evaluation of community singing programme with mental health services users	Mental distress  CORE questionnaire	OP taking part in the singing programme experienced a reduction in <u>mental distress</u> over a period of 8 months (MD= 2.58 p<0.001) with a moderate effect size of 0.44. Improvements were shown in the three sub-scales of mental distress	L-M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
			were volunteers taking part in the programme		Key features: the new choirs met weekly in community centres under the direction of facilitators who received training and support as part of the project		within the CORE questionnaire: wellbeing (MD=0.37 p< 0.003), problems (MD=0.07 p 0.005) and functioning (MD= 0.29 p< 0.003). The risk subscale showed non-significant improvement.	
17	Davidson 2014, MIXED  (only QUANT included; QUAL part excluded as data were not stratified by institutional and community setting)	Australia Pre and post-mixed methods one group design (the second group was excluded from this review as recruited from an institutionalised setting)	Participants (community group): N=16 OP Mean age: 70 years M/F= NR	Subjects acted as own controls	To evaluate the effect of a community singing programme on measures of health and wellbeing in OP  Key features: singing sessions were led by an experienced community musician at a	Physical and mental health; depressive symptoms  Medical Outcomes Study Short-Form (SF-36) Health Survey Version 2; Geriatric Depression Scale (GDS)	OP taking part in the singing programme experienced non-significant reductions in <u>depressive symptoms</u> (MD= -0.2), and in <u>physical and mental health</u> scores apart from the vitality subscale (MD=10; p= 0.03) at 8 weeks' follow-up.	M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			Recruitment			Scales		
					local community centre			
18	Creech 2013, QUANT (same study as Hallam, 2012 MIXED)	UK Before and after group design with a control group  (3 case studies of musical community involvement and comparisons with control group)	Intervention group: N= 398 OP involved in musical activities Modal age: 65 years F>M  Study participants were volunteers taking part in the programme	Comparison group: N= 102 Modal age: 65 years F>M  OP in the control group participated in non-music activities (e.g. language, book, yoga, and social groups)	To explore the impact of active engagement with music making on the wellbeing and quality of life of a sample of OP  Key features: musical activities included steel pans, guitars, etc. Participants in each case study site had the opportunity to take part in performances.	Quality of life; subjective wellbeing  The Basic Needs Satisfaction Scale (sub-components control, autonomy and relatedness); 12-item version of CASP to measure the dimensions of control, autonomy, self-realisation and pleasure	OP taking part in the music making programme (intervention group) experienced improvements in two components of the <u>quality of life</u> scale related to control (p = .0001) and pleasure (p = .0001) at 9 months' follow-up if compared to the controls, but non-significant improvements in the other two components of the <u>quality of life</u> scale related to autonomy or self-realisation. OP taking part in the music making	M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			Recruitment			Scales	programme (intervention group) experienced improvements in the total score of the <u>subjective wellbeing</u> scale (p = .01), and in the sub-scale linked to relatedness (p = .002) at 9 months' follow-up.	
19	Davidson 2011, MIXED  (only QUANT included; QUAL part excluded as data were not stratified by institutional and community setting)	Australia Before and after mixed methods one group design (the second group was excluded from this review as recruited from an institutionalised setting)	Participants (community group): N=23 including 11 OP with dementia Mean age: 71 years M/F=NR  N=11 caregivers  Study participants were recruited from a community centre	Subjects acted as own controls	To assess the impact of the singing programme on the quality of life of OP  Key features: 6-week singing program targeted for OP with dementia and their caregivers and delivered by a program facilitator	Quality of Life – Alzheimer's Disease (QoL-AD)	OP taking part in the singing group experienced non-significant improvements in the overall <u>quality of life</u> scores, or for scores given to each individual item at 6 weeks' follow-up. This is in contrast with what observed by combining the two groups of OP and by their carers. [Further details on results NR]	H

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			Recruitment			Scales		
<b>GROUP N 5: Information-communication technology interventions</b>								
20	Slegers 2008, QUANT (same study as Slegers 2013 QUANT)	Netherlands Individual randomised controlled trial	Randomisation 1 Intervention group: N=123 OP (training) aged between 64 and 75 years M/F=NR  Randomisation 2 Group 1 (training and intervention): N=62 OP Group 2 (training- no Intervention): N=61 OP  Study participants were recruited through flyers and were randomly	Randomisation 1 Group 3 (no training-no Intervention): N=68 OP  Group 4: (participants with no interest in computer use): N=45 OP	To examine the impact of a computer training programme on between the measures of physical wellbeing, social wellbeing, and emotional wellbeing in OP  Key features: OP in in the intervention group received a personal computer with a broadband Internet connection and were given weekly and monthly Internet	Physical health; emotional wellbeing (depression, anxiety, and sleep complaints)  36-item Short-Form Health Survey (SF-36), 90-item Symptom Check List SCL Anxiety Self-report measures of wellbeing and quality of life	OP taking part in the computer training programme (Group 1 training and intervention) experienced non-significant improvements on the <u>physical</u> (p=0.14) and <u>mental health</u> (p=0.10), and reduction in <u>depression</u> (p=0.56), <u>anxiety</u> (p=0.13), and <u>sleep complaints</u> (p=0.89) at 4 and 12 months' follow-up when compared with the other groups (training-no intervention; no training-no intervention; not interested)	L  Moderate

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
			assigned to the intervention or control group		assignments and a helpdesk			
21	Woodward 2011, QUANT	USA Individual randomised controlled trial	Intervention group: N=45 OP (first wave Technology and Aging Programme (TAP1)) Mean age: 72 years F>M  Study participants were survey respondents who expressed interest in participating in future research and were randomly assigned to the	Control group N=38 OP (first wave of TAP1) Mean age: 72 years F>M  Participants who expressed an interest in participating in the project	To examine the impact of a computer training programme on OP's mental health related outcomes  Key features: classes were taught by a project coordinator and topics included basics of using a computer, using voice and video via the Internet , etc. every 2 weeks.	Mental health related outcomes (depression; quality of life)  NS scale for quality of life; Geriatric Depression Scale (GDS)	OP taking part in the computer training programme experienced improvements in <u>quality of life</u> at 6 months' follow-up (fixed effects model 2: 4.99; p<.05) and non-significant reduction in <u>depressive symptoms</u> (fixed effects model 2: -0.12 non-significant) at 6 months' follow-up if compared to the control group.	M Moderate

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
			intervention or control group					
22	Woodward 2012, QUANT	USA Before and after group study one controlled group design	Intervention group (second wave Technology and Aging Programme (TAP2)): N= 19 OP Mean age: 73 years F>M  Participants were from the control group of a previous programme (TAP1) [see above Woodward 2011]	Control group (first wave Technology and Aging Programme (TAP1)): NR (N=45) OP Mean age: 72 years F>M  This study used as a control group a sample of participants who participated in a previous programme TAP1 [see above Woodward 2011]	To test a peer tutor model to teach older adults how to use information and communication technologies, and to examine its impact on mental health related outcomes  Key features: weekly programme based on a peer tutor model to teach OP how to use information and communication technologies	Mental health related outcomes (depression; quality of life)  NS scale for quality of life; Geriatric Depression Scale (GDS)	OP taking part in the peer tutor model computer training programme experienced non-significant improvements in <u>quality of life</u> and <u>depressive symptoms</u> at 3, 6 and 9 months' follow-up if compared with the control group (TAP1) staff-directed model.	M-H
<b>GROUP N 6: art and culture-based interventions (including Cohen 2006)</b>								
23	Phinney 2014, MIXED	Canada	N=51 OP (4 groups)	Subjects acted as own controls	To evaluate the effect of a	2 domains of health: physical	OP taking part in the community-engaged	L

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
	(only QUANT part reported; QUAL reported in Table 8)	Before and after one group design	F>M Mean age: 73.5 years  Recruitment occurred through the Alzheimer's Society, Extra Care Charitable Trust and the host galleries		community-engaged arts programme on the physical, emotional, and social wellbeing of OP  Key features: Weekly workshops for 3 years where artists worked with OP to produce a collective art piece or performance for public presentation	wellbeing (daily function, perceived health status, chronic pain); emotional wellbeing (depressive symptoms)  PHYSICAL wellbeing: Older Americans Resources and Services Activities of Daily Living Questionnaire (OARS-(I)ADL); single item perceived overall health; single item verbal descriptor scale EMOTIONAL wellbeing: Geriatric Depression	arts programme experienced improvements in <u>perceived health</u> (MD=-0.4; p< .10; medium effect size d= 0.41) and a reduction in <u>chronic pain</u> measures (MD=0.5 p<.05; medium effect size d=0.52) at 1st year and 2nd year and half follow-up. OP also experienced non-significant improvements in daily function (MD=0.4, effect size d=0.19) and reduction in <u>depression measures</u> (MD= 0.7, effect size d=0.20) at 1st year and 2nd year and half follow-up	

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
						Scale short (GDS short)		
24	Cohen 2006, QUANT	USA Individual controlled trial	Intervention group (chorale singing) N=90 OP F>M Mean age: 79 years  Study participants were recruited through notices requesting volunteers  Study participants were assigned to either an intervention (chorale) or comparison (usual activity) group.	Comparison group: N=76 OP Age mean: 79.9 years  The control group was a specific subsample of a longitudinal study	To measure the impact of community-based cultural programmes on the physical health, and mental health of OP  Key features: the cultural programmes comprised participatory art programmes, ranging from painting, writing, to music in the form of singing in chorales. The intervention consisted of participating in a professionally conducted	Overall perceived health; falls; depression  Self-reported assessments of general physical health; Geriatric Depression Scale-Short Form (GDS)	OP taking part in the participatory cultural programme experienced improvements in <u>perceived health</u> (MD= 0.72, p< .01), and a decrease in <u>falls</u> to an average of 0.23 <u>falls</u> per person (p< .05) and fewer other health problems (MD= -0.15, p< .10) than the comparison group at 12 month-follow-up. However, OP taking part in the participatory cultural programme experienced non-significant improvements in <u>depression</u> (MD= -0.7) than the comparison group at 12 month-follow-up.	L

Study no.	First author, year published, study type	Country and study design	Study participants Recruitment	Comparison group(s)	Study aim and intervention	Outcome measures Scales	Summary of main results	Risk of bias <sup>1</sup>
25	Camic 2014, MIXED  (only QUANT part reported; QUAL reported in Table 8)	UK Before and after one group design (2 intervention sites)	N=24 OP (12 with dementia) Mean age=78.3 years M/F=NR  Study participants were recruited through the Alzheimer's Society, Extra Care Charitable Trust and the host galleries	Subjects acted as own controls	chorale in which there were weekly singing rehearsals for 30 weeks as well as public performances  To examine the impact on OP's quality of life of an 8-week art-gallery-based intervention conducted at two distinct types of galleries (traditional and contemporary)  Key features: sessions included one hour of art viewing and discussion followed by one hour of art making	Health-related quality-of-life  Dementia Quality of Life (DEMQOL-4) questionnaire	OP taking part in both art-gallery-based interventions (traditional and contemporary) groups experienced non-significant improvements in <u>health related quality of life</u> (p=0.88).	M

Study no.	First author, year published, study type	Country and study design	Study participants Recruitment	Comparison group(s)	Study aim and intervention	Outcome measures Scales	Summary of main results	Risk of bias <sup>1</sup>
26	Yuen 2011, MIXED  (only QUANT part reported; QUAL reported in Table 8)	USA Before and after one group design	N=12 OP Aged between 62–88 years' old F>M  Study participants were volunteers currently involved with the programme	Subjects acted as own controls	To evaluate the impact of the theatre programme on OP's psychological wellbeing and health-related quality of life  Key features: the theatre programme included a 6-week acting class and 4 public performances	Subjective wellbeing; distress; health-related quality of life  General Wellbeing Schedule (GWBS); the 36-Item Short-Form Health Survey (SF-36)	OP taking part in the theatre programme experienced improvements in <u>subjective wellbeing</u> (MD=20.2, p=.002), <u>physical health</u> (MD=11.9, p=.03) at one-month follow-up. OP taking part in the theatre programme experienced non-significant improvements in <u>mental health</u> (p=.154) at one-month follow-up.	M
27	Vogelpoel 2014, MIXED  (only QUANT part reported;	UK Before and after one group study design	N=12 OP with sensory impairments (measures of wellbeing)	Subjects acted as own controls	To describe the benefits on wellbeing of a 12-week social prescribing art	Wellbeing  Warwick and Edinburgh Mental	OP taking part in the social prescribing service programme experienced non-significant	M-H

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
	QUAL reported in Table 8)		<p><b>Recruitment</b></p> <p>collected for N=8) Mean age: 80 years F&gt;M</p> <p>Study participants were referred by general practices</p>		<p>service programme for OP with sensory impairments experiencing social isolation</p> <p>Key features: The programme included participation in an arts workshop programme; ongoing individual assessments of health status; and ongoing observations of OP's health status</p>	<p><b>Scales</b></p> <p>Wellbeing Scale (WEMWBS); an extension of Thiele and Marsden's Dynamic Observation scale</p>	<p>improvements in <u>wellbeing</u> at the last week of the programme. The overall mean score for the group increased by six points, from 41 to 47. [Further details on results NR]</p>	
<b>GROUP N 7: Multi-activity interventions</b>								
28	Saito 2012, Japan, QUANT	Individual randomised controlled trial	Intervention group: N=21 socially isolated OP	Control group: N=42 OP aged between 66–84 years	To examine the effect of a programme focused on	Depression; subjective wellbeing	OP taking part in the programme experienced (intervention group) improvements in	L-M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
			aged between 66–84 years F>M  Study participants were recruited from the Basic Resident Registration Cards  Participants were randomly allocated to the intervention or control group	F>M  OP in the control group were sent several newsletters or written information about group activities in the city during the intervention period	preventing social isolation on depression, and subjective wellbeing of OP  Key features: four sessions of a group-based programme were designed to prevent social isolation by improving community knowledge and networking with other participants and community gatekeepers	Geriatric Depression Scale (GDS); The Life Satisfaction Index A (LSI-A)	subjective <u>wellbeing</u> (p =0.039) at 1 and 6 months' follow-up (improvement of 1 point at 1 month and 1.9 points at 6 months' follow-up). OP in the intervention group experienced a non-significant reduction in <u>depression</u> at 1 and 6 months' follow-up (increase of 1.1 points at 1 month but a reduction of 0.4 point at 6 months) [p-values for depression NR].	
29	Greaves 2006, MIXED  (only QUANT part reported; QUAL reported in Table 8)	UK before and after one group design	N=229 socially isolated OP Mean age=77 years F>M  (Data were available for	Subjects acted as own controls	To evaluate the impact of a programme focused on preventing social isolation on the depressive symptoms, and	Depressive symptoms; physical and mental wellbeing/health	OP taking part in the programme experienced improvements in <u>mental health</u> (MD=3.02, 95% CI: 1.01-5.04, p < 0.005) and a reduction in <u>depressive mood</u> (MD =	M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<p><b>Recruitment</b></p> <p>N=172 OP at baseline, N= 72 OP at 6 months and N=51 OP at 12 months)</p> <p>Study participants purposively selected among those who participated in the programme</p>		<p>on physical and mental wellbeing of OP</p> <p>Key features: activity-based interventions were combined with visits from peers initially on a weekly basis, and regular telephone contact, which is gradually diminished as participants become more confident</p> <p>Participants determined programmes of creative, exercise and/or cultural activities</p>	<p><b>Scales</b></p> <p>Geriatric Depression Scale (GDS)</p> <p>SF12 Health Quality of Life</p>	<p>0.60, 95% CI: 0.14-1.05, p &lt;0.02) at 6 months' follow-up. OP taking part in the programme experienced non-significant improvements in <u>physical health</u> (p=0.996) at 6 months' follow-up. At 12 months, OP taking part in the programme experienced non-significant improvements in <u>mental health</u> (p=0.654), and improvements in <u>depressive mood</u> (MD =-0.57, 95% CI: 0.02-1.11. p &lt; 0.05). <u>Physical health</u> was close to significance (MD = 1.57, 95% CI: -0.08-3.22, p= 0.06). OP taking part in the programme experienced improvements in health utility scores</p>	

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>	(combining mental and physical components) at 12 months' follow-up (MD= 0.027, 95% CI: 0.002-0.052, p < 0.05).	
30	Gonyea 2013, QUANT	USA Before and after one group design	N=33 OP Mean age: 81 years M/F=NR  Study participants were recruited from the census data	Subjects acted as own controls	To examine a support community based programme and the effects on stress, and depression on OP  Key features: the programme was a neighbourhood-based membership organisation supported OP's ability to continue to live in their homes even as their	Perceived stress; depressive symptoms  10-item Perceived Stress Scale (PSS); Geriatric Depression Scale (GDS)-Short Form of 15 items	OP taking part in the community based programme experienced reductions in <u>perceived stress</u> (MD=3.3 p < .001), and non-significant reductions in <u>depression</u> at 9 months' follow-up (MD=0.03 p > .33). [At enrolment, the OP's mean for depression was 3.64; although no individual scored 10 or higher (indicative of severe depression), 18% were in the 6 to 9 range, suggestive of at least mild depression]	L-M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			Recruitment			Scales		
					functional abilities decline. Activities included regular gatherings in neighbours' homes, meetings, special events, and a weekly personal telephone call from a fellow member.			
31	Kocken 1998, QUANT	Netherlands Individual controlled trial	Intervention group: N=138 OP of which the majority was aged 65 years F>M  Study participants were volunteers interested in taking part in the programme	Control group: N=182 OP of which the majority was aged 65 years F>M  Controls were people in the waiting list to join the programme	To evaluate the effect of participation in a health promotion programme on the wellbeing and subjective health of OP  Key features: the course included social clubs, exercise programmes and memory training.	Wellbeing; subjective health  Short version of the validated Dutch scale for wellbeing; NS scale or subjective health	OP taking part in the health promotion programme (intervention group) experienced improvements in <u>subjective health</u> immediately after the programme and at 3 months' follow-up, when compared to the control group (p < 0.01 99% CI 0.02–0.72). OP in the intervention group experienced non-	L-M

Study no.	First author, year published, study type	Country and study design	Study participants	Comparison group(s)	Study aim and intervention	Outcome measures	Summary of main results	Risk of bias <sup>1</sup>
			<b>Recruitment</b>			<b>Scales</b>		
					It was facilitated by peers, called senior health educators, who had received prior to the course intensive training		significant improvements in <u>wellbeing</u> at 3 months' follow-up (MD= 0.42 95% CI 20.43–1.28).	
32	Ruffing-Rahal 1994, QUANT	USA Individual controlled trial	Intervention group: N=14 OP recruited purposively M/F= F only  Study participants were recruited purposively for participation in the intervention group	Control group: N=14 OP  A comparable but non-equivalent control group of people living in the same metropolitan census area was followed over the same time	To assess the impact of a 26 weeks' health promotion programme on the wellbeing of OP  Key features: weekly meetings where group facilitators encouraged OP to discuss health information and self-care topics including their feelings and health	Psychological-spiritual wellbeing  The integration inventory as a measure of psychological-spiritual wellbeing	OP taking part in the health promotion programme (intervention group) experienced non-significant improvements in psychological-spiritual <u>wellbeing</u> scores at 6 months' follow-up when compared to the control group (MD control group= 1.38; MD intervention group= 1.47; p 0.2699).	M-H

Table 8 - Summary of the qualitative evidence of the studies included in the systematic review stratified by intervention type

NA= not applicable; NS= non-standardised; NR= not reported; OP= older people (aged 60+ or where the age mean/mode/median is 60+); CI= confidence interval; N= number; Risk of bias: H= high; M= medium; L= low; QUANT= quantitative; MIXED= mixed methods; MD= mean difference; M= mean; <sup>2</sup> [Adapted from Harden et al. 2009 (in Puzzolo et al., 2013; Rehfuess et al., 2014) and Mays & Pope 2000]

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
<b>GROUP N 1: Mentoring interventions</b>							
33	Ellis 2003, MIXED  (only QUAL part reported; QUANT excluded for no info on data and analysis)	UK Qualitative study  Focus group discussions (N=9)	N=42 OP, of which majority were aged 60-75 years F/M= NR  Study participants were volunteers currently involved with the programme  N=54 students (11-12 years old)	To investigate the use, relevance and effectiveness of a mentoring programme, adopting an intergeneration approach, targeting secondary school children in need of support and guidance from older mentor volunteers	<u>Making a difference</u> (feeling valued): mentors reported development of positive relationships with children (quotes provided). <u>Improved confidence, self-esteem and happiness</u> : mentors reported how being involved in the programme increased their confidence and self-esteem by seeing how mentees improved (quotes provided). <u>Coping</u> : Mentors found the programme helpful as a coping strategy for retirement (quotes provided)	OP reported an enhanced physical and mental <u>wellbeing</u> as a result of taking part in the intergenerational mentoring programme. Being a mentor and being involved in the programme helped OP going through difficult times in their lives.	M-H

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
<b>GROUP N 2: Intergenerational interventions (including Ellis 2003)</b>							
34	De Souza, 2003, QUAL	Brazil Qualitative study (focus groups)	N=26 OP were divided into 3 groups separated by sex. Aged 60 and over 1 M group and 2 F groups F>M  Study participants were volunteers who have to have been participating in the programme for at least a year  N=84 students (13-19 years old) randomly selected and divided into 9 groups	To evaluate the intergenerational programme from the participants' viewpoint and assess the impact on the health and wellbeing  Key features: the programme aimed at improvising social cohesion, self-perception of OP health status, reduce stereotypes between generations, and enhance social capital.  10 sessions comprised of five groups with 40 students and 5 OP each. Reminiscence activities included discussing old objects. OP were encouraged	Female groups reported an <u>improvement in perceptions of ageing and towards the younger generation</u> (quotes provided); <u>improved interactions with young people</u> . Female groups reported <u>reduced isolation and sharing their emotions; enjoying partying together</u> (quotes provided). All groups reported <u>strengthening sympathies and developing empathy</u> (quotes provided). Male groups reported <u>satisfaction with being admired by young people</u> , the opportunity of meeting other people and taking part in other activities as well as a <u>feeling of freedom</u> (quotes provided)	Female and male groups reported improvement in their <u>health status</u> . E.g. related relief of their <u>pain</u> and aches (quotes provided). All female groups reported that the intergenerational programme helped them to alleviate their <u>depressive mood</u> and to improve their overall <u>wellbeing</u> and humour (quotes provided)	L-M

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
				to share their experiences with the students over the course of a year.			
35	Weintraub 2007, QUAL (same study as Weintraub 2009, QUAL)	USA Qualitative study (guided interviews)	N=13 OP of which majority were aged 77-83 years F>M Aged 65-90 years' old  Study participants were volunteers recruited through fliers and room visit invitations  N=7 OP (contact group: occasional interactions with children); N=6 OP (engaged group: numerous	To examine perceptions held by OP about the impact of the programme on their emotional and physical wellbeing.  Key features: the centre has an OP day program and a child care centre serving preschool age children in a single building and provides opportunities for daily interaction between children and OP.  Two respondents had daily contact with their children whereas	<u>Emotional wellbeing</u> : OP in the engaged group reported more <u>positive attitudes regarding the children</u> and their involvement than did participants in the contact group. Dimensions of emotional wellbeing: responses of those in the contact group suggested that they were impacted through processes related to <u>peer support, the freedom of choice, manners, and youth and enthusiasm</u> as important dimensions of emotional wellbeing. The engaged group identified <u>being needed</u> . OP in both groups mentioned the importance of <u>familial</u>	<u>Emotional wellbeing</u> : OP reported a positive impact on emotional wellbeing. Seven themes were identified all contributing to the emotional wellbeing (quotes provided). OP reported a feeling of calm as a result of being surrounded and interacting with children (quotes provided). <u>Physical wellbeing</u> : OP in the engaged and contact group reported physical benefits on wellbeing. Six themes were identified all contributing to the physical wellbeing (quotes provided). OP in the contact and engagement groups reported feeling that existing physical	

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
			interactions with children and participated regularly in the programme) Children attended the child care centre. Sample and sampling method NR	others saw their children anywhere from twice a month to two times a year.	<u>connections</u> . OP from the contact group reported an <u>increased physical movement</u> . They spoke of the necessity to be more physically active around the children. OP in the engagement group reported <u>engaging in more physical activity</u> by virtue of lifting and carrying children during intergenerational activities.	limitations reduced their participation in the programme. OP reported a sense of accomplishment that left them feeling good long after they went home for the day. Attending the programme made OP feeling better, and it was perceived as a recovery strategy.	
33	Ellis 2003, MIXED  (only QUAL part reported; QUANT excluded for no info on data and analysis)	UK Qualitative study  Focus group discussions (N=9)	N=42 OP, of which majority were aged 60- 75 years F/M=NR  Study participants were volunteers currently involved with the programme	To investigate the use, relevance and effectiveness of a mentoring programme, adopting an intergeneration approach, targeting secondary school children in need of support and guidance from older mentor volunteers	<u>Making a difference</u> (feeling valued): mentors reported development of positive relationships with children (quotes provided). <u>Improved confidence, self-esteem and happiness</u> : mentors reported how being involved in the programme increased their confidence and self-esteem by seeing how mentees improved (quotes provided).	OP reported an enhanced physical and mental wellbeing as a result of taking part in the intergenerational mentoring programme. Being a mentor and being involved in the programme helped OP going through difficult times in their lives.	M-H

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
			N=54 students (11-12 years old)	All the sample schools were involved with the scheme for a minimum of three years.	<u>Coping</u> : Mentors found the programme helpful as a coping strategy for retirement (quotes provided).		
<b>GROUP N 3: Dancing interventions</b>							
36	Houston 2011, MIXED (only QUAL part reported; QUANT part excluded) Grey literature	UK Qualitative study (Pre, during, and post-test semi-structured interviews. Diaries written by participants during the programme, or their perceptions of each session)	N=24 OP with Parkinson's disease, of which majority were aged 60 and over (N=14 chose to be interviewed, N=4 kept diaries; observations of N=24) F/M=NR Study participants were volunteers currently involved with the programme	To explore the impact on health and OP's experiences from 12 dance sessions  Key features: the programme introduced OP to the ballet <i>Romeo &amp; Juliet</i> and provided 12 dance sessions of structured and creative movement accompanied by live piano and flute	Others outcomes reported by participants included (quotes provided): Fluency and dynamics of movement and mobility, Loosening of the spinal area, Balance and stability, posture, energy, body awareness, determination and achievement, freedom, sociability, dancing as a group, aid to daily life, confidence, and learning	N=2 OP reported an impact on <u>subjective health</u> (quotes provided). Particularly, they mentioned of their recent visits to their consultants, which occurred during the last few weeks of the dance programme. OP talked about how the programme made them feel better, giving them a sense of wellbeing (quotes provided)	M-H

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
13	Houston 2015, MIXED (only QUAL part reported; QUANT reported in Table 7)	UK Qualitative study (Multiple interviews, focus groups and observations over the course of three years)	N=43 OP with Parkinson's of which the majority was aged between 60 and 80 years old. F/M=NR  Study participants were volunteers currently involved with the programme	To examine the effects of the dancing programme on OP's health, quality of life, and falls over the course of 3 years  Key features: introduced OP to various ballets and provided dance sessions of structured and creative movement accompanied by live piano and flute	Others outcomes reported by participants included (quotes provided): fluency of movement and mobility, balance and stability, posture, cognitive functioning, aid for life, relationships, motivation (e.g. feeling included), freedom, social participation	OP reported a positive impact on <u>physical health</u> (quotes provided). Several described the general feeling of being energised, rather than more specific physical changes (quotes provided). OP reported how the programme contributed to their sense of <u>wellbeing</u> (quotes provided), and to feeling good and capable despite some worsening of symptoms (quotes provided)	M-H
<b>GROUP N 4: Music and singing interventions</b>							
37	VarVarigou 2012, QUAL	UK Qualitative study (qualitative comments offered in response to open questions included in the	N=27 OP Mean age: 69 years F>M  Study participants were selected randomly from a larger group of	To explore the benefits from the programme based on active music-making reported by OP who participated in weekly musical activities led by professionals over the period of one year	OP reported cognitive benefits (quotes provided): rising to new challenges, acquiring new skills, improved concentration and memory and a general sense of achievement. Social benefits (quotes provided): sense of belonging, opportunities to socialise, a	OP reported: improvements in <u>quality of life</u> , cognitive, social, emotional and physical benefits as a result of taking part in the programme. OP described <u>emotional and mental health</u> benefits: ability to cope effectively with stress, and protection against	L-M

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
		questionnaires. comments are combined with data from pre-post-test face-to-face interviews)	questionnaire respondents who had expressed an interest in being interviewed and had provided their contact details		sense of playing a valued and vital role within a community, having fun and having contact with younger people in intergenerational groups. Emotional benefits and mental health (quotes provided): positive feelings, sense of purpose, renewed sense of vitality and rejuvenation and improved mobility, enhanced confidence, positive feelings about life in general, and support following bereavement	depression. Although OP reported that health constraints (e.g. hearing) sometimes made participation in and enjoyment of music difficult, they reported improvements to <u>physical health</u> as a result of the programme (e.g. good for asthma and breathing)	
38	Skingley 2010, QUAL	UK Qualitative study Interviews	N=17 OP Mean age: 77 years F>M  Study participants were recruited from six	To examine OP's experiences of the singing programme, particularly their potential benefits on health and wellbeing Key features: community-based	Other outcomes reported by OP included: enjoyment (quotes provided); increased social interactions (quotes provided); cognitive stimulation and learning (quotes provided); and improved memory and recall (quotes provided)	OP reported better <u>mental health</u> (e.g. breathing) and <u>wellbeing</u> (quotes provided) and improvements in <u>physical health</u> (quotes provided)	M

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
			clubs (of twelve then existing)	groups providing opportunities for OP to come together and sing, facilitated by experienced musicians and volunteers			
<b>GROUP N 5: Information-communication technology (ICT) interventions</b>							
39	Schlag 2011, QUAL	USA Qualitative study (two in depth interviews with each participant)	N=7 OP aged between 64-81 years' old F>M  Study participants were recruited from a pool of OP who completed the questionnaires and who were chosen for this study	To examine the effects of computer technology use and involvement on the lives of OP who participated in the information-communication technology programme. Key features: the programme relied on peer volunteers to teach and coach	OP reported that ICT use helped them to improve their health maintenance (e.g. researching health issues). OP related their enhanced sense of wellbeing acquired from the ICT use to an increased sense of purpose, accomplishment, productivity, usefulness, and enjoyment to their lives. Some OP reported the programme served as a medium for strengthening existing relationships. Several OP mentioned that having ICTs as a common interest brought them closer to family members, and	OP reported enhanced sense of <u>wellbeing</u> as a result of taking part in the programme	M

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
					mentioned using ICT to keep in touch with family members. For several OP the training undertaken in the programme was a means of enhancing their effectiveness in other volunteer pursuits (e.g. sharing their ICT knowledge with others)		
<b>GROUP N 6: art and culture interventions</b>							
23	Phinney 2014, MIXED (only QUAL part reported; QUANT reported in Table 7)	Canada Qualitative study (focus groups interviews)	N=51 OP Four groups of OP aged between 55 to 90 years Mean age: over 60 years F>M  Study participants were purposively recruited from diverse range of urban neighbourhoods and communities	To evaluate the effect of the programme on the physical, emotional, and social wellbeing of OP  Key features: weekly workshops over a three-year period at community centres where artists worked with four groups of OP to produce a collective art piece or performance for public presentation	OP reported an enhanced sense of cohesion and commitment among themselves, describing a “feeling of belonging” and having a place “within community” (quotes provided). OP felt a strong sense of belonging and commitment within the group, and felt more socially connected beyond the group as well. OP reported that their involvement in the programme enhanced their	OP reported that the programme helped them to sustain a healthy lifestyle and to overcome some health barriers including <u>depression</u> and <u>chronic health problems</u> , and as a result they felt more socially and physically active (quotes provided). OP also described how creative work was an opportunity to focus their attention on something beyond themselves, and reducing their feelings of	L-M

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
					status as valued members of society (quotes provided)	<u>stress and anxiety</u> (quotes provided).	
26	Yuen 2011, MIXED (only QUAL part reported; QUANT reported in Table 7)	USA Qualitative study (semi-structured interviews)	N=12 OP aged between 62–88 years F>M  Study participants were volunteers currently involved with the programme	To evaluate the impact of the programme on OP's psychological wellbeing and health-related quality of life  Key features: the theatre programme included a 6-week acting class and four public performances	OP reported some factors relating to psychological wellbeing and health-related quality of life: improved self-worth (quotes provided), and self-advocacy (quotes provided), overcoming self-imposed limitations (quotes provided) Self-worth: several OP were surprised that they could do or learn something new that they did not think they could. As a result of this achievement, it heightened their sense of self-worthiness. Self-advocacy: some OP reported that they had their confidence boosted after the programme. Overcoming self-imposed	OP who participated in the programme revealed an <u>psychological wellbeing</u> and <u>health related quality of life</u> .	L-M

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
27	Vogelpoel 2014, MIXED (only QUAL part reported; QUANT reported in Table 7)	UK Qualitative study (semi-structured interviews)	N=12 OP with sensory impairments aged between 61 to 95 years Mean age: over 80 years F>M  Study participants were referred by general practices	To describe the benefits on wellbeing of a social prescribing art service for OP with sensory impairments experiencing social isolation  Key features: participation in a 12-week arts workshop programme; ongoing individual assessments of health status; and ongoing observations of participant's health statuses	limitations: Some OP reported that taking part in the programme made them pushing themselves to stay more active and focussing less on their health problems.  OP reported increased self-confidence through involvement in different art-making processes. The programme enabled OP to build relationships and new friendships (quotes provided); OP experienced: reduced social isolation (quotes provided); sense of belonging and group cohesion (quotes provided); enjoyment in engaging with art or craft (quotes provided)	Mental wellbeing: some OP reported an improvement in their psychological <u>wellbeing</u> (quotes provided). The biggest positive change reported by OP was "feeling more relaxed".	H

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
<b>GROUP N 7: Multi-activity interventions</b>							
40	Buijs 2003, QUAL	Canada Qualitative study (semi structured interviews)	N=23 OP aged between 61 to 90 years old. Mean age: 76 F>M  Study participants were volunteers who participated in the programme. N=4 OP Aged between 74 to 84 years old. Mean age: 77 years F>M Study participants recruited among the group of programme withdrawers	To assess the impact of a 10-month health promotion programme on OP's health and wellbeing  Key features: programme interventions delivered in 7 OP's apartment buildings included exercise classes, health information sessions ( <i>i.e.</i> health corners), and newsletters	Specific impacts were also noted in physical, mental, and social domains. Five key program processes that linked program interventions and impacts were: having fun, adapting program delivery, providing opportunities for autonomy, encouraging social interactions, and developing meaningful staff-participant relationships (quotes provided). Barriers to participation, reported by participants, were other priorities, deteriorating health, and forgetting to come.	The main impact reported by OP was ' <u>feeling better</u> ' (quotes provided). Specific <u>physical health</u> impacts described were being more flexible, having increased strength, noting some weight loss, and experiencing less pain	L-M

Study no.	First author, year published, study type	Country and study design Methods	Study participants Recruitment	Aim of the study relevant for this review	Mediating factors/mechanisms identified by OP as important in improving health and wellbeing	Summary of main results	Risk of bias <sup>2</sup>
29	Greaves 2006, MIXED (only QUAL part reported; QUANT reported in Table 7)	UK Qualitative study (semi-structured interviews and one focus group)	N=18 OP F>M Age range: NR  Study participants purposively selected among those who participated in the programme (one additional focus group was conducted with further 8 participants)	To evaluate the impact of the programme on the depressive symptoms, and on physical and mental wellbeing of OP  Key features: Activity-based interventions were combined with visits from peers initially on a weekly basis, and regular telephone contact, which is gradually diminished as participants become more confident and able. Participants determined programmes of creative, exercise and/or cultural activities	The data indicated a wide range of responses (both physical and emotional), including increased alertness, social activity, self-worth, optimism about life, and positive changes in health behaviour. Psychological and social benefits: The vast majority of OP reported increased confidence in engaging in new activities, and in interacting socially with others. Physical health benefits: four of the 18 OP provided of changes affecting multiple aspects of their lives: increased sense of meaning in life, increased social and physical activity, and more attention to self-care (quotes provided)	OP reported psychological and <u>physical health</u> benefits (quotes provided). Only 3 of the 18 individually interviewed OP reported no change in their <u>mood</u> or health-related behaviours since they became involved with the programme. Physiological and physical health benefits include recovery from <u>depression</u> and better quality of sleep (quote provided). Four OP talked specifically about the programme acting like a ‘catalyst’ that speeded their recovery from depression (quotes provided)	L-M

## **2.6 Discussion**

To my knowledge, this is the first systematic review of the literature reporting on the health impacts of interventions promoting respect and social inclusion in older people. As noted in the introduction of this chapter, although other systematic reviews have been conducted in the field of ageing and concepts related to social inclusion, most have looked at social isolation and loneliness (Cattan 2005; Dickens, A.; Richards, S.; Greaves, C. & Campbell 2011); or have looked at the impact of specific type of interventions on older people, including gender-based interventions (Milligan et al. 2015).

### **2.6.1 Summary of main results**

In terms of the impact of interventions fostering respect and social inclusion in older people, the 40 studies included in this systematic review found some quantitative evidence of an effect on (i) psychological outcomes (depression, mental health, and perceived stress and anxiety), (ii) subjective health and physical health outcomes and (iii) wellbeing and quality of life. However, there were very few studies, looking at the effect of interventions on chronic pain and falls, and no studies reporting on other health conditions (*e.g.* cardiovascular disease).

Based on available evidence, the interventions appearing to have the highest impact on improvements in psychological outcomes, wellbeing, subjective and physical health of older people included intergenerational initiatives and music and singing programmes. The studies suggested a positive effect on depressive symptoms and general mental health associated with intergenerational interventions, and a reduction in depressive symptoms, perceived stress and

anxiety, and improved general mental health associated with music and singing interventions.

Intergenerational and music and singing interventions had the largest evidence base (14 studies for intergenerational initiatives, and eight studies for singing and music interventions) and showed an overall positive effect on some health outcomes. The most common components of intergenerational initiatives included an active and regular involvement and interactions between older people and young people. Older people were involved (i) in assisting young people in school activities (*e.g.* math problems or science experiments), and (ii) in reading books to pre-school children.

Qualitative studies complemented the quantitative findings and identified some common mediating factors that may lead to improvements in health and wellbeing. With regard to intergenerational initiatives (Figure 13), it appears that active and regular interaction with young people may have led older people to feeling more valued, included, and appreciated. The mediating factors reported by study participants included an improved self-esteem and confidence, enjoyment and satisfaction, and happiness; improved interactions and relationships with others; feeling valued, and positive perceptions towards ageing and children. Older people's narratives reported a perceived enhanced emotional and physical wellbeing, and subjective health. Similarly, in music and singing interventions, older people had regular interactions and opportunities to learn something new while socialising. From the included studies and the qualitative evidence (Figure 17), it appears that taking part in music and singing

programmes may have led older people to have an increased sense of purpose, renewed sense of vitality and enjoyment, and enhanced confidence.

With regard to multi-activity, art and culture based programmes, some studies showed an effect on subjective health (Phinney et al. 2014; Cohen & Perlstein 2006; Kocken & Voorham 1998; Greaves 2006). However, findings were mixed, with some interventions showing an effect on wellbeing and quality of life (Yen et al. 2009; Saito et al. 2012), and others showing no effect (Vogelpoel & Jarrold 2014; Ruffing-Rahal 1994; Kocken & Voorham 1998), making it difficult to draw any conclusion.

In contrast, results from mentoring, dancing, and ICT interventions did not provide adequate evidence to make a judgement of the impact on improved health outcomes. It is important to emphasise that, with dance initiatives for example, there is evidence that they helped directly with some aspects of physical health – but that was not what this review focused on. The main weakness of the studies – which might also explain why some interventions did not find a significant effect – included small sample sizes, short follow-up and duration of the programme(s), non-adequate sampling methods and lack of control.

Despite some quantitative studies failed to capture the effects of various interventions, or showed mixed results, the qualitative evidence offered explanations for mediating factors that may lead to improved health outcomes. As suggested by Cattan *et al.* (2005) when looking at how public health interventions are assessed, it is important to understand why outcomes are or are not achieved. In fact, when the interventions fail to achieve an effect, it may not

because of the intervention in itself, but because of the influence of the complex context – and interacting factors – in which the interventions take place (De Savigny & Adam 2009; Koelen 2001; Hawe et al. 2009). Qualitative studies can thereby be very useful to clarify some aspects of the complexity related to *how* and *why* interventions work (Petticrew et al. 2012). In this review, qualitative evidence informed my understanding of the wide range of components of each intervention, and the several mediating factors that might lead to eventual health outcomes. As Petticrew (2013 p.94) argues:

“The end goal of evaluation – and of evidence-based decision making – is not the simple separation of the social world into ‘things that work’ and ‘things that don’t’. It is to clarify research questions, to develop or use appropriate methods to answer those questions and to use the evidence that results – or which is already available – to show and explain what changes and for whom, and to use this information to inform decision making.”

In Section 2.4 I presented a logic model of intergenerational initiatives that I developed at the start of this review. In Figure 3 I identified some possible mediating factors in the pathways to improved health and wellbeing. Based on the findings that emerged from the current systematic review, I have been able to identify the type of activities that constitute intergenerational initiatives, and to check if there is supporting evidence for some mediating factors and health outcomes that I identified at the start (see Figure 24). More importantly, I have been able to identify some impacts and factors that I did not anticipate in the original logic model (Figure 3, Section 2.4). Unanticipated changes that emerged

from this review included ‘feel needed’, improvements in self-esteem and confidence, happiness and humour, satisfaction and enjoyment. Moreover, taking part in the intergenerational interventions not only improved the perceptions that young people held towards older people – which was not the focus of this review – but also the perceptions that older people felt towards young people (Figure 13, Section 2.5.3). Intergenerational initiatives have also appeared to suggest an impact on wellbeing, quality of life, and other outcomes (*e.g.* depressive symptoms) – which initially I did not consider.

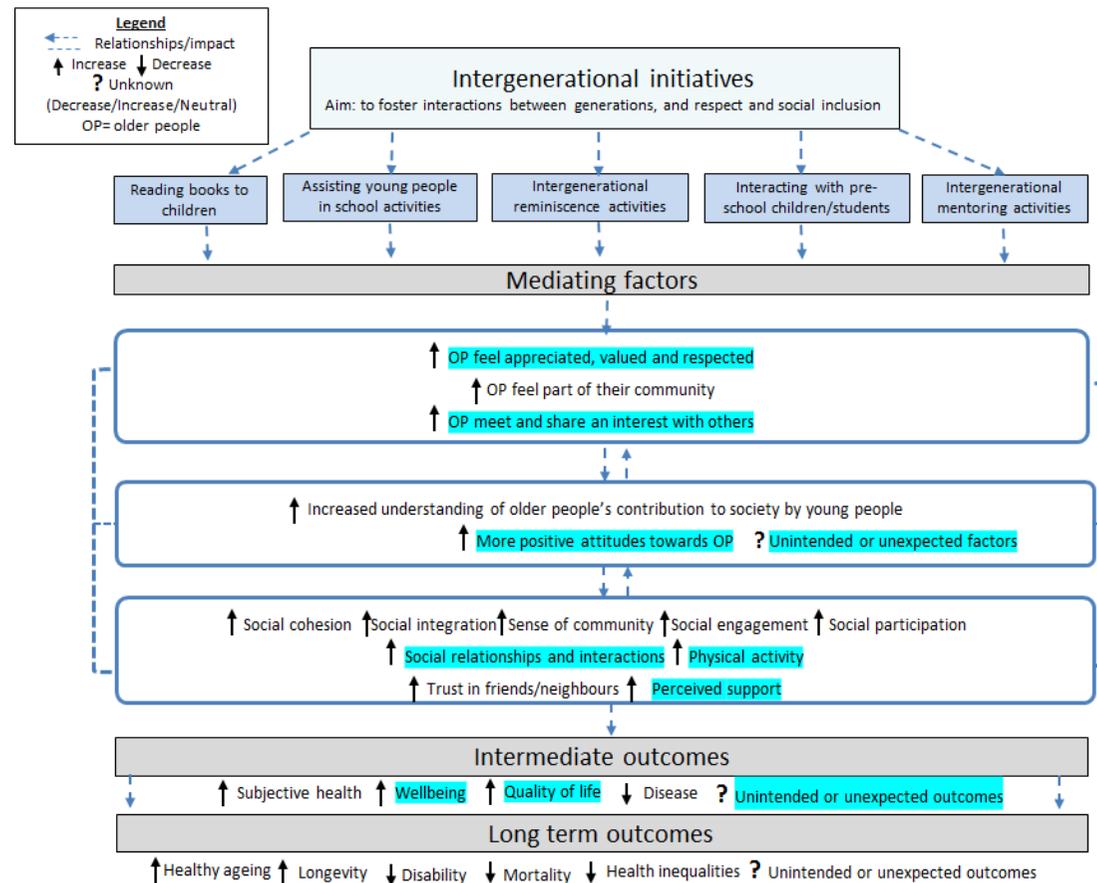


Figure 24 Logic model for intergenerational initiatives. Highlighted in blue are the mediating factors and outcomes where there is supporting evidence.

## 2.6.2 Strengths and limitations of this review

In conducting the systematic review, I have adopted a rigorous and thorough approach to address a very complex topic and research question. The search strategy, was developed using a combination of existing terms adopted in previous systematic reviews on social inclusion and ageing and through consultation with experts in the field. By drawing on quantitative and qualitative evidence I was able to address the full scope of the systematic review, covering both the effectiveness of these interventions for health and wellbeing and the mediating factors to improve health outcomes.

An important limitation of the review relates to the nature and quality of the available evidence. Interpretation of the results must thereby include consideration of the RoB of the included studies. Milligan *et al.* (2014; 2015) faced similar challenges in reviewing literature assessing the health benefits of health promotion interventions (*Men's Sheds*) in older men. These included poor reporting of collection and analysis of qualitative and quantitative data and sample representativeness. In this review, 15 studies lacked a control group, making it difficult to be confident that self-reported improvements in psychological outcomes, subjective health, wellbeing and quality of life were directly attributable to the actual interventions.

The evidence was not sufficient to support any useful sub-analysis of how any impacts of the interventions may vary by age, gender, education, ethnic, or socio-economic status of older people. While these characteristics were recorded in the data extraction tables, only two studies reported them, and overall the quantity and heterogeneity of the evidence precluded useful analysis of differential

effects. Newman *et al.* (1995) explored the effect of an intergenerational programme in reducing perceived depression by education level (high school and college), and age (60-69 and 70+ years). Saito *et al.* (2012) looked at the effect of a multi-activity intervention by the level of loneliness. One qualitative study (De Souza 2003) has reported differences in perceived impacts between males' and females' narratives, such that while male and female participants reported an improvement in subjective health, only females reported that the project helped them to alleviate their depressive moods and to improve their overall well-being and humour. This would be a potentially important topic for future analyses as the evidence base is expanded.

Other limitations include that – due to practical reasons – the search was restricted to studies published in English, and this may have introduced language bias. In fact, results that have a significant effect are more likely to be published in English journals than those reporting non-significant results (Egger & Zellweger-Zahner 1997).

I will discuss the implications of this systematic review for policy and public health in the final and main part of the thesis (Chapter 7).

## **2.7 Conclusions**

In conclusion, this systematic review has found some quantitative evidence to suggest that interventions on respect and social inclusion, particularly intergenerational and music and singing initiatives, may have an impact on health and wellbeing health of older people. However, the evidence for some other intervention categories – mentoring, ICT, dancing, art and culture and multi-activity – is limited and/or mixed.

Whilst there is some moderate evidence on interventions fostering respect and social inclusion – of the 32 studies reporting quantitative evidence, seven were individual or cluster RCTs, seven were quasi-experimental (cluster or individual controlled studies), four controlled before and after studies, and 15 uncontrolled before and after studies – the evidence is limited due to reliance on self-reported outcomes. Findings from this review have also highlighted that many studies had variable quality and moderate to high RoB, particularly regarding sample representativeness. Many, though not all, of the interventions were delivered as projects to selected groups of older people, raising important questions about feasibility and impact of wider implementation to secure population benefits (Whitehead 2007).

This review has provided a foundation from which larger, extended, and more robust interventions (using rigorous methodologies including randomised controlled designs) may be developed. Recommendations from the review include that future studies should i) take advantage of natural policy experiments fostering respect and social inclusion, and (ii) include a qualitative component to identify some of the perceived benefits and the mediating factors involved in improving health outcomes. Future studies incorporating some of these features may therefore be more beneficial in improving older people's health and wellbeing.

## **Chapter 3 METHODOLOGY**

### **3.1 Introduction**

In Chapter 2 I detailed the results of the systematic review component, addressing objectives 2 and 3. Objective 2 aimed at clarifying the relationships and related pathways by which factors in the domain of respect and social inclusion either promote or impair health and wellbeing. Objective 3 aimed at understanding if interventions on respect and social inclusion in older people have been shown to have an impact on health and wellbeing, and how this impact has been measured.

This chapter is divided into two main parts, which relate to the two empirical qualitative studies developed in this research. The chapter starts with the methodology of the photovoice study with older people, while the study with city stakeholders is the subject of the second part. I first discuss the philosophical and methodological considerations that underpin these studies, situating the research in a specific tradition. I then go on to explain the research design for each study. This includes a discussion of methods, the approaches that I used to enhance methodological quality, my positionality and ethical implications.

## **3.2 Photovoice study: philosophical and methodological considerations**

### **3.2.1 An interpretative approach to enquiry**

My objective for this study was to explore perspectives of older people on aspects that promote and inhibit respect and social inclusion in an aspiring Age-Friendly City (AFC) (Liverpool, UK), and to encourage them to find solutions to some of the issues identified. As a result, I have adopted a qualitative research approach as I felt that this perspective on knowledge was the most appropriate for addressing this objective.

Qualitative research aims at understanding the world in terms of the meanings that people attach to aspects of the world, and seeks to answer questions about the ‘what’, ‘how, and ‘why’ of a phenomenon (Green & Thorogood 2009c). Neo-Kantian idealism, from which interpretive approaches originate, considers that objects exist only as a product of our interpretation (Smith 2010). However, this does not mean that objective things are not relevant – objects are as real as the consequences they have for us. This study is rooted in the interpretive tradition aimed at exploring individuals’ interpretation of reality. Within the interpretive approaches, I draw upon the interpretive tradition for this study. With this approach, data are interrogated with respect to the meanings people attach to their experiences of social reality (Green & Thorogood 2009c; Merriam & Tisdell 2015; Smith 1998).

This study sought to understand the perceptions and meanings that older people have of respect and social inclusion in the urban context, within a Community-

Based Participatory Research (CBPR) methodology. CBPR is a research approach which comprises participation, action and collaborative inquiry often employed to solve urban health problems and benefit community's health (Minkler 2005). Therefore, the purpose of this study was not to observe the rules that govern the social reality, or systematically measure these in order to generalise and predict the course of events (Green & Thorogood 2009c; Benner 1994). By contrast, the purpose was to explore the different meanings that people attribute to the social reality, by acknowledging that different people might see the reality in different ways (Denscombe 2007b).

### **3.2.2 Photovoice methods to explore older people's respect and social inclusion within a CBPR methodology**

In Chapter 1 I argued that although older peoples' involvement in decision-making processes within their neighbourhoods is acknowledged as important, this rarely happens in practice (Buffel, McGarry, et al. 2014). A number of methods using CBPR approaches (Minkler 2005) are available for addressing the crucial question of "How do individuals and communities most effectively make their voices heard?" (Buffel et al. 2013 p.54). It is important to note that CBPR is not a method, but rather an approach. This means that within this approach, researchers and communities can select which methods best fit the specific contexts and population, objectives, time and resources, and ethical considerations of their study (Catalani 2009).

Visual methods are commonly employed in CBPR as participatory visual research methods (Prosser & Loxley 2008). Thanks to their interdisciplinary

nature (Pink 2006), have been increasingly developed in the field of health, social sciences, and education (Fraser & al Sayah 2011; Catalani & Minkler 2010; Rose 2012c; Pauwels 2010; Strack et al. 2004). Studies incorporating these methods to facilitate older people's participation, and to explore characteristics and issues of neighbourhoods/cities have included: (i) photovoice (Belon, Nieuwendyk, et al. 2014; Mahmood et al. 2012; Baker & Wang 2006; Novek & Menec 2013; Nykiforuk et al. 2011; Alcock et al. 2011); (ii) participatory videos (Capstick & Ludwin 2015); (iii) drawings (Scott 2015); and (iv) photo-elicitation techniques (Pilcher et al. 2015).

While photo-elicitation is an individualised visual research method wherein participant – or researcher – produced photographs are explored in a research interview on a particular topic (Harper 2002), photovoice is a predominantly collective visual research method. In fact, photographs taken by participants are used to explore and address community needs, stimulate individual and collective empowerment, and create a critical dialogue to advocate community change (Hergenrather 2009; Sanon et al. 2014).

Among these methods, photovoice, through the use of digital cameras and collective discussions, offers a practical and accessible means to encourage older people at identifying community concerns and priorities, which can be brought to the attention of city stakeholders in order to stimulate policy change (Wang & Burris 1997). This can be achieved by encouraging dialogue between study participants and city stakeholders during the dissemination of the results (*e.g.* photo-exhibition event).

### **3.2.3 Photovoice methods**

Photovoice, originally developed by Wang & Burris (1997), is a method used in CBPR, which focuses on individual and community assets, co-creation of knowledge, community building, individual and community empowerment, and combines research with action. Participants take part in group discussions and interviews, and use photography to document their experiences. The stories they tell about the photographs identify and represent issues of importance to them (Nykiforuk et al. 2011; Baker & Wang 2006). In the context of this study, photographs and accompanying narratives presented through a photo-exhibition, were used as an advocacy tool to bring older people's voices to the attention of city stakeholders to stimulate change (Wang & Pies 2004). A description of each phase the photovoice method is given in Section 3.12 .

### **3.2.4 Theoretical foundation**

The theoretical foundation of photovoice is grounded in Paulo Freire's approach to education for critical consciousness (Freire 1974), which suggests that the visual image is an important tool for enabling people to reflect about their community and also about the contradictions within it. In doing so, individuals could become progressively aware of their own views of that reality, and cope with it.

Three levels of critical consciousness that influence the way in which a person interprets and responds to the reality were identified. Firstly, what Freire (1970, 1974) called the process of 'decoding': the act of knowing. In this first level (magical level) the person is not conscious of the contradictions prevailing

within the society, which are being perceived as something outside her/him, in which the “behaviours of passive adaptation actively contribute to his/her own oppression” (Carlson et al. 2006 p.837). In the second level there is a gradual perception of the societal reality along with its incongruities, but personalisation of the problems and questioning of key issues, such as social injustice, is not present. Lastly, the greatest level of critical consciousness is represented by the individual’s perception that his/her presumptions influence his/her perception of the reality. Here, the individual becomes “aware of” his/her “own responsibility for choices that either maintain or change that reality” (Carlson et al. 2006 p.837). Freire (1974) sought to stimulate individuals to discover and create their own learning through the practice. He used drawings to encourage collective reflection about community issues, leading participants to take action. According to Freire (1970 cited in Hodgetts et al. 2011 p.32), “dialogue can enhance reflection, understanding and action through a process of walking together while questioning”. Photovoice aims at engaging research subjects in ‘seeing the world and transforming it’ (Wang & Burris 1997). By taking photographs, the participant gradually becomes an ‘interpreter of the world’. This process is strengthened by using individual and collective discussions to raise awareness about community strengths and issues. In the current study, participants’ photographs and their associated stories were used to generate discussions about respect and social inclusion, and advocacy to impact on AFC policy.

### **3.2.5 Photovoice and the link with health promotion**

The aims of photovoice, and indeed of this study – to stimulate individuals through photography to become more critical of the contradictions that govern the world and advocate for change – can be related to the concepts of health promotion and empowerment (Chiu 2008; Bruce 2000).

In this context, health promotion is defined as “the process of enabling people to increase control over, and to improve, their health” (WHO 1986, no page). One of the most influential documents in health promotion is the Ottawa Charter, which set out a series of pre-requisites for health and areas for health promotion action, including the creation of supporting environments and advocate for change (WHO 1986, no page). Core activities of the Ottawa Charter include enabling, mediating and advocating, with the ultimate goal of improving population’s health. Although this definition was theorised in 1986, its key principles are still considered valid at the present time (Kökény 2011), and some aspects are currently being updated (Politics of Health Group 2016). While the concept of ‘enabling’, as expressed in the Ottawa Charter refers to achieving equity in health (Saan & Wise 2011), it can be argued that photovoice has the potential to contribute, on a small scale, to this core activity of the Ottawa Charter.

It can do so in several ways. First, enabling participants access to digital cameras to identify issues that are important to them, is a way to support participants to ‘become conscious of the social reality’ (Freire 1970). Second, photographs are taken by participants themselves, instead of by the researcher (Bayer & Albuquerque 2014). This is important, because in photovoice the production of

knowledge is in the hands of community members, which determine what is really important to be represented in a photograph. As Harley (2012 p.322) points out, photovoice “rests on the assumption that people themselves can best identify and represent their own realities”. However, this involves more than simply taking snapshots, as participants are invited to share their stories in group discussions. Third, by organising a public engagement event (*e.g.* a photo-exhibition), photovoice methods enable participants to raise awareness of some issues that they have identified. It creates a platform to enable dialogue amongst participants, researchers, and city stakeholders, where research findings are communicated in a way that reflects the needs of local people (Wang et al. 1998; Wang et al. 2004).

Community engagement is at the heart of CBPR, wherein the involvement of participants and organisations in the research process is critical. As noted in Chapter 1, one key mechanisms necessary to build AFCs is the commitment of local policy makers to involve older people in decision making processes of their city. The current study aimed thereby to (i) encourage dialogue between older people and city stakeholders at the exhibition; and (ii) to bring older people’s views to the attention of city stakeholders so that they could incorporate these in the planning processes for an AFC. Specific findings on this are presented in Chapter 6.

### **3.2.6 Opportunities and challenges of photovoice methods**

Publications incorporating photovoice methods have typically been descriptive, with most lacking an assessment on the comparative advantages and limitations of the process, and ways of dealing with these (Prins 2010; Switzer et al. 2015; Harley 2012; Drew & Guillemin 2014; Castleden et al. 2008; Pilcher et al. 2015; Evans-Agnew & Rosemberg 2016). Among the few studies that have considered these issues, Packard (2008), Harley (2012) and Prins (2010) critically discussed some ethical dilemmas experienced using the photovoice methods including: (i) balancing the power dynamics between researchers and participants; (ii) barriers to participants' involvement, particularly with vulnerable people (*e.g.* homeless) and (iii) challenges related to asking consent for subjects who appear in the photographs. Prins (2010) discussed the 'power' of photography and its unintended consequences, highlighting that, depending on the context, the 'innocent' act of photographing can generate suspicion amongst community members. Hodgetts *et al.* (2007) and Radley *et al.* (2005) examined the value of exploring photographs not taken by participants, calling for a more critical description of the entire photo-production process, which includes how participants engage with taking – or not taking - photographs. In the limitations of photovoice related to personal judgement, Wang & Burris (1997) have also raised the issue of considering what the participant chooses not to photograph.

This limited discourse on photovoice methods employed with older people in exploring city issues, including how participants and researchers experience the photovoice process, and implications for interpreting the results, has important implications for its effective application in producing valid and comprehensive

data, for example through the triangulation of transcripts from interviews, focus groups and photographs (Noble & Smith 2015; Mays & Pope 2000). As a consequence, there may also be limited efforts to refine the approach and techniques, for example in engaging with participants and city stakeholders to identify potential solutions (Catalani & Minkler 2010).

Drawing on older people's photographs, associated quotes and my field notes, in Chapter 6 I provide an assessment of the suitability of photovoice methodology for exploring how individuals perceive respect and social inclusion in the urban setting.

### **3.3 Issues of rigour and quality in photovoice and qualitative research**

It is often argued that due to the interpretative nature of the data produced by qualitative research, it is not possible to assess its quality and rigour in the same way as for quantitative studies, and there are ongoing debates about whether using terms such as validity and reliability are appropriate for qualitative research (Seale 2010; Rolfe 2006; Morse et al. 2002; Noble & Smith 2015; Hope & Waterman 2003). Guba & Lincoln (1982) have argued that a more appropriate way to think of reliability and validity in qualitative research was to refer to the concept of 'trustworthiness'. Trustworthiness comprises four aspects: credibility, transferability, dependability, and confirmability. Each of these aspects has specific verification strategies, including prolonged engagement in the field, observations, critical reflection, rich description of the context, and data triangulation (Guba & Lincoln 1982).

While accepting that there are different ways of viewing validity and reliability in qualitative and quantitative research, and that these concepts are less meaningful in a social science context, in this study I found it useful to adopt some verification strategies which assisted me during the research process, and which contributed to enhance the quality and rigour of this study (Mays & Pope 2000; Morse et al. 2002; Flick 2009c; Noble & Smith 2015; Creswell & Miller 2000; Flick 2009d).

I adopted triangulation through multiple sources of data collection (*i.e.* photographs, interview and focus group transcripts, and reflexivity notes), and through different data sources (*i.e.* comparing data from different groups) (Mays & Pope 2000; Noble & Smith 2015). The constant comparison of different data sources and methods, contributed to ensure comprehensiveness of my interpretation of results (Flick 2009c; Denscombe 2007a). The different methods complemented each other, and enhanced my understanding of the participants' views of respect and social inclusion (see also the data analysis in Chapter 3). This was strengthened by engagement with other researchers in discussing my data analysis. As noted in Chapter 3 (Section 3.13), subthemes were constantly refined and approved by the supervisory team, which served as expert review. Further, 20% of the transcripts were double coded by another member of the research team (Flick 2007). When presenting the results of this thesis, I included various verbatim extracts from participant interviews to support the findings. These verification strategies have contributed to the rigour of the findings (Noble & Smith 2015; Creswell & Miller 2000; Flick 2007).

As I will describe in the next section (Section 3.12), I wrote a brief summary based on the participant's original description of the photograph. To ensure that these stories reflected the intentions of the participant, I conducted extensive member checking of the captions. These were reviewed and approved by each participant prior to being printed and displayed in the photo-exhibition, and reported here. By doing this, I ensured that the participant, not the researcher, was responsible for interpreting the significance of the photograph (Foster-Fishman et al. 2010; Finney & Rishbeth 2006).

To ensure that data were not later overlooked or forgotten, I took reflexivity notes covering the whole period from my initial informal meetings with participants until the completion of data collection (Morse et al. 2002; Green & Thorogood 2009c; Merriam & Tisdell 2015). Reflexive notes covered my observations about: prospective participants and group dynamics; the interactions between the gatekeeper(s) and the prospective participants; the different phases of relationship building with participants; reflections on the research strategies and selection of participants (*e.g.* Did it make older people feel more comfortable as research participants?); notes about the decisions that I made in collecting and interpreting the data (Gibbs 2007; Mays & Pope 2000; Ballinger 2003). As noted in Section 3.5, reflecting on my perspectives was important to show the ways in which my role and the research process have shaped the data (Mays & Pope 2000; Creswell & Miller 2000; Saumure & Given 2008).

My continuous reflection was complemented by my attempt to describe in a clear and transparent way the entire research process throughout the thesis. Lastly, my prolonged engagement with gatekeepers, older people, and city stakeholders, wherein I have feed backed the findings informally at community events, has contributed to the credibility of the findings (Zambrana 2014; Lundy 2008; Flick 2009d).

### **3.4 Ethical considerations**

As for all research, the ethical implications of this study are an essential part and require careful attention. I planned considerable time to revisit the purpose and phases of the research before asking the participants' consent (see consent form

and information sheet Appendix B and Appendix C). I was aware that being involved in research might have an emotional impact on participants. Upon commencement of data collection and throughout the process it was therefore important to minimise the risk of emotional harm or distress. I addressed this by informing (i) the participants that they could opt out of any aspect of the study that made them feel uncomfortable, and (ii) that they could withdraw from the study at any time without having to give a reason. I was also ready to address any concern that participants might have had throughout the process (Green & Thorogood 2009d).

As a part of the ethics application, I developed a protocol to adopt in case of any distress experienced by participants. In case, participants would have become distressed during the focus groups or interviews, I would have given time and support to the participant, and I would have interrupted the focus group or interview. I also worked with the gatekeepers to guarantee that there was emotional support available if participants required it. In case, where I, the researcher, became distressed, I referred to my supervisors for support.

Photovoice presents a unique set of ethical challenges related to taking photographs. These include photo ownership and individuals appearing in the photographs. To address these issues, I have followed the ethics guidance on photovoice methods developed by Wang & Redwood-Jones (2001), who recommend the use of two additional consent forms: acknowledgment and release forms – for people who appear in the photographs (Appendix E), and a release of the photographs – which asks permission to use participant's photographs in dissemination of results (Appendix D). Alongside the use of

consent forms, it was important to plan an ethical training with participants during the initial meeting, covering specifically: ‘rules’ on when written consent was needed (*e.g.* individual or group is ‘featured’) and when not (where people can be regarded as a crowd), as to allow participants to take photographs of topics involving people more easily.

I was also conscious of the ethical implications related to individuals under 18, with respect to the photographs taken by participants. The training included advising participants not to take photographs of people under 18, unless they were family members or close friends. Another aspect of the training consisted in explaining to the participants the necessity of signing a specific form, where permission is asked to use their photographs in dissemination of results (*e.g.* photo-exhibitions). This was an important ethical aspect to consider, as participants are the owners of the photographs. Therefore, they have the right to have their voices heard through the representation of photographs and accompanying captions as they feel appropriate (Evans-Agnew & Rosemberg 2016). I was also aware of the importance to explain to participants what the photo-exhibition event would have entailed (*e.g.* that photographs and captions would have their names removed), to ensure that only participants who felt comfortable and signed the consent would have participated to the event. After considering these implications, and before the start of the study, I applied for ethical approval, which was granted by the University of Liverpool in July 2014 (see Appendix K for letter of approval).

### **3.5 Researcher positionality**

In qualitative research it is important to consider the researcher's positionality, as it becomes "central to how understandings and knowledge are produced, understood, and mediated" (Manderson et al. 2006 p.1318).

The design of this photovoice study was informed by relationships that I built with each community centre before, during and after the study. I was aware that my class, background, age, ethnicity, and gender could greatly influence the research process (Finlay 2003). I am a young, white, Italian, female PhD student. My study participants, on the other hand, were people aged 60 and over living in Liverpool, and most of them were British. Therefore, my perceptions and experiences of ageing and of living in the City were different from my participants. Through my involvement in the City and in this research, I constantly experienced the complexities of my new identities as a researcher and as a young Italian. Study participants recognised my role as a researcher, but they also perceived me as a young 'foreign' student who did not know what living in Liverpool and/or being an older person meant. This was evident when, in some instances, the participants explained me in detail the political and historical changes that they experienced throughout the years living in the City. My positionality inevitably created a differential power relationship between myself and the research participants (Finlay 2003; Gough 2003). I attempted to minimise these power relationships by allowing the participants to take control of the photographs and give me permission to use them in publications and exhibitions (see consent form Appendix D) (Evans-Agnew & Rosemberg 2016). I also consulted participants in the decision-making processes surrounding the

venue for the exhibition, and how their photographs and captions would have been used in the dissemination of results (Chapter 3).

I was aware that the researcher's presence, in whatever form, shapes participants' actions (Prins 2010). My role as a researcher, was to facilitate and guide the direction of the individual and group discussions, alongside the organisation of the photo-display event. This involved working with gatekeepers, listening to the participants, engaging in discussions about respect and social inclusion and Liverpool City more generally. I tried to keep the research open to adaptation and "flexible to the on-going dynamics of individual and group development and change" (Finley 2008 p.98).

I practiced reflexivity through the research process (Finlay 2003; Gough 2003). This comprised listening carefully and constantly reminding myself to be open to my approach in learning the views that my participants had about the subject that I was investigating (Tervalon & Murray-García 1998). By participating in this photovoice study and the previous ones that I conducted (Ronzi 2013; Ronzi & Kennedy 2012), I have learnt to accept the participants' and gatekeepers' opinions.

During this study, I interacted with various actors, including: gatekeepers (*i.e.* volunteers and project managers in community organisations); older people; attendees of the various activities that the community centre provided; and volunteers who helped to run certain activities. As a result, my approach varied depending on who I was interacting with. As noted earlier, there were some age, language, and ethnicities differences between myself and the participants. With active listening, I tried to create an environment that promoted open

communication with participants. I followed some verbal and nonverbal active listening strategies suggested by Ayres (2008). For instance, I was focused on the participant's responses and I kept an open and relaxed posture. Without expressing any critique about what it was said, I summarised what the participant reported between one topic and the next, and this helped me to check my understanding of the participant's perceptions.

Another aspect of reflexivity is recognising that the relationships with participants can influence the research process and the resulting interpretations (Gough 2003; Nicolson 2003). Building a trusting relationship with participants is essential, as people are not usually comfortable in sharing their views with a person who they do not know (McGinn 2008). I was aware that gatekeepers would have played a very important role in helping build trust among participants, starting from the ethics application. Therefore, prior to apply for ethics, I contacted six prospective organisations in the City who advised me on how to best approach participants and plan the phases of the project. Prior to starting the recruitment, as suggested by gatekeepers, I allocated time to attend regularly these centres in order to be introduced to prospective participants and start building informal interactions with them (Chapter 3, Section 3.15).

### **3.6 City stakeholders study: philosophical and methodological considerations**

- **An interpretative approach to inquiry**

The objective of this study was to explore the factors that influence the ability of stakeholders to promote respect and social inclusion for older people in Liverpool City. This included identifying and discussing wider political, economic and social influences, and what may be required to better promote respect and social inclusion in Liverpool City. Although the city stakeholder study was different from the photovoice study – as it involved experienced professionals working in the City – the phenomenon that I was exploring (enablers, barriers, and solutions to respect and social inclusion) was very similar. Therefore, I felt that an interpretative approach was the most appropriate for addressing the study objective (Merriam & Tisdell 2015; Green & Thorogood 2009c; Smith 1998). Similar arguments previously explained for the photovoice study (Section 3.2.1) apply to selecting interpretivist approach as the most appropriate for the stakeholder study.

- **Research design**

The photovoice and stakeholder studies complement each other. In the stakeholder study, semi-structured interviews were conducted with participants to explore their meanings, views, and concerns related to promoting respect and social inclusion in Liverpool City. Interviews are one of the most used source of qualitative data in health research (Green & Thorogood 2009b). Given that city stakeholders were very busy with their jobs and had little time available to

dedicate to this study, and based also on the results of previous studies with city stakeholders (Orton et al. 2011; Taylor-Robinson et al. 2008; Taylor-Robinson et al. 2012; Oliver et al. 2013), using interviews seemed the most appropriate method to elicit their views. Semi-structured interviews enabled me to ask the participants different aspects of the topic that I was interested in (Appendix J). At the same time, general questions allowed the participants to tell their stories, which I facilitated using prompts and probes (*e.g.* “Tell me more about that...”) (Green & Thorogood 2009b; Merriam & Tisdell 2015).

### **3.7 Issues of quality and rigour in qualitative research**

With regards to the verification strategies adopted throughout the research process to enhance the rigour of this study, I took a similar approach to the one used in the photovoice study (Section 3.3). For instance, I engaged with other researchers in discussing my data analysis; I constantly refined the subthemes, which were later approved by the supervisory team; 20% of the transcripts were double coded by another member of the research team; I included numerous verbatim descriptions of participants’ transcripts to support the findings. Moreover, I took reflexivity notes during the entire research process (Gibbs 2007; Mays & Pope 2000; Ballinger 2003), and I adopted an open and non-judgmental approach to learning from participants. Lastly, I provided a clear and transparent description of the research process throughout the thesis (Noble & Smith 2015; Creswell & Miller 2000; Lundy 2008; Flick 2009d; Mays & Pope 2000).

### **3.8 Ethical considerations**

As with the photovoice study, I was aware of the importance of dedicating time (i) to revisit the purpose and phases of the research before that I asked the participants' consent, and throughout the study (see consent form and information sheet Appendix F and Appendix G), and (ii) to address any anxiety or concern that participants might have throughout the process. An important aspect in building a trusting relationship with city stakeholders was the need to reassure them that I was not interested in assessing their job or their organisation in any way, and that anything said would have had their names, specific roles, and organisations removed. Ensuring that they would have felt comfortable with revealing their activities and their views of the City, with respect to factors promoting or inhibiting respect and social inclusion, was very important. To address other ethical implications that could emerge in this study (*e.g.* in case of distress), I took a similar approach to the one described in the photovoice study (Section 3.4).

### **3.9 Researcher positionality and reflexivity**

As noted previously, I was aware that many of my experiences and viewpoints were different from those held by the city stakeholders I have engaged with (Manderson et al. 2006; Finlay 2003; Gough 2003; Nicolson 2003). I have adopted a non-judgmental approach when learning about their perspectives and have included this knowledge into this study (Tervalon & Murray-García 1998). During this study, I interacted with various actors, including local policy makers, clinical commissioning groups representatives, voluntary organisations, and

service providers with an interest in older people in the City. Many of them were in managerial positions, while others had positions of chiefs and directors. As a result, my approach varied depending on who I was interacting with. For instance, several city stakeholders were generally experienced professionals, and we shared the interest for older people issues and to improve their health and wellbeing. This shared interest was crucial in building mutual respect and trust. By adopting an active listening approach I tried to create an environment that promoted open communication with city stakeholders (Ayres 2008). As with the photovoice study, (i) I adopted a neutral attitude toward the participant, without expressing any critique about what it was said; and (ii) I summarised what the city stakeholder reported to check my understanding of the participant's perceptions.

Although my role of doctoral student and researcher was different from theirs, many of them saw the value of my research, and my intent to improve the current situation of older people. One particularly important step in developing this trusting relationship was attending events in the City, where I met several city stakeholders. The two initial events were the same as those I attended for the photovoice study. On these occasions, I exchanged contacts with some gatekeepers, and some city stakeholders suggested potential organisations or people that I could link with (*e.g.* one city stakeholder offered to put me in touch with a gatekeeper working in a grassroots organisation). The following meetings that I attended were not the same ones that I attended for the photovoice study. I kept attending some of these events until the end of the PhD, so that I could keep them informed on my progress and give feedback informally about the

findings. In doing so, they perhaps saw the true interest and motivation that I had in engaging with them. This made me realise that if I wanted to truly engage with the City and city stakeholders, I needed to ‘go to the community’. In the context of this study, community refers to the individuals I was researching as well as those with whom I engaged with. Specifically: older people, volunteers, policy makers, and service providers with an interest in older people in Liverpool City.

Academics are often perceived as an ‘elite’ who rarely interact with community members. In some initial conversations, I felt that this was a common perception held by many of city stakeholders who took part in this study. My prolonged engagement with them benefitted both the data collection and the overall photovoice process. This was evidenced by being offered a room for the photo-exhibition in the Museum of Liverpool at no cost through the Executive Director Education & Visitors and the Education team. I managed successfully to convey the importance of this topic in a way that met the needs of organisations such as the Museum of Liverpool. In doing so, the photo-exhibition that I organised represents an example in which my approach – as a part of the photovoice study and my sampling recruitment – has been used to engage both with the public and professionals in meaningful way (Chapter 3, Section 3.12).

### **3.10 Methods**

This section is divided into two main parts: the first deals with the methods for photovoice study with older people, the second with the methods for the study with city stakeholders. I first present an overview of the research setting, and the participants, including sampling strategies and recruitment. I then describe the process of gaining consent and the procedures. I conclude the chapter by describing my approach to data analysis.

### **3.11 Photovoice study: research setting and sampling**

#### **recruitment**

The city of Liverpool, in the North West of England, has recently initiated the process of becoming an Age-Friendly City (AFC), and was chosen as the setting for this study. According to Buckner *et al.* (2016), it appears that there has been some momentum around age-friendliness in the City in recent months. On 30 August 2012 there was an inaugural meeting organised by the Mayor of Liverpool and Liverpool Clinical Commissioning (LCC) Adult Social Services, wherein delegates received and discussed a cabinet document from LCC that detailed a way forward to make Liverpool an AFC, and a checklist for an AFC (WHO 2007). Despite this promising meeting, it seems that there has been not any concrete follow up of the AFC initiative since 2012 (Buckner et al. 2016).

The health of people in Liverpool is worse than the England average, including deprivation (Public Health England 2015). Liverpool is ranked the 4th most deprived local authority area according to the Index of Multiple Deprivation

2015, wherein the greatest deprivation is concentrated in the north of the city (Liverpool City Council 2015).

Four groups of older people (total sample: N=26) were recruited from four electoral wards; two representing the most disadvantaged areas and two the least disadvantaged areas in Liverpool (Jones & Mason 2015). This was done to potentially different experiences of respect and social inclusion in the City (Scharf & Keating 2012). The geographical areas selected for sampling recruitment are highlighted with a black circle (in Figure 25):

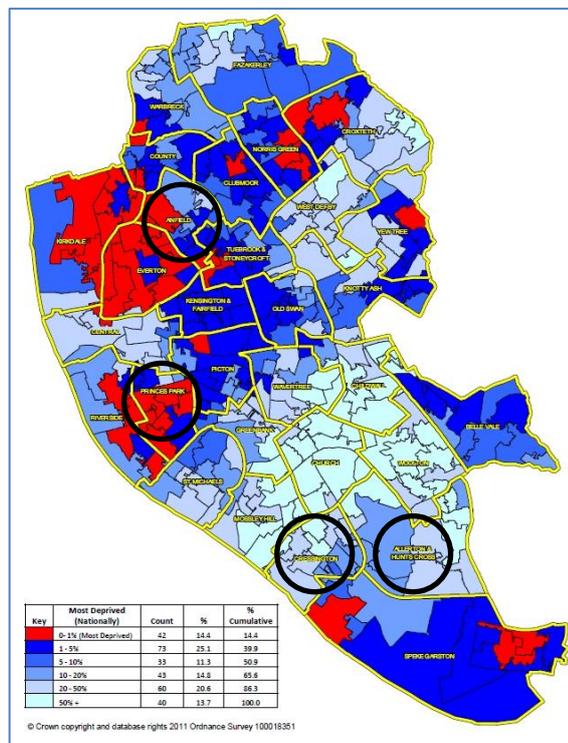


Figure 25 Four electoral wards in Liverpool recruited for this study: Princes Park, Anfield, Cressington and Allerton (blue: low deprivation; red: higher deprivation).

Older people in the most deprived areas are known to experience worse health, social exclusion, and poorer access to services and support, compared to those residing in more affluent areas (Marmot 2010). Life expectancy also differs

markedly between different areas of Liverpool, being almost 10 years shorter in the most deprived areas (Jones & Mason 2015).

In addition to the need to have a mix of affluent and less affluent areas, these four geographical areas were accessed through connections that I developed with gatekeepers working in local community organisations. Since February 2014, I built links with six organisations and their gatekeepers – defined as volunteers and project managers working in these organisations – across the different areas of Liverpool City. However, after attending some of their events (Age Concern Liverpool and Sefton; Liverpool Citizen Advocacy; Lee Valley Pensioners Club; Plus Dane; St. Mary’s church; Inclusion Matters; Merseyside Dance Initiative), I decided to start recruiting participants in those organisations that I define as ‘grassroots organisations’. Grassroots organisations are typically small and work directly with the community which lives in the surrounding area. I wanted to have a mix of more and less socially included older people to get different views of the subject I was exploring. Grassroots organisations played an essential role in helping me to recruit a mix of those. I was aware that it was more likely to recruit people more included, therefore, I asked gatekeepers to help me to reach older people who were less actively involved in the community. One organisation, in particular, organises activities targeted to people of all ages who were less actively involved in the community for several reasons (*e.g.* disability or socio-economic difficulties).

Gatekeepers were provided with details of study inclusion criteria (Table 9) and assisted me with the invitation of participants. Participants were selected purposively based on being people aged 60 and over, and having experience of

living in Liverpool that allowed them to offer insightful information about respect and social inclusion in the City. Full details on the number and demographic characteristics of the participants recruited in this study are reported in the Results (Chapter 4, Section 4.2).

- 
- |   |
|---|
| 1. Being able to consent for themselves.  |
| 2. Being an older person aged 60 or more.   |
| 3. Being able to speak English.   |
| 4. Living in Liverpool.   |
| 5. Being British or having lived in the UK for at least 10 years.                             |
| 6. Being able to manage simple digital cameras and take pictures about the topic under study. |
| 7. Being able to attend and participate in group meetings and interviews.                     |

Table 9 Inclusion criteria of study participants.

Inclusion criteria 1, 2, 3 and 4 (Table 9) were assessed with the help of the gatekeepers prior to the recruitment. Inclusion criteria 5, 6 and 7 were assessed during the first meeting, wherein I introduced the purpose of the study.

- **Sample size**

As noted previously, my aim was to include older people living in contrasting areas using purposive sampling based on the criteria above. At the time of submitting the ethics application, I planned to recruit approximately three groups of older people. However, the decision to end the sampling was based on the emerging analysis. I kept recruiting participants until I realised that no additional information was emerging, in terms of addressing the study objectives.

This is called ‘theoretical saturation’, for which, however, there are not guidelines to follow for approximating sample sizes to reach saturation (Morse 1995). As the study progressed, the guiding principle for sampling was theoretical relevance (Rudestam & Newton 2007). Older people were recruited to find examples that could capture a detailed description of the topic investigated. This included what factors contributed most to their feeling of respect and social inclusion, and what prevented this. At the conclusion of data collection with the third group, I realised that I needed more detailed information, particularly on barriers to respect and social inclusion. Therefore, I recruited a fourth group of participants. By the end of the data collection with the fourth group, I felt that the objectives 4 and 6 had been adequately covered/addressed, and no additional material was emerging.

The size of each group varied between four and ten participants, as this size of group has been shown to best promote effective group dynamics (Morgan 1998). To allow for dropouts, a greater number of participants were recruited than were judged to be required to meet the study aims, so as to ensure that each group had between four and eight participants completing the project. Among those who did not attend the second focus group, two participants took part in an additional interview that included questions asked during the second focus group.

The ethical principles of community-based participatory research (CBPR) emphasise commitment to include participants whose voices are often ignored. Four people with limited mobility (*e.g.* use of walking aids), participated in the study. Older people were told that they could be accompanied to take

photographs if they needed assistance. I accompanied three participants to places where they wanted to take photographs, and prepared the cameras for them.

### **3.12 Accessing research participants**

Ethical approval for this study was granted by the University of Liverpool in July 2014. The process of building relationships with older people started in June 2014, and data were collected between September 2014 and March 2015. As noted in Section 3.5 (Chapter 3), gatekeepers advised to attend their weekly sessions prior to starting the recruitment. This emerged as an essential step to build a trusting relationship with participants, as it allowed the group to get to know more about me and my research, as well as helping me to target my sampling strategy in the best way.

They also advised me on other aspects of the data collection process (*e.g.* preferred times and days to conduct interviews and focus groups). This meant, in one case (group 1), that I conducted two initial focus groups instead of one, as originally planned. In fact, the gatekeeper suggested to me that in order to recruit a greater number of participants, it would have been better to give them two options. The support from gatekeepers, with their ‘insider’ perspective and who understood the culture of participants, contributed to the recruitment of participants. In the next paragraphs, I present an overview of how I interacted and gained consent from participants, the data collection procedures, including a detailed description of the data collection sessions.

Gatekeepers personally introduced me to prospective participants throughout the course of activities organised on a weekly basis and/or through the connections that they had within the community. On this occasion, I explained the purpose

of the study and assessed their eligibility using a set of open questions which reflected the inclusion criteria (Table 9). I invited those meeting all inclusion criteria to take part in the initial focus group (Nykiforuk et al. 2011; Wang et al. 1998; Novek et al. 2011), and provided with an information sheet and a consent form (Appendix B and Appendix C). These forms were developed with lay input to ensure that these were clear and comprehensible.

The comfort levels of older people with my presence in the community centre improved over the duration of the project. To make this happen, I soon realised that I had to find a connection with them, and the only way to get closer to their ‘world’ and culture, was to be part of it. Therefore, I started taking part in their lunches and coffee mornings. I started playing Bingo with them. I focused my conversations on other subjects (*e.g.* the City, my family, and Bingo). I did not, however, use any of the aspects which emerged from these informal conversations as research findings, as I did not have consent for this.

Following various visits to the community centres, I was able to establish consistent and regular interactions with potential participants. I was still perceived as a ‘person coming from the University’, but slowly, something was changing. From discussions about general topics (*e.g.* Bingo), participants started asking me questions about the study. For instance, one person, who subsequently participated in the study, asked me how I got interested in ageing and older people. I recorded all these observations in my reflexivity notes after the meetings.

- **Gaining informed consent**

Participants had around one week to read the information sheet and reflect on their possible participation in the study. If they wished, I contacted them by phone to review the research process and to clarify any aspect of the study. Interested participants signed a written consent form at the start of the initial focus group (Green & Thorogood, 2009). I ensured that participants were comfortable by asking before and after the start of the focus groups and/or interview if there was any concern or need of further information. Moreover, I was ready to clarify any other aspect that might have emerged throughout the course of the following meetings.

Given the nature of photovoice, which uses the additional element of photographs, alongside the participant's consent to take part in the study, multiple consent forms were used (Wang & Redwood-Jones 2001). These included: (i) the acknowledgment and release forms – for people who appeared in any photograph (Appendix E), and (ii) a form for release of the photographs, asking permission to use participants' photographs in dissemination of results (Appendix D). The steps that I followed to instruct participants about these two forms are presented in the following section on data generation.

- **Data generation**

Each of the four photovoice projects lasted approximately one month and a half. Each group of participants participated in two focus groups (of approximately one to two hours' duration each) and an individual semi-structured interview with an average duration of thirty minutes). These were audio recorded with

permission. At the end of the study, each participant received a supermarket voucher (valued £20) to compensate his/her time. Given the context of this study, and based on my experience in conducting previous photovoice projects with older people (Ronzi 2013; Ronzi & Kennedy 2012), the duration of each project (of one month and a half) was deemed as appropriate to collect the data and to keep the participants involved.

Each photovoice project consisted of six phases, which are detailed hereafter (Figure 26).

(1) An initial focus group (n=5 focus groups; one group had two initial focus groups with different participants) was focused on the introduction of the project, photography and ethical training. During the ethical training, I gave participants the acknowledgment and release forms (Appendix E) and asked them to obtain written consent from people who appeared in the photographs. I instructed participants to inform every person who appeared in the photographs on the purposes of the study and that the photographs were to be used as a part of a doctoral thesis, to write publications and make photo-exhibitions. I clarified to participants the 'rules' on when consent was needed (*e.g.* individual or group is 'featured') and when it was not (where people can be regarded as a crowd), so as to allow participants to take photos of topics involving people more easily (Wang & Redwood-Jones 2001). I advised the participants to avoid taking photographs of individuals under 18, unless they were family members or close friends. After that, participants received digital cameras, and I gave instructions about how to operate a digital camera. They were given a broad pre-identified problem to be explored. They were asked to photograph aspects of Liverpool

that they felt 'enabled or prevented them to feel valued and part of the community' and to identify potential solutions to any problems identified. To limit my influence over subject matter for participants' photographs, the photography task was kept very general. Participants were left free to take any photo of object/person/place that related to respect and social inclusion in the City. Participants were encouraged, but not restricted, to take photographs of aspects of their local geographical area. However, they were left free to take photographs of other wards and the main city centre as well, if they felt that it was appropriate.

(2) Participants took photographs over a period of one week.

(3) Semi-structured interviews were conducted (n=21 individual interviews; n=2 interviews were conducted in pairs, with a total N=25 participants being interviewed). The semi-structured interview enabled building a closer connection with the participant. It provided the opportunity to explore the participants' perceptions in greater depth, when compared to the group discussions, which were mainly focused on encouraging the discussion amongst the participants (Novek & Menec 2013). During the individual interviews, photographs were displayed on a laptop and shown to each participant who was asked to select the most meaningful (between three and six), which were to be discussed in a subsequent focus group. Participants, who did not spend much time in reviewing the photographs they had taken before the interview, selected 127 photographs in total. Each participant was stimulated to discuss the meanings of the photographs using the SHOWeD technique (Wang et al. 1998;

Wang & Burris 1997). The SHOWeD technique consists of different questions that relate to the photograph:

- What do you **S**ee here?
- What's really **H**appening here?
- How does this relate to **O**ur lives?
- **W**hy does this problem, concern, or strength **E**xist?
- What can we **D**o about it?

Additional questions were adapted from the literature on ageing and social inclusion (Buffel et al. 2012; Buffel et al. 2013; WHO 2007; Menec et al. 2011; Scharlach & Lehning 2012) and from two photovoice studies exploring perceptions of ageing that I had previously conducted (Ronzi 2013; Ronzi & Kennedy 2012) (Appendix H and Appendix I). After exploring the photographs taken, and the stories that the participants associated with them, I asked if there were any photographs that the participants wanted to take but that, for various reasons, they did not take. This was aimed at stimulating a discussion on aspects that were not photographed. Furthermore, I asked participants about how they experienced the photovoice process and the overall project (*e.g.* How did you find the project? What did you like most and least about the project? What can I improve next time?). At the interview, I also asked participants to sign a form asking permission to use their photographs in dissemination of results (Evans-Agnew & Rosemberg 2016).

(4) Participants discussed their photographs during a second focus group (n=4 focus groups). Participants were asked how they wanted that the findings to be communicated to relevant people in the City. I suggested a photo-exhibition, and participants greatly welcomed this idea. At the end of the focus group I again

asked participants (now as a group) how they experienced the photovoice project and what could have been improved in future projects. I also asked their opinions about the venue(s) in which they would most liked to see their work presented (with their consent). I suggested the City council, as I thought that it represented a meaningful venue for participants. However, many participants did not like that idea, as they wanted a more neutral venue to display their findings. I then suggested a community venue represented by an art gallery/museum (*e.g.* the Museum of Liverpool), which they were very supportive of.

(5) I wrote a summary based on the participant's original description of the photograph (from interview and focus group transcripts) to accompany each photograph. To ensure that these stories reflected the intentions of the participant, I showed all the photographs and the associated summaries to each participant, who reviewed and edited the final summary and title prior to these being printed and displayed at the photo-exhibition (Foster-Fishman et al. 2010). For the exhibition, I asked participants to review and agree on (i) the choice of the photographs and accompanying captions to be displayed; and (ii) the different sub-headings used to group photographs and accompanying captions (*e.g.* "Access to public transportation"). Due to limited space at the Museum, 60 out of the 127 photographs were displayed, but all of the photographs that the participants considered most meaningful were included (each participant had between 2 and 3 photos displayed).

(6) The exhibition of the older people's photographs took place in May 2015 in a landmark community setting – the Museum of Liverpool. The aim of the exhibition was to provide a forum (i) to disseminate study findings; and (ii) to

encourage critical dialogue amongst invited participants, city stakeholders, researchers and members of the community about those aspects of the City that were perceived to be important to older people, and to influence policy and social change.

The organisation of the exhibition required a lot of preparation. At the beginning of the study, I explored various venues that could host an exhibition (*e.g.* the City council, art galleries and museums, and venues that offered space to organise conferences) and I suggested these to participants. As noted in phase (4), they were very supportive at organising the event in a museum or in an art gallery. I explored this possibility throughout my interactions with some city stakeholders. Thanks to the mutual respect that was created with the Executive Director Education & Visitors and the Education team, I was offered a room for the photo-exhibition in the Museum of Liverpool at no cost due to their recognition of the importance of this research and its potential public interest.

The organisation of the event started approximately six months prior to the event. Once the date of the event was confirmed, I made a flyer that I circulated to gatekeepers and participants, including their family members, friends, or people potentially interested in attending, such as city stakeholders involved in the stakeholder study (Section 3.14); but also colleagues, local media representatives, and researchers based at the University of Liverpool or other universities.

In total 71 people attended the event. Local media (journalist and radio) were present and reported the event locally. On the opening of the exhibit, I gave a short speech to the guests, thanking all of those involved, including the

participants, the Museum, the supervisors and the University, which certainly contributed in making the photo-exhibition a successful event. I then introduced the speakers who included a representative from the council (mayoral lead for older people), an executive of the museum, and two leading academics from the university. I assessed the event with a short evaluation survey and observation notes that were taken by five researchers. The main purpose of this small evaluation was to assess the ability of the method to engage participants and city stakeholders in a meaningful dialogue.

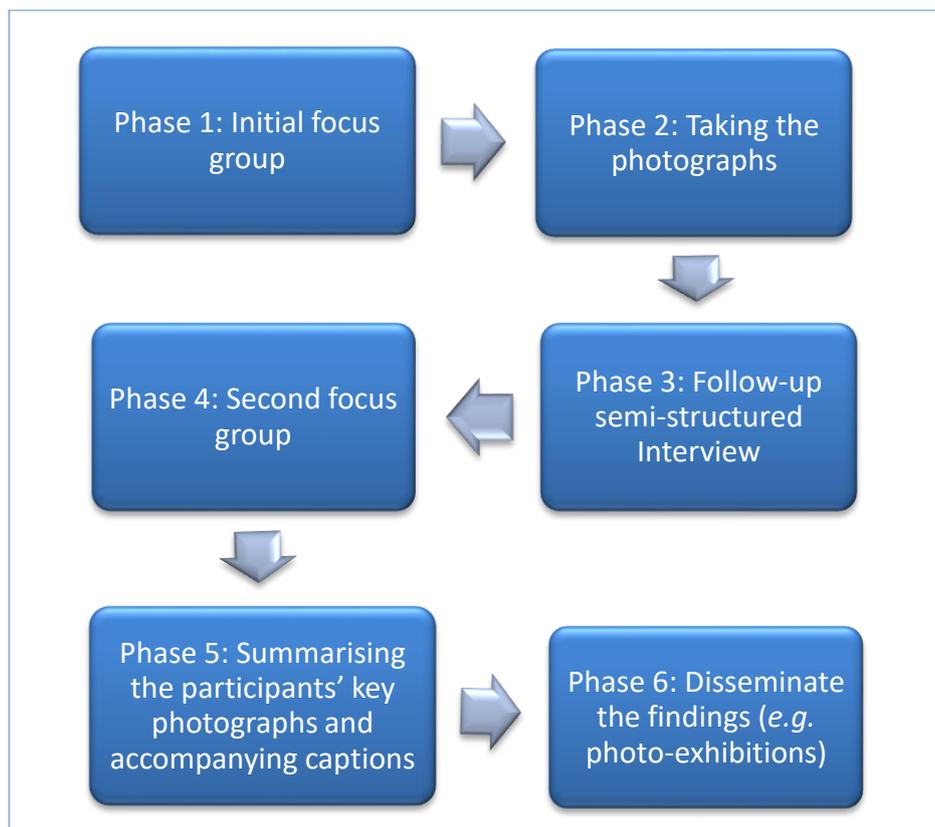


Figure 26 Phases of the photovoice process adopted in this study. Adapted from Nykiforuk et al. (2011).

- **Modification to use of the SHOWeD technique**

As noted previously, during the individual interviews I used the SHOWeD technique (Wang et al. 1998) in combination with some additional questions (Appendix I). The purpose of the SHOWeD technique is to discuss the origins of the issue and develop strategies for positive change of the current situation (Wang et al., 1998). To date, there is no consensus concerning the value of the use of the SHOWeD technique. According to a qualitative review of photovoice studies (Hergenrather 2009), some authors found it useful to stimulate discussion, some others reported that the use of the questions was felt as an impediment for discussion. According to Hergenrather (2009), after the development of the SHOWeD technique, a new mnemonic called PHOTO was developed and employed in some photovoice studies. Questions included:

- Describe your **P**icture.
- What is **H**appening in your picture?
- Why did you take a picture **O**f this?
- What does this picture **T**ell us about your life?
- How can this picture provide **O**pportunities for us to improve life?

In some other studies, questions were developed to trigger discussion. I decided to use the SHOWeD technique because it has been widely used in various photovoice studies, and therefore, those questions have been tested previously (Catalani & Minkler 2010; Hergenrather 2009; Wang et al. 1998). However, perhaps due to the fact that I did not ask the SHOWeD questions right at the beginning of the interview, scarce additional information was collected concerning explanations of the photographs. In fact, the first set of questions that I asked was very general ('tell me why you took this picture; why do you want

to share this picture; why is it important to you'). In some occasions I did not even ask those questions as the participant started talking about the photographs spontaneously.

When I started asking the SHOWeD questions, I realised that the questions were appropriate in terms of exploring the content of the photograph, why it was related to their lives, and possible solutions to the issues identified. However, the participant was not able to give me a more detailed and 'thick' description of the reasons why the photograph was taken in relation to feeling valued and part of the community (respect and social inclusion). After a few interviews, I added another question: 'How, in what way does this photo (name of the building/place in the photograph) make you feel valued/part of your community?'. With this question, I found that participants were able to make a more direct connection with the photograph and the topic under study. Therefore, they were able to tell me why/in what way the object of the photograph made or did not make them feel part of the community.

Moreover, modifications to the questions came from participants themselves. For instance, at the conclusion of the first focus group (Group 1), some participants suggested that it would be better to use the term 'elderly person' instead of 'older person' in asking the questions. Participants reported that the term 'elderly person' was felt to be more respectful. Since English is not my first language, this advice was very important to create a better interaction with participants and future groups. Following this, I used the term 'elderly person' when asking questions and in communicating with participants.

### 3.13 Data analysis

As this study aimed at exploring individuals' interpretation of reality, an interpretivism was chosen as the most appropriate approach to guide the analysis (Green & Thorogood 2009c). I conducted the analysis of text and photographs in parallel, with iterative cross-referencing of the emerging themes (Flick 2009a; Miles & Huberman 1994). Figure 27 shows the relationship between the different elements of the data analysis process.

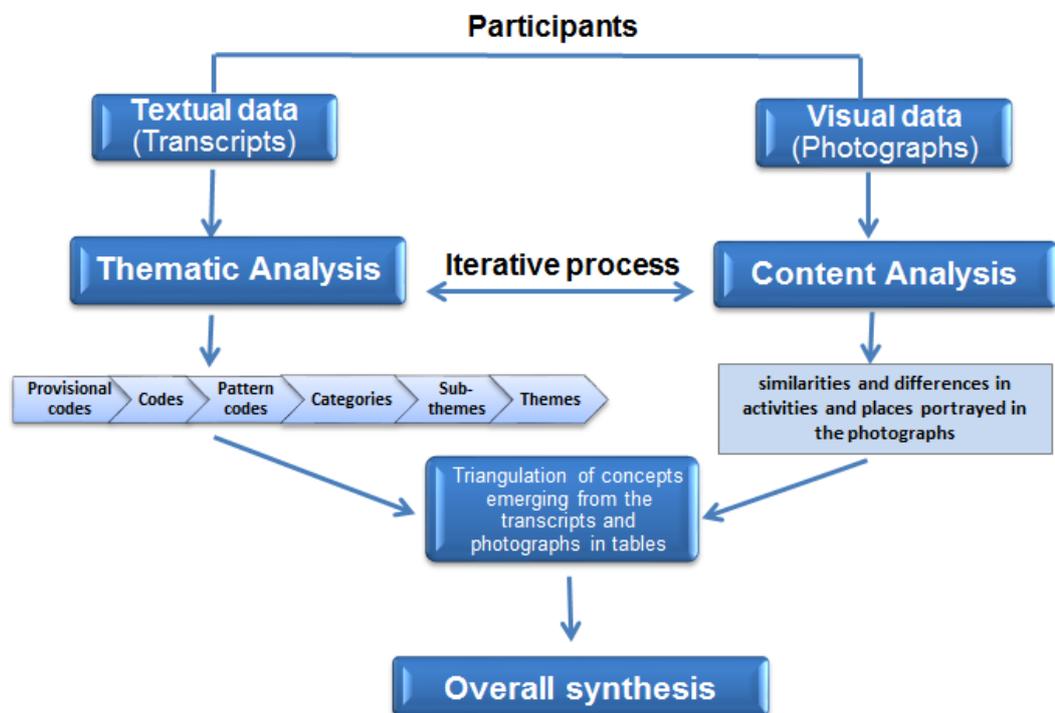


Figure 27 Flow chart of the overall data analysis process

I started with the thematic analysis of the interviews and focus groups; content analysis of the photographs followed. Reflexive notes helped to give context to the recorded material (Merriam & Tisdell 2015). For instance, the notes gave me context on the group dynamics; the different phases of relationship building with

participants; and served as a record for the decisions that I made in collecting and interpreting the data.

### **3.13.1 Thematic analysis**

The overall analysis process took me one year and half (from February 2015 to August 2016). The analysis continued through the writing process, wherein I produced three drafts of the results, which were commented by the supervisors, and some results were presented at conferences. The feedback received during this process improved my overall interpretation of the findings.

- **Transcription process**

During the data collection, I also started the process of transcribing the audio recordings, because I wanted to be able to analyse the data simultaneously. I transcribed verbatim approximately 70% of the interviews (n=21 individual interviews; n=2 interviews were conducted in pairs. N=25 participants were interviewed) and group discussions (n=9). The rest were transcribed by an experienced transcriber who was recommended by colleagues in my Department. Given the large body of data, I stored and coded the transcripts using NVivo 10 qualitative data analysis software (QSR International 2014).

Having transcribed nearly 70% of the interviews and focus groups allowed me to be familiar with the majority of the transcripts (Flick 2009b). I listened back to the recording of those transcripts that I did not transcribe myself, or when I felt that the analysis was particularly challenging. For instance, I re-listened to the recording when I felt that there was a clear sense of disappointment or frustration when participants talked about the barriers to respect and social

inclusion (*e.g.* lack of street cleanliness), as it was important to listen the tone of their voice.

- **Coding**

Based on the objective of this study, three ‘a priori’ domains were identified: enablers and barriers to respect and social inclusion, and potential solutions to perceived barriers. Based on these three ‘a priori’ domains, a thematic analysis of the transcripts identified several sub-themes (Miles & Huberman 1994; Flick 2009a).

Initially, I reviewed transcripts one-by-one. I derived a brief list of codes by adopting a deductive approach which was based on my knowledge on the topic of respect and social inclusion in the urban setting (*e.g.* feeling valued and included). After coding a couple of interviews, the pre-existing framework started expanding, and codes were refined iteratively by adopting an inductive approach (Pope et al. 2000). An inductive approach enabled me to identify many aspects on the topic that I did not consider at the start (*e.g.* perceptions of the physical environment and buildings).

A first set of codes (Table 10) was developed during the initial six months of the analysis. As the analysis progressed, codes were iteratively refined and categorised. The second and final set of codes was produced approximately nine months after the first set of codes. Table 10 and Table 11 show how the coding framework changed over time.

Codes developed in the thematic analysis (66 codes)	
Access to places in the city	Lack of confidence
Access to technology	Lack of intergenerational respect
Access to transportation	Lack of publicity-awareness
Activities as a space to interact with people	Limited access
Age-perceptions	Loss of informal networks - social interactions
Barriers to full inclusion	Making a difference
Bureaucracy	Meeting place
Challenging labels-stereotypes	Maintaining-Using Skills
Competition for facilities-resources	Mobility issues
Contributing to the community	Neighbourhood fragmentation
Cultural-religious differences	Overcoming barriers
Daily-Weekly activity	Past- memories
Dereliction of services-places	Perceived support
Disrespectful behaviours-attitudes	Perception of mental health and social isolation
Economic support	Perception of the physical environment and buildings
Enabler to social participation-social inclusion	Perception-value of key individuals
Enjoyment	Personal attitude
Entrepreneurship	Personal responsibility
Facility-asset in the community	Physical activity
Family connections	Reciprocal benefits
Feeling vulnerable-fear of crime	Respectful attitudes
Feeling connected-included	Role
Feeling valued	Sense of disregard-alienation
Feeling welcome	Sense of identity
Future plans	Sense of pride
Healthy food-diet	Sharing interests
Healthy life-lifestyle	Social Engagement- Social interactions
Hobby	Solutions to issues
Impact of retirement and growing old	Staying busy
Impact of the methodology	Transformation of the physical environment and things
Impact-fear of budget cuts	Variety of activities-opportunities
Improvement of services	Volunteering
Intergenerational and multi-ethnic place-interactions	
Joined-up services	

Table 10 Coding framework for the photovoice study: second round of analysis.

**Codes refined in the thematic analysis (55 nodes)**

<p>Access to churches</p> <p>Access to community centres</p> <p>Access to cultural activities-opportunities</p> <p>Access to green spaces</p> <p>Access to gyms-leisure centres</p> <p>Access to health services</p> <p>Access to information-IT- learning resources-opportunities (Access to technology was merged in this node)</p> <p>Access to libraries</p> <p>Access to museums</p> <p>Access to other places in the city</p> <p>Access to transportation</p> <p>Activities as a space to interact and sharing interests (Sharing interests was merged in this node)</p> <p>Age-perceptions (Impact of retirement and growing old was merged in this node)</p> <p>Barriers to R &amp; SI (Bureaucracy; Mobility issues; were merged in this node)</p> <p>Challenging labels-stereotypes</p> <p>Competition for facilities-resources</p> <p>Contributing to the community (Volunteering + Making a difference were merged in this node)</p> <p>Cultural-religious differences</p> <p>Dereliction of services-places</p> <p>Disrespectful behaviours-attitudes</p> <p>Economic benefits- free-low cost activities</p> <p>Enabler to social participation-social inclusion</p> <p>Facility-asset in the community</p> <p>Family connections</p> <p>Feeling vulnerable-fear of crime (Lack of confidence was merged in this node)</p> <p>Feeling connected-included</p> <p>Feeling valued and enjoying (Enjoyment was merged in this node)</p> <p>Feeling welcome</p> <p>Healthy food-diet (healthy life-lifestyle and physical activity were merged in this node)</p>	<p>Hobby (Staying busy; Entrepreneurship; Daily-weekly activity were merged in this node)</p> <p>Impact of the methodology</p> <p>Impact-fear of budget cuts</p> <p>Improvement of services (Joined-up services was merged in this node)</p> <p>Lack of intergenerational respect</p> <p>Lack of publicity-awareness</p> <p>Limited access</p> <p>Loss of informal networks - social interactions</p> <p>Meeting place</p> <p>Maintaining-Using Skills</p> <p>Neighbourhood fragmentation</p> <p>Overcoming barriers (Solutions to issues was merged in this node)</p> <p>Past- memories</p> <p>Perceived support</p> <p>Perception of mental health and social isolation</p> <p>Perception of the physical environment and buildings</p> <p>Perception-value of key individuals</p> <p>Personal attitude (personal responsibility was merged in this node)</p> <p>Reciprocal benefits</p> <p>Respectful attitudes</p> <p>Role</p> <p>Sense of disregard-alienation</p> <p>Sense of identity and pride (Sense of pride was merged in this node)</p> <p>Social Engagement and social-Intergenerational interactions (Intergenerational, multi-ethnic place-interactions was merged in this node)</p> <p>Transformation of the physical environment and things (Future plans was merged in this node)</p> <p>Variety of activities-opportunities</p>
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Table 11 Coding framework for the photovoice study: final round of analysis.

- **Categories and sub-themes**

Following the development of the first set of codes, I analysed transcripts more deeply, and I collated categories into sub-themes emerging in the text. As the analysis progressed and after producing a first draft of the results, I refined themes and sub-themes names, and these were agreed by the supervisory team. Table 12, Table 13, Table 14 and Table 15 present the different categories stratified into sub-themes for each of the three domains of respect and social inclusion, which will be presented in more detail in Chapter 4. Here the purpose is to show how I arrived at the main sub-themes through the analysis process.

Access to places	Positive perceptions of the urban environment	Access to opportunities	Perceived community support
<ul style="list-style-type: none"> <li>• Transportation</li> <li>• Health services</li> <li>• Shops and cafés</li> <li>• Community centres</li> <li>• Green spaces</li> <li>• Libraries</li> <li>• Museums</li> <li>• Gym and leisure centres</li> <li>• Churches</li> <li>• Feeling connected and included</li> <li>• Feeling welcome</li> <li>• Meeting place</li> <li>• Intergenerational multi-ethnic place-interactions</li> <li>• Social engagement and interactions</li> <li>• Facilities-assets in the community</li> <li>• Past memories</li> </ul>	<ul style="list-style-type: none"> <li>• Sense of pride</li> <li>• Sense of identity</li> <li>• Feeling connected</li> <li>• Feeling valued</li> <li>• Feeling welcome</li> <li>• Meeting place</li> <li>• Social engagement and interactions</li> <li>• Variety of activities opportunities</li> <li>• Transformation of the urban environment</li> </ul>	<ul style="list-style-type: none"> <li>• Transportation</li> <li>• Learning opportunities</li> <li>• Culture, technology and IT skills</li> <li>• Activities that allow to cultivate interests, hobbies, relationships, and social interactions</li> <li>• Variety of activities and opportunities</li> <li>• Staying busy</li> <li>• Maintaining and using skills</li> <li>• Feeling included</li> <li>• Feeling valued</li> <li>• Contributing to the community</li> <li>• Hobby</li> </ul>	<ul style="list-style-type: none"> <li>• Economic benefits</li> <li>• Respectful attitudes</li> <li>• Value of key individuals</li> <li>• Family connections</li> <li>• Congregations</li> <li>• Churches, transportation, libraries, museums, community centres, shops, cafés, and health services</li> <li>• Feeling valued</li> <li>• Feeling welcome</li> </ul>

Table 12 Domain of enablers to respect and social inclusion: attributes (categories) identified in each sub-theme.

Accessibility, affordability and inclusivity of places in the City	Positive perceptions of the urban environment
<ul style="list-style-type: none"> <li>• Green and blue spaces</li> <li>• Places to cultivate learning, art and culture: museums, libraries, book clubs, libraries</li> <li>• Places to cultivate interests and informal and formal interactions: community centres, soup kitchens, restaurants, benches</li> <li>• Places to cultivate interests and a healthy lifestyle: parks, allotments, gym and leisure centres</li> <li>• Public transportation system</li> <li>• Feeling connected and included</li> <li>• Meeting place</li> <li>• Intergenerational multi-ethnic place-interactions</li> <li>• Facilities-assets in the community</li> <li>• Staying busy</li> </ul>	<ul style="list-style-type: none"> <li>• Sense of pride and identity</li> <li>• Friendly and welcoming places</li> <li>• Perceived safety: CCTV cameras</li> <li>• Variety of activities and opportunities</li> <li>• Feeling connected</li> <li>• Feeling valued</li> <li>• Feeling welcome</li> <li>• Meeting place</li> <li>• Social engagement and interactions</li> <li>• Variety of activities opportunities</li> <li>• Facilities-assets in the community</li> <li>• Transformation of the urban environment</li> <li>• Churches</li> <li>• Famous historical buildings</li> <li>• Health centres</li> <li>• Cafès and shops</li> </ul>

Table 13 Domain of enablers to respect and social inclusion: attributes (categories) identified in each sub-theme (final version).

Limited accessibility to places and opportunities	Negative perceptions of the urban environment	Negative age-perceptions
<ul style="list-style-type: none"> <li>• Transportation</li> <li>• Public toilets</li> <li>• Health services</li> <li>• Shops and cafés</li> <li>• Community centres</li> <li>• Green spaces</li> <li>• Libraries</li> <li>• Museums</li> <li>• Gym and leisure centres</li> <li>• Churches</li> <li>• Meeting place</li> <li>• Past memories</li> <li>• Lack of publicity-awareness</li> <li>• Impact-fear of budget cuts</li> <li>• Transformation of the physical environment</li> <li>• Limited access</li> <li>• Loss of informal networks and interactions</li> </ul>	<ul style="list-style-type: none"> <li>• Sense of disregard and alienation</li> <li>• Direspectful behaviours-attitudes</li> <li>• Sense of identity</li> <li>• Feeling vulnerable-fear of crime</li> <li>• Transformation of the physical environment</li> <li>• Limited access</li> <li>• Impact-fear of budget cuts</li> <li>• Loss of informal networks and interactions</li> <li>• Meeting place</li> <li>• Social engagement and interactions</li> <li>• Transformation of the physical environment</li> <li>• Neighbourhood fragmentation</li> </ul>	<ul style="list-style-type: none"> <li>• Direspectful behaviours-attitudes</li> <li>• Lack of intergenerational respect</li> <li>• Maintaining and using skills</li> <li>• Volunteering</li> <li>• Hobby perceptions</li> <li>• Neighbourhood fragmentation</li> <li>• Loss of informal networks and interactions</li> </ul>

Table 14 Domain of barriers to respect and social inclusion: attributes (categories) identified in each sub-theme.

Overcoming barriers	Challenging negative age-perceptions
<ul style="list-style-type: none"> <li>•Transportation</li> <li>•Health services</li> <li>•Shops and cafés</li> <li>•Community centres</li> <li>•Green spaces</li> <li>•Libraries</li> <li>•Museums</li> <li>•Gym and leisure centres</li> <li>•Churches</li> <li>•Feeling connected and included</li> <li>•Feeling welcome</li> <li>•Meeting place</li> <li>•Intergenerational multi-ethnic place-interactions</li> <li>•Social engagement and interactions</li> <li>•Facilities-assets in the community</li> <li>•Past memories</li> </ul>	<ul style="list-style-type: none"> <li>•Transportation</li> <li>•Learning opportunities</li> <li>•Culture, technology and IT skills</li> <li>•Activities that allow to cultivate interests, hobbies, relationships, and social interactions</li> <li>•Variety of activities and opportunities</li> <li>•Staying busy</li> <li>•Maintaining and using skills</li> <li>•Feeling included</li> <li>•Feeling valued</li> <li>•Volunteering</li> <li>•Cultivate interests and hobbies</li> <li>•Challenging labels-stereotypes</li> </ul>

Table 15 Domain of potential solutions to perceived barriers of respect and social inclusion: attributes (categories) identified in each sub-theme.

- **Linking themes and developing a narrative around respect and social inclusion**

Following the development of the sub-themes, I started linking the themes (Pope et al. 2000; Green & Thorogood 2009a). This involved writing memos (notes), and developing a narrative to explain the phenomenon under study (Gibbs 2007). Initially, I focused on the characteristics of the places that prevented or enabled older people’s respect and social inclusion (*e.g.* “blue and green spaces” versus “lack of street cleanliness”). This led me to recognise three characteristics that overarched many of the sub-themes (*i.e.* affordability and accessibility of places and transportation), which I considered in developing the narratives around

respect and social inclusion. An additional overarching feature is how participants reacted to these places (*e.g.* “sense of pride and belonging” versus “sense of disregard and alienation” towards places in the City). Reflecting on these overarching features helped me to map and develop a narrative around the themes and their key interrelationships, which I refined further through discussions with and feedback from my supervisors.

- **Strategies to enhance the validity/rigour**

As noted previously (Chapter 3, Section 3.3), I adopted various strategies to ensure the generation and analysis of valid and comprehensive data, for example through the triangulation of transcripts from interviews, focus groups and photographs (Noble & Smith 2015; Mays & Pope 2000; Flick 2009c).

About 20% of the transcripts were double coded by a member of the supervisory team. I compared the codes, and any discrepancy that arose was discussed. I and three researchers were involved in the process of analysis, which was iterative, with sub-themes and themes that were refined as the analysis progressed. I then triangulated concepts emerging from the interview and focus group transcripts and photographs (n=127 in total) in tables: analysing each photograph in relation to the meaning(s) that the participant attached to it (Keats 2009). To each photograph, I then allocated themes and sub-themes identified through the thematic analysis, with supporting quotes referring to the photograph. Table 16 shows an example of this integration of concepts emerging from a photograph with related quotes used to define and reinforce the main findings.

Supporting information [Quotes]	Photograph [Title]: Access to museums
<p><b>Voice of the photographer represented by selected text from participant’s description of photograph which was checked and agreed with participant (P15 – Phase 3 interview):</b></p> <p>“This is the library. I like books and inside it’s absolutely beautiful... we have such as lovely facility here [...] it’s lovely to have a look and see whatever you want to see... it’s open for anyone in Liverpool to go in, so it’s not local community but it’s for the community of Liverpool”. (P15, IV) (Central Library, Liverpool)</p> <p><b>Other quotes related to the same photograph (P15 Phase 4 focus group):</b></p> <p>“This is the Central Library, and a) the building is lovely, and b) anyone can go in. [...] It’s lovely to have a look and see whatever you want to see”. (P15, FG2) (Central Library, Liverpool)</p> <p>“I just like going around [...] we have such as lovely facility here. [...]”. (P15, FG2) (Central Library, Liverpool)</p>	<p><b>Central Library, Liverpool</b></p> 
<p style="text-align: center;"><b>Overall synthesis [themes and sub-themes]</b></p> <p><b>Theme:</b> Enablers to respect and social inclusion</p> <p><b>Sub-themes</b> (obtained from thematic analysis of all transcripts) to which content of this image relates:</p> <ul style="list-style-type: none"> <li>• Access to libraries</li> <li>• Access to learning opportunities</li> <li>• Symbol of Liverpool</li> <li>• Asset in the community</li> </ul>	

Table 16 Example of integration of concepts emerging from the photograph and quotes (from P15) arising from the interview and focus group discussion; integration of these sources of data was used to define and reinforce the main findings.

The data obtained in the interview and focus group transcripts reflected the questions that were asked using a structured format (Appendix H and Appendix I). As mentioned previously, the interview reflected more the individual participants’ experiences, and provided most of the substantive data on the

meaning and importance of the photographs, and how participants experienced the photo-production process, including challenges in representing some concepts through photographs. The focus groups generated more spontaneous conversations. The initial focus group transcripts provided most data on general issues of enablers and barriers to respect and social inclusion (*e.g.* age-stereotypes, negative age-perceptions, community support, friends and family). The second focus groups transcripts provided data on the participants' description of the chosen photographs, and more general discussion that occurred spontaneously amongst the participants. Participants spontaneously commented other people's photographs, by making comparisons and/or by referring to similar issues that they experienced. The transcript data, therefore, reflected this. As I highlighted before, the combination of different methods for gathering data improved my understanding of respect and social inclusion from the participants' viewpoints, and enhanced the quality/validity of the findings.

- **Content analysis of the photographs**

Content analysis of the photographs (N=127) explored similarities and differences between objects or people portrayed by the participants, and aimed to complement the thematic analysis (Rose 2012a). For instance, I looked at similarities in activities (*e.g.* attending community centres and libraries), places portrayed (*e.g.* green spaces and historical buildings), and location of these places (*e.g.* if photographs were taken in the local areas of participants or in different areas/city centre). I grouped the photographs into categories that were developed through the thematic analysis (*e.g.* access to green spaces). Some photographs fit into more than one category (*e.g.* a park can be perceived as a

place to socially interact with people; a place to do physical activity; a place to mix with people; nice memories; to walk). Categorising the photographs was useful to get an overview of how many photographs were taken by different groups, and to observe if the most photographed places reflected also the most talked about places in interview and focus group transcripts. This process helped me to integrate the findings from the thematic and content analysis.

The details of the content analysis are presented in Chapter 4.

### **3.13.2 Considering the context in which the photograph was taken**

As noted earlier, I used the photographs to complement and reinforce the findings that emerged from the interview and focus group transcripts. In this section I examine why, the participant's explanations of the photographs is an significant element to consider when analysing the data (Pink 2006; Foster-Fishman et al. 2010; Evans-Agnew & Rosemberg 2016; Murray & Nash 2016).

As mentioned in the section dedicated to the procedures (Section 4.3), to ensure that I captured accurately the meaning that the participant wanted to attribute to the images, participants reviewed and edited the final summary and title prior to being printed and displayed in the photo-exhibition (Foster-Fishman et al. 2010).

Without the caption, the visual context of the image can be interpreted in many different ways, and therefore, the meaning associated to the image is likely to change (Collier & Collier 1986). In front of the same photograph, two different individuals are likely to see aspects of it that can vary slightly or greatly. Viewing is not a passive action, but is intrinsically connected with our experiences,

beliefs, culture, which influence our perceptions of the world (Collier & Collier 1986; Bruce 2000; Wright 1999).

Photographs show what the participant decided to portray as an important aspect for the issue under study. However, the meaning of the images resides most significantly in the ways that participants interpret those images, rather than as some inherent property of the images themselves (Stanczak, 2007 p.11). If the caption used was not carefully checked against participant's intended meaning, it would be easy for the researcher to convey the wrong meaning by attaching a caption that, for example, he/she had generated based on his/her own views.

Time is also an important factor that can alter the way in which we perceive an image. As time passes, memory tends to become blurry, experiences and culture are likely to change, and our perspective of a photograph may be different (Wright 1999). As the participant is immersed again in his/her everyday life, the relationship that he/she has with the photo may change (Hodgetts et al. 2007). This is one of the reasons why interviews were carried out one week after that participants had taken the photographs, since they were not provided with any journal/diary to act as a prompt.

- **Data access and storage**

At the end of each interview or focus group, I uploaded and saved the record on the University's secure server. In the interview and focus group records, I used the same number and name allocated to the participant on recruitment (*e.g.* interview 1-participant 1). After that, I deleted the interview or focus group record from the audio recording device.

As with the records, in the interview and focus group transcripts, I used the same number and name allocated to the participant on recruitment (*e.g.* participant 1) to the study. During the transcription process, I replaced any identifying features of the participants with a code, so as to anonymise the data. I kept the key which linked the code to each participant separately from this information (in an encrypted memory stick). I kept the encrypted memory stick and all data which was retained in hard copy (*e.g.* signed consent forms) in a University locked filing cabinet as outlined in the 1998 Data Protection Act. All data will be kept for 5 years and then securely destroyed.

### **3.14 City stakeholders: research setting and sampling**

#### **recruitment**

City stakeholders working in Liverpool were initially recruited using purposive and snowballing sampling. Semi-structured interviews were conducted with each individual to explore the current situation of respect and social inclusion in Liverpool City. Purposive sampling was used to recruit much of the sample (N=16). Later in this section I will explain how I recruited additional participants (N=7) using a snowballing technique, a technique whereby existing participants recruit forthcoming participants from among their connections (Buffel 2015).

City stakeholders were selected based on their experience and specific expertise that allowed them to provide a perspective from their organisation. Specifically, this included who could provide information on (i) perspectives on needs, (ii) what was done (planned or implemented) in terms of the organisation of interventions which promote respect and social inclusion in older people, wider

policy and influences and (iii) the informant’s views on the challenges associated with making Liverpool a better place to grow old in (in relation to respect and social inclusion). Inclusion criteria for selection are presented in Table 17:

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1. Being able to consent for themselves.
2. Being able to speak English.
3. People who work in Liverpool City Council and/or NHS and who have a remit/interest in public health and/or respect and social inclusion and/or older people in the Liverpool City.
4. People from organisations that have a role/interest in public health/social inclusion/advocacy and older adults in the Liverpool City.
5. People who work in social and/or health care and older people.
6. Working/doing voluntary work in an organisation in Liverpool, and having a role and/interest, that is relevant for the topic of this study.
7. People whose roles include executive/senior/project management positions so that could be representatives of their organisations and/or team(s) and/or project(s).
8. Being able to attend and participate in the interview.

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Table 17 Inclusion criteria for city stakeholders.

- **Rationale for including managers, directors, and chief executives in the sample**

As suggested by Oliver et al. (2013 p.453) “the most powerful individuals in public health are managers, not usually considered targets for research... they are highly influential through all stages of the policy process.” This was one of the reasons why I recruited city stakeholders that had various roles within their organisations including: chief executives, directors of public and third sector organisations, as well as project managers.

In addition, I was looking at a specific typology of interventions involving older people, that is respect and social inclusion. Managers were able to provide me with a more detailed view on day-to-day barriers and the various actors involved in social inclusion and respect in the City, including processes, project evaluation, and informal links that were happening between organisations. This was in contrast with views from city stakeholders in senior roles, who provided more a strategic and general perspective on factors influencing their ability to promote respect and social inclusion. Both perspectives were very useful, and provided me a comprehensive understanding of respect and social inclusion in the City, including wider influences.

- **Sample size and recruitment**

A diverse sample of 23 city stakeholders was recruited. In this section I explain how I moved from purposive sampling, to snowball sampling, and theoretical sampling. Some participants were recruited at targeted community events on loneliness, ageing, and dementia, which were organised by local charities, the Museum of Liverpool, and in collaboration with Liverpool City Council. The strategy that I adopted to facilitate the sampling recruitment in this study, was also used to involve city stakeholders in the dissemination of the findings (photo-exhibition) as a part of the photovoice study (Section 3.11).

The events above constituted valuable networking opportunities with possibility to informally speak with city stakeholders who could potentially be invited for interview. This process of networking started approximatively 6 months prior to obtaining ethical approval. In February 2014, I went to the first event, which was attended by 60 different organisations. Following this event, I arranged follow-

up meetings with some prospective participants to explain the study. This series of informal meetings worked well to build trusting relationships. This is evidenced by the fact that 12 city stakeholders – who were met on one or more occasions prior to starting data collection – subsequently took part in the study, and the interviews proceeded smoothly.

Alongside attending community events, I recruited other city stakeholders through websites and by talking to experts or others working in the field, who recommended some participants for the purpose of this study (snowballing technique). In the text below I explain how I applied the various sampling techniques in the recruitment of city stakeholders.

- **Purposive sampling**

Although my PhD research had a specific focus on respect and social inclusion, interrelations and overlaps between the domains have been acknowledged (Menec et al. 2011). To gain a comprehensive understanding, I wanted be able to capture city stakeholders' perceptions of respect and social inclusion from different angles (domains). At the beginning of the recruitment, I created a diagram where I put the domain of respect and social inclusion in the middle, and related domains followed. I referred to each organisation where the participant was working (since names were anonymised). Each organisation was placed within one or multiple areas, depending on the participant's main area of expertise and role in relation to respect and social inclusion (Figure 28). It was the result of an iterative process: as the recruitment and data collection progressed, more information and contacts were added to Figure 28, and new areas were covered. This scheme provided a visual representation on the

different areas of city stakeholders, as well as identifying those areas (*e.g.* communication and information) for which I did not have detailed information.

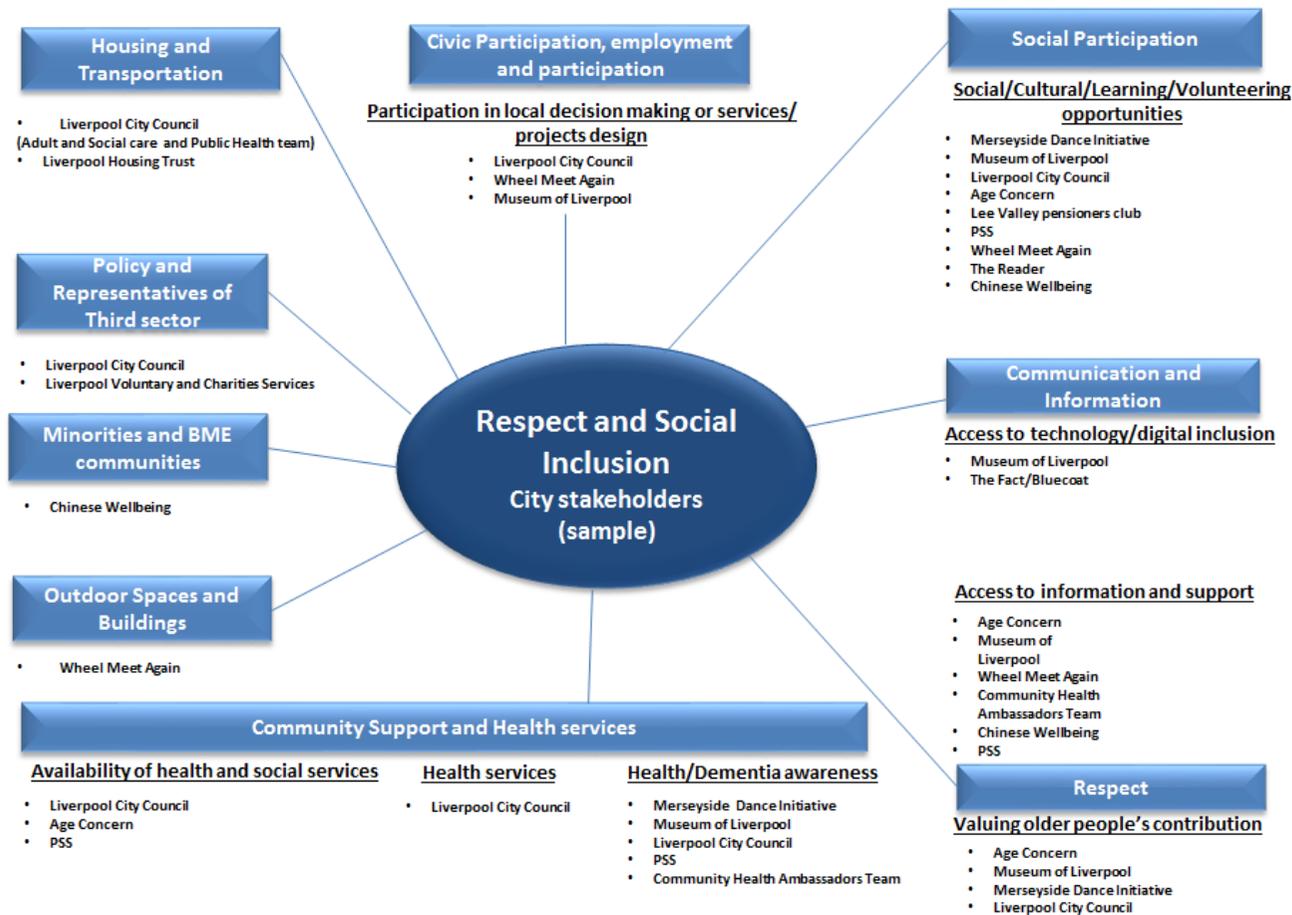


Figure 28 Diagram of sampling recruitment phase 1 (purposive sampling): coverage of multiple areas of respect and social inclusion

- **Snowball sampling**

Snowball sampling was a strategy I used to assist in the purposive sampling, and emerged as the most appropriate method to access a wider range of participants (n=7) in areas that were not covered yet (Figure 28). By asking participants to identify people who had a specific expertise/experience that I was interested in (*e.g.* digital inclusion), I managed to recruit some people in the City that I would have been able to locate otherwise. Some city stakeholders gave me direct access to potential contacts by email and/or other means. This strategy was successful in most of the cases, as being introduced by people who were known and trusted facilitated me in building a trusting relationship. Figure 29 represents how the snowball and purposive sampling contributed to the overall sample size.

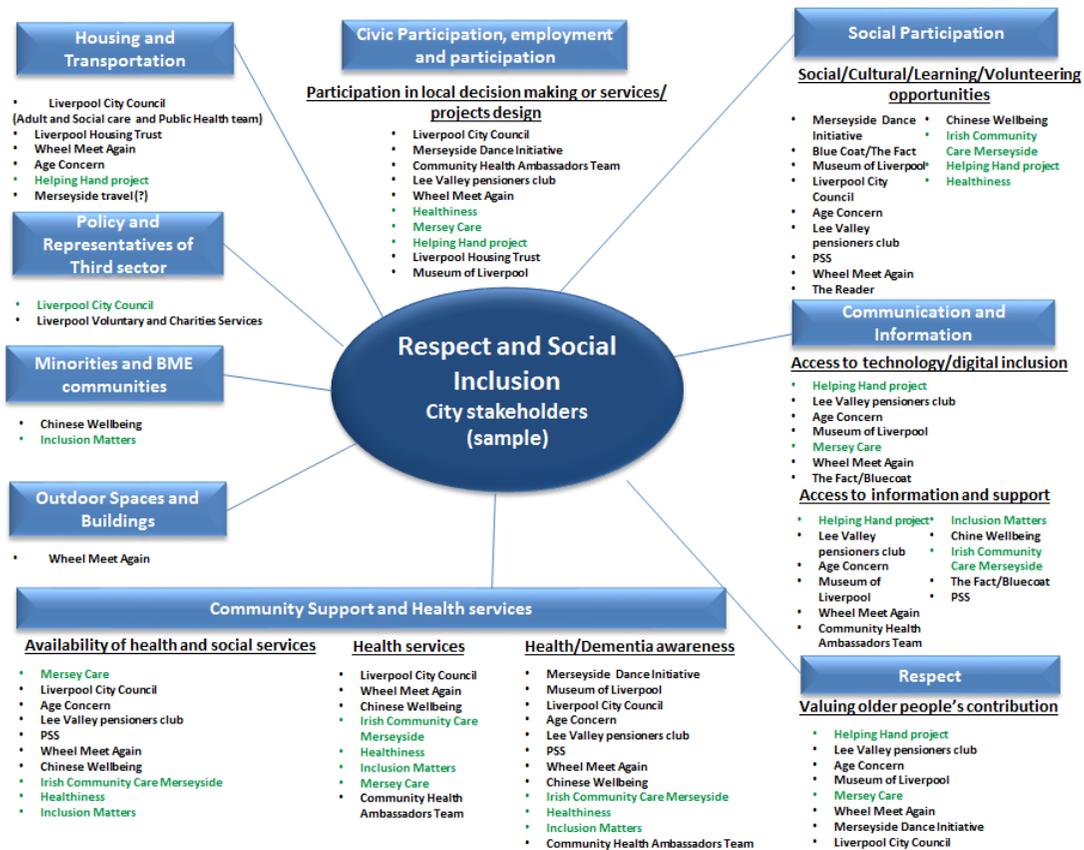


Figure 29 Diagram of sampling recruitment phase 2 and coverage of multiple areas of respect and social inclusion. Purposive sampling (in black) and snowballing sampling (in green).

As noted previously, city stakeholders were recruited to find different perspectives that could capture a detailed description of factors preventing or enabling their ability to promote respect and social inclusion in the City. Despite adopting a snowball and purposive sampling, the decision to end the sampling was based on the emerging analysis. As Morse (1995) noted, there are not guidelines to follow for approximating sample sizes to reach saturation. Since I was focused on the City of Liverpool and on specific expertise of stakeholders, I kept recruiting participants until I realised that no additional information was emerging, and when participants started suggesting me contacts who I had already interviewed.

### **3.15 Accessing research participants**

The process of building relationships with city stakeholders started in February 2014, and data were collected between October 2014 and March 2015.

The inclusion criteria (Table 17) were assessed during the first approach (face to face and/or by email), wherein I introduced the purpose of the study to potential participants. I then arranged follow-up meetings with some prospective participants to explain the study. Whenever possible, I tried to meet face to face with potential participants, as I found this beneficial to build a trusting relationship, and to show them that I was trustworthy and it was reasonable for them to give their time to my research. However, on other occasions I arranged the informal meeting by phone, given that some participants were very busy with their jobs, and their availability was limited.

- **Gaining informed consent**

I sent to each potential participant an email containing the information sheet (Appendix F and Appendix A), the consent form (Appendix G), and the general list of topics and interview questions (Appendix J). Prospective participants had an average of one month to read the information sheet and reflect on the possible participation in the study. If they wished, I contacted them by phone to provide additional information to and to clarify any aspect of the study. Interested participants signed a written consent form at the start of the individual interview (Green & Thorogood, 2009). I continued to check that each participant was happy with his/her involvement throughout the interview, by asking if there were any concerns or need for further information. The procedures that I followed for data access and storage were the same as those described for the photovoice study in Section 3.12.

- **Data generation**

I conducted a semi-structured interview with each participant, lasting between 30 minutes to and an hour and a half. The interview was audio recorded with permission. To accommodate the availability of participants, as many of them were busy with their jobs, I offered to conduct the interview at their work place either in their office or in a meeting room. After the participant gave me the written consent, I started the interview by reminding the participant about the purpose of my research, and with the definition of respect and social inclusion. I asked the questions, using prompts and probes to facilitate the participant to tell a more detailed description of some aspects. Because I informally met with

participants in more than one occasion, the atmosphere was more relaxed and the interviews went smoothly.

The interview guide was developed by reviewing the literature on respect and social inclusion and on the use of evidence by policy makers and factors influencing partnership working (Orton et al. 2011; Taylor-Robinson et al. 2008; Taylor-Robinson et al. 2012). It is important to note that several participants asked me a list of approximate questions that I planned to ask. Therefore, I provided participants with an overview of the questions some weeks prior to the meeting (Appendix J). This aspect of the participant being aware in advance of the interview guidance, may have also contributed to the fact that interviews went smoothly.

### **3.16 Data analysis**

Based on similar arguments for the photovoice study (Section 3.13), I chose an interpretive phenomenology approach to guide the analysis. With this approach, data are interrogated with respect to the meaning people attach to their experiences of social reality (Green & Thorogood 2009c). I conducted a thematic analysis to identify sub-themes from data (Miles & Huberman 1994). Despite adopting the same approach to thematic analysis that I described in Section 3.13, the coding framework that I used in this study was different, as well as the sub-themes which emerged from the data.

- **Transcription process**

I started the process of transcribing interviews (n=23 in total) during data collection. I transcribed verbatim approximately 20% of the interviews.

Initially, my plan was to transcribe everything personally, but due to the lack of time, I decided to get some of the interviews processed by a professional transcriber. In fact, I wanted to start the analysis whilst collecting data, and I was, at the same time, collecting and transcribing data from the photovoice study. I chose an experienced transcriber who was recommended by colleagues in my Department. After that I received the transcriptions, I checked these against the recording. This was an essential step to familiarise myself with the data prior to start coding. Given the large body of data, I stored and coded the transcripts using NVivo 10 qualitative data analysis software (QSR International 2014).

- **Thematic analysis**

The overall analysis process lasted one year and half (from February 2015 to August 2016). The analysis continued through the writing process, wherein I produced two drafts of the results, which were commented by the supervisors, and some results were presented at conferences. The feedback received during this process improved my overall interpretation of the findings.

My main source of data was represented by 23 semi-structured interviews. The reflexive notes provided me with some context to the recorded material, including information on how the relationship with participants evolved. As for the analysis of the photovoice study (Section 3.13), I identified three ‘a priori domains’ based on the objective of this study, which were: enablers and barriers to respect and social inclusion, and solutions to perceived barriers. Following the process of developing and refining codes and categories, I subsequently identified sub-themes from data (Miles & Huberman 1994).

Initially, I derived a brief list of codes by adopting a deductive approach (*e.g.* impact of budget cuts and competing priorities-interests). This was based on emerging aspects that I remembered from collecting the data, knowledge on the topic of respect and social inclusion in the urban setting, and previous studies that I used to develop the interview questions (Orton et al. 2011; Taylor-Robinson et al. 2008; Taylor-Robinson et al. 2012).

During the initial six months of the analysis, the pre-existing framework started expanding, and codes were iteratively refined and categorised by adopting an inductive approach (Table 18). An inductive approach enabled me to identify many codes that I did not consider at the start (*e.g.* organisational culture, supporting individual skills and abilities).

Codes developed in the thematic analysis (65 codes)	
Access to services, information, opportunities	Listening to older people's voices
Age-perceptions	Making people feeling welcome and included
Barriers to social inclusion (in general and in the city)	Managing expectations
Challenging labels-stereotypes	Mixed community
Changing ways of working and thinking	Mutual respect and trust
Collaborations-partnership work	North-South Liverpool differences
Competing priorities-interests	One size doesn't fit all
Contrast and examples from other organisations-cities	Organisational culture
Cultural engagement	Organisational structure
Cultural, socio-economic, ethnic differences	Overcoming barriers
Definition of concepts-values-ideas	Past events, initiatives
Dementia	Perception of social inclusion as important
Economic value	Perception of social isolation
Enabling people to take control over the lives	Perception of volunteering
Exchange of information	Physical activity
Focus on older people	Possible solutions-enablers
Fulfilment of various roles	Potential benefits, impact
Future plans, initiatives	Power dynamics-relationships
Health and related issues	Project evaluation
Impact of budget cuts	Projects-activities in the organisations
Impact on methodology	Role
Improvement of services, activities	Sense of disappointment
Key players on SI	Sense of insecurity due to budget cuts
Lack of coordination of services in the city	Sense of pride
Lack of information-awareness	Short-term activities-projects-collaborations
Lack of intergenerational interactions, exchange	Social engagement and participation
Lack of joined-up services and specialities	Social inclusion
Lack of political-city commitment to social inclusion	Social-intergenerational interaction
Lack of recognition	Support
Learning opportunities	Supporting individual skills, abilities
Limited access	Valuing individuals
	Variety of activities-opportunities
	Various tasks
	Value of key individuals

Table 18 Coding framework for the study with city stakeholders: second round of analysis.

The final set of codes was produced approximately nine months after the previous set of codes (Table 19).

<b>Codes refined in the thematic analysis (52 codes)</b>	
Access to services, information, opportunities (Cultural engagement was incorporated into this node)	Lack of political-city commitment to social inclusion and OP (Lack of recognition was incorporated into this node)
Age-perceptions	Limited access-support
Barriers to social inclusion (in general and in the city)	Listening people's voices (One size doesn't fit all was merged in this node)
Challenging labels-stereotypes	Making people feeling welcome and included
Changes in policies	Mutual respect and trust
Changing ways of working and thinking	Need for more capacity building-staff
Collaborations-partnership work	Organisational culture
Competing priorities-interests	Overcoming barriers
Contrast and examples from other organisations-cities	Perception of R & SI as important (Key players on SI was merged in this node)
Cultural, socio-economic, ethnic, gender, geographical differences (Mixed community; North-South Liverpool differences; were merged in this node)	Perception of volunteering
Definition of concepts-values-ideas	Physical activity
Economic value	Possible solutions-enablers
Effort to keep going	Potential benefits, impact
Enabling people to take control over the lives	Power dynamics-relationships
Exchange of information	Project evaluation
Fulfilment of various roles-tasks	Projects-activities in the organisations (Role; Organisational structure; were merged in this node)
Future plans, initiatives	Sense of disappointment
Health and related issues (Dementia; perception of social isolation and mental health; were merged in this node)	Sense of insecurity due to budget cuts
Holistic view	Sense of pride
Impact of budget cuts	Short-term activities-projects-collaborations
Impact on methodology	Social inclusion, social engagement and participation
Improvement of services, activities	Social-intergenerational interactions
Lack of coordination of services in the city	Support (Supporting individual skills, abilities; Value of key individuals were merged in this node)
Lack of information-awareness	Use of evidence
Lack of intergenerational interactions, exchange	Valuing individuals
Lack of joined-up services- specialities & service repetitions	Variety of activities-opportunities

Table 19 Coding framework for the study with city stakeholders: final round of analysis.

Following the development of the coding framework, I analysed transcripts more deeply, and I collated categories into sub-themes emerging in the text. After producing a first draft of the results, I refined the sub-themes' names, and these were approved by the supervisory team. Table 20 presents an overview of the sub-themes identified for each of the three domains of respect and social inclusion, which will be presented in more detail in Chapter 4.

<b>Enablers</b>	<b>Barriers</b>	<b>Solutions to perceived barriers</b>
<ul style="list-style-type: none"> <li>• Collaboration and partnership working between organisations</li> <li>• Commitment of the organisations to older people and respect and social inclusion</li> <li>• Perceived commitment to respect and social inclusion in the City</li> </ul>	<ul style="list-style-type: none"> <li>• Impact of budget cuts and reduced service infrastructure</li> <li>• Competing interests and priorities</li> <li>• Negative age perceptions and</li> <li>• Issues affecting older people</li> </ul>	<ul style="list-style-type: none"> <li>• Overcoming perceived barriers</li> <li>• Addressing wider societal issues</li> </ul>

Table 20 Sub-themes identified in each of the three domains.

- **Linking themes and developing a narrative around respect and social inclusion**

As with the analysis for the photovoice study, I started linking the themes. This involved writing memos (notes), and developing a narrative to explain respect and social inclusion (Gibbs 2007). I examined the links between the themes, particularly how some of the barriers influenced the enablers identified by city stakeholders (*e.g.* budget cuts had many impacts on collaboration and partnership working between organisations). This process enabled me to map and develop a narrative around the themes and their key interrelationships, which I refined further through discussions with and feedback from my supervisors.

### **3.17 Linking the findings: similarities and differences between older people's and city stakeholders' perceptions**

After conducting the analysis of the data from the photovoice and stakeholder study, I aimed to link the findings (Pope et al. 2000). Some quotes from older people and city stakeholders revealed consistent and contrasting views about some aspects of respect and social inclusion in the City (*e.g.* negative perceptions towards ageing and older people). I synthesised these similarities and differences in a summary table (Table 31, Chapter 4). For each similar or contrasting aspect, I included the quotes of older people and city stakeholders, and a commentary of the results. This summary table enabled me to link the city stakeholder data with that from the photovoice study.

# **Chapter 4 RESULTS: OLDER PEOPLE’S VIEWS OF RESPECT AND SOCIAL INCLUSION IN THE URBAN SETTING**

## **4.1 Introduction and presentation of the results**

In this chapter I present some of the most important findings on aspects that older people taking part in the photovoice study identified as promoting and/or inhibiting their respect and social inclusion in Liverpool City. From this study, there was enormous amount of depth and breadth of information. Therefore, I structured the presentation of the results into three main sections reflecting the study objectives. These are:

- **Enablers to respect and social inclusion**
- **Barriers to respect and social inclusion**
- **Potential solutions to perceived barriers to respect and social inclusion**

Results relating to each domain are organised into different sub-themes (including photographs and supporting quotes), which are sometimes based on access to different types of ‘spaces’ (*e.g.* green/blue, arts/culture), and sometimes on more analytic criteria based on the properties of these spaces (*e.g.* to cultivate interests and social relationships). Other times they are based on how participants reacted to the spaces in the City – feeling of pride and identity, or feeling of alienation and disregard. At the end of each section, there is summary table of the findings. I conclude the section of the photovoice study with an illustration of three overarching themes that emerged from the analysis: accessibility, affordability, and integration of services.

## 4.2 Participants

A total of 26 older people participated in the study. Participants took part in nine focus groups, and 23 semi-structured interviews (n=21 individual interviews; n=2 interviews were conducted in pairs, with a total N=25 participants being interviewed). Four participants (one per group), partly completed the project due to illness or medical appointments. Demographic details are shown in Table 21.

Group	Geographical Area	Level of Deprivation	N	Gender (M= male; F= female)	Age group	Ethnic Background
1	A	High	10 (n.1 participant attended the 1 <sup>st</sup> focus group only; n.1 participant did not attend the 2 <sup>nd</sup> focus group)	3 M, 7 F	60-70: 4 70-80: 3 >80: 3	5 White British, 2 Asian British: (Chinese, Pakistani) 3 Black British (2 Black African, 1 Caribbean)
2	B	Low	4	2 M, 2 F	60-64: 1 65-70: 2 70-75: 1	4 White British
3	C	Low	6 (n.1 participant did not attend the 2 <sup>nd</sup> focus group)	2 M, 4 F	60-64: 2 75-80: 2 80-85: 1 >85: 1	5 White British, 1 Other White Background: Italian
4	D	High	6 (n. 1 participant attended the 1 <sup>st</sup> focus group only)	6 F	65-70: 1 70-75: 3 75-80: 1 >80: 1	6 White British
<b>Total</b>			26	7 M, 19 F		

Table 21 Details of participants taking part in the photovoice study.

## 4.3 Content analysis of photographs

As noted in Section, participants selected 127 photographs in total (between 3 and 6 photographs each). I selected some of the photographs and accompanying

captions to be presented in this chapter, choosing those that I thought were best representing the aspects of respect and social inclusion for each of the sub-themes. In the presentation of the results, I tried to balance the number of photographs and captions for each group. Additional photographs, which are not included in this chapter, are presented in Appendix P. As noted in Chapter 3, results from the content analysis complemented the thematic analysis. It is important to note that some photographs relate to more than a category (*e.g.* a park with a lake will be included in both green and blue spaces).

Table 22 shows the number of photographs taken by each group stratified by category (*e.g.* green spaces). Photographs were stratified into categories that were developed through the thematic analysis, and are included in the three sub-themes presented in the following sections.

Table 22 Content analysis of the 127 photographs selected by participants and included in the photovoice study. Photos in each study group are stratified by category. Some photographs fall into more than one category, and they are marked with a \* symbol.

<b>Categories developed through thematic analysis included in the sub-themes</b>	<b>Group 1</b>	<b>Group 2</b>	<b>Group 3</b>	<b>Group 4</b>	<b>Total</b>
Green spaces*	14	2	3	2	21
Transportation	5	3	1	2	11
Blue spaces*	2	3	4	2	11
Streets, pedestrian paths, benches*	2			3	5
Libraries*	1	1	2	2	6
Museums*			3	1	4
Theatres*				2	2
Community centres	3		2	3	8
Health centres	1		2		3
Sport/Leisure centres	1	2		1	4
Places to eat, drink ( <i>e.g.</i> cafes) and shops	2		4	1	7
Churches*	7		1	2	10
Hobbies, interests, volunteering*	7	4	3	10	24
Family, friends	1		1	1	3
Famous and historical buildings*	3	2	7	3	14
Cultural/learning opportunities*	1	2	4	3	10
IT skills/training		2		3	5
Lack of street cleanliness	1			2	3
Dereliction of services/amenities				2	2
Home	1			3	4
Good memories	5		1		6
Public toilets	1	1			2

## **4.4 Enablers to respect and social inclusion**

This section presents the most important findings that emerged from the thematic analysis on the enablers to respect and social inclusion in the City that were identified by the four groups of older people. Results relating to this domain are organised into different sub-themes (including photographs and supporting quotes), which are based on (i) accessibility, inclusivity, and affordability of different types of ‘spaces’ (green/blue, arts and culture, libraries, churches, community centres, benches, restaurants), and on (ii) the positive perceptions that participants felt towards these different types of ‘spaces’ (sense of belonging and pride, friendly and welcoming places).

### **4.4.1 Accessibility, affordability and inclusivity of places in the City**

Many participants identified accessibility, affordability and inclusivity of places in the City as one of the key enablers to respect and social inclusion.

- **Green and blue spaces**

Green and blue spaces, particularly parks, were the most photographed and talked about places identified by the four groups of older people. Interestingly, parks and gardens were often illustrated with the presence of water, this being represented by lakes or small streams in parks, or by the River Mersey next to a green space, and therefore highlighting a close connection between the two (*e.g.* the Otterspool Promenade Figure 31). Several participants emphasised the relationship between green spaces and physical activity and wellbeing. According to participants, green and blue places had an impact on older people’s mental wellbeing, as older people could enjoy the beauty of the physical

environment. Moreover, parks and walking paths offered opportunities for physical activity, as they encouraged people to walk and practice sport. Green and blue spaces also provided a space for multi-generational social interactions and engagement, including activities with friends and families, or informal conversations with people. For instance, a participant highlighted the main benefits of parks for the social inclusion, health, and interactions of older people in the City (Figure 30).

*'We have so much, good open spaces with trees and water around the city... and they're really good for your mental health and wellbeing... and feeling included, as you mix with everybody in a park! It gives you interest, it gets you out, and it gets you in the open area. Sefton Park is a focal point for life in the city. It's a real bonus that we have. We're lucky!'* (P1) (Sefton Park)



Figure 30 Access to green spaces (P1; location: Sefton Park, Liverpool).

Several participants identified some aspects that made access and use of green spaces in the City easy and convenient for older people, which are described below (e.g. free entrance, accessible walkways, opportunities to meet other people). Furthermore, a participant described how important it was to access a

green space that promoted multi-generational interactions and a healthy life-style (e.g. walking and breathing fresh air) (Figure 31):

*'People of all ages can access it, there's parking, so you can walk down and on a nice summer's day **people of all ages are out**, going up and down the Prom...**it's a good place to go and have a good walk and take the fresh air**....we're lucky in the South end of Liverpool that we have something like this'. (P9) (Otterspool Promenade)*



Figure 31 Access to green spaces (P9; location: Otterspool Promenade, Liverpool).

In addition to accessing a space for people to practice sport or walking, the aesthetic aspect of blue and green spaces was emphasised and contributed to a sense of identity felt by participants. The sense of identity, connected with the participant's aesthetic experience, can be noted in the following quote. The participant reported that the presence of the park (Otterspool Promenade), with the view of the River Mersey, enabled people to enjoy the beauty of the surroundings. (Figure 31):

*'It's such a beautiful view of the river, and the river is such a big part of Liverpool [...]. It gives people the opportunity to walk, or cycle along the Promenade... it also gives happy memories ... and*

*there is a pub just there where you can get lunch, and overlook the river.’ (P11) (Otterspool Promenade)*

Several participants also mentioned the aspect of accessibility of walking paths in relation to green spaces as particularly important for older people and/or people with mobility issues (Figure 33):

*‘This is the Promenade, it’s a great facility and I thought **for older people it’s all on the flat...for everyone to go for a walk, there are no hills involved** and you’ve got the nice aspect of the river... It’s a lovely facility to have and it’s used by lots of different age groups.’ (P17) (Otterspool Promenade)*

This illustrates an interesting observation that participants are thinking about issues affecting social inclusion (in this case, accessibility of green spaces) not just for themselves, but also for other older people and indeed for the interaction between age groups.



Figure 32 Access to green spaces (P11; location: Otterspool Promenade, Liverpool).



Figure 33 Access to green spaces (P17; location: Otterspool Promenade, Liverpool).

Participants reported additional aspects of green and blue spaces to consider in the definition of places promoting respect and social inclusion in the City. In the example below, for instance, the participant related the park to facilities that respect people's need for calm, rest, and reflection. The participant also illustrated that going to the gardens made her remember joyful memories spent with her family (Figure 34):

*'This is the Japanese garden. It's just a very **beautiful place, and very peaceful, you can just sit down and relax. It's nice memories of my children and my dad. Liverpool often gets a bad press, and I don't think they always realise how much beauty there's in it. (P15) (International Garden Festival)***

Along with being sources of happy memories, several participants identified free entrance to all parks in the City as very important aspects for older people's use of green spaces (Figure 34, Figure 35):

*'This is my favourite place in Liverpool, Sefton Park. If it's a nice day we go for a walk... there are so many events take place and we have many happy memories. **It does cost nothing to go to and it's***

*uplifting, it's exercise, it's nice memories that you can make there [...].'* (P11) (Sefton Park)

*'This is the Palm House. I love it because it's got so many plants from around the world... you can go and see them, and they wouldn't grow outside. [...]. It's important because it's part of the park, and it's free for the citizens to go in and observe foreign plants.'* (P18) (Palm House)



Figure 34 Access to green spaces (P11; location: Sefton Park, Liverpool).



Figure 35 Access to green spaces (P18; location: Palm House, Sefton Park, Liverpool).

Further, in Figure 35 the participant reported that along with being free for people to access, the tropical plants inside the Palm House contributed to make this place so interesting and attractive for people.

Looking at the comparison between more disadvantaged and affluent areas, participants across the four groups talked about and took most of the photographs of green and blue spaces mainly in the South (and more affluent) part of the City. Participants took only a few photographs (n=5) of green spaces in more disadvantaged areas of the City (*e.g.* in the North).

Table 23 illustrates how many locations in the photographs relate to the place of residence of the participants (the local community), and how many photographs refer to places located in the centre or in other areas of the City. Some participants in more disadvantaged groups (group 1 and 4) reported that they visited some of the parks located in South Liverpool (*e.g.* Sefton Park, Otterspool Promenade) even though these were quite some distance from where they lived (*e.g.* half an hour by bus). They identified these parks amongst the most important enablers for respect and social inclusion. Although some participants in group 1 and 4 reported that they no longer accessed the parks in South Liverpool due to mobility issues or other reasons, they identified these places as a source of happy memories that they had with family members and friends:

*'When I had my children we used to love going to the park [Sefton Park] in the summertime, we couldn't afford going on holidays, so we used to go to the park'. (P4, FG1)*

Findings from this study highlight an important link between access to mobility and transportation. This aspect was significant for older people from more disadvantaged areas in accessing the blue/green spaces that were perceived so important for their sense of wellbeing.

	<b>Number of photographs portraying places located in the local community/ward</b>	<b>Number of photographs portraying places located in the centre or other parts of the City</b>
<b>Group 1</b>	31	12
<b>Group 2</b>	18	3
<b>Group 3</b>	26	9
<b>Group 4</b>	33	8

Table 23 Mapping of photographs of places taken in the participants’ place of residence or in other areas (this is based on the overall number of photographs taken, not those that the participants selected).

Overall, participants’ photographs and discussions demonstrated that participants identified themselves with some local aspects of their community (*e.g.* local parks, museums and libraries) as well as with other places located in the centre or in other parts of the City (*e.g.* Central Library). Most participants did not seem to put strict physical boundaries around what they considered to be ‘their community’, or at least not around those aspects that they wanted to photograph in order to illustrate what they thought promoted respect and social inclusion in the City.

- **Places to cultivate learning, art and culture: libraries, book clubs, museums and theatres**

Places to cultivate learning, art and culture were the second most commonly photographed and talked about aspect by older people. Participants photographed a variety of places including libraries, museums, book clubs, and theatres.

All four groups of older people took photographs of libraries. With only one exception (Figure 36), participants took photographs of libraries located in their area of residence, suggesting that libraries are facilities that are mainly used by people who live locally. Several participants identified libraries as free and accessible facilities to cultivate interests, as well as meeting places for older people to interact and mix with others (Figure 37). As for green spaces, a participant emphasised the aspect of inclusivity of libraries along with its aesthetic aspect. In this example, aesthetic refers to the perceptions that the participant felt towards the presence of some features in the library (e.g. the interior and external of the building). Both the aspect of inclusivity and its aesthetic contributed to the sense of belonging perceived by this participant towards the City (Figure 36).

*‘This is the library. I like books and inside **it’s absolutely beautiful...** we have such a **lovely facility** here [...] it’s lovely to have a look and see whatever you want to see... **it’s open for anyone** in Liverpool to go in, so it’s not local community but **it’s for the community of Liverpool**’. (P15) (Central Library)*



Figure 36 Places to cultivate learning, art and culture: libraries (P18; location: Central Library, Liverpool).

Libraries were also identified as key facilities involved in IT training and for seeking advice on how to learn computer skills (Figure 37). In this example, the participant identified digital inclusion as an important aspect for the social inclusion of older people.

*'This is our library and **anybody can go there** and read the books... if you wanna **learn computers**...they can teach you. It's nice and quiet, and **it's a mixed community** that goes in there. It's **a place to meet up with each other and discuss things**, and you can make new **friends** in there!'* (P2) (Toxteth Library)

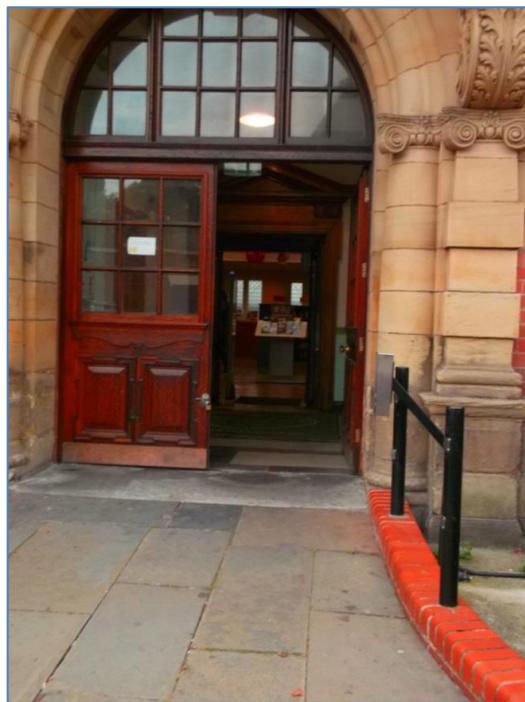


Figure 37 Places to cultivate learning, art and culture: libraries (P2; location: Toxteth Library, Liverpool).

It is important to note that during the data collection period (Autumn 2014-Spring 2015) there was a consultation in Liverpool City to close some libraries due to budget cuts, and a petition to save the libraries was organised. Hence, some of the participants' photographs and discussions about the importance of libraries for the community may have been influenced by what was happening during that time. Participants may have used the photovoice project to raise

awareness about their concerns about the closure of libraries in the City, and to express their views about governmental and council strategies. However, if participants did not perceive libraries as important to them, they would not have highlighted this concern during the study.

Along with libraries, book clubs were also identified as places to access books. These were open to older people as well as to the whole community. For instance, a participant identified a book club as an inclusive place wherein people could cultivate their interests, and could also interact with others (Figure 38):

*‘This is the Reader café. You can go along and they have book clubs once a week. I like reading anyway, it’s nice joining a book club, and discussing the book, they also do nice breakfast! The booklet says what they do; **they also help people who can’t read... I think it helps the community as a whole, as it encourages people to go out into the community.**’ (P15 (The Reader cafe))*



Figure 38 Places to cultivate learning, art and culture: libraries (P15; location: The Mansion House, the Reader cafe, Liverpool).

Participants reported museums as very valuable enablers for older people’s respect and social inclusion in the City. Overall, participants expressed a strong

sense of appreciation for having free access to art and culture, highlighting, also in this case, the importance of affordability (Figure 39):

*'This is Liverpool Museum... it's just a lovely facility. All the museums that we have in Liverpool... they're all free.'* (P17) (Museum of Liverpool)

As with the findings on green spaces, a participant emphasised that the proximity of the museum to her local community facilitated ease of access and encouraged her to use the museum often (Figure 40):

*'This is Sudley House. It's been kept as a 19th century house; it has also very nice art inside. It is free to get in... They also do Shakespeare's plays in there in the summer. I use it because it's a local facility for me, and I can walk there.'* (P15) (Sudley House)



Figure 39 Places to cultivate learning, art and culture: museums (P17; location: Museum of Liverpool, Liverpool).



Figure 40 Places to cultivate learning, art and culture: museums (P15; location: Sudley House, Liverpool).

Additional places to cultivate interest in art and culture identified by some participants included theatres, which provided a space for people of all age groups to go out and meet friends in the centre (Figure 41):

*'This is the Empire theatre. Theatres are very important to the community [...]. This is what I do with some friends. We [...] have a meal and we go to the theatre. It's the feel good factor... [...] It gets people out and that's why I think theatres are important to the community.'* (P20) (Empire Theatre)



Figure 41 Places to cultivate learning, art and culture: museums (P20; location: Empire Theatre, Liverpool).

Participants from disadvantaged and affluent areas took a similar number of photographs of cultural enablers (Table 22). Hence, based on the participants' photographs and quotes, there was no strong evidence of a social divide in the importance given to cultural enablers across the four groups.

- **Places to cultivate interests and a healthy lifestyle: parks, allotments, leisure and sport centres**

Several participants reported that parks and leisure centres had an impact on the wellbeing of older people indirectly due to their sociability – providing a space for people to come together and cultivate hobbies. They were also related to physical activity – providing a space for people to walk, exercise, and do gardening through volunteering opportunities.

For instance, a participant identified a golf club (Figure 42), and a leisure centre (Figure 43) with many features for older people's respect and social inclusion. These places welcomed all people irrespective of their ages by creating (i) a space to meet up with friends and new people; and (ii) a supportive environment for people to keep healthy and learn a new sport without feeling frightened or uncomfortable:

*'That's Allerton Golf club: it's a brilliant golf club... **it's a really healthy option for people to go and play there...all ages in the community.** A lot of my friends play there, they're all pensioners, so it's somewhere for them to go and **meet people, get some fresh air, get some sport. It is somewhere where you're not frightened to learn golf because there are all sorts of people hanging around.**' (P10) (Allerton Park Golf Club)*

*'That's Garston Sports Centre. **Older people do use that and it's really important to get out and get some exercise. I think that sports centres around the city are very important for the community, not just for older people; (It is) a meeting place for people, and it is very important that you keep moving, doing things that are going to keep you fit, keep you healthy, and keep your weight down!**' (P10) (Garston Sports Centre)*



Figure 42 Places to cultivate interests and a healthy lifestyle: sport clubs. (P10; location: Allerton Park Golf Club, Liverpool).



Figure 43 Places to cultivate interests and a healthy lifestyle: leisure centres. (P10; location: Garston Sports Centre, Liverpool).

The quotes above represent another example in which participants emphasised the aspect of inclusivity of these places and the importance of practicing a healthy lifestyle not only for older people, but for all age groups.

Related to hobbies, some participants (particularly men) identified community gardens and allotments as places to do gardening, to breath fresh air, and to engage with other people. For instance, two participants emphasised the sense

of identity and community that they felt towards these places, which was facilitated by working with others (Figure 44, Figure 45):

*'I have one of those plots in the community garden. **It's an occupation that I enjoy.** [...] They [vegetables] taste so much nicer than when you buy them in a shop. **It's engaging with others, there're all sort of people involved in this.** [...] from my memories... it was a wasteland, and people used to throw rubbish in there... and now it's a beautiful oasis in Liverpool 8!' (P3) (Fern Grove community garden)*

*'That is part of the allotments called 'the valley'; there are 100 plots all together. **I love growing things and I love the company down there.** There're about 12 plots in that little area, and **we all work together.... we have fun, we're a little gang together...and it makes me feel part of something bigger than myself.**' (P18) (Dingle Vale allotment)*



Figure 44 Places to cultivate interests and a healthy lifestyle: allotments (P3; location: Fern Grove, Liverpool).



Figure 45 Places to cultivate interests and a healthy lifestyle: allotments (P18; location: Dingle Vale, Liverpool).

- **Places to cultivate interests, informal and formal relationships**

Participants often referred to community centres when explaining aspects of the City that contributed to their respect and social inclusion. Some participants attended community centres on a weekly and/or monthly basis to cultivate a hobby and to socially engage in one or more activities with others. Additional places for social interactions included soup kitchens and restaurants.

Some participants illustrated an example of a community centre which created a space for social interaction that was linked with a perceived sense of wellbeing felt by participants. Here, the community group was seen as a source of support. Participants reported enjoying sharing an interest with others, and looked forward to attending the centre (Figure 46, Figure 47). A clear sense of feeling valued and welcome emerged from the participants' quotes:

*'It gives you a reason to go out and this is important. It keeps me lively, it keeps me in touch with people's lives, [...] it's just nice having a connection with people [...]. We just have a good laugh! It makes you feeling better... [...] It's nice seeing what other people*

are doing, and everyone likes to see what everyone else is doing.’(P20) (Knit and Natter group, St. Luke’s court).

*‘This is the Knit and Natter group. We do things for charities, which is good. [...] It gives me something to live for, something to look forward to. It gets you out and it’s another reason to get up in the morning. It makes you feel good because we’re all nice people, and we all talk and have ideas together. We help each other.’ (P22) (Knit and Natter group, St. Luke’s court)*



Figure 46 Places to cultivate interests, informal and formal relationships (P20; location: Knit and Natter group, St. Luke’s court, Liverpool).



Figure 47 Places to cultivate interests, informal and formal relationships (P22; location: Knit and Natter group, St. Luke’s court, Liverpool).

Soup kitchens were identified as an alternative place to interact with others, especially for those that were not interested in joining a club. For instance, a

participant illustrated that the canteen created a space for people to enjoy some nice and affordable meal while being able to have a chat with others:

*'This is the Soup kitchen, [...] I go every week and [the cook] makes the most gorgeous soup of the house. [...] it makes people who wouldn't normally come out to get out and meet up with people. I think that meeting with people is very important for our health and wellbeing. Lots of people don't want to join a club... this is a nice way to have a bowl of soup, and some nice crusty bread, [...] and you can just talk to the people of your table, that's a very good thing to have and it's a cheap meal for people!'* (P20) (*The Soup Kitchen, Liverpool*).

For those who could afford it, participants mentioned that restaurants were also friendly places to cultivate social relationships. For instance, a participant highlighted that having a meal together monthly enabled her to go out to the centre and see her friends, and it contributed to her sense of community (Figure 48):

*'Time going out and meeting people into Liverpool, and having our lunch, for me it's a very nice social thing to do. [...] We get together, have a chat, and catch up on what's going on in our lives [...]. We are all come from different areas, and I think it makes me feel that we all made a commitment, once a month, and it's really nice to meet up with people that you might not see, and it makes me feel that I do belong to the town.'* (P21) (*Williamsons Square, Liverpool*)



Figure 48 Places to cultivate interests, informal and formal relationships (P21; location: Williamsons Square, Liverpool).

Participants identified spaces that provided opportunities for informal and formal socialisation. Formal socialisation included community centres, soup kitchens, and restaurants, where participants met people that they knew. Key places for informal socialisation included benches at the bus stops, wherein people could rest and have a chat with other people while waiting for the bus:

*'This is the new bus shelter and [the council] they've provided seating again, [...] that is very good because [...] you can rest while you're waiting for the bus, you can get chatting to people, and you also are covered from the wind. [...] it's part of the community, because you get to be more sociable if you're sitting down, and you will talk to people'. (P23) (Bus stop)*



Figure 49 Places to cultivate informal relationships (P23; location: bus stop, Aintree, Liverpool).

A participant reported that sitting on the benches located in green spaces could serve as a means to enable older people to informally socialise with others while looking at the surrounding environment (Figure 50):

*'They should advertise: 'you don't have to be lonely, go and sit on the park's benches on Princes avenue and meet people, have a chat, make your life more worthwhile' [...] **nine times out of ten someone'll come and sit next to you and you can have a good chat... and make a day of it.** (P2)' (Princes Avenue)*

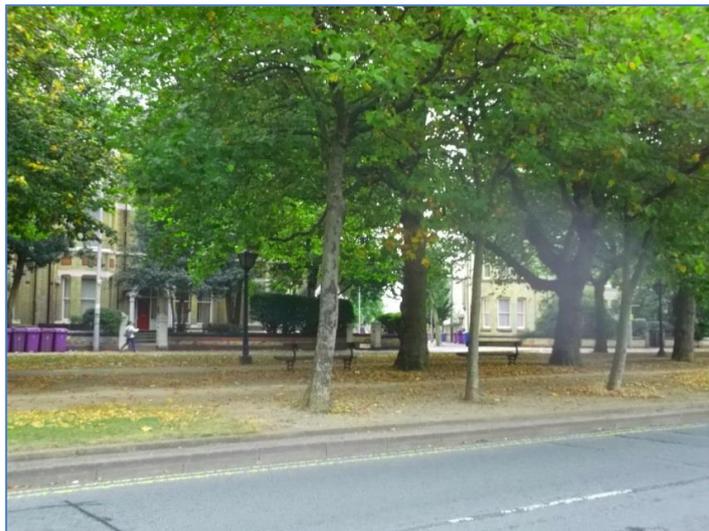


Figure 50 Places to cultivate informal relationships (P2; location: Princes avenue, Liverpool).

- **Affordability and accessibility of the public transportation system**

Several participants across all groups considered public transportation a significant aspect of older people's ability to remain independent, to participate in social, cultural, volunteer and recreational activities. Hence, the affordability of transportation options became essential, particularly for those less willing to drive, with no car ownership, or with low income.

Several participants emphasised the importance of the free travel pass for people aged 60 or more. As was the case with green spaces, libraries and museums, affordability of transportation allowed participants to regularly access places in the City in a way that would not have been possible without the free travel pass. A participant illustrated that without the free travel pass he would not have been able to go out regularly and participate in the community. This indicated that he would have been at greater risk of reducing his community involvement and of social isolation. Further, this quote suggests a link with low income/poverty (Figure 51):

*'The free travel pass helps me to connect with the community that I live in. That's my travel pass. It allows me to travel across Merseyside for nothing, and doing things that I would not otherwise being able to do. It saves me about £50 a month [...]. It is very important.'* (P3) (Free travel pass, Liverpool)



Figure 51 Affordability and accessibility of the public transportation system (P3; location: free travel pass, Liverpool).

Most participants reported that the free travel pass was one of the most important facilities that Liverpool City was providing to older people. To illustrate this point, a participant highlighted that older people living in Liverpool could use their free travel pass to travel on trains, buses and ferries, and not just for buses as currently in many cities of the UK (Figure 52):

*'In Liverpool we can use the buses, as the rest of the country uses the local buses, but... we can use it [the bus pass] for the trains...and we can also use the Mersey Ferry, so we can just go for a trip on the ferry if we want to... **we've got a lot more on offer with our bus pass than people in other parts of the country.**' (P17) (Manchester Ship Canal Cruise ticket office)*

The transportation system was perceived as efficient and accessible. For instance, a participant indicated that the efficiency of public transportation gave her freedom to go out to places in the City (Figure 53).

*'I really appreciate our very good bus and train services. With my bus pass I can come out in the morning and I can get on a bus and go to so many places, and I don't have to wait long for a bus. **It gives me freedom: freedom to get out. We're so lucky! Buses and trains are such a vital part in our lives.**' (P20) (Liverpool city centre)*



Figure 52 Affordability and accessibility of the public transportation system (P17; location: Manchester Ship Canal Cruise ticket office, Liverpool).



Figure 53 Affordability and accessibility of the public transportation system (P3; location: bus, Liverpool city centre).

This aspect of accessibility also encompassed train and bus stations. According to two participants, Liverpool South Parkway station offered a safe and warm environment for people while waiting for the bus or train (Figure 54 and Figure 55). This aspect was seen as important for their social inclusion, and also showed respect for needs of older people. Further, one of the features of an accessible station was the integration of services, thereby providing access to both buses and train options and making it easier for older people to travel:

*'I am very lucky because I have got all of that near to me, and it gives me access to a lot of options to travel. We've got the trains in and out and the buses in and out...and it just makes it so much easier for people to travel. Once you get inside the building, you're protected from the weather and the wind, it is very cosy, convenient, and very accessible. Older people deserve the respect and a good travel experience.'* (P1) (South Parkway Railway Station)

*'This is South Parkway Railway Station. We use South Parkway a lot... This is just to show what we think of it... and what a good job that they did of it, and a lot of people use it now. It makes it a lot easier to get into the city centre as well. You can go everywhere you want from here.'* (P12) (South Parkway Railway Station)



Figure 54 Accessibility of the public transportation system (P1; location: South Parkway Railway Station, Liverpool).



Figure 55 Accessibility of the public transportation system (P12; location: South Parkway Railway Station, Liverpool).

Since some participants experienced some mobility issues (e.g. inability to walk for long distances, or need of walking aids), they reported that travelling on buses that can be levelled with the pavement was very important. Also in this quote, participants identified that these small changes could improve the social inclusion not just for themselves, but for both older people and people with disabilities (Figure 56):

*‘This is the little circular C4 which goes to the city centre. It is levelled with the pavement, there are no steps... I think that’s an asset for the people of Liverpool, if you are in a wheelchair or you have mobility problems.’ (P17) (Bus circular C4, Liverpool)*



Figure 56 Accessibility of the public transportation system (P17; location: bus, Liverpool city centre).

#### 4.4.2 Positive perceptions of the urban environment

- **Sense of identity and pride towards places in the City**

When explaining their photographs of aspects of the urban environment, several participants felt a sense of pride and identity towards the riverside, parks, and some famous buildings such as churches and libraries, which were considered amongst the symbols of Liverpool City. In this sense, their perceptions of the physical surroundings were fundamental for their sense of social inclusion and connection.

For instance, some participants identified various aspects of the River Mersey where they felt a sense of pride and belonging: a recently renovated pedestrian path (Figure 57) and the Promenade (Figure 58), both which overlooked the riverside:

*'[...] I think that's' a wonderful idea and a real achievement for Liverpool. It gets me out in the fresh air, I like to walk anyway, but how pleasant is to walk there along the river? [...] this is about the feel-good factor that's so important in life.'* (P20) (Albert Dock)

*'That's the Prom and it shows the river down there. The river has always been a part of my life. It just feels Liverpool when you stand by the river. We do a lot in the Promenade, it is great. It gets very busy when the weather is nice.'* (P12) (Promenade Otterspool)



Figure 57 Positive perceptions of the urban environment: walking paths and blue spaces (P20; location: Albert Dock, Liverpool).



Figure 58 Positive perceptions of the urban environment: green and blue spaces (P12; location: Promenade Otterspool, Liverpool).

Alongside green and blue spaces, some participants felt positive perceptions towards some historical buildings in the City. For instance, a participant was particularly proud of a building that was renovated after being destroyed during the war, and for which she felt a strong sense of connection and good memories (Figure 59). This was also identified as a meeting place for older people, particularly during the summer time:

*'The first time I saw that building was in 1949, just after the war. It was absolutely desolate, devastated, and it's been bombed. You would have thought: 'it will never be brought back' [...] but they have done it. It's beautiful and it's a place now where people like us can go [...]. I think the more people will know about it, the more people will use it [...]. During the summer they have a band in the band stand and it draws people out, and particularly older people, who need to be brought out.'* (P19) (Stanley Park)



Figure 59 Positive perceptions of the urban environment: historical buildings (P19; location: Stanley Park, Liverpool).

Furthermore, two participants reported a strong sense of identity and pride towards an iconic museum and a cathedral. The World Museum was described as a landmark setting not only for the local community, but also for the City as a whole. The main emphasis was on the accessibility and attractiveness of the building (Figure 60). Another landmark setting was represented by the Liverpool Anglican Cathedral (Figure 61). The participant described various aspects that contributed to a strong sense of belonging that she felt towards the Cathedral: it was open to anyone irrespective of nationalities, it was beautiful and majestic, it was a space for social interactions, and a source of happy memories:

*'I just like going around and seeing things, I wouldn't say that's particularly for older people, it's just for anyone, and anyone can*

*go in. It's a beautiful building and it's also a lovely facility ...it's a Liverpool museum, but it's a World museum... so, as being from Liverpool, it makes me feel good.'* (P15) (World Museum)

*'It's close to me and I know that I can go there anytime I want to, and I can meet people in there. The cathedral is open to all nationalities, everybody [...]. It stands out in the community, and you know that you're part of that church or cathedral because you sang in there like I was privileged to [...]. It brings back a lot of memories ... it's so majestic to look at, and it makes you feel good inside.'* (P2) (Liverpool Anglican Cathedral)



Figure 60 Positive perceptions of the urban environment: historical buildings (P15; location: World Museum, Liverpool).



Figure 61 Positive perceptions of the urban environment: historical buildings (P15; location: Liverpool Anglican Cathedral, Liverpool).

The quotes above represent another example in which participants are thinking about facilities in the City not just for themselves, but also for all age groups. As noted above in the example of the cathedral, the sense of pride felt by some participants towards some famous buildings was also linked to their roles in contributing to the community. For instance, a participant felt very proud of Paul McCartney's house, where the Beatles' singer had grown up. She explained that she was happy to see that this place near her house was helping the community in attracting many tourists (Figure 62):

*'We embraced the Beatles, and we are pleased that the tourism is helping our city. That's Paul McCartney's house...we live in a house like this around the corner...it's from my area, and it was a preservation of something in our area that's brought tourism to Liverpool. Our area is full of tourists which is a very positive thing for Liverpool...It's a plus for the city!' (P11) (Paul McCartney's house)*



Figure 62 Positive perceptions of the urban environment: historical buildings (P15; location: Paul McCartney's house, Liverpool).

- **Friendly and welcoming places: health centres, shops and churches**

Participants described some places as particularly friendly and welcoming. Photographs included health services, community centres, cafes, shops, and churches. A friendly place could be broadly characterised by a combination of features, including ease of access, integration of services, and social connections. Participants reported that the definition of a friendly place was connected to their experiences and perceptions that they felt in interacting with a place (*i.e.* feeling respected, welcome, and part of a community for which the participants shared with others an interest and/or a belief). The definition of friendly places encompassed interactions with people and the perception that someone in there was always approachable for help or advice (Figure 63 and Figure 64):

*'That's my centre in Princes Road. I can go there, and if I've got any problems, I can ask to see my key worker and she'll help me [...], it doesn't cost you nothing. We can all meet together [...], we can talk to each other, none is bossy or anything, we're all friends and we all treat each other equally, which is very nice.'* (P2) (Princes Road)

*'It's just the place where you feel as you're welcome, and people are so nice! This is Garston Hospital. There's everything in there that you need. It's very accessible... you can walk there. We feel part of the community because we are welcome there, whatever we go for, they are always very attentive to us...we do know people who work there, and this is the community aspect'. (P13 & P14) (Garston Hospital)*



Figure 63 Friendly and welcoming places: mental health centre (P2; location: Princes Road, Liverpool).



Figure 64 Friendly and welcoming places: health centres (P13 & P14; location: Garston Hospital, Liverpool).

Shops, grocery stores, and cafes were identified as friendly places that were used by participants in everyday life, and therefore, quite important in promoting their sense of community. For instance, two participants reported how a garden centre enabled them to meet and interact with people locally. It was defined as the perfect store for asking advice and exchanging ideas about gardening (Figure 65):

*'Dobbies is a lovely place to find what you need and also to seek advice. We like it so much, it's a lovely garden centre, the prices are reasonable... we meet people there who belong to the community, who live in the area. We always have a chat with somebody there, and we exchange ideas: it stimulates our interest in gardening... what should we put in the garden, which plants we want.'* (P13, P14) (Dobbies shop)



Figure 65 Friendly and welcoming places: shops (P13 & P14; location: Dobbies shop, Liverpool).

Others identified coffee shops as familiar places that contributed to enhance their everyday life:

*'This is my favourite coffee shop. It's called Bold Street Coffee Shop: there are a lot of places like that... that are really good for people. (P1) (Bold Street)*

*'I love going there for a coffee. It's nice in here, and I can walk there, have a nice cup of coffee, see people and then walk back home. They're very friendly in there and they all know me.'* (P16) (Cosy Bean Coffee)

Several participants (particularly women) identified churches as places in the City that made them feel welcome and included, and where they could meet and mix with other people. Churches were described as welcoming places to seek help and comfort if needed (Figure 66), and as having an important role in creating a sense of community within the City (Figure 67):

*'I go to that church [...], and it makes me feel better, it makes me feel comfortable; [...] you're welcome in this church, and everybody knows one another.... it's a nice atmosphere. [...] it is*

*important to me, because you come here every week, and you get to know more people.’ (P4) (St. Clément’s church)*

*‘Without the church, there’s not community. I think it’s what means for me. It’s there: without it, it wouldn’t be a proper place, village, or town. People can always come. It’s somewhere where you can go if you’re in troubles or if you feel lonely and vulnerable.’ (P21) (St. Mary’s church)*



Figure 66 Friendly and welcoming places: churches (P4; location: St. Clément’s church, Liverpool)



Figure 67 Friendly and welcoming places: churches (P13 & P14; location: St. Mary’s church, Liverpool)

Even participants who did not have faith recognised the role of churches for older people’s social inclusion and the whole community (Figure 68):

*'I am not a religious person personally, but it's nice when there's something going on and you are invited to join in ... especially over Christmas, Carol's services... it's very important for the community.'* (P20) (Blessed Sacrament R C Church)

This relates to the aspect of inclusivity, whereby churches were involved in bringing the community together by organising social events (e.g. weekly or monthly lunch clubs). Furthermore, some churches were involved in fundraising activities to improve either the church or promote a wider range of activities for people of all ages (Figure 69).

*'Our church is quite good for getting the community together ... we are always looking for more ways of improving and we're going to embark a big fundraising project soon... We're hoping with our fundraising that we can change the church hall and the church into more useable space for getting the community in.'* (P17) (St. Mary's church)



Figure 68 Friendly and welcoming places: churches (P20; location: Blessed Sacrament R C Church, Liverpool).



Figure 69 Friendly and welcoming places: churches (P20; location: St. Mary's church, Liverpool).

A social divide was not apparent from the number of photographs portraying friendly and welcoming places taken by participants from more disadvantaged and affluent geographical areas (Table 22).

- **Perceived safety: accessible roads and CCTV cameras**

Some participants identified other aspects related to accessibility of the physical environment. For instance, a participant illustrated the importance of the little bumps at the end of the sidewalks for people with lower levels of mobility and disability. Because of this, the participant felt safe to walk in the road, particularly in bad weather. The participant also reported that being able to walk safely had a positive impact on social participation, as older people could get out more often (Figure 70):

*'These are little bumps, and they also ensure safety when there's bad weather. For some people, just stepping off the side is not much, but when you've got bad legs, it is awful; so if you have these bumps to help you getting around, then it helps you in the community; you can actually get out more, and you can socialise a bit more [...]'. (P23) (Road in Aintree)*



Figure 70 Perceived safety: accessible roads (P17; location: road in Aintree, Liverpool).

The same participant went to illustrate the importance of CCTV cameras for the community. Thanks to this she felt safe walking in the area, and this contributed to her sense of community (Figure 71):

*‘We have a row of shops here, so they have the camera there for security. We had a time when there were young lads there with drugs, so they put the camera up and we don’t have that problem now. **It’s important to me because it’s safe to walk around there.** The advantage is that if you’ve got cameras watching you...if you haven’t done anything wrong you’ve got nothing to worry about.’*  
(P23) (CCTV cameras in Aintree)



Figure 71 Perceived safety: CCTV cameras (P17; location: CCTV cameras in Aintree, Liverpool).

Table 24 shows the sub-themes identified and a summary of key findings for each sub-theme.

Table 24 Summary of the main enablers to respect and social inclusion in Liverpool City emerging from the thematic analysis.

Sub-themes	Summary of key findings
<b>Accessibility, affordability and inclusivity of places in the City</b>	<ul style="list-style-type: none"> <li>– Most common places/facilities were green spaces (<i>e.g.</i> parks and gardens), blue spaces (<i>e.g.</i> the River Mersey and lakes), pedestrian paths, libraries, museums, cafes and shops, health services, leisure’s centres, community centres and churches.</li> <li>– Places to cultivate learning, art and culture included libraries, museums, book clubs, and theatres.</li> <li>– Places to cultivate interests and a healthy lifestyle included parks, allotments, leisure and sport centres.</li> <li>– Places to cultivate interests and meet other people included community centres included soup kitchens and restaurants.</li> <li>– Access to the places above allowed older participants to feel valued and included, cultivate social relationships, maintain and use skills, stay busy, do volunteering, practice sports, and cultivate interests.</li> <li>– Main learning opportunities included IT and technology, craft and hand making cards, gardening, singing, and access to libraries.</li> <li>– Affordability (<i>e.g.</i> free access and the free travel pass) was a key component that impacted on older people’s access to various places (<i>e.g.</i> parks) and activities/opportunities.</li> </ul>
<b>Positive perceptions of the urban environment</b>	<ul style="list-style-type: none"> <li>- Participants felt a sense of pride and identity towards some famous and historical buildings, the riverside, some parks and churches. They identified some places (<i>e.g.</i> parks) as a source of happy memories.</li> <li>- Participants used photography to signpost some facilities in the City (<i>e.g.</i> historical buildings), so that more people could be aware of these.</li> <li>- Participants described some places as particularly friendly and welcoming, making older people feeling included and respected (<i>e.g.</i> health services, community centres, shops, and churches). Participants mentioned the importance of finding some individuals who worked there as approachable people that they could seek help/advice from if needed.</li> </ul>

## **4.5 Barriers to respect and social inclusion**

This section presents key findings on the main barriers to respect and social inclusion identified by participants. It is important to note that some participants found it challenging to take a wide range of photographs of negative and social aspects of the City. Some of the most important reasons for taking fewer photographs of barriers than they did for enablers are explored in Chapter 6. Therefore, this section had fewer photographs to draw on than was the case for Section 4.4.

Results relating to this domain are organised into different sub-themes, which are based on (i) the negative perceptions that participants felt towards different types of ‘spaces’ – *e.g.* sense of alienation towards negative aspects of the community and/or by the attitudes that participants experienced; on (ii) poor and limited accessibility to some services – *e.g.* public toilets and stations; closure of amenities; and (iii) negative age perceptions – *e.g.* disrespectful attitudes towards older people; lack of social and intergenerational interactions towards older people.

### **4.5.1 Negative perceptions towards the urban environment**

- **Disrespectful attitudes and sense of disregard and alienation towards the community**

As noted Section 4.4.2, several participants identified various places (*e.g.* the River Mersey and the Central Library) for which they reported a strong sense of pride and identity. Conversely, poorly maintained neighbourhoods were portrayed as key barriers to respect and social inclusion.

There was evidence of a social division in reporting of these issues, since all the photographs and quotes relating to negative perceptions towards the urban environment originated from participants living in more disadvantaged areas of Liverpool (group 1 and 4) (Table 22). The photographs and quotes presented here are an example of how participants used photovoice to raise awareness of some issues that were not currently addressed by the council, or for which other residents were responsible.

According to some participants, the main issue related to lack of street cleanliness (*e.g.* litter and dogs' muck in the streets) had to do with lack of respectful attitudes of some citizens towards their local community, and failure of the council to address this. For instance, a participant reported that the litter in the street did not only look bad as it lowered the tone of the neighbourhood, but it was also a bad educational example to give to young people. In fact, by seeing that litter in the street, young people did not learn how to be respectful towards their community (Figure 72):

*'This lowers the tone of the neighbourhood. I think I live in a quite nice neighbourhood, and that's in my neighbourhood. [...] the bin man's just been...but that mess is still there. I think that [...] **does not engender any respect in the young.** The young see that and thinks "well, everyone else is throwing away their rubbish". [...] **The people who live there should be aware of it [...] There's no respect for yourself or for anyone else with that around.**' (P20)  
(Near Walton Library)*



Figure 72 Negative perceptions towards the urban environment: lack of street cleanliness (P20; location: near Walton Library, Liverpool).

Another participant highlighted two distinct perspectives: individual littering and failure of the council to address litter and/or emptying bins. In this quote, the participant stressed that keeping the community clean was a responsibility of each citizen as well as of the council (Figure 73):

*'It has been there for weeks! I live near, [...] and the bin man's just passed there, but they didn't empty them. [...] the council should take a look at that, it's rubbish and everything over [...]. People live there. I think about the community, and they should keep it clean.'* (P5) (Street in Toxteth)



Figure 73 Negative perceptions towards the urban environment: rubbish in the streets (P5; location: Street in Toxteth, Liverpool).

As shown by the quotes below, participants tried to raise awareness of some of the most significant unresolved issues in the community. When some older people tried to improve the situation (*e.g.* pointing out to a person who threw away something that the rubbish bin was close), an action that aimed to improve the community, often resulted in disrespectful attitudes (*e.g.* from the person(s) dropping the litter) being experienced by some of the participants. Hence, after those episodes, these participants felt vulnerable and reluctant to get involved in future situations. These quotes show how participants felt alienated by the attitudes that they experienced:

*'The other day I was in the bus stop and a young woman was eating a package of crisps, she finished the crisps and threw the package on the floor. Five yards away there was a rubbish bin. I said to her: "why you don't put the package on the rubbish bin?" And she told me to f\*\*k off. So I said ok, bye bye! It's a very disappointing aspect, but... never mind.'* (P3, IV)

*'I have pointed out at two people, that their child has dropped down rubbish, and you always get a mouthful of abuse: "you tell me how to bring up my children?" And I generally say: "Well somebody should". My daughter told me that I mustn't do it anymore. One day someone*

*is gonna bring a knife out on you... and now I look at the other way, as I promised her that I won't do it anymore.* (P20, FG1)

In the quotes below, participants felt generally disappointed with the appearance and attitude in their community and alienated towards it in describing some negative aspects. Living in an area with streets that were not clean resulted in some participants expressing feelings of shame:

*'I feel alienated by the community when I see rubbish in the streets.'* (P3, IV) (Group 1, Liverpool)

*'The litter makes me ashamed to tell people that I come from Liverpool. [...] people need to be re-educated about picking up the litter.'* (P24, FG1) (Group 4, Liverpool)

*'This is everywhere. I want to do something about it when nobody does anything about it. It's just disgusting. Why should people with dogs be allowed to do that? [...] it makes me feel ashamed of my community; it really does when we have people coming from other areas.'* (P21) (Group 4, Liverpool)

*'I think that's disgusting. If you're responsible owner, if you've got dogs, you watch them, and you're a responsible member of the community. You don't want your dog to be messing. It's un-respectful and it's unhealthy.'* (P20, IV) (Group 4, Liverpool)

During a focus group, two participants further discussed the lack of cooperation in keeping their neighbourhoods clean, and pointed out that this contributed to the poor reputation of their area:

*P25: '[...] there are not many people in my street that come out, and do the brush [...]. I think that is so central when you walk out your front door and how you feel. And I sometimes feel like crying...why everybody can't, I am not asking them to do anything or buying anything... but can't they make the environment lifted and more clean?'*

*P4: 'Yeah more clean... because they're always talking about L8, and the city, but it's to do with the people themselves.'*

Furthermore, one of these participants reported that the negative perceptions that people from affluent areas had about her ward intensified her feelings of shame and humiliation in relation to these aspects of the community. The participant felt that she was unable to improve/change the situation, for instance, by going to live in a nicer neighbourhood:

*'I found a difference in Allerton [more affluent area], when you go down there to up here... [...] you come in and you're walking in our footsteps of living here, and **knowing how we feel, and when you go down there, it's different!** People down there, you can go on the bus and they may say hello to you and that, but they don't know what we have. [...]. I have been on the bus sometimes, because the 76 goes right to Walton [more disadvantaged area], and I have been hearing people saying: "**How do people live here?**" [...] sometimes there are troubles and [...] gangs. I would very like to hearing people saying there're good people here as well, and a lot of us have no choice to live anywhere else, and move out.'* (P25, FG1)

- **Dereliction of local shopping areas**

Some participants mentioned the decline of some local shopping areas, with many shops shutting down due to the presence of large new supermarkets in the area and the impact of austerity policy/decisions in the City. For instance, two participants raised awareness of issues affecting a local shopping area (Garston Village), which was not well looked after by the council, and with many shops closing (Figure 74, Figure 75). This impacted particularly on those who used to do shopping locally and who were unable to walk long distances to go to the large stores:

*'It shows that there are a lot of shops which are closed down in Liverpool, and that's a shame... The recession hasn't helped, but then, the big supermarkets have taken over, and it is putting the smaller shops out of business. **For people like my mum, if she doesn't get a lift, she wouldn't be able to go to the shops [...]. I think it's a barrier of social inclusion because a lot of people like***

*walking to the shops and doing a little browse around.’ (P20)  
(Garston Village)*



Figure 74 Negative perceptions towards the urban environment: dereliction of amenities in the city (P20; location: near Walton Library, Liverpool).

The quote below further indicates that Garston Village used to be a shopping area, but the building of a bypass and a retail park contributed to its decline and neglect. This did not encourage people to walk around and do shopping there:

*‘Garston Village used to be the main shopping area, and **now the shops are empty...some are falling into pieces... I know that they have to encourage people to go and use them, but there’s nothing there to encourage people there.** Since they built the bypass, that’s affected the shops in the village ... but a lot of the problems have been because they built the retail park... and people tend to go there now...so small businesses are going to be hit by that.’ (P13, P14)  
(Garston Village)*



Figure 75 Negative perceptions towards the urban environment: dereliction of amenities in the city (P13, P14; location: Garston Village, Liverpool).

Furthermore, in more disadvantaged areas a lot of the factors that inhibit respect and social inclusion tended to cluster and compound one another. For instance, a participant emphasised that the dereliction of this shopping area had also an impact on how safe she felt:

*'[...] I wouldn't go down in there at night on my own.'* (P13, IV)

#### **4.5.2 Poor and limited accessibility to public toilets, bus and train stations**

Several participants reported that some public conveniences in the City were not easily accessible, and this was an important barrier to promoting respect and social inclusion. These included public toilets in the city centre, train and bus stations, and libraries. As noted in the quotes below, the main perceived causes to this were budget cuts that Liverpool City council had to manage, and lack of organisation and/or importance given to addressing some issues affecting older people and all age groups.

Lack of accessible public toilets in the City centre was recognised as a barrier that could prevent many older people from going there. This limited their opportunities to go to places, take part in activities and interact with people. For instance, two participants identified different aspects of this issue (Figure 76, Figure 77). A participant stressed that the existing public toilets in the centre were not accessible and were perceived as not very safe:

*'This toilet's not inviting, it's not accessible...and I'll be a bit anxious about getting locked in... It's counterproductive to meeting the needs of older people. Your body is changing and you've different needs..., but you need immediate access to clean toilets. It's against social inclusion. **It's a barrier because no many older people will be confident to go to town if there're not enough accessible public toilets.**' (P1) (Bold Street, Liverpool)*



Figure 76 Poor/limited accessibility to public conveniences (P1; location: Bold Street, Liverpool).

The other participant took a photograph of a former public toilet (Figure 77) and expressed her concerns about the implications that this loss could have had on the whole community, not just on older people. In fact, these public toilets were located nearby a main park of the City (Sefton Park), and regularly used by the whole community:

*'It used to be a public lavatory, and they sold it off, and I think that they're advertising some sort of business space. For older people public lavatories are very important, and possibly for younger ones...and it's at the edge of Sefton Park... this may stop people going for a walk, getting some fresh air, going out and meeting people.'* (P10) (Lark Lane)



Figure 77 Poor/limited accessibility to public conveniences (P10; location: Lark Lane, Liverpool).

Although most participants stressed the positive aspects of the transportation system and the free travel pass in the City (Section 4.4.1), they also identified some negative aspects. For instance, a participant took a photograph of a staircase located in a train station, and reported that this station did not provide functioning lift equipment. This was considered a main barrier that prevented some older people and/or people with mobility issues from using that station, negatively impacting on their ability for social inclusion (Figure 78):

*'It's Cressington Station... and that's the staircase that you have to walk up from the platform... elderly people struggle with those steps...people in wheelchairs can't get off at this station, they have to get off at the next one, which has a lift... and that stops people who live locally, and who perhaps aren't too good on their legs, using the station.'* (P9) (Cressington Station)



Figure 78 Poor/limited accessibility to train stations (P9; location: Cressington Station, Liverpool).

#### **4.5.3 Closure of amenities and opportunities: leisure centres and libraries**

Closure of amenities and consequent poor access to opportunities was another barrier identified by participants. One of the main reported causes for lack of accessibility to these facilities was the impact of budget cuts that the council and other organisations in the City had to face (austerity measures). As shown by the quotes below, budget cuts mainly limited older people's access by shutting down some of these facilities. This was perceived as an important barrier inhibiting older people's participation in the community. Although participants showed some understanding of these cuts, a sense of disappointment due to fear of further shrinkage of current facilities/opportunities was evident:

*'[...] the community swimming pools in Park Road are closing. Everything that I use is closing...'* (P3, IV)

*'The central government are talking about getting rid of the free travel passes, which is a disaster! Not just for me, but all elderly people across the country that use them.'* (P3, IV)

Participants reported that closure of amenities was linked to the council's failure to understand the importance of some facilities (e.g. libraries) for both older people and the whole community (Figure 79, Figure 80):

*'Libraries are important to the whole community, from little children...up to my age. I've used it not only to borrow books, but to study in and to learn computers, because they're equipped with all sorts of computers.... I would hate to see it destroyed. They're part of the community, and if you destroy them, you destroy part of the community.'* (P18) (Sefton Park Library)

*'I do borrow books there, I do actually use that, it's very important for me [...] That's a wonderful thing that they kept it open, it would have been a disaster if they had close them [libraries]. If you haven't got a computer at home, you can go there and use one. Garston Library has the 'the one stop shop', where people can go for advice on all sort of things.'* (P10) (Garston Library)



Figure 79 Closure of libraries (P18; location: Sefton Park Library, Liverpool).



Figure 80 Closure of libraries (P10; location: Garston Library, Liverpool).

#### 4.5.4 Challenges in access to information

Several participants reported that they (and older people more generally) often faced challenges in finding out information about what was going on in their local community and the city centre. The Internet was felt to be the main means of accessing information for most participants, and thus, access to services and activities. Given that the information is spread in this way, those unable to use the Internet risked being cut off from important information and events going on in the City and with possible consequences on their social inclusion. Further, the aspect of having a computer and being able to use it was emphasised:

*'It's about knowing what's going on even in the neighbourhood down the road or across the park... it's still a problem if you have missed out on the technology thing.'* (P1, FG1)

*'They assume that you're computer literate, [...] because a lot of youngsters run these things, and, why should you be cut off because you don't know how to use computers, when you haven't got one in the first place! And you should be included, because it costs money to buy a computer.'* (P9, FG2).

*'We live in a society which just uses computers all the time [...] so if you haven't got a computer, or if aren't computer literate, [...] like my age group, it's a barrier'. (P17, IV)*

Some participants wanted to raise awareness of this issue. They highlighted that it was increasingly up to the individuals themselves to seek information about events and activities taking place in the City, as opposed to someone telling them about events:

*'That's a shame to hear "oh I've never heard of that" [...], because [information] it's there and the council should make people aware of it. Unless you're particularly interested in that, it's hard to find out. You find because you wanna do yourself.' (P9 FG2)*

*'We have to go and find a lot of these things ourselves. But there's a lot that is free out there, and there's no real need for any of us to be stuck in our houses ... because there's so much to do, more in this city than in any other cities.' (P21, IV)*

In the quote below a participant pointed out that people who could go out in the community were potentially able to search for information if they wished to. However, others who were unable to get out due to lower mobility or other issues were less likely to know about activities organised in the City. They highlighted the need to advertise events more widely:

*'I can get out and about and find out these things, [...] maybe they should advertise it more.' (P4, IV)*

Overall, participants reported that it was important to be computer and Internet literate these days. However, most participants reported how useful it still was for them to receive information through the 'old' means (e.g. leaflets and free newspapers), and how this was progressively becoming rarer, with information being circulated online only.

*'We used to get a paper through a letter box, free, and that's been stopped and now you have to buy it, and if you don't buy it, you miss lots of these things...'* (P4, FGI)

Based on the participants' quotes, there was no strong evidence of social disparities in obtaining information and being computer and Internet literate across the four groups. Some solutions to address this issue are presented in Section 4.6.

#### **4.5.5 Negative age perceptions**

Negative age perceptions were perceived as the main barriers to respect and social inclusion in the community. As with poor cleanliness of the streets (Section 4.5.1), participants reported an increasing lack of respect for older people that contributed to participants' feeling of vulnerability in the community. They felt that this was mainly due to today's social and media pressure to look young and to contribute economically to the society, which intensified the negative perceptions of ageing. Participants reported that media images and language had a big impact on conveying a negative image of ageing in society. Moreover, participants pointed out that family fragmentation made it difficult to cultivate intergenerational relationships and get to know older people, as families increasingly lived away from each other.

- **Disrespectful attitudes and perceptions towards older people**

In addition to disrespectful behaviours related to street cleanliness issues, participants experienced similar episodes on the bus which contributed to negative perceptions of ageing. Most quotes derived from participants living in more disadvantaged areas. In the quotes below some participants perceived that

young people were responsible for disrespectful attitudes towards them in various occasions:

*'I don't like the way you get on the bus, where there is a man sitting on the seat, and an elderly person standing there, and you won't get any seat for the elderly person. I think that's very rude.'* (P2, FG1)

*'More respect for older people. I think that's where we are lacking now. People on buses are very disrespectful, and that's negative, and not a nice thing to know that the kids today don't care'* (P21, IV)

Although not intentionally, some participants reported examples of negative age-perceptions towards the younger generation too, and some internalised stereotypes emerged from the narratives:

*'[...] the young people [...] don't value themselves and they don't value anybody, it's all about material things, young people around their 20s, or younger, [...] I don't know anything that could make it better.'* (P22, FG1)

*'They're selfish; they have got the money, but they don't use the money wisely.'* (P3, FG1)

Some older participants pointed out how the terminology used to refer to older people was often disrespectful towards them, and contributed to the overall negative age perceptions in the community:

*'A lot of it it's about feeling valued. I really don't like being called an old aged pensioner, I ignore them.'* [...] *I like the phrase elder. In Australia, we call older people 'elder' because they respect them, and I really think that's missing in English society.* (P3, IV)

Most participants indicated that although older people made useful contributions to the society (e.g. kinship, voluntary work, source of experience and skills),

society considered people to have a value only in terms of working life (economic value), which diminished the sense of respect in older people:

*'Not just in Liverpool, within Western culture, we don't value older people. It's almost like that you retire, and you don't work anymore for money, so you have no value in society; while we have a great deal of resources up here. [...] we have a great deal of knowledge and wisdom that we could pass on young people if they want to listen to us'. (P3, IV)*

*'There is so much talent out there in us, and the older generation. It feels that you stop working now and you have no value, you are not valued for anything after that.'* (P1, FG1)

Because of negative age perceptions, participants reported that some older people themselves considered ageing and retirement as barriers for doing certain activities, highlighting the need to challenge age-perceptions amongst the older generation as well.

*'[...] I found that people [...] once they're retired they say: "Oh I am 65, now, I can't do that" ... "You can't do that at my age" ...and I said: "my age? What the hell is my age? Your age is what you wanted to be."' (P21, IV)*

- **Neighbourhood fragmentation and lack of social and intergenerational interactions**

Several participants reported that lack of intergenerational respect was the result of loss of informal networks and neighbourhood fragmentation. As shown in the quote below, lack of knowledge of older people was linked to lack of intergenerational respect and negative age perceptions.

*'Young children can go and get to know older people because there's an awful lot of them that don't talk to older people. If their own grandparents have died they don't get used to know older people...they just see old people as being old and miserable, and then they get to know them and they realise that they're not. It's*

*like old people think young boys with hoods on are all bad children, but they're not.'* (P23, IV)

Participants reported that social trends were leading to loss of community and isolation, impacting on their respect and social inclusion. Some participants stated that in the past people used to know their neighbours more than nowadays, and they used to mix with each other. This was also facilitated by women staying at home more to look after their children, instead of being employed full time:

*'Neighbourhoods have changed a lot [...]. When I had my children, I left work, [...].and I was at home. That's how a lot of us got to know each other, because a lot of young mums were at home with their children [...]. You got to know your neighbourhoods, and you got to know the elders' one. But now, I think, **the society has changed, young mums now tend to work: so, because they work maybe 5 days a week, they don't get to know their neighbours**.'* (P17, IV)

Moreover, participants stressed that the community aspect and neighbourhoods' co-operation were getting lost. In fact, people were constantly moving houses, and this made difficult to cultivate a trusting relationship with neighbours:

*'[...] what we lost is possibly the community aspect where people in the road looked after other people.'* (P15, FG2)

*'[...] because families lived very close to each other, there was a very close community. I have just found out the name of the lady opposite to me! And I have been in that house for 17 years....'* (P20, FG1)

*'All the neighbours' friendship is gone, because you don't know who is coming to live next door to you... often [...] they come from different towns, and some people don't want to mix.'* (P4, FG1)

In the quote below a participant highlighted that the fact that families were increasingly living apart could have an impact on social isolation of older people:

*'Isolation is a big problem for older people, especially when their families are moved away. [...] **There're a lot of people whose***

*families have moved away, so unless they belong to something like the church or a group, they can become isolated.* ' (P17, IV)

Some participants reported that they tried to create opportunities for informal interactions, but they found it difficult to meet people to speak to in their neighbourhoods. The main reasons given were that nowadays most people use their cars for transport, and many children now play inside, thereby reducing the opportunities to meet people in the streets.

*'I used to walk to school and you met people, but people come out of their house now, get into a car and go. Nobody walks, unless you walk down the street or to the shops [...], also, it's quite lonely and the older people feel a bit vulnerable.'* (P11, FG2)

*'I have lived in the same street now for 36 years, and I knew everyone, I knew all the kids, but now the kids are all indoor, you don't see them, so it's a ghost town.'* (P21, FG1)

*'There's a lot of focus on students in this area, and when it comes to summer, everything goes quiet, and particularly in Smithdown road area, and I think there're more and more people moving out, so that's breaking up the community, isn't, it's awful.'* (P26, FG1)

By contrast, other participants from more affluent areas felt that their streets were neighbourly:

*'Our road is very neighbourly; people are around all the time. We know all our neighbours, we say hello to them, it may be not much more than that but [...] we do see them, and our next door is actually one of our friends, [...].so I think that depends on the road.'* (P10, FG2)

Table 25 shows the three sub-themes identified and a summary of key findings for each sub-theme.

Table 25 Summary of the main barriers to respect and social inclusion in Liverpool emerging from the thematic analysis.

Sub-themes	Summary of key findings
<p><b>Negative perceptions towards the urban environment</b></p>	<ul style="list-style-type: none"> <li>– Participants felt a sense of disregard and alienation in describing some negative aspects related to lack of street cleanliness.</li> <li>– The main issues identified were lack of respectful attitudes of some citizens towards their local community, and failure of the council to address some of these issues.</li> <li>– Disrespectful episodes experienced when they tried to improve the situation (<i>e.g.</i> pointing out to a person who threw away something that the rubbish bin was close).</li> <li>– Dereliction of some local shopping areas in the City was identified as another important barrier for older people, particularly for those unable to go to the big stores due to mobility issues.</li> </ul>
<p><b>Poor/limited accessibility to places and activities/opportunities</b></p>	<ul style="list-style-type: none"> <li>– Key barriers included limited accessibility to public toilets in the city centre, train and bus stations, libraries, and information.</li> <li>– Closure of amenities and consequent poor access to opportunities.</li> <li>– The main perceived causes to the barriers above were budget cuts that Liverpool City had to face, and lack of organisation and/or perceived importance of addressing some issues affecting older people.</li> <li>– The Internet was felt to be the main means of accessing information for most participants, and thus, access to services and activities. This had implications for those unable to use Internet, who risked to be cut off from several events going on in the City and with possible consequences on their social inclusion.</li> </ul>
<p><b>Negative age perceptions</b></p>	<ul style="list-style-type: none"> <li>– Participants reported a lack of respect towards older people. This was mainly due to today’s social pressure and media to look young and to contribute economically to the society, which intensified the negative perceptions of ageing.</li> <li>– Neighbourhoods’ fragmentation made difficult to cultivate intergenerational relationships and get to know older people, as families increasingly lived away from each other.</li> </ul>

## 4.6 Potential Solutions to perceived barriers

Participants were encouraged to think of ways to address some of the issues that they identified. It is important to acknowledge that many of the solutions appear, by implication, in the earlier Section 4.4 on enablers. Nevertheless, in this section, I add to and reinforce those already implied by reporting some sub-themes wherein some participants offered more active solutions.

### 4.6.1 Overcoming personal barriers to social inclusion

At the individual level, some participants described the impact of retirement and growing old that they experienced, and the importance of reacting to these challenges, for instance, by cultivating interests and participating in some activities in the community:

*'It's very difficult to be in a community when you've worked full time; [...] when you've come out from work and you retire as we have, then, **unless you've got some activities to join in, it can be very isolating and lonely for a lot of retired people.**' (P11, FG1)*

Several participants mentioned personal attitude and resilience as ways to cope with everyday challenges that derived from loss of mobility and other health issues that negatively impacted on their social inclusion:

*'Someone said to me a few weeks ago: (we were talking about bad health [...]): "it's alright for you; you keep healthy" and I said: "[...] I work at it: it doesn't just happen!" **You've got to come out and do things and being amongst people.**' (P20, IV)*

*'I only go out for an hour, maybe I go out shopping, maybe I have no shopping to do, but **I go out, so this is an element of helping yourself [...], and not being too dependent on what other people think or they do.**' (P19, FG1)*

Related to physical barriers, a participant provided a practical example of overcoming mobility issues in the allotment, wherein people with lower mobility could still do gardening thanks to the raised beds (Figure 81):

*‘This [photograph] shows that **people can still do outdoor activities, and grow for themselves vegetables...and disability or immobility is not gonna stop them doing it!** [...] they are called raised beds: if you’re old and you can’t get down, **you can sit in a wheelchair next to the beds and it makes it much easier** [...].’ (P9, FG2) (Allotment in Mersey Road)*



Figure 81 Overcoming mobility issues: raised beds (P9; location: allotment in Mersey Road, Liverpool).

Furthermore, a participant illustrated that age did not have to be considered a barrier to being part to a club and playing sport. He emphasised that belonging to a sport club was a way to overcoming physical barriers (Figure 82):

*‘This is Liverpool Cricket club, and this is the oldest cricket club in England. It’s to show other people that **you can be in old age and still belong to a club, a sport club and do things... to keep you fit.** It takes quite a big part of my life, I play bowls a couple of times a week [...]. There are lot of my friends, so...**you do meet a lot of people there.**’ (P12) (Liverpool Cricket Club)*



Figure 82 Overcoming barriers: being a member of a sport club (P12; location: Liverpool Cricket Club, Liverpool).

- **IT training and skills**

As noted in Section 4.5.4, participants reported that the Internet was the main means of accessing information about events and activities going on in the City, and they highlighted the implications for the social inclusion of those unable to use computers. Despite the challenges associated with the lack of confidence and unfamiliarity with using the Internet and computers, some participants had learned basic IT skills after retiring. Participants from more disadvantaged and affluent areas showed consistent views on this issue. They proposed IT training as a means to access information more easily, and to counteract some practical challenges, such as not being able do shopping due to health issues:

*‘When you have difficulties, as I did, I have done the online shopping and it was a great help to me. When I am fit enough to go out, I will go out shopping... but when you know how to do the Internet, it makes you independent.’ (P22, FG1)*

Training was often facilitated by community organisations and libraries, which created a friendly and supportive environment for older people to learn (Figure 83):

*'Going to this computer class with the other girls, **they're all the same age as me and I do not feel embarrassed.** It's very helpful, particularly shopping online. **I was very ill last year and I could not get out; people had to do my shopping, but it would have been easier if I could have gone online and do shopping online.'** (P21, IV) (St. Luke's court)*



Figure 83 Overcoming barriers: access to IT classes (P21; location: St. Luke's court, Liverpool).

One participant highlighted the importance of using the Internet not only to access information but also to stay in touch with family members who moved away. The participant also suggested the use of Face Time as means for older people to tackle social isolation:

*'[...] the iPad is such a big part of our life... if a lot of older people had FaceTime with their families, because their families are in other parts of the country, they would feel part of them and not as lonely. We Face Time and...you keep contact with people...but without that, you just feel isolated, and that [iPad, Face time] stops you feeling isolated.'* (P11, IV)

Some participants, particularly from a more disadvantaged group, provided some solutions that the local government could undertake to improve access to information for older people. In earlier Section 4.5.4, participants pointed out that leaflets and free newspapers were still important means for them to be aware of activities in their local area and in the city centre. Participants suggested that although useful, there was no need to distribute leaflets in every house. Instead, participants suggested that organisations and the council could put some leaflets and/or small display boards in the bus stops, buses, post offices, and supermarkets to advertise weekly events and activities, as these amenities were accessed daily by most people. This was felt to be a good way to keep informed on what was going on in the City:

*'They should advertise [events] more: in the papers, in the supermarkets, because [...] everybody goes in the supermarkets [...], or flyers, get someone to take flyers around to shops... no just the supermarkets, but in different areas.'* (P4, FG1)

*'[...] all the local shops could have just little weekly or monthly summary on what's going on in the immediate neighbourhood in the next few weeks. So, if you go to the post office in the area, or you're going to the local shop and the area, or supermarket, you are going to be able to see it in the notice board.'* (P1, FG1)

- **Improving accessibility to stations and public toilets**

In the earlier Section 4.5.2, some participants identified lack of more accessible bus and train stations as main barriers to respect and social inclusion. In this example, a participant was concerned about a bus station (Liverpool One Bus station) considered very uncomfortable due to lack of protection from the wind (Figure 84):

*'Growing older is not about changing a lot...or being in a transition... but it's about keeping the opportunities the same for you*

*as they are for everybody else. So, things like this (transportation) become very important. As you can see, Liverpool One bus station is completely open, and wind can still get in! We should use the learning from South Parkway station, and apply it to this station, so that you're behind closed doors, in comfort, while waiting for a bus.' (P1) (Liverpool One bus station)*



Figure 84 Barrier: lack of accessible bus stations (P1; location: Liverpool One bus station, Liverpool).

The participant then went on to illustrate how this could be remedied. Solutions included use of large canopies and closed spaces to protect from the wind and cold weather (Figure 84).



Figure 85 Accessibility of the public transportation system (P1; location: South Parkway Railway Station, Liverpool).

In Section 4.5.2, lack of access to public toilets was identified as a barrier to respect and social inclusion. A participant identified how inaccessible and unsafe some of the public toilets located in the city centre (Figure 76). The same participant went to illustrate a solution, whereby premises in the city centre could allow older people provided with the free travel pass to use their toilets:

*'[...] the city council could have a scheme whereby if you are an older person with a bus pass, or if you are disabled and you have your car badge, they should negotiate with all the restaurants and cafes, and pubs that people won't be stopped from accessing those toilets.'* (P1, FG2)

#### **4.6.2 Challenging negative perceptions of ageing**

Participants identified several ways to challenge macro-societal barriers such as negative perceptions of ageing in the community. The key actors were community members of all ages, journalists, and policy makers. Based on the findings, participants suggested that change needed to happen (i) at the community level (*e.g.* journalists should improve the terminology used to refer

to older people in newspapers and television); and (ii) at the individual level (e.g. older people should show to others their various ways of contributing to the community including volunteering; older people should stop seen growing old as a barrier to taking part in activities, including playing sport).

In Section 4.5, some participants pointed out that they experienced a lack of respectful attitudes towards them, and this was identified as a very important barrier to their respect. In the quote below, the participant suggested to improve the terminology for older people in general:

*'First I'll call them elderly that they've got skills: they knit, they sew, [...] and even if they don't have skills they can be taught by those ones that have got skills and form a nice group and they could make things and sell them in the community, and raise funds for the elderly. [...] you can tell them, 'get your skills out' [...].'* (P2, FG1)

Moreover, several participants suggested that a way to address negative perceptions of older people was to show to others the various ways in which they can contribute to the community. For instance, volunteering activities were seen as means of using the skills and applying the experience acquired through life to contribute to the community and, in turn, feeling valued (Figure 87, Figure 88, and Figure 86). Examples include doing free massages provided through a charity; arranging flowers in churches; and making blankets to send to people living in more disadvantaged countries:

*'My sewing machine is probably the most important thing that I own. It's a simple thing that anybody can learn to do because it's straight sewing and [...] you take a few pieces of material and in a very short time you can have a very useful thing. [...] I do a lot of charity work on this. We've adopted an orphanage in Romania and I do a lot of cot covers for this orphanage. [...] I feel that a lot more people could do this.'* (P19)



Figure 86 Maintaining and cultivating skills: sewing machine (P19; location: home, Liverpool).

*'This's just an example of using the skills and talent that you have learnt in the past and you can still contribute to the general life of people.'* (P17) (St. Mary's church, Grassendale, Liverpool)



**Figure 87** Maintaining and cultivating skills: arranging flowers (P17; location: St. Mary's church, Liverpool).

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*'It's an extension of my working life [...]; this is a way of giving back to Liverpool community some skills that I have for free. This is a massage chair. Two days a week I do sitting massages for people in a charity in Liverpool. I enjoy working and it helps to keep my skills with my hands as well. I feel very valued, and it's good for social interaction as well.'*  
(P3) (Liverpool)



Figure 88 Maintaining and cultivating skills: massage chair (P3; location: charity, Liverpool).

Table 26 shows the two sub-themes identified and a summary of key findings for each sub-theme.

Table 26 Summary of the main solutions to perceived barriers to respect and social inclusion in Liverpool emerged from the thematic analysis.

<p><b>Overcoming barriers to social inclusion</b></p>	<ul style="list-style-type: none"> <li>– Participants identified ways through which they could promote their own respect and social inclusion, as well as ways through which the local and national government and/or the City as whole could help address some of the barriers identified, and promoting respect and social inclusion.</li> <li>– Some participants described the impact of retirement and growing old that they experienced, and the importance of reacting to these challenges, for instance, by cultivating interests and participating in some activities in the community.</li> <li>– Participants suggested that organisations and the council could put some leaflets and/or small display boards in the bus stops, buses, post offices, and supermarkets to advertise weekly events and activities, as these amenities were accessed daily by most people. Participants reported that IT training could enable older people to access information more easily, and to counteract some practical challenges, such as not being able to do shopping due to health issues.</li> <li>– To overcome the challenge of lack of accessible public toilets in the centre, some participants suggested that premises could allow older people provided with the free travel pass to use their toilets.</li> </ul>
<p><b>Challenging negative age perceptions</b></p>	<ul style="list-style-type: none"> <li>– Ways to challenge negative age-perceptions included: improving the terminology used to refer to older people, and showing examples of older people contributing to the community in various ways (<i>e.g.</i> volunteering).</li> <li>– Some participants also suggested finding ways to show to the whole community that growing old did not have to be a barrier to taking part in various activities (<i>e.g.</i> playing sport).</li> </ul>

# **Chapter 5 RESULTS: CITY STAKEHOLDERS’ VIEWS OF RESPECT AND SOCIAL INCLUSION IN THE URBAN SETTING**

## **5.1 Introduction and presentation of the results**

This chapter presents findings of a qualitative study that investigated the views of city stakeholders in relation to factors that influenced their ability – as individuals and as representatives of their organisations – as individuals and as representatives of their organisations – to promote respect and social inclusion for older people in Liverpool City, and what they believed was required to strengthen this. Identifying and discussing wider political, economic and social issues and influences was also part of this stakeholder study. As explained in Chapter 1, city stakeholders were defined as representatives from local authority, clinical commissioning groups, and organisations with an interest in older people.

The same three ‘a priori’ domains reflecting the study objective were used to explore stakeholders’ views and to organise the findings including:

- **Enablers to respect and social inclusion**
- **Barriers to respect and social inclusion**
- **Solutions to perceived barriers to respect and social inclusion**

Results relating to each domain are organised into different sub-themes identified using thematic analysis of the interview transcripts. The three sections below that report these sub-themes start with a detailed discussion with

quotes, followed by a summary table of the main findings. I conclude this chapter by presenting key similarities and differences between older people's and city stakeholders' narratives about some aspects of respect and social inclusion.

### 5.1.1 Participants

A total of 23 city stakeholders participated in a semi-structured interview, all of whom worked or were based in Liverpool City. They included representatives from local authority and clinical commissioning groups (n=7), the third sector (n=14) and art and culture representatives (n=2) (e.g. museums), as shown in Table 27.

Table 27 Demographics of participants.

<b>Organisation</b>	<b>Position held: Directors, executive directors, chief executives, and councillors</b>	<b>Position held: Project managers and consultants</b>	<b>Gender (M= male; F= female)</b>	<b>N</b>
Local authority, clinical commissioning groups, and housing sector	2	5	F=4 M=3	7
Third sector	4	10	F=12 M=2	14
Art and culture	1	1	F=2	2
Total			F=18 M=5	23

### 5.1.2 Enablers to respect and social inclusion in the City

This section presents main findings on the factors which city stakeholders described as facilitating their ability to promote respect and social inclusion for older people in Liverpool City.

### 5.1.2.1 Collaboration and partnership working between organisations

Most participants viewed partnership working as an effective way to work and promote respect and social inclusion in the City. Collaboration with other organisations was a frequent way of working, particularly among third sector representatives:

*‘There’s the 800 Group, [...] Between us we’ve got over 800 years’ experience in delivering charitable services to a range of people - not just older people, so **we work collaboratively together with them.**’ (K11)*

Some participants reported clear benefits associated with partnership working. For instance, it allowed the creation of a greater capacity to reach a wider audience:

*‘We’ve spent many years and a lot of resource developing a service between three Black and Minority Ethnicity organisations [working with older people] [...]. **We are quite a force, and we have quite a huge reach.**’ (K13)*

In addition to reaching a wider audience, some participants considered collaboration between organisations as an appropriate means of avoiding competition for scarce resources between services:

*‘Everybody is thinking about similar audience diversity, and we thought it would just make good sense to **bring the different networks working with and supporting older people together with the cultural partners in the city to [...] more intelligently work together and programme, so that we spread the resources out, so that we’re not in competition with each other, and [...] we reach a wider group of older people in the city.** [...] It’s really exciting that so many people have come together to have that shared conversation.’ (K19)*

For smaller organisations (particularly charities), partnership working was often imposed for practical reasons, including the need of a bigger space to run certain activities (*e.g.* dance classes):

*'We always work in partnership [...] because **this is the only space we have, if we programme stuff to this space we can do it by ourselves, but if we're doing anything outside we're always in partnership.**' (K11)*

Although this enforced partnership was felt to be a necessity given the scarcity of resources, participants reported that this was having a positive impact on their work. For instance, it allowed them to deliver a greater variety of projects and activities, and to reach a wider audience.

#### **5.1.2.2 Perceived commitment of the organisations to support respect and social inclusion and older people in the City**

Several participants, particularly those working in the third sector, reported that respect and social inclusion were values and priorities that embedded in their organisations' remit. Some participants expressed a sense of pride for past and current successes. These included having seen some benefits experienced by older people as a result of taking part in their projects (*e.g.* day trips and dance classes):

*'For those 3 hours they're socially active, they're engaged, so that's a real key project at the moment.'* (K13)

*'They enjoyed it, they were a little bit achy the next morning, but they said they felt really better for it. So we make sure where we can there's physical activity.'* (K15)

Many participants reported that their organisations' drive for respect and social inclusion of older people was shown by their ongoing motivation for developing projects designed to improve respect and social inclusion in the face of challenges such as budget cuts and scarcity of staff and volunteers:

*'Unfortunately we haven't got the funding to pay for any transport, but we've got that organised as well, so we phone them [taxis] up and within a matter of a couple of minutes the cabs are outside as soon as the club's finished.'* (KI2)

Related to improving respect and social inclusion, some participants stressed the importance of recognising older people as a heterogeneous group characterised by different needs. To address this diversity of needs and preferences, they pointed out the need to develop targeted interventions that reflected older people's preferences:

*'[...] we mustn't assume ever that we know older people, and I think sometimes we put older people into a little category box.'* (KI9)

*'Don't just do tea dances because tea dances are not relevant for every older person, people hold tea dances and bingo and I think for some older people yeah, but not for all, and actually if you think of someone who's 65, their cultural reference is more the Rolling Stones... [...] and even 70s'* (KI10)

*'Trying to really consider what you're providing for older people, whatever it is that you do, whatever the service is, trying to consider what they really need.'* (KI1)

Further, city stakeholders went on to explain how they involved older people in their organisations. This included listening to their ideas, and enabling them to influence the design of a project or an activity. Participants reported that doing so improved their ways of working and delivering some activities:

*'[...] it is their luncheon club, we run it, we facilitate it, we organise it, but it's their luncheon club, so we ask them.'* (KI13)

*'We often propose things to them and they'll say yes or no. And then they'll be part of that process of developing the piece itself.'*  
(K11)

*'The remit of that project is around user-led innovations, so **people who are living with dementia are driving the innovation process and telling us what they want and what's important to them**, and we're using that to inform products that we've been developing to enable people to live well with dementia.'* (K117)

*'They come to us with the ideas and we put them into practice.'*  
(K14)

*'It is our older people who lead us, we don't lead them, and they tell us what they want.'* (K16)

When I asked who was involved in these processes, some participants reported that they involved the majority of the users. One way to do so was to use 'champions' that served as representatives of the older people's group and reported the suggestions back to the organisation. Others had a steering group comprising older people that met regularly to discuss the plans for activities. Overall, most city stakeholders reported that service users were constantly encouraged to come up with new ideas about activities and projects.

Participants reported clear benefits for the staff as well as for older people themselves associated with involving older people in their projects. In these two quotes, older people were involved in designing two apps to help people with dementia to live independently and/or their family members to better interact with them. Benefits included being able to improve their services and having confidence that they were meeting the needs of older people.

*'[...] they've told us what type of colours...do they want words; do they want pictures? They've told us they want pictures, **it's been their concept**, [...] ...**it's just been great**.'* (K16)

*'The patients are leading, showing us the way how they want to be cared for, what it means to live with dementia. We only support them; we don't live with dementia so we don't know what is best for them. [...]' (KI8)*

Involving older people made some participants realise that what professionals and staff sometimes thought would be best for the project was not always directly relevant to older people's needs. To illustrate this point, a participant described the experience of her organisation that involved older people in developing an app. This app aimed to help carers and family members to interact with people with dementia and to contribute to their social inclusion:

*'At every step of the way of developing the app all the ideas we tested with them, and that was **challenging for us because we had to let go of a lot of things that we thought would work, which they clearly said they won't** [...]. So, we've completely re-done it'. (KI9)*

Table 28 Summary of the main enablers to respect and social inclusion in Liverpool City identified by city stakeholders.

Sub-themes	Summary of key findings
<b>Collaboration and partnership working between organisations</b>	<ul style="list-style-type: none"> <li>– Partnership working was a good means of avoiding service duplication, reaching a wider audience, and improving information exchange about projects and activities for older people in the City.</li> </ul>
<b>Commitment of the organisations to older people and respect and social inclusion</b>	<ul style="list-style-type: none"> <li>– Some participants reported that respect and social inclusion were part of their organisations' remit and provided examples on how they were committed to older people (e.g. continuous efforts to run projects despite scarcity of economic resources).</li> <li>– Participants highlighted the need to consider older people as a heterogeneous group, and therefore to develop targeted interventions that reflected their preferences.</li> </ul>

**Perceived  
commitment/support to  
respect and social  
inclusion in the City**

- Participants reported clear benefits for the organisations as well as for older people themselves associated with older people’s involvement in project planning.
- Participants identified some key organisations and individuals that they thought were essential to drive the political agenda on respect and social inclusion.
- Participants reported that there was, in general, a degree of political commitment to improving the health and wellbeing of older people in the Liverpool.

### **5.1.3 Barriers to respect and social inclusion in the City**

This section presents main findings on the factors described as preventing the ability of city stakeholders to promote respect and social inclusion for older people in Liverpool City. The section starts with a detailed discussion with quotes that expand the sub-themes, and concludes with summary table of the findings (Table 29).

#### **5.1.3.1 Impact of budget cuts and reduced service infrastructure**

Amongst the barriers identified, older participants raised awareness of some of the consequences that they attributed to government budget cuts, including limited access or closure of libraries, public toilets, local shopping areas, and limited IT training.

- **Short-term activities and insecurity**

Most participants identified budget cuts as an important barrier to promoting respect and social inclusion in the City. This resulted in the necessity for

activities to be only short term, with consequent feelings of disappointment due to the constant unsustainability of projects:

*'[...] nobody is looking at the longer game, it's all short termism, it's like how do we get from here to next year.'* (K13)

*'We can't have funding; we just can't believe it. We don't know what will happen after that [the current funding runs out]. We weren't successful, which was really frustrating.'* (K11)

*'Within my role the funding we access is never long term [...] ...the best would be for a year, and then another year we struggle to find all the funding and so on.'* (K18)

- **Impact on the third sector: project evaluation and volunteers**

Some third sector participants noted that, due to budget cuts, their organisations experienced a reduction in staff, and this led some of them to fulfil various roles and tasks at the same time. Hence, although project evaluation was recognised as important, some participants – particularly those working in small organisations – reported to have limited time and resources for carrying out evaluations as frequently and rigorously as they would have considered appropriate:

*'We did intend to do continuous evaluations, so...we would do questionnaires at the end of any sort of specific activity. Unfortunately, because we haven't got the staff it's not happening on a regular basis. [...] Basically it's just people talking to us; that's how we evaluate.'* (K14)

*'[...] a lot of project time is on delivering, whereas there's not enough to capture data and there isn't ever enough money in other organisation's budgets for a full evaluation because they're priced out of the market. For example, I think the average evaluation is about £1,000 to £5,000, and when you're struggling with a very limited budget it can't be done, which is why I think some organisations use simple tools that aren't very effective'* (K119)

Most participants reported the benefits they believed their projects provided to older people (Section 5.1.2.2), but the use of a rigorous evaluation process was not often described. Lack of resources was not the only reason for this limited evaluation activity, and challenges in finding suitable evaluation measures to show an impact were also evident:

*'I feel like the work we do is hugely beneficial ...but it's how do you prove it, because it's all the woolly stuff around the edge, it's really difficult.'* (K11)

*'People will say at the social club, [...] "I've met so many friends, it's made such a difference to me, I am getting up, I am getting washed and dressed rather than staying in their nightclothes all day". They look forward to the highlight of the week to going out, and it's improved their mental health, [...] that's got to be an outcome.'* (K111)

*'It is difficult, [...] in terms of demonstrating our outcomes we have a lot of case studies, [...] in terms of people who use our services, and we're building up a portfolio of case studies...but [...] we have to tweak them if you like to demonstrate to the different funders what they want to see.'* (K18)

In relation to shortage of staff, some participants working in charities highlighted that volunteers were very important for their organisations. However, they felt that volunteers' commitment and other charity work were often taken for granted by funders and key decision makers. In the quotes below, for instance, the participants reported that funders were increasingly asking charities to rely on volunteers to sustain the organisations, but volunteers could not replace the need of a workforce capacity. Participants reported the need for trained, experienced, professional staff to deliver and organise their activities, alongside volunteers:

*'The local authorities and the government are saying more volunteers, more volunteers, more volunteers, but an awful lot of the services can't run on volunteers.'* (K113)

*'Sometimes because we're a charity and we have volunteers, people think we can do things for nothing, which is obviously not the case because we employ staff, we have one or two assurance systems, we have risk assessments, volunteers are checked, they're paid expenses and they're managed effectively [...].'* (K111)

### 5.1.3.2 Competing interests and priorities

Most participants felt that the perceived commitment to promote respect and social inclusion was not translated into actions and implementation of the strategies that were proposed, and the main reasons included scarcity of resources and will:

*'I think there are leaders... [...] there are drivers, there are people that are driving the agenda and wanting to talk about older people and making sure that their voice is heard, and I think it begins with your city leaders [...], your mayor and your chief exec ....., political makes it happen.'* (K19)

*'The intention is there but [...] these things need to happen, somebody needs to lead on these things and inject the appropriate resources.'* (K111)

*'Politically the politicians will say that they want inclusion, politically.'* (K112)

Local and national budget cuts created tough competition for funding for priority services in the City, and commissioners had to make difficult decisions on what to fund, and had to cut some services. The perceived impact was a lower prioritisation of older people's services relative to other activities needing funding, as mentioned by these participants from the third sector:

*'Liverpool, like a lot of the City Councils, funding is being cut [...], so it's how older people stack up against cancer, against children [...]. It depends whether it's perceived as a priority by the people that are making those kinds of decisions really.'* (K117)

*'I would say things have begun to change in the last few years. But there is still that gap; [...] we still have children's centres being more visible rather than older people's centres.'* (K18)

Despite some perceived political commitment to older people within the City, shrinkage of resources and competition for services meant that respect and social inclusion were not often perceived as priorities by the key decision makers and funders. According to some third sector participants, this translated into some services for older people being lost or reduced, particularly those focussing on health promotion projects to strengthen social inclusion:

*'With national budget cuts the local authority decided that that [our project to support social inclusion] would be one of the areas which was cut, and in a way, that perhaps addresses one of your questions in terms of support for the elderly and social inclusion and respect, that the local authority deemed it appropriate to cut that particular budget.'* (K13)

*'The sad thing is it's the funding, and [...] unfortunately, government is not looking after our older people and listening to them.'* (K17)

*'I don't think it [supporting social inclusion] is a priority, I really don't.'* (K14)

Shrinkage of resources meant not only competition for resources in the City between different services (e.g. services for children versus services for older people), but also competition between organisations delivering similar services. Participants reported that this competition for resources had negative consequences on exchange of information between organisations working with older people, and affected the quality and range of services. For instance, some services were repeated, and some gaps in services were not yet addressed. The combination of all these factors often created an atmosphere of 'suspicion' as opposed to collaboration, particularly among charities:

*'[...] organisations tend to be quite inwardly looking, and instead of thinking where are the gaps and what can we provide, they think: 'well we'll all do this' [...]. I don't know whether that's about competing interests, but it's certainly about people going for the same pots of money and [...] not looking at where the gaps are and just thinking: 'oh, this is what we've always done, we'll carry on doing it', so you're going to have 6 organisations all providing the same kind of thing instead of thinking actually, this is a gap, and let's do something for these people here.'* (KI7)

Furthermore, funding for smaller charities was even more difficult to justify if comparing with bigger and well-known organisations:

*'There isn't enough evidence of the impact of small organisations and small amounts of money is the reality, so if you are Age UK nationally you'll do a national piece of research and you'll have the size, scale, scope, media contact to [...] be taken seriously. For small organisations that doesn't happen, and yet the reality is most activity at that low level comes from small organisations.'* (KI5)

Participants reported that there was some recognition by local government of the importance of prevention work in relation to improving older people's health. However, they felt that there was not the financial commitment towards organisations wanting to develop health promotion initiatives such as those promoting respect and social inclusion as there was to health and social care initiatives:

*'I think the statutory agencies understand the importance of prevention work, but they're not putting enough resources into it, that's the problem.'* (K11)

In this quote, the participant reported that this lack of investment might also be due to the perceptions of social inclusion as softer by many commissioners:

*'Prevention even in terms of keeping people connected [...] they're the kind of things that are threatened, because the money's*

*tight, so the things that are maybe seen as softer and nicer, [...] they're not essential.'* (K117)

The focus on addressing health implications and associated social care, however, reflected a well-recognised and historical issue in public health:

*'The competing interests are heavily politically based around what is seen as right for the city and one of the key areas of conflict is with the diminishing resources how much do we focus on dealing with the demand inter services versus how much do we focus on prevention and tackling things in a more upstream way around the wider determinates of health. There's a real tension there that exists, and there's a good understanding of that I think in the city, but it is heavily pulled...and I can understand it in a way, heavily pulled downstream to dealing with [...] health and social care as opposed to more wellbeing and promotion of health and prevention and self-care. There's a real tension there between the two. I think that would capture a lot of what the issues are about.'* (K15)

### **5.1.3.3 Negative perceptions towards older people and ageing**

In addition to the challenges presented above, participants identified some macro-societal-level barriers affecting their ability to promote respect and social inclusion, as well as preventing older people to fully contribute to the society: negative perceptions and attitudes towards older people. These wider issues and influences were perceived as very challenging to counteract, because they required people's willingness to change their perceptions on ageing and older people. Some influences were particularly difficult to control (e.g. information conveyed by media):

*'Our society actually devalues older people and sees them as a burden, [...] although there are [...] some improvements...essentially I don't think growing old is valued in our culture.'* (K117)

*'Recognising they do have a value [...], just because maybe they're not part of the labour market any more doesn't mean they've lost value.'* (K114)

Furthermore, some participants felt that today’s society was promoting a culture for the youth. They reported social pressure and influence of the media as a barrier that denied the signs of ageing by promoting the importance of looking young, and therefore devaluing older people:

*‘The challenge is that you want people to value growing old, and that is not what our society is saying to people.’ (KI17)*

*‘a) we’re a youth obsessed society where we only think you’re relevant till you’re 25, and b) we’re afraid of ageing, we’re afraid of death and demise, and people see ageing as death and demise. (KI10)*

*‘Just because we reach a certain age band in our lives that’s classified as being older doesn’t mean that we want to lose our choice and our independence and our ability to even try some new...I think you don’t stop wanting to be engaged and stretch yourself and... just because you’re older, and in fact you’ve actually got more time to do it if you’re retired, so we don’t think of older people as doing less, we think of older people wanting to do more.’ (KI9)*

The combination of these societal factors was perceived as impacting on the ability of city stakeholders to deliver projects having a wider impact – beyond the service users themselves – on the society, culture, and services of the City.

Table 29 Summary of the main sub-themes barriers to respect and social inclusion in Liverpool City identified by city stakeholders.

Sub-themes	Summary of key findings
<p><b>Impact of budget cuts and reduced service infrastructure</b></p>	<ul style="list-style-type: none"> <li>– Impact of national and local budgetary cuts led to scarcity of economic and human resources, short-term activities and projects, instability and disappointment experienced by participants.</li> <li>– Reduced service infrastructure in charities led to having less (or more limited, or restricted) time and resources to conduct rigorous and frequent project evaluations.</li> </ul>
<p><b>Competing interests and priorities</b></p>	<ul style="list-style-type: none"> <li>- Local and national budgetary cuts created an environment characterised by tough competition for funding, and commissioners had to make difficult decisions on what to fund.</li> </ul>

**Negative age perceptions and issues affecting older people**

- Although participants reported that there was an overall city-political commitment to older people, shrinking resources and competition for priorities and services often prevented this process.
- Participants recognised that the perceived commitment to promote respect and social inclusion was not translated into actions and implementation of the strategies that were proposed. Main reasons included scarcity of resources and will.
  - Local government was often not supportive towards organisations wanting to develop initiatives focused on respect and social inclusion, highlighting a focus on addressing health implications and associated social care rather than on health promotion.
  - Negative age-stereotypes and attitudes towards older people were identified as macro societal barriers affecting the ability of city stakeholders to promote respect and social inclusion, as well as preventing older people to fully contribute to the society.
  - Participants felt that today's society was mainly focused on the youth and working-class people, and this contributed to reinforcing negative perceptions of ageing and older people.

#### **5.1.4 Solutions to perceived barriers to respect and social inclusion in the City**

This section presents main findings on the factors described as solutions to perceived barriers to respect and social inclusion identified by the city stakeholders, and concludes with a summary table of the findings (Table 30).

##### **5.1.4.1 Overcoming perceived barriers**

As mentioned previously (Section 5.1.3), several participants identified some common challenges to respect and social inclusion which led to repetition of services and activities, unsuccessful funding bids, and an associated sense of

disappointment. Participants proposed various solutions to overcome these barriers that are presented below.

- **Improving collaboration and partnership working**

Participants suggested the need to change ways of working and thinking within organisations to tackle budget cuts and competing interests and priorities. For instance, they identified the creation of networks and partnership working as good ways to foster more collaboration and to avoid repetition of services for older people in the City:

*'At the moment we've adopted a practical solution to the needs of individual communities here, [so we are] three organisations coming together.'* (KI14)

*'We need to connect things up rather than starting different things all the time, I think we tend to start new things and actually probably we need to look at who's doing what and connect things together in a better way.'* (KI17)

*'[...] to be inclusive for older people the city needs to connect...to have a similar conversation across the whole city, all its services, all its infrastructure, all of its stakeholders [...] by connecting we can have a much bigger impact on social inclusion.'* (KI9)

Collaboration was also viewed as a means of joining-up forces for grant applications, and some participants reported the need to continue working together despite experiencing previously unsuccessful bids for funding:

*'Unfortunately we applied for funding from the lottery, but it fell through. But we're not giving up. We're still coming together [...] because we believe that loneliness, isolation, exclusion of older people is a big factor.'* (KI8)

*'The city went for a big lottery bid and we didn't get it, but it brought lots of partners together, and I think we shouldn't give up. You can't win every opportunity, but once you've started something and there's willingness and there's a coalition of thinking, you can build on that.'* (KI9)

- **Seeking alternative resources and looking at commercial models**

Some participants suggested sourcing external funding to address current budget cuts. For example, two participants in management positions recognised that organisations needed to be more commercial in their approach to be able to become sustainable in the long-term. These quotes refer to the current development of apps in their organisation to help carers and family members to interact with people with dementia and to contribute to their social inclusion:

*'I want to sustain it, so I'm now looking at a model that is a commercial model because there's lots of interest in the (anonymised name) from Europe... [...] we're looking at how it can generate an income for us, so that that contributes back and it allows me to sustain the programme in the UK.'* (KI9)

*'Our strategic direction is that we have to be a lot more commercial in our approach because of these funds drying up.'* (KI11)

- **Improving ways of thinking within the older people's community**

Participants reported that budget cuts have forced organisations to use resources more wisely and efficiently. It also forced organisations to implement actions and to re-organise the planning of services. For instance, they had to cut or reduce some activities for older people. One action that was deemed as appropriate was to charge fees for some activities. Some participants, particularly from third sector organisations, reported that to ensure future sustainability they could not be able to provide every activity for free, but they would have required older people to pay a small fee. Hence, some participants suggested the need for changing mind-sets about access to services and activities, not only among organisations but also among older people:

*'There's also very much a sense of expectation on state services.'*  
(KI5)

*'[...] that's a culture change for older people because they've been used to getting services for free in the past, and that's not going to continue, it can't, not with the Council and not with charities [...]. So, they will get some services for free, but...not everyone [...]; the money's not there.'* (KI11)

*'It was never to pay for them things. But now unfortunately you're getting nothing for nothing, no more.'* (KI7)

- **Strengthening project evaluation**

As mentioned previously (Section 5.1.3.1), scarcity of economic and human resources affected the frequency and rigour of project evaluations. However, several participants recognised the importance of evaluation to show the benefits and impact of their projects to funding bodies, and therefore, to have better chances of securing funding:

*'[...] because it's a competitive environment, [...] if I'm competing against five other organisations I want the strongest possible evidence base that says my intervention [...] works, so that the commissioner, when they have to make their decision on quality, [...] they can make an informed decision, so [...] increasing the level of evidence about what works is vital.'* (KI5)

*'I do a lot of evaluations for organisations as well because I know that a lot of them can't...they don't have the capacity to do so. [...] but it needs to be done, because they do so much fantastic work for the community.'* (KI9)

Ways to strengthen project evaluation included using external evaluations and better use of evaluation measures. The most popular scales that were used by participants were the Five Ways of Wellbeing and the Warwick-Edinburgh Mental Wellbeing Scale. As mentioned previously (Section 5.1.3.1), lack of resources was not the only reason for this limited evaluation activity. In fact, challenges in finding suitable

evaluation measures to show an impact were also evident. Related to this, some participants highlighted the need for more training on evaluation methods to be able (i) to conduct more rigorous monitoring and evaluation and (ii) to interpret the results in a way that could help them to show to funders the benefits of their projects on older people.

*'[...] sometimes having an external person come in and evaluate is beneficial, because I'm so emotionally involved, the older men know me so well, they won't respond to me in the way they would someone from the outside, but at the same time, then when I get the evaluation back from someone from the outside, I [...] find it really hard to decipher what the evaluation actually means. (K110)'*

*'So some of the measures I find maybe aren't measuring what people think are important, they're more what professionals think are important.'* (K117)

*'A lot of problems that you'll see with organisations is that they don't have the tools necessary to do the evaluations as such, and it's a big part of the commissioning process that data is captured properly'. (K119)*

#### **5.1.4.2 Addressing internal and wider societal issues**

To address wider societal issues, for example, negative perceptions towards ageing and older people, city stakeholders included solutions to issues that were internal to the services and the City. In the quote below, city stakeholders advocated for a greater involvement of older people in projects and activities:

*'Respect, [...] people need to listen more to older people. We only need to encourage them a little bit more and then we could actually benefit from their wisdom. [...] some of them have the capacity and the time to volunteer, so these are some of the things that could build up the respect of older people, build up their confidence, make them feel more valued.'* (K18)

*'[...] they still have a very important role within the community, [...] so it's not forgetting about people and leaving them in their*

*homes; it's about bringing them out, to encourage them to get involved again. (K14)*

*'A lot of time things are led by professionals who think they know what people need and want, and actually...it doesn't fit with what people really need, so it just makes sense to do it the other way up'. (K117)*

Another suggested way to challenge negative age-perceptions was to not label events specifically for older people:

*'We tend not to label everything for older people, because we don't think that is helpful, but we're always thinking about the diversity of our audience that might come to our events, without labelling it for the older person [...].'(K19)*

Furthermore, organisations in the City needed to have a more holistic view of what was required to make older people feel valued and part of the community:

*'[...] the city needs to take a holistic view to what social inclusion should look like for older people.' (K19)*

Table 30 Summary of the main solutions to perceived barriers to respect and social inclusion in Liverpool City identified by city stakeholders.

Sub-theme	Summary of key findings
<p><b>Specific approaches to overcoming perceived barriers</b></p>	<ul style="list-style-type: none"> <li data-bbox="624 1317 1348 1480">– Improving partnership working and collaboration between organisations were considered appropriate ways to improve information exchange and communication about the services and activities for older people in the City.</li> <li data-bbox="624 1503 1348 1715">– Seeking alternative resources and looking at commercial models (<i>e.g.</i> development of an app to help carers and family members to interact with people with dementia and to contribute to their social inclusion) were suggested as ways to make organisations more sustainable in the long term.</li> <li data-bbox="624 1738 1348 1850">– Participants recognised the need to strengthen project evaluation to show the benefits and impact of their projects to funding bodies.</li> <li data-bbox="624 1872 1348 1953">– Some participants, particularly from the third sector, reported that to ensure future sustainability they would have required</li> </ul>

**Addressing  
wider societal  
issues**

older people to pay a small fee to access their services and activities.

- Ways to address wider social issues represented by the negative age perceptions included more active involvement of older people in project planning in the City and within organisations.

### **5.1.5 Summary of the main findings and conclusions**

These findings have explored the views of city stakeholders in relation to factors that influenced their ability – as individuals and as representatives of their organisations – to promote respect and social inclusion for older people in Liverpool City, also considering some of the wider political, economic and social issues and influences.

- The key enablers included collaboration and partnership working, commitment to involve older people in project planning, and developing targeted interventions that reflect older people's preferences.
- Among the main barriers encountered were impact of budget cuts and reduced service infrastructure, competition for funding for priority services in the City (*e.g.* downstream versus upstream interventions), and negative perceptions towards ageing and older people.
- Improved collaboration between organisations, greater involvement of older people in project planning in the City, and strengthening project evaluation were reported as examples that could overcome some of the barriers to promote respect and social inclusion.

### **5.1.6 Similarities and differences between older people's and city stakeholders' perceptions**

Although I used different methods to explore older people's and city stakeholders' perspectives, the topic that I explored was similar: barriers and enablers to promoting respect and social inclusion, and potential solutions to the

identified issues. At the time when city stakeholders were interviewed, they were not presented with any summary of the older people's views (via the photovoice study). In this section I thereby compare quotes from older people (Chapter 4) and city stakeholders on their views of respect and social inclusion (Table 31). Alongside their quotes, I provide a commentary on the similarities and differences between the views expressed by the two groups.

City stakeholders and older people shared similar concerns about budget cuts, that forced organisations to reduce or shut down some activities and services for older people in the City. Although I did not ask to older people and city stakeholders directly whether they recognised the perspectives of the other group, their quotes suggest that there was some degree of mutual understanding between them. For instance, despite older people were concerned about the consequences that they attributed to government budget cuts (*e.g.* limited access to IT training or closure of local shopping areas), some of them recognised that local policy makers had to make difficult decisions.

Moreover, city stakeholders and older people reported similar perception of the benefits of projects on older people's health and wellbeing. Both expressed very consistent views about the negative perceptions held by the society towards older people, and stressed the importance of recognising older people as a heterogeneous group characterised by different needs and preferences (*e.g.* by developing targeted interventions).

Despite the similarities between the concerns and perspectives of these two groups of study participants, older people and city stakeholders did show more contrasting views on affordability of places and activities for older people in the

City. On one hand, older people expressed a strong sense of appreciation for having free access to some services (*e.g.* free travel pass). Furthermore, they reported cost as a barrier, and the impact that budget cuts had on access to some services (*e.g.* libraries). On the other hand, city stakeholders, particularly from the third sector, reported that in the future, to ensure sustainability they would have required from older people the payment of a small fee. In this regard, third sector representatives reported to be aware of older people's views, and of the impact that this could have on access to services. It is important to note that some of these concerns were not probably perceived by older participants.

Table 31 Similarities and differences of factors promoting and preventing respect and social inclusion according to older people and city stakeholders: key quotes and findings.

Sub-Theme	Older people	City stakeholders	Brief description of findings/commentary
<b>SIMILARITIES</b>			
<b>Impact of budget cuts and competing interests-priorities</b>	<p>‘[...] the community swimming pools in Park Road are closing. Everything that I use is closing...’ (P3, IV)</p> <p>‘The central government are talking about getting rid of the free travel passes, which is a disaster! Not just for me, but all elderly people across the country that use them.’ (P3, IV)</p> <p>‘Libraries are important to the whole community, from little children...up to my age. I’ve used it not only to borrow books, but to study in and to learn computers, because they’re equipped with all sorts of computers...I would hate to see it destroyed. They’re part of the community, and if you destroy them, you destroy part of the community.’ (P18, IV)</p>	<p>‘Liverpool, like a lot of the City Councils, funding is being cut [...], so it’s how older people stack up against cancer, against children [...]. It depends whether it’s perceived as a priority by the people that are making those kinds of decisions really.’ (KI17)</p> <p>‘[...] nobody is looking at the longer game, it’s all short termism, it’s like how do we get from here to next year.’ (K13)</p> <p>‘We can’t have funding; we just can’t believe it. We don’t know what will happen after that [the current funding runs out]. We weren’t successful, which was really frustrating.’ (KI1)</p> <p>‘Within my role the funding we access is never long term [...] ...the best would be for a year, and then another year we struggle to find all the funding and so on’. (KI8)</p>	<p>Older people and city stakeholders showed similar views on the impact of the current budget cuts on their ability to promote respect and social inclusion in the City. Older people raised awareness of some of the consequences that they attributed to government budget cuts, including limited access or closure of libraries, public toilets, local shopping areas, limited IT training. Older participants also felt that closure of amenities was linked to the council’s failure to understand the importance of some facilities (<i>e.g.</i> libraries) for both older people and the whole community. However, the quotes from city stakeholders illustrate that they shared similar concerns about impact of budget cuts, although some of these were not probably perceived by older participants.</p> <p>City stakeholders experienced an environment characterised by tough</p>

Sub-Theme	Older people	City stakeholders	Brief description of findings/commentary
			<p>competition for funding with other organisations; shrinking resources led to short term activities and services; some services were being lost or reduced; and sense of instability and fear of further cuts.</p> <p>Some city stakeholders – particularly third sector organisations – were almost presenting themselves as victims of the budget restrictions.</p>
<p><b>Negative perceptions towards ageing and older people</b></p>	<p>‘A lot of it it’s about feeling valued. I really don’t like being called an old aged pensioner, I ignore them.’ [...] I like the phrase elder. In Australia, we call older people ‘elder’ because they respect them, and I really think that’s missing in English society. (P3, IV)</p> <p>‘Not just in Liverpool, within Western culture, we don’t value older people. It’s almost like that you retire, and you don’t work anymore for money, so you have no value in society; while we have a great deal of resources up here. [...] we have a great deal of knowledge and wisdom that we could pass on young people if they want to listen to us’. (P3, IV)</p>	<p>‘Our society actually devalues older people and sees them as a burden, [...] although there are some improvements...essentially I don’t think growing old is valued in our culture.’ (KI17)</p> <p>‘The challenge is that you want people to value growing old, and that is not what our society is saying to people.’ (KI17)</p> <p>‘Just because we reach a certain age band in our lives that’s classified as being older doesn’t mean that we want to lose our choice and our independence and our ability to even try some new...I think you don’t stop wanting to be engaged and stretch yourself and... just because you’re older, and in fact you’ve actually got more time to do it if you’re retired, so we don’t</p>	<p>Older people and city stakeholders showed consistent views on some macro-societal-level barriers preventing respect and social inclusion in Liverpool City. Negative perceptions and attitudes towards older people prevented city stakeholders’ ability to fully promote respect and social inclusion, as well as older people to fully contribute to the society and feel part of the community.</p> <p>The combination of these societal factors was seen as impacting on the ability of city stakeholders to deliver projects having a wider impact – beyond the service users themselves –</p>

Sub-Theme	Older people	City stakeholders	Brief description of findings/commentary
	<p>‘There is so much talent out there in us, and the older generation. It feels that you stop working now and you have no value, you are not valued for anything after that.’ (P1, FG1)</p> <p>‘I don’t like the way you get on the bus, where there is a man sitting on the seat, and an elderly person standing there, and you won’t get any seat for the elderly person. I think that’s very rude.’ (P2, FG1)</p> <p>‘More respect for older people. I think that’s where we are lacking now. People on buses are very disrespectful, and that’s negative, and not a nice thing to know that the kids today don’t care’ (P21, IV)</p>	<p>think of older people as doing less, we think of older people wanting to do more.’ (KI9)</p>	<p>on the society, culture, and services of the City.</p>
<p><b>Addressing stereotypes of ageing</b></p>	<p>‘First I’ll call them elderly that they’ve got skills: they knit, they sew, [...] and even if they don’t have skills they can be taught by those ones that have got skills and form a nice group and they could make things and sell them in the community, and raise funds for the elderly. [...] you can tell them, ‘get your skills out’ [...].’ (P2, FG1)</p> <p>‘This is Liverpool Cricket club, and this is the oldest cricket club in England. It’s to show other people that you can be in old age and still belong to a club, a sport club and do things... to keep you fit. It takes quite a big</p>	<p>‘Recognising they do have a value [...], just because maybe they’re not part of the labour market any more doesn’t mean they’ve lost value.’ (KI14)</p> <p>‘Respect, in terms of respect, I think people need to listen more to older people. We only need to encourage them a little bit more and then we could actually benefit from their wisdom. And then we could encourage them to volunteer more, some of them have the capacity and the time to volunteer, so these are some of the things that could sort of build up the respect of</p>	<p>Older people and city stakeholders showed similar views on the ways to address stereotypes of ageing and negative attitudes towards older people. Older people suggested to improve the terminology used to refer to older people, and to show to the public various positive examples of older people contributing to the community (<i>e.g.</i> volunteering).</p> <p>City stakeholders, instead, advocated for a greater involvement of older people in projects and activities in the</p>

Sub-Theme	Older people	City stakeholders	Brief description of findings/commentary
	<p>part of my life; I play bowls a couple of times a week [...]. There are lot of my friends, so...you do meet a lot of people there.’ (P12, IV)</p> <p>This’s just an example of using the skills and talent that you have learnt in the past and you can still contribute to the general life of people.’ (P17, IV)</p> <p>‘It’s an extension of my working life [...]; this is a way of giving back to Liverpool community some skills that I have for free. This is a massage chair. Two days a week I do sitting massages for people in a charity in Liverpool. I enjoy working and it helps to keep my skills with my hands as well. I feel very valued, and it’s good for social interaction as well.’ (P3, IV)</p> <p>‘My sewing machine is probably the most important thing that I own. It’s a simple thing that anybody can learn to do because it’s straight sewing and [...] you take a few pieces of material and in a very short time you can have a very useful thing. [...] I do a lot of charity work on this. We’ve adopted an orphanage in Romania and I do a lot of cot covers for this orphanage. [...] I feel that a lot more people could do this.’ (P19, IV)</p>	<p>older people, build up their confidence, make them feel more valued.’ (KI8)</p> <p>[...] They still have a very important role within the community, [...] so it’s not forgetting about people and leaving them in their homes; it’s about bringing them out, to encourage them to get involved again. (KI4)</p> <p>‘Don’t just do tea dances because tea dances are not relevant for every older person, people hold tea dances and bingo and I think for some older people yeah, but not for all, and actually if you think of someone who’s 65, their cultural reference is more the Rolling Stones... [...] and even 70s’ (KI10)</p> <p>‘[...] the city needs to take a holistic view to what social inclusion should look like for older people.’ (KI9)</p>	<p>City as a means to recognise older people’s contribution to the community. They also stressed the importance of recognising older people as a heterogeneous group, and to develop targeted interventions that reflect older people’s preferences.</p> <p>One older participant suggested soup kitchens as an example of an alternative for those who were not interested in joining a community group.</p>

Sub-Theme	Older people	City stakeholders	Brief description of findings/commentary
	<p>‘This is the Soup kitchen, [...] I go every week and [the cook] makes the most gorgeous soup of the house. [...] it makes people who wouldn’t normally come out to get out and meet up with people. I think that meeting with people is very important for our health and wellbeing. Lots of people don’t want to join a club... this is a nice way to have a bowl of soup, and some nice crusty bread, [...] and you can just talk to the people of your table, that’s a very good thing to have and it’s a cheap meal for people!’ (P20, IV) (The Soup Kitchen, Liverpool).</p>		
<p><b>Benefits and impact of projects on older people</b></p>	<p>‘It gives you a reason to go out and this is important. It keeps me lively, it keeps me in touch with people’s lives, [...] it’s just nice having a connection with people [...]. We just have a good laugh! It makes you feeling better... [...] It’s nice seeing what other people are doing, and everyone likes to see what everyone else is doing.’ [...] (P20, IV)</p> <p>‘This is the Knit and Natter group. We do things for charities, which is good. [...] It gives me something to live for, something to look forward to. It gets you out and it’s another reason to get up in the morning. It makes you feel good because we’re all nice people, and we all talk and have ideas together. We help each other.’ (P22, IV)</p>	<p>‘For those 3 hours they’re socially active, they’re engaged, so that’s a real key project at the moment.’ (K13) [dance classes]</p> <p>‘They enjoyed it, they were a little bit achy the next morning, but they said they felt really better for it, yeah. So, we make sure where we can there’s physical activity’ (KI5) [day trip]</p> <p>‘People will say at the social club, [...] “I’ve met so many friends, it’s made such a difference to me, I am getting up, I am getting washed and dressed rather than staying in their nightclothes all day”’ (KI11)</p>	<p>Older people and city stakeholders showed similar views on the perceived benefits of projects on older people’s health. Older people reported a clear sense of enjoyment, feeling valued and welcome. They reported enjoying interacting and sharing an interest with others, and highlighted the aspect of looking forward to taking part in their activities. City stakeholders reported that their service users showed a sense of enjoyment and benefits to health and wellbeing as a result of taking part in the activities.</p>

Sub-Theme	Older people	City stakeholders	Brief description of findings/commentary
	<p>‘That is part of the allotments called ‘the valley’; there are 100 plots all together. I love growing things and I love the company down there. There’re about 12 plots in that little area, and we all work together.... we have fun, we’re a little gang together...and it makes me feel part of something bigger than myself.’ (P18) (Dingle Vale allotment)</p>		

**CONTRASTS**

<p><b>Affordability of places and activities</b></p>	<p>‘This is Liverpool Museum... it’s just a lovely facility. All the museums that we have in Liverpool... they’re all free.’ (P17, IV)</p> <p>‘This is Sudley House. It’s been kept as a 19th century house; it has also very nice art inside. It is free to get in... They also do Shakespeare’s plays in there in the summer. I use it because it’s a local facility for me, and I can walk there.’ (P15, IV)</p> <p>‘The free travel pass helps me to connect with the community that I live in. That’s my travel pass. It allows me to travel across Merseyside for nothing, and doing things that I would not otherwise being able to do.</p>	<p>‘[...] that’s a culture change for older people because they’ve been used to getting services for free in the past, and that’s not going to continue, it can’t, not with the Council and not with charities [...]. So, they will get some services for free, but...not everyone [...]; the money’s not there.’ (KI11)</p> <p>‘It was never to pay for them things. But now unfortunately you’re getting nothing for nothing, no more.’ (KI7)</p> <p>‘There’s also very much a sense of expectation on state services.’ (KI5)</p>	<p>Older people and city stakeholders showed contrasting views on affordability of places and activities for older people in the City. Two main perspectives were identified. Older people expressed a strong sense of appreciation for having free access to art and culture and related activities, highlighting, the component of affordability. Furthermore, older people reported cost as a barrier, and the impact that budget cuts had on access to some services and amenities (e.g. libraries. See quotes in earlier section ‘Impact of budget cuts and competing interests-priorities’).</p>
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Sub-Theme	Older people	City stakeholders	Brief description of findings/commentary
	It saves me about £50 a month [...]. It is very important.' (P3, IV)		City stakeholders, instead, reported that budget cuts forced organisations to cut or reduce some activities for older people. Some participants reported that in the future, to ensure sustainability, they would have required from older people the payment of a small fee. City stakeholders suggested the need for changing mind-sets about access to services and activities, not only among organisations but also among older people.

# **Chapter 6 A CRITICAL REVIEW OF THE PHOTOVOICE STUDY**

## **6.1 Introduction**

In this chapter I provide an assessment of the photovoice methodology based on the present study, rather than a presentation of the findings from photovoice sessions, which were presented in Chapter 4. This chapter has been published in *SSM Population Health*:

Ronzi, S., Pope, D., Orton, L., & Bruce, N. (2016). Using photovoice methods to explore older people's perceptions of respect and social inclusion in cities: opportunities, challenges and solutions. *SSM Population Health*.

I adapted the format of the article to be consistent with the rest of the thesis. The objective of this chapter reflects one of the PhD objectives, that is, to assess the strengths and limitations of photovoice methods to (i) effectively explore features of an urban setting that promote or inhibit older people's perceptions of respect and social inclusion, and (ii) stimulate constructive dialogue between participants and city stakeholders.

## **6.2 Context and purpose of the chapter**

Within the overall study, the photovoice component served to explore older people's perceptions of enablers and barriers to respect and social inclusion in the city, and to encourage them to find solutions to some of the issues identified. It also served to generate dialogue between older people and city stakeholders and to advocate policy change, which was facilitated by the photo-exhibition event.

In previous chapters, I have covered aspects of the photovoice methodology (Chapter 3), and the methods used for data collection and analysis. This chapter presents the most important findings on the opportunities, challenges and solutions of using photovoice methods to meet the objectives of the study. I provide a critical discussion of how the photovoice methods performed in this study, including the impact that ethical procedures had on the application of the method. This discussion is structured as follows: I start by introducing the photo-production process as a way to raise participants' consciousness (Section 6.3.2); then, the factors influencing participants' ability to take photographs are analysed (Section 6.3.3); I conclude with considerations about how to overcome some of the challenges (Section 6.3.4).

## 6.3 Results

### 6.3.1 The photo-production process as a way to raise participants’

#### consciousness

Most participants stated that photovoice stimulated them to effectively engage with the photographs, with the collective discussions offering an opportunity to critically think as a group about various aspects of their city:

*“I have enjoyed the interactions with other people, your focus groups, and it was interesting for me to find things to photograph. I really thought: what is important for me as an older person?” (P3 IV)*

The photo-production process facilitated participants to become more aware of some features of the city which contributed to or prevented their respect and social inclusion, as illustrated by the following quotes and my observations. These quotes illustrate how the photovoice process increased awareness at the individual level, and made participants break with their habitual ways of thinking, and to see beyond what they started to take for granted:

*“It’s the city we have lived in so long! It did make you thinking...” (P13 FG2)*

*“Taking pictures was quite good [...] I had to look at things and I thought ‘what can I do there?’ and it makes you thinking a bit.” (P11 FG2)*

*“It actually made me thinking on what I want from Liverpool as an older person”. (P3 IV)*

Through the photographs, participants identified some barriers to respect and social inclusion in the City, and ways to address some of the issues identified.

An example is shown below, where the participant portrayed a station considered very uncomfortable due to lack of protection from the wind (Figure 89). The participant was concerned about how some aspects of the City were not being considered by local policy makers:

*‘Growing older is not about changing a lot...or being in a transition... but it’s about keeping the opportunities the same for you as they are for everybody else. So things like this (transportation) become very important. As you can see, Liverpool One bus station is completely open, and wind can still get in! We should use the learning from South Parkway station, and apply it to this station, so that you’re behind closed doors, in comfort, while waiting for a bus.’  
(P1) (Liverpool One bus station)*



Figure 89 Example of a perceived barrier to respect and social inclusion (P1; location: Liverpool Bus Station, Liverpool).

In a second photograph (Figure 90) the participant went on to illustrate how this could be remedied and suggested that the local government could make some improvements to the structure, taking inspiration from an accessible and efficient station (South Parkway station).

*‘I am very lucky because I have got all of that near to me, and it gives me access to a lot of options to travel. It just makes it so much easier for people to travel. Once you get inside the building, you’re*

*protected from the weather and the wind, it is very cosy, convenient, and very accessible.” (P1) (South Parkway Railway Station)*



Figure 90 Example of a perceived enabler and solution to respect and social inclusion (P1; location: South Parkway Railway Station, Liverpool).

It would have been difficult to convey the same rich information on what aspects the participant considers important using other qualitative methods such as interviews or focus groups. The photographs provide a deeper level of detail on the context that helps ‘to see’ and explore the participant’s perceptions of the City, and to understand what they are seeing (in these examples). Indeed, in Figure 89 and Figure 90 the participant described the scene to help highlight what aspects were important to him in the photographs (*e.g.* in the first station the glass and canopies are unable to protect users by the wind, while the second station is behind closed doors).

### **6.3.2 Generating a critical dialogue between older people and city stakeholders**

The photographs and accompanying captions also allowed direct communication of what was meaningful to the participants through the photo-exhibition, and attendees highlighted that some participants engaged with visitors in explaining their own photographs:

*“Seeing photovoice participants explain their pictures to other visitors.” (Anonymous attendee)*

The fact that some participants spontaneously explained their photographs to city stakeholders suggested that the photovoice approach had truly engaged participants with the study, and empowered participants’ voices. Related to this, some participants reported a sense of ‘ownership’ over some of the photographs, saying, for example, ‘that was mine’ (no photographs had names). In doing so, the photovoice process stimulated participants to express their perceptions to the attendees.

Some (anonymous) comments provided by attendees on the photo-exhibition reported that the photographs and accompanying captions provided a greater impact than could be achieved with traditional reports. These comments demonstrate an increased awareness at the community level as a result of the photovoice process:

*“The photographs clearly show the life in Liverpool and how older adults engage with it. Fantastic!” (Academic)*

*“An excellent cross-Section of how different people see our city.” (Participant)*

Further (anonymous) comments provided by attendees noted that the photo-exhibition event managed to create a forum where participants, academics and city stakeholders met together to discuss older people's views of the City:

*“Very nice to see an example of research that truly connects the University with its surrounding community.” (Academic)*

*“Getting people from the community, museum, and university together.” (Clinical commissioning group representative)*

### **6.3.3 Factors influencing the participants' ability to take the photographs**

Connected with the photo-production process, and as noted previously, at the interview I asked participants if there were any photographs that the participant wanted to take but that for various reasons they did not take. Most of the participants did not comment on this, and reported that they were able to take all the photographs of enablers and barriers in the City that they wanted to portray. However, a small number of participants reported some challenges in finding suitable images to represent the constructs that they wished to portray, and these were identified during the interviews and the second focus group, as summarised in Figure 91.



Figure 91 Factors reported by participants that can prevent them taking photographs that they want to take, as identified in this study.

### 6.3.3.1 Photographing negative aspects

Overall, participants took more photographs of positive, than negative aspects of Liverpool City. The reasons for taking fewer negative photographs included that participants did not perceive many negative aspects, but also wanted to portray their city in a positive light. In this quote, a participant considered that individuals prefer thinking of positive aspects:

*“We don’t like to think things being negative of course, [...] but there are negative things.” (P13 FG2)*

This might not represent an issue of itself, but if participants were unable to identify negative aspects despite being aware of them, potentially important perspectives of their city would be missed. A connected explanation is that

many participants used photography to promote awareness of various facilities that were available and were contributing to respect and social inclusion in Liverpool.

*“It costs nothing to go to and it’s a very nice, tranquil and beautiful park. I think that should be promoted because people would go and enjoy the gardens.” (P11) (International Festival Gardens, Liverpool)*

In this example the participant used photography to ‘signpost’ a facility, so that more people could be aware of it. Figure 92 further indicates that since some participants wanted to promote awareness of those places for which they recognised a strong sense of pride and identity, this might explain why more positive aspects emerged.

*“Wouldn’t that engender pride in anyone? I think that’s just beautiful. The feel-good factor [...] I think everyone should see how magnificent this place is. Just living in an area that has such buildings is wonderful.” (P20) (Pier Head, Liverpool)*



Figure 92 Example of a perceived enabler to respect and social inclusion. (P20; location: Pier Head, Liverpool).

### 6.3.3.2 Photographing negative social concepts

Some participants reported that they found it most difficult to take photographs of negative social concepts (*e.g.* social isolation) rather than negative physical aspects (*e.g.* rubbish in the street) or positive social concepts (*e.g.* social participation). However, a few participants managed to capture negative social concepts. Figure 93 provides an example of this:

*“This toilet’s not inviting, it’s not accessible...and I’ll be a bit anxious about getting locked in. It’s counterproductive to meeting the needs of older people. Your body is changing and you’ve different needs..., but you need immediate access to clean toilets. It’s against social inclusion. It’s a barrier because no many older people will be confident to go to town if there’re not enough accessible public toilets.” (P1, IV) (Bold Street, Liverpool)*



Figure 93 Example of a perceived barrier to respect and social inclusion (P1; location: Bold Street, Liverpool).

The following quotes show three important ‘social’ concepts identified by three participants at interview and focus group: negative age-perceptions, neighbourhood fragmentation, and social isolation. However, the participants were not able to represent these concepts in a photograph:

*“Not just in Liverpool, within Western culture, we don’t value older people. It’s almost like that you retire, and you don’t work anymore for money, so you have no value in society; while we have a great deal of resources up here. [...] we have a great deal of knowledge and wisdom that we could impart to young people if they want to listen at us”. (P3, IV)*

*‘All the neighbours’ friendship is gone, because you don’t know who is coming to live next door to you... often [...] they come from different towns, and some people don’t want to mix.’ (P4, FG1)*

*‘Isolation is a big problem for older people, especially when their families are moved away. [...] There’re a lot of people whose families have moved away, so unless they belong to something like the church or a group, they can become isolated.’ (P17, IV)*

### 6.3.3.3 Time-period for taking photographs

As noted in Chapter 3 (Section), I discussed with participants the photographs both taken and untaken. This was useful to generate group discussion about some aspects which were not portrayed in the photographs. During the second focus group, I asked participants what they liked least and most about the project. Some participants reported that time constraints were another reason for recording fewer negative and social aspects:

*“Some of the vandalism, which does happen, and just didn’t happen when I had the camera!” (P15 FG2)*

This shows that some participants might have been unable to photograph some negative aspects due to these not happening during the timeframe for taking photographs. Participants reported that they wanted to capture recent episodes of vandalism, not just evidence of past acts of vandalism. This episode stimulated other participants to comment on recent episodes of vandalism in the City, even if they did not take any photograph of it. Even though they did not all identify this as a topic to photograph at the time of the study, it represents an important example in which exploring aspects of photographs not taken (in this case, vandalism) allowed me to identify important concerns that some older participants had about the City. Similarly, the quote below shows that extra time might have allowed more aspects to be portrayed, not just negative aspects:

*“I could have taken hundreds of pictures! [...] some of the museums and the art galleries [...] I would have liked to have told you more about Liverpool in photographs; I may do that anyway for myself.” (P21 IV)*

One week to take photographs was considered an appropriate time to keep participants engaged, and to complete the task. It was also important to ensure that participants remembered clearly the meanings of the photographs, since they were not provided with any journal/diary to act as a prompt.

#### **6.3.3.4 Ethical aspects**

During the photography training the importance of gaining informed consent prior to taking photographs of individuals was stressed (Chapter 3 **Errore. L'origine riferimento non è stata trovata.**, Section). This was successful, as all participants who took photographs of people obtained the required signed consent. However, given that the study explored respect and social inclusion in the urban context, there were not many photographs portraying individuals. In this quote, a participant wished to have captured some aspects of Liverpool spontaneously, without the need to asking consent:

*“I would have liked to take photographs of Liverpool just doing ordinary things without them knowing that I was taking pictures...like someone singing outside one of the big stores... kids dancing in the music.” (P21 IV)*

The requirement for consent might therefore have prevented some participants taking photographs of individuals, and some participants’ perspectives would have been missed.

#### **6.3.3.5 Social expectations related to taking photographs and comfort with using the camera**

Minimum guidance was given concerning what aspects to photograph to avoid influencing participants, and they were left free to photograph aspects that were

most meaningful to them. However, when I uploaded photographs onto a laptop, some participants expressed feelings of anxiety to please, for example saying “I hope that I took the pictures that you wanted”. This relates to wanting to please the researcher by taking photographs of what the participant considers appropriate to show for the project, rather than what the participant perceives as worth photographing.

*“I was thinking to take a picture of my grandson and daughter but then I thought; it’s too obvious! Obviously, they’re important to me...but it’s too obvious so I didn’t take it”. (P3 IV)*

This example shows that the pressure to take the ‘proper’ photographs might have prevented some participants from photographing some aspects that were meaningful to them. Besides, some participants expressed feelings of expectations about their technical ability with the camera, as illustrated by these quotes:

*“I should have taken one of inside [Central library]” (P16, IV)*

*“There could be better pictures of that [International Festival Gardens]” (P12, IV)*

*“The picture just doesn’t do it [Japanese garden] justice, to be honest” (P15, IV)*

One reason for this could be that some participants were not familiar with the use of digital cameras (some of them have never used one before, or the cameras used previously were not digital). Although participants were reassured throughout the research process, the lack of familiarity with digital cameras

might have led participants to feel that taking ‘proper’ photographs was beyond their ability.

### **6.3.4 Overcoming some of the challenges**

#### **6.3.4.1 The ‘missing photographs’**

After the episodes reported above and drawing on the work of Hodgetts and colleagues (2007), during subsequent interviews I explored the participants’ untaken photographs at the interview. This made it possible to identify those aspects that were not photographed (the ‘missing photographs’), and to generate discussion on topics that were not otherwise addressed by the research. In the example below, one participant did not take photographs of barriers to social inclusion, but when prompted to reflect on why, new evidence on this construct emerged:

*“Some of the negative aspects that I thought you can’t take a picture of are: I don’t know my neighbourhoods or [...] of somebody who is isolated or lonely.” (P17 FG2)*

Asking about untaken photographs encouraged one participant to subsequently take the photograph that she had wanted to take (in this case, a tree outside her road that she was caring for). After meeting with the participant to check the captions accompanying each of her photographs, she spontaneously showed me a photograph recorded on her camera of ‘that tree’ mentioned in her interview (Figure 94). She reported that planting flowers surrounding the tree enabled her to speak to neighbours:

*“You were asking how we could make the community better [...]; I felt that by doing that, I was going out into the community to give pleasure to the community [...]. I’ve lived there 41 years, and I’ve*

*spoken to people out there that I'd never spoken to before since.”*  
(P19 IV2)

This quote indicates that exploring untaken photographs can reveal very important aspects that would otherwise not have been available to the research.



Figure 94 Planting flowers around a tree near her home was described by one participant as an example of an enabler to respect and social inclusion (P19).

#### **6.3.4.2 Photography training**

Training in photography was important in addressing other potential challenges. Since I was unsure of how familiar participants were in taking photographs, I selected simple digital cameras with large, clear controls and default automatic operation. I showed them how to use the cameras during the recruitment process and first focus group. I also provided participants with written instructions and a reminder of the photography mission. These steps were important, particularly to reassure those participants who showed some initial ‘scepticism’ about their ability to use cameras.

I reassured participants that I was interested in exploring the ‘stories’ within the photographs, so that they could focus on the content of the photograph, rather than on its beauty. At the end of the study, the initial scepticism felt by some participants turned into a sense of ‘pride’ regarding the photographs taken.

*“Initially I thought: ‘oh no, that does not really apply to me’ ...but actually it did it in so many ways! I thought ‘I would just pass that’, but then I enjoyed!” (P10 FG2)*

*“I think people get frightened of new things, and you’re saying to the group ‘you have to take these photographs and you have to discuss in a group’, and you’re: ‘oh!’, and that’s fear [...] but once we started it was alright.” (P11 FG2)*

These quotes show that the photography training and ongoing support are essential to make participants comfortable with the entire photo-production process.

#### **6.4 Summary of the main findings**

These findings demonstrate the photovoice was effective in meeting the study objectives 5 and 6. There were a number of challenges, however, including anxiety to please, difficulties in photographing negative social concepts, and the need to obtain permission of subjects. Discussing photographs that were not taken, and photography training, could help overcome these challenges.

This study has addressed the limitations in the literature of some of the strengths and limitations of the photovoice process referred to by various authors (Switzer et al. 2015; Hodgetts et al. 2011; Prins 2010; Harley 2012; Evans-Agnew & Rosemberg 2016). This has included whether and how photovoice helped to effectively explore city issues of respect and social inclusion and to stimulate

constructive dialogue between participants and city stakeholders. In addition, this study has identified potential issues and solutions that would be common to other research areas using photovoice methods. This study adds to the current knowledge on CBPR and visual methods used in public health to engage individuals in exploring the urban context, and to encourage individual and community empowerment and policy change. The main issues arising with using photovoice in practice are discussed in more detail in Chapter 7 (Section 7.4).

## **Chapter 7 DISCUSSION**

### **7.1 Introduction**

I start this chapter by providing a summary of the findings in relation to the PhD study objectives. I then go on to synthesise the main findings from the older people and city stakeholder studies, and compare these with the findings from the systematic review. For example, I examine whether there is evidence in the literature that interventions identified as important by the study participants (*e.g.* intergenerational initiatives) can benefit health and wellbeing, and I also identify the gaps in the evidence. This is followed by a discussion of the overall strengths and limitations of the thesis, including opportunities and challenges of using photovoice methods. Subsequently, I provide an analysis of the findings in relation to the literature on Age-Friendly Cities (AFCs) and complex public health interventions. I then highlight the implications for public health policy and practice, the implications for research, and the conclusions.

### **7.2 Key findings with reference to my study objectives**

In this section I provide a summary of the findings in relation to the study objectives, and I explain how I addressed them.

#### **Objective 1:**

**To explore the concept of age-friendliness in terms of respect and social inclusion, including how its meaning may vary in different contexts, and how it may be assessed.**

I sought to address Objective 1 with a narrative synthesis, and the photovoice and city stakeholder studies, which explored an aspect of age-friendliness: respect and social inclusion. The findings from the narrative synthesis and the qualitative component suggest that age-friendliness is context specific, and it is influenced by the interrelationships between domains and the interactions with the wider context. It requires thereby to adopt a system thinking perspective, which can consider the various interactions between the wide-range of components involved in the intervention and its context. Older people and city stakeholders identified specific aspects that could enhance or prevent age-friendliness in the urban setting, which are presented under Objectives 4 and 5.

**Objectives 2 and 3:**

**To clarify the relationships and pathways by which factors in the domain of respect and social inclusion either promote or impair health and wellbeing in older adults in the context of AFCs.**

I sought to address Objectives 2 and 3 with a systematic review of the quantitative and qualitative literature looking at interventions on respect and social inclusion that assessed an impact on health and wellbeing. This systematic review has (i) clarified the likely impact on health of interventions on respect and social inclusion in older people, and the type of outcome measures that have been used, and (ii) contributed to a better understanding of the possible mediating factors to improve health and wellbeing.

A broad range of interventions were identified, focusing on (i) mentoring, (ii) intergenerational initiatives, (iii) dancing, (iv) music and singing, (v) art and culture, (vi) information and communication technology, and (vii) multi-activity

programmes. Positive and negative impacts were reported on a range of health outcomes including psychological outcomes (depressive symptoms, perceived stress, and mental health), physical health and subjective health, quality of life and wellbeing, chronic pain and falls.

There are some indications that intergenerational initiatives and those based on music and singing may have a positive impact on psychological outcomes, wellbeing, subjective and physical health of older people. However, the evidence for other types of intervention – mentoring, dancing information communication technology, art and culture, and multi-activity initiatives – was more limited and inconclusive. Qualitative studies were linked to and complemented the quantitative evidence, and provided insightful information on the possible mediating factors in the pathways (*e.g.* improved self-esteem and social relationships) to improved health and wellbeing.

**Objective 4:**

**To explore perspectives of older people on aspects that promote and inhibit respect and social inclusion in Liverpool City and, what may be required to strengthen this.**

I used a photovoice study to address Objective 4, wherein older people used photography for documenting their perceptions, and critically discussed the issues of respect and social inclusion that were of importance to them in individual and group discussions. The photovoice approach, including the photo-exhibition, was well-suited to bringing older people and stakeholders together, and to discussing the way forward for respect and social inclusion in the City. Physical environmental features were crucial in older people's perceptions of

respect and social inclusion, including access to green spaces, train and bus stations, public toilets, and libraries. Conversely, disrespectful attitudes towards the elderly and the city itself, and a poorly maintained neighbourhood were seen as detrimental to their respect and social inclusion. Potential solutions to some of these issues emerged.

**Objective 5:**

**To explore the factors which influence the ability of city stakeholders to promote respect and social inclusion for older people in Liverpool City.**

I sought to address Objective 5 of this thesis with a qualitative study using semi-structured interviews with local policy makers, service providers, and third sector representatives with an interest in older people. The main enablers included collaboration and partnership working, and development of interventions that reflected older people's needs. Barriers comprised impact of budget cuts and reduced service infrastructure, competition for funding for priority services in the City, and negative perceptions towards older people and growing old. City stakeholders suggested a greater engagement with older people and with organisations, and strengthening project evaluation to improve respect and social inclusion in Liverpool City.

**Objective 6:**

**To assess the strengths and limitations of photovoice methods to (i) effectively explore features of an urban setting that promote or inhibit older people's perceptions of respect and social inclusion, and (ii) stimulate constructive dialogue between participants and city stakeholders.**

I reviewed my experience of implementing the photovoice study, including data from participants and my field notes about the process, to address Objective 6. The findings demonstrate that photovoice enabled the dissemination of personalised relevant knowledge as well as stimulating dialogue between participants and city stakeholders at the photo-exhibition. The photo-exhibition aimed to advocate policy change around concerns and priority issues identified by participants by bringing these to the attention of city stakeholders, so that participants' views may be included in decision making and planning processes. The main challenges experienced by older people included photography of negative and social concepts, and anxiety when taking photographs due to (i) expectations of what is a 'proper' photograph, and (ii) the need to obtain consent from subjects who might have been featured in the photos. Discussing photographs that were not taken, and photography training, could help overcome these difficulties.

**Objective 7:**

**To compare the perspectives of city stakeholders and older people on key priorities for promoting respect and social inclusion – and thereby health and wellbeing of older people – in the context of current research evidence.**

I used a synthesis table to address Objective 7, wherein I examined whether there is evidence that interventions and actions (*e.g.* intergenerational initiatives) proposed by older people and city stakeholders were also supported by evidence of improving health and wellbeing. The synthesis has shown that there have been no evaluations of the health/wellbeing impact of some of the most important aspects for respect and social inclusion identified by the older people and/or city

stakeholders (*e.g.* attempts to promote affordability and accessibility of green spaces and transportation). Moreover, although city stakeholders appeared to understand some of the important views of older people and vice versa, city stakeholders' views were more driven by their need to address budgets constraints.

### **7.3 Overall synthesis**

To inform public health policy, it was important to cross-check if there is evidence of impact on health and wellbeing that supports older people and city stakeholders' perspectives of what is important for promoting respect and social inclusion, and – equally important – to identify where evidence about issues raised by participants is weak or absent (Table 32). As I explain in Section 7.6, the synthesis has shown that there have been no evaluations of the health/wellbeing impact of some of the most important aspects for respect and social inclusion identified by older people and/or city stakeholders. For instance, the complete absence of studies examining the health impact of improving access to public toilets in the city centre, or the affordability and accessibility of green spaces and transportation, suggests that these aspects have not yet been tested as interventions on respect and social inclusion in older people.

As a result, Table 32 seems to suggest that more evidence is required on how to intervene in the domain of respect and social inclusion (WHO 2007). For example, transport is very important for older people to access some of the services/facilities that have been tested (*e.g.* art and culture). Findings from Table 32 further support the overall inter-relationships and influences between the different domains of an AFC. A change in transportation, for instance, is

likely to affect the domains of respect and social inclusion, and social participation. When studying the health impact of AFC initiatives, researchers need to examine the overall ‘system’ in the urban setting, if they are to understand how these interventions can benefit all older people, and not just those who are involved in a project. The implications for public health policy and research of these findings are discussed in Sections 7.6 and 7.7.

Moreover, some of the issues emerging from the photovoice study were not identified by city stakeholders (*e.g.* the importance of museums and art galleries), and this is reflected in Table 32 . Although at the time when city stakeholders were interviewed, they were not presented with any summary of the older people’s views (via the photovoice study) or asked to comment on the issues identified by older people, it is still instructive to see the results from city stakeholders’ interviews as a reflection of what they did or did not identify as important for achieving respect and social inclusion for older people in the City.

Table 32 Synthesis table of the main findings from this PhD research. OP= Older people.

<b>Photovoice study with OP</b>	<b>Study with city stakeholders</b>	<b>Systematic review</b>	<b>Commentary</b>
<b>Key issues identified by older people through PV study</b>	<b>Key issues reported by city stakeholders in interviews</b>	<b>Is there (qualitative and/or quantitative) evidence of this?</b>	<b>Key conclusions and implications</b>
<p>Older people identified some places (<i>e.g.</i> green and blue spaces, libraries, and leisure centres) that enabled them to interact and mix with young people, and were very important for their social inclusion.</p>	<p>City stakeholders emphasised the importance of developing initiatives to foster intergenerational interactions.</p>	<p>Intergenerational initiatives were identified in this review and findings seem to suggest that these may have a positive impact on psychological outcomes, wellbeing, subjective and physical health of older people. Activities included reading picture books to children, and assisting young people in school activities.</p>	<p>Intergenerational initiatives have been identified as important aspects for respect and social inclusion by older people, city stakeholders, and in this review. However, older people and city stakeholders did not refer specifically to the kind of projects tested in the studies included in the systematic review. For instance, older people referred to places (<i>e.g.</i> green spaces) that created a supportive environment to meet and interact with young people. Despite some discordance about the specific activities that should be promoted, the findings suggest a degree of common understanding and supportive evidence which recommends that initiatives that promote intergenerational interactions should be one key element of an AFC.</p>

<b>Photovoice study with OP</b>	<b>Study with city stakeholders</b>	<b>Systematic review</b>	<b>Commentary</b>
<b>Key issues identified by older people through PV study</b>	<b>Key issues reported by city stakeholders in interviews</b>	<b>Is there (qualitative and/or quantitative) evidence of this?</b>	<b>Key conclusions and implications</b>
Green and blue spaces were identified as places to meet with other people and do physical activity, which were linked with a perceived sense of wellbeing felt by participants.	City stakeholders did not identify this issue, although some third sector representatives reported that organised day-trips were a valuable activity for older people.	Studies including an assessment of initiatives on green and blue spaces were not identified in this review.	Whilst older people identified green spaces as very important enablers to their social inclusion, these seem to have not yet been tested as interventions on respect and social inclusion, and were not identified by city stakeholders as important. However, the findings from the photovoice study suggest that initiatives that promote accessibility of green spaces should be one key element of an AFC.
Museums and art galleries were identified as places to cultivate interests and learning opportunities, and to socially interact with other people.	Only city stakeholders working in the art and culture sector reported the importance for older people of engaging with art.	Few studies were available on interventions on art and culture initiatives. These found an effect on depressive symptoms and anxiety. Findings were mixed for the studies looking at quality of life outcomes, making it difficult to draw any conclusion. Studies including an assessment of initiatives promoting access to museums were not identified in this review.	Art and culture initiatives have been identified as important aspects for respect and social inclusion by older people, and in this review. Although art and culture initiatives were identified only by a few city stakeholders as important, the findings suggest that they should be one key element of an AFC. Further research should examine the health/wellbeing impact of initiatives promoting access to museums.

<b>Photovoice study with OP</b>	<b>Study with city stakeholders</b>	<b>Systematic review</b>	<b>Commentary</b>
<b>Key issues identified by older people through PV study</b>	<b>Key issues reported by city stakeholders in interviews</b>	<b>Is there (qualitative and/or quantitative) evidence of this?</b>	<b>Key conclusions and implications</b>
Older people identified libraries and book clubs as places to cultivate interests, and learning opportunities.	City stakeholders did not identify this issue.	Studies including an assessment of initiatives promoting access to libraries and book clubs were not identified in this review.	Older people identified libraries and book clubs as very important enablers to their social inclusion. However, city stakeholders did not identify these as important. Initiatives promoting access to libraries and book clubs seem to have not yet been tested as interventions on respect and social inclusion. Therefore, future research should assess the health/wellbeing impact of these initiatives.
Older people identified poor accessibility and lack of public toilets in the city centre as one of the most important barriers to their respect and social inclusion.	City stakeholders did not identify this issue.	Interventions aiming to increase access to public health toilets suitable for older people in the city centre were not identified in this review.	Whilst older people identified access to public toilets in the city centre as a priority for their social inclusion, city stakeholders did not identify these as important. Interventions aiming to increase access to public health toilets seem to have not yet been tested as interventions on respect and social inclusion. However, the findings from the photovoice study suggest that these interventions should be

<b>Photovoice study with OP</b>	<b>Study with city stakeholders</b>	<b>Systematic review</b>	<b>Commentary</b>
<b>Key issues identified by older people through PV study</b>	<b>Key issues reported by city stakeholders in interviews</b>	<b>Is there (qualitative and/or quantitative) evidence of this?</b>	<b>Key conclusions and implications</b>
			one key element of an AFC, and further research should examine their impact on health and wellbeing.
Older people identified accessibility of train and bus stations, and affordability of transportation options as key enablers for their social inclusion and participation in the city.	City stakeholders considered limited mobility of older people in delivering their projects. For example, some third sector organisations provided free transport to older people with limited mobility, to enable them to attend to their events.	Interventions aiming to improve access to bus and train stations and affordability of transportation were not identified in this review.	Whilst older people identified accessibility and affordability of transportation as very important enablers for their social inclusion, these seem to have not yet been tested as interventions on respect and social inclusion. Due to the lack of good transport options for people with limited mobility, some city stakeholders reported to provide free transport to enable older people to access their activities. The findings suggest that these interventions should be one key element of an AFC, and further research should examine their impact on health and wellbeing.
Older people reported that cultivating interests, and engaging with others were very important for their respect and social inclusion. They reported that attending	City stakeholders – particularly third sector representatives – reported various activities that they were delivering to older people ( <i>e.g.</i> dancing, multi-activity	Singing and music initiatives, dancing, and multi-activity initiatives were identified in this review as interventions on respect and social inclusion. Findings seem	Whilst older people and city stakeholders recognised the importance of activities that could enable older people to socially interact and cultivate interests, this

Photovoice study with OP	Study with city stakeholders	Systematic review	Commentary
Key issues identified by older people through PV study	Key issues reported by city stakeholders in interviews	Is there (qualitative and/or quantitative) evidence of this?	Key conclusions and implications
community centres created a space for social interaction, which was linked with a perceived sense of wellbeing. Other activities included playing sport, and doing gardening.	interventions, and walking groups). However, city stakeholders reported that shrinking resources led to short term planning of activities and services; some services were being lost or reduced; and there was a sense of instability and fear of further cuts.	to suggest that singing and music interventions may have an impact on psychological outcomes, wellbeing, subjective and physical health of older people. Few studies were available on dancing showing an effect on depressive symptoms. Findings were mixed for falls outcomes, making it difficult to draw any conclusion. Few studies were available on multi-activity initiatives, showing an effect on mental health, perceived stress, subjective health. Findings for wellbeing were mixed, making it difficult to draw any conclusion.	review has shown that only some of these initiatives – music and singing – were found to benefit older people’s health and wellbeing. The findings suggest that these interventions should be one key element of an AFC, but further research should assess the health/wellbeing impact of dancing and multi-activity initiatives.
Older people reported to be involved in various volunteering (e.g. arranging flowers in the church). They suggested that to address negative perceptions of older people it was important to show to others the various ways in which older people can contribute to the community.	City stakeholders – particularly third sector representatives – reported that some older people were volunteers in their organisations, and they were very important for the development of their organisations. However, they reported that shrinking resources led to short term planning of activities and services; some services were	Multi-activity initiatives were identified as interventions on respect and social inclusion in this review, but only a few studies were available showing an effect on mental health, perceived stress, and subjective health. Findings for wellbeing were mixed, making it difficult to draw any conclusion.	Volunteering was identified as an important aspect for respect and social inclusion by older people and city stakeholders. The findings suggest that these interventions should be one key element of an AFC, but further research should assess the health/wellbeing impact of multi-activity initiatives.

<b>Photovoice study with OP</b>	<b>Study with city stakeholders</b>	<b>Systematic review</b>	<b>Commentary</b>
<b>Key issues identified by older people through PV study</b>	<b>Key issues reported by city stakeholders in interviews</b>	<b>Is there (qualitative and/or quantitative) evidence of this?</b>	<b>Key conclusions and implications</b>
	being lost or reduced; and it created a sense of instability and fear of further cuts.	Only volunteer activities related to respect and social inclusion met the inclusion criteria of the review.	
Older people reported that having churches, health centres, shops, coffee shops, and community centres available were very important for their respect and social inclusion. These were defined friendly and welcoming, and as a source of support.	Third sector representatives reported perceived benefits of their projects conducted in community centres on older people's health and wellbeing.	Studies including an assessment of initiatives aiming to improve access to churches, health centres, shops, coffee shops, and community centres were not identified in this review.	Whilst older people identified access to churches, health centres, shops, coffee shops, and community centres as very important enablers for their social inclusion, these seem to have not yet been tested as interventions on respect and social inclusion. Third sector representatives identified community centres as important for older people's respect and social inclusion. The findings suggest that these interventions should be one key element of an AFC, but further research should assess the health/wellbeing impact of these initiatives.
Whilst older people reported the they were interested in passing on their skills ( <i>e.g.</i> sewing) to the younger generation, they did not	City stakeholders did not identify this issue.	Mentoring interventions were identified as interventions on respect and social inclusion in this review. Only a few studies were	This review identified mentoring interventions as interventions on respect and social inclusion. Whilst older people reported to be

Photovoice study with OP	Study with city stakeholders	Systematic review	Commentary
Key issues identified by older people through PV study	Key issues reported by city stakeholders in interviews	Is there (qualitative and/or quantitative) evidence of this?	Key conclusions and implications
raise the issue of mentoring initiatives as important for their respect and social inclusion.		available, and neither study found an effect on health outcomes.	interested in passing on their skills ( <i>e.g.</i> sewing) to the younger generation, they did not raise the issue of mentoring. Also, city stakeholders did not identify mentoring interventions as important. Further research should assess the health/wellbeing impact of mentoring initiatives.
Older people reported that IT skills (and IT training) could enable them to stay connected with family and friends who lived at some distance from them. They considered the Internet as a way to feel integrated in the community and to maintain independence, despite their physical limitations. Some older people reported that IT training was often delivered by libraries and community centres.	City stakeholders considered IT training very important to older people. Various third sector representatives reported to providing free IT training to older people. Others were involving older people in the development of apps that could help carers and family members to better interact with other people with dementia.	Information-Communication Technology interventions were identified as interventions on respect and social inclusion in this review, but only a few studies were available showing an effect on depressive symptoms, anxiety, and mental health. Findings were mixed for quality of life outcomes.	Information-Communication Technology interventions have been identified as important aspects for respect and social inclusion by older people, city stakeholders, and in this review. The findings suggest that these interventions should be one key element of an AFC, but further research should assess the health/wellbeing impact of these initiatives. A systems approach ( <i>e.g.</i> as for interventions promoting access to transportation and green spaces), may help to understand the role of IT within the domain of respect and social inclusion, which may benefit health of older people.

<b>Photovoice study with OP</b>	<b>Study with city stakeholders</b>	<b>Systematic review</b>	<b>Commentary</b>
<b>Key issues identified by older people through PV study</b>	<b>Key issues reported by city stakeholders in interviews</b>	<b>Is there (qualitative and/or quantitative) evidence of this?</b>	<b>Key conclusions and implications</b>
Older people identified the benches at the bus stop and adequate seating at the train/bus station as spaces that enabled informal interactions and contributed to their social inclusion.	City stakeholders did not identify this issue (or public seating in general).	Interventions assessing the impact of increasing benches (public seating) in public spaces were not identified in this review.	Whilst older people identified benches at the bus stop as very important for social interactions, and as enablers for their social inclusion, these seem to have not yet been tested as interventions on respect and social inclusion. City stakeholders did not identify benches and adequate seating in public spaces as important for older people's respect and social inclusion. Further research should assess the health/wellbeing impact of interventions increasing public seating in public spaces.

## **7.4 Strengths and limitations of this research**

### **7.4.1 Strengths**

- **Triangulation of data sources**

As noted in Chapter 1, among the key elements necessary to the further development of AFCs are (i) an active involvement of older people in planning processes; and (ii) the need for more evaluation research to assess the health and wellbeing outcomes of AFC initiatives (Buckner et al. 2016; Goldman et al. 2016; Beard & Bloom 2015).

A key strength of this research is that it has used a triangulation of different sources of evidence – older people’s perspectives; city stakeholders’ views; and a systematic review of intervention evidence – to advance our knowledge on development and evaluation of AFC initiatives, and our understanding of evaluation of complex interventions. These sources brought together different perspectives on a wide range of issues related to promoting respect and social inclusion in an aspiring AFC (Liverpool). The findings have also summarised the extent, quality and results of studies examining the impacts on older people’s health and wellbeing of various interventions aimed at strengthening respect and social inclusion.

- **Applying a rigorous approach to a complex review topic**

In the systematic review, I adopted a rigorous approach to address a complex topic and the set of inter-related research questions on respect and social inclusion which I deemed appropriate to move this field forward. By drawing on both quantitative and qualitative evidence, I was able to address the scope of the

systematic review in a more comprehensive manner, covering both the effectiveness of relevant interventions fostering respect and social inclusion (primarily quantitative evidence), and the mediating factors to improve health and wellbeing outcomes (primarily qualitative evidence). Despite the complexity involved in synthesising this broad set of studies, I feel that this approach has led to a better overall understanding of the current evidence base on interventions on respect and social inclusion in older people than would have been possible using either quantitative or qualitative evidence alone (Petticrew 2015).

- **Participation of older people and dialogue with city stakeholders**

The Community-Based Participatory approach – using photovoice methods – builds on the principles developed by the WHO (2007) in the AFC framework – which advocates for an active involvement of older people in decision making processes within their neighbourhoods (WHO 2016a; Buffel 2015; Gubrium & Harper 2013; Moulaert & Garon 2016).

This approach culminated with a photo exhibition where two groups (public and professionals) represented by older people and community members, and city stakeholders, were brought together to engage in meaningful discussions on the way forward for respect and social inclusion in the Liverpool City. The direct quotes from participants and feedback from attendees resulted in an increased awareness at the individual and the community level as a result of the photovoice process (Warren 2005; Evans-Agnew & Rosemberg 2016; Sanon et al. 2014; Foster-Fishman et al. 2010). Furthermore, the photovoice study impacted on the individual empowerment, because at the photo-exhibition participants

spontaneously engaged with city stakeholders and other attendees in explaining their own photographs and stories (Warren 2005) (Chapter 6).

- **Added value of the photovoice methods**

A crucial requirement of photovoice studies is to dedicate time and commitment to build a trusting relationship with both gatekeepers and participants (Catalani & Minkler 2010). As shown by my reflexivity notes taken during the photovoice study, building a trusting relationship with older people from disadvantaged geographical areas was more challenging, and required more time than for the better-off participants. In more affluent areas I found a more immediately welcoming environment. People were generally happy to speak to me from the beginning of the study, and it was much easier to initiate conversations. By contrast, in one group from a disadvantaged area, older people were more sceptical about the research, and were less willing to engage with me in conversations. Here, the help of gatekeepers was essential. In fact, they advised me to attend their weekly meetings to start building informal interactions prior to the recruitment. Although it was something that I had planned to do, it emerged as a critical step to build a trusting relationship with these participants. Gatekeepers advised me on other aspects of the data collection process, for example, preferred times and days to conduct the focus groups. The support from gatekeepers, with their 'insider' perspective, contributed to the effective completion of this study. By the end of the research, I had developed a close relationship with many of the participants. This appeared evident when, at the end of the second focus group (with group 4), participants gave me a thank you card with two homemade scarfs. The episode made me realise that they enjoyed

and valued the study, and that I changed from being a complete outside observer to a marginal member in their community, a process referred to by Malone (2003).

- **Increased awareness and access to multiple levels of knowledge**

As illustrated in Chapter 6, the photovoice process facilitated participants in acquiring a greater consciousness of their perceptions, and led them to become more critical of the of features of the City contributing to or preventing respect and social inclusion (Novek et al. 2011). This highlights one of the strengths of photovoice, wherein the visual element invited participants to actively engage with the photographs, and the discussions offered an opportunity to think critically as a group, and to propose some solutions to the issues that they identified (Carlson et al. 2006; Wright 1999).

Photovoice brought to the surface older people's experience and views about what was most important for their respect and social inclusion in their City. It can therefore enable to uncover the 'hidden things that are important to people', which we may not be able 'to see' solely through interviews or focus groups. This seems to be an additional strength that the use of photovoice methods has brought to the overall study.

The findings from this study have shown how photovoice methods allowed to access multiple levels of knowledge (Figure 95). Participants' perceptions are not confined to the photographs that were taken with exploration of the 'missing photographs'. This emphasises the potential of photos when complemented by thorough interviews. Sanders (2001) and Visser *et al.* (2005) explained how

different levels of knowledge can be accessed by different research methods. They distinguish between ‘conventional techniques’ (*e.g.* interviews), and ‘generative techniques’ (*e.g.* drawings) calling the first ‘explicit knowledge’, providing a context for the second. Thus, users can use generative techniques (drawings), and then can discuss their meanings, allowing them to gradually express not only the ‘observable knowledge’ (*e.g.* the drawing itself), but some deeper levels of the knowledge. Those levels are the ‘tacit knowledge’ – knowledge difficult to express in words, and ‘latent knowledge’, which individuals are not conscious of.

The combination of different methods in photovoice allowed me to access a broader and deeper level of knowledge, gaining a greater comprehensiveness of understanding of the topic from the participants’ point of view (Barbour 2001). As mentioned in Chapter 6, the issue of the ‘missing photos’ would not have emerged without engaging people in the photovoice project. It is therefore a product of bringing the interviews/focus groups and photographs together. Figure 95 illustrates conceptually the interrelationships between the domains of knowledge that can be accessed through photovoice methods.

A part of the ‘explicit knowledge’ is accessible through other methods (*e.g.* structured questionnaires) which can be expected to identify some of the issues that emerge from the photographs and interviews. The same applies with a part of the ‘observable and tacit knowledge’ (*e.g.* accessible through drawings), and from field work notes, which relate to aspects of what participants express or are unwilling to express. However, part of the ‘tacit knowledge’ and the ‘latent knowledge’ are hidden to the researchers and perhaps can never be accessed

fully, either through barriers (reluctance, social expectations) or as individuals (study participants) are not yet aware of it.

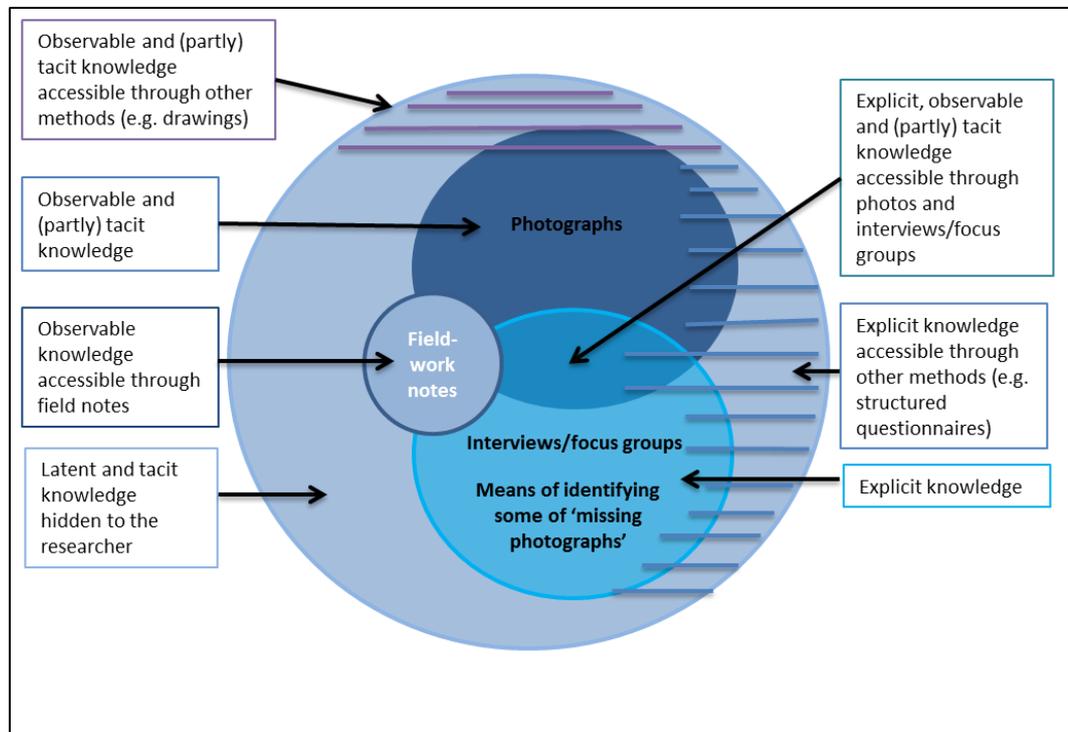


Figure 95 Conceptualisation of the different levels of knowledge that can be accessed through photovoice methods. Adapted from Visser *et al.* (2005) to reflect my observations in the light of theoretical work (from literature) on these domains of knowledge. Photographs have been added as an example of generative techniques; other methods that can be used to access explicit knowledge – not part of photovoice – have been acknowledged (*e.g.* questionnaires).

- **Challenges and solutions**

As reported in Chapter 6, some of the participants expressed anxiety in taking what they perceived to be ‘proper’ photographs. Evans-Angnew & Rosemberg (2016) have raised the issue of the influence that researchers can have over the participants’ choice of photographs. This aspect needs to be considered, as participants may want to please the researchers by taking photographs that reflect more what [they believe that] the researchers would like to see, rather than the

participants' own experience. In a study conducted by Prins (2010) some participants reported being indecisive on what to photograph, and being embarrassed to be seen taking photographs by other community members. This either stopped them taking photographs, or involved participants asking others (*e.g.* relatives) to take photographs for them. However, this study took place in a rural community characterised by post-war fear and mistrust, and taking photographs might have been seen as a violation of local social norms. In the current study, some participants raised concerns due to their social expectations for taking photographs and comfort using the camera. Therefore, ensuring participants are comfortable with the photo-production process is important.

Some of my participants faced challenges in photographing negative social concepts. Previous studies have attempted to overcome this by encouraging participants to take photographs of both physical and social aspects of their cities (Novek et al. 2011). In their paper, Novek *et al.* (2011) reported that older people photographed more tangible aspects, but also social aspects of the city were portrayed (*e.g.* vandalism). In the current study, participants captured some similar social concepts (*e.g.* intergenerational relationships and safety issues in the neighbourhoods). However, the main challenge for our participants was capturing negative social concepts rather than positive ones. Although Novek *et al.* (2011) described many positive social aspects of the urban setting, and some negative physical aspects (*e.g.* cracked sidewalk surfaces), they did not discuss the issue of barriers experienced by older people in portraying negative social issues. This may partly be due to their much more diverse photography mission, which aimed to capture age and non-age-friendly features in the urban setting.

The current study focused on features of respect and social inclusion in the city – which included an important focus on the social environment.

In the present study, most of the negative and/or social aspects not taken in photographs emerged during the interview, when I asked participants if there were photographs that they wanted to take but that for various reasons they did not. Based on this study, I argue that exploring untaken photographs reflects more an individual experience that can be discussed at the individual interview. However, exploring untaken photographs can also help to generate group discussion. In this study, this emerged when, in the focus groups, some participants reported that more time would have allowed them to take some photographs of specific aspects of the City (*e.g.* vandalism) that they wanted to take. This prompted other group participants to discuss related topics. Therefore, exploring untaken photographs can: (i) encourage the participant to reflect a more personal experience at the interview; and (ii) stimulate discussion in focus groups about aspects not identified in the photographs and/or in participants' narratives. In this study, discussing photographs that were not taken with participants ensured that I covered views on respect and social inclusion which were not captured in the photographs, and helped to identify potential limitations of the method as used. This approach was recommended by Hodgetts *et al.* (2007) – who advised that researchers using photovoice methods should also incorporate this aspect in their methodology.

In this study, time constraints were reported as another reason for identifying fewer negative and social aspects. Since participants did not use diaries/journals that could act as a prompt, I considered that one week would be sufficient time

to complete the task. A review by Catalani & Minkler (2010) reported that the most participatory photovoice studies engaged with participants in several cycles of taking photographs and discussions. This can be a way of addressing time constraints and participants' difficulties in taking certain photographs. However, given the context of this study, it was not my intention to pursue an extended process of cycles of photographs and discussions, and this was based on a combination of pragmatic reasons. This study aimed to create a platform to encourage dialogue between older people and city stakeholders; and to bring older people's views to the attention of city stakeholders so that they could include the older people concerns in decision making processes. I also wanted to minimise the risk of drop-outs, given various chronic and mobility issues experienced by participants. Maintaining older people's involvement in the long term throughout the study can be challenging, and this aspect has been raised by Novek *et al.* (2011) as well. I was aware that a longer time for photo sharing may be desired. However, as this research incorporated a study of city stakeholder perspectives, I prioritised a photo sharing event where participants, city stakeholders, researchers, and the public, could come together and initiate a collective dialogue to achieve an impact on AFC policy.

In this study, the photography training addressed some of difficulties experienced in the photovoice process. These included social expectations related to taking photographs and comfort using the camera, and ethical implications related to asking written consent to individuals appearing in the photographs. In their review, Catalani & Minkler (2010) reported that the most participatory photovoice studies had intense photography training. For example,

participants can be taught how to photograph challenging social issues. However, focusing on a particular way of taking photographs may alter the participants' ability to discover further ways to observe the world and learn photography through practice. In their discussion of the importance of covering technical and ethical aspects of photovoice, Wang & Burris (1997), stressed that participants should continue to improve their abilities, confidence and understanding through the photovoice process, rather than through more intensive training. I took the view expressed by Wang & Burris (1997) that photographic training on ethical aspects and using the cameras is essential, but should limit the influence of the researchers over the choice of photographs taken by participants (*i.e.* it should keep to a very general 'photographic mission').

Many authors have discussed ethical considerations for CBPR and visual methods (Banks & Armstrong 2012; Wang & Redwood-Jones 2001; Rose 2012b; Evans-Agnew & Rosemberg 2016). Harley (2012) and Evans-Agnew & Rosemberg (2016) noted that many photovoice papers did not provide adequate description of the ethical process for participants and researchers. In the present study, I carefully discussed ethics and consent with participants. Wang & Redwood-Jones (2001) have suggested that training should cover rules on images ethics. Therefore, clarifying, as part of the training, the 'rules' on when consent is needed (*e.g.* individual or group is 'featured') and when not (where people can be regarded as a crowd), might allow participants to take photos of topics involving people more easily.

#### **7.4.2 Limitations of this research**

- **Generalisability**

Given that the city stakeholder and photovoice studies were conducted within a single geographical area, Liverpool City, the generalizability of the findings from these studies may be somewhat limited. However, as I explain in the following Section 7.5, I related the findings from Liverpool to the wider literature, and many of the aspects identified by city stakeholders and older people reflect many issues and opportunities identified by the WHO in the *World report on Ageing and Health* (WHO 2016b), and by the Government Office for Science (2016) in the *Future of an Ageing Population report*.

- **Gender balance and time available for the photovoice study**

One potential limitation of the photovoice study is the gender imbalance in the sample (males: 7; females:19). A review by Catalani & Minkler (2010) however, reported that most of the photovoice projects (78% of 46 studies) recruited a greater number of female groups. This reflects both the greater proportion of women in the population aged 65 and over in the UK (Office for National Statistics 2015), and that women might be more inclined to participate in community groups. In this study, for instance, one group was recruited from a grassroots organisation that had a greater prevalence of females attending their activities, with only a few men who attended occasionally. This was specifically reflected in the sample for group 4, which was constituted only by females (Chapter 4, Section 4.2, Table 21). In this study, however, the guiding principle for recruiting participants was to have a mix of included and less included

participants, rather than focusing on gender differences. Although the findings might reflect a more female perspective, data were considered sufficient to allow me to explore the depth of the topic under study, and to address study objectives 4 and 6.

When exploring some of the reasons for not taking part in this study, some women reported that they did not take part in this study because of the use of digital cameras. Some did not feel comfortable in managing a digital camera due to inexperience and arthritis in their hands. Some others felt that ‘going around the city and taking photographs’ was a too demanding commitment that they could not devote due to health issues. This aspect has been found in previous photovoice studies involving older people as well (Novek et al. 2011; Ronzi 2013). Therefore, some important information may have been missed.

If more time were available, this could have been used for additional participation in different phases of the photovoice study. For example, older people could have been involved in the data analysis and in further dissemination of the findings. On that second point, it would have been useful to carry out more detailed feedback on the older people’s views with city stakeholders, after the organisation of the photo-exhibition, for example by organising face to face meetings with each stakeholder. Moreover, older people had limited time available to take photographs (1 week), which had to be balanced against goal of keeping participants engaged and the ideas behind their photographs fresh, and working to develop the engagement event through the exhibition.

- **Follow-up with city stakeholders**

Time and other factors also constrained opportunities to make the most of the city stakeholder study. At the outset, I had planned to meet the stakeholders on two occasions. The first meeting was the interview. The second was originally planned to take place once both the systematic review and the study with older people were completed, with the aim of discussing the research findings. However, due to the limited availability of stakeholders, it was difficult to organise a second meeting with each participant only to go through the study results (in addition to the photo-exhibition to which they were invited to attend). Hence, I agreed with each participant that I would have circulated a report illustrating the findings at the conclusion of this PhD research. This approach worked well, as many of the invited stakeholders attended the photo-exhibition. Moreover, I attended several events in the City throughout the course of this research, and this has allowed me to meet some of the city stakeholders that I interviewed. On these occasions, I informally gave feedback to them about the findings (Zambrana 2014; Lundy 2008).

- **Systematic review**

Concerning the systematic review, the most important limitation relates to the nature and quality of the available evidence. Interpretation of the findings from this review must therefore include consideration of the quality of the overall evidence and the risk of bias (RoB) of the included studies. Findings from this review have highlighted that many studies had moderate to high RoB, including poor reporting of data collection and analysis and sample representativeness. Further limitations specific to the systematic review have been previously discussed in Chapter 2.

## **7.5 Findings in relation to the literature**

- **Photovoice study**

As noted in Chapter 1, Moulaert & Garon (2016), Menec *et al.* (2011), and Buffel 2015, have stated that to further progress the AFCs agenda, city stakeholders need to better engage older people in the planning processes within their neighbourhoods. In the current study, I used photovoice methods as a relatively novel approach in this field of practice to address the crucial question posed by Buffel *et al.* (2013 p.54): “How do individuals and communities most effectively make their voices heard?”. In the next paragraphs, I briefly examine some of the most important findings in relation to the literature.

This study supports the view of previous research (Scharlach 2016; Menec *et al.* 2011; Lui *et al.* 2009) that AFC features typically reflect the physical (*e.g.* housing) and social environment (*e.g.* community projects). In the current study,

physical environmental features related to respect and social inclusion included accessibility, inclusivity, and affordability of green and blue spaces; museums; libraries; community centres; allotments; and sport centres. Social features mainly referred to places to cultivate social interactions or that offered support (*e.g.* church, health centres). Other sub-themes referred to the positive or negative perceptions that older people felt towards different types of ‘spaces’: sense of belonging and pride versus sense of disregard and alienation.

While older people reported that these places were very important for their social inclusion and wellbeing, they identified affordability of transportation (*i.e.* free travel pass) and accessibility as being the two key factors that enabled them *to use* these places. This result is consistent with previous literature which argues that the primary challenge for older people is to maintain mobility, regardless of their physical limitations or disabilities associated with advancing age (Mahmood & Keating 2012; WHO 2007; Plouffe & Kalache 2010). Hence, providing affordable transportation options can ensure that older people reach the places and enhance their participation in the community (Government Office for Science 2016; Scharlach & Lehning 2012).

Through photography, older people have identified lack of accessible trains and bus stations among the main barriers for their social inclusion (*i.e.* lack of functioning lift equipment, canopies and glass unable to protect users by the wind). By contrast, participants identified an accessible train and bus station in the City with the following features: it was behind closed doors; it had appropriate signage and seating for people when waiting the bus/train; and it provided access to both train and bus options. These aspects are consistent with

previous studies on older people that have explored issues and strategies to create AFC stations and to maximise older people's mobility (Andonian & MacRae 2011; Phillipson, White & Faheem Aftab 2013; Scharlach & Lehning 2012; Scharlach 2016; Ormerod et al. 2015; Buffel et al. 2014). Responding to the transport needs of different age groups and maximising the mobility of older people is one of the priorities for action highlighted in the *Future of an ageing population report* (Government Office for Science 2016) and in the *World report on Ageing and Health* (WHO 2016b).

Another important aspect that emerged from this study and reported by other studies (Buffel, De Donder, et al. 2014) was the sense of attachment, pride, and identity that many older people expressed towards some features of the City. These included green spaces, the riverside, and iconic buildings (*e.g.* museums, libraries, and the Cathedral). The sense of identity and inclusion expressed by older people was often connected with the participant's aesthetic experience, particularly concerning green and blue spaces. The presence of the water and good views enabled older people to enjoy the beauty of the surroundings. This result is consistent with previous literature on green spaces (Finlay et al. 2015; Milligan et al. 2004).

By contrast, some older people – living in more disadvantaged geographical areas – felt generally disappointed with the appearance of, and attitudes in, their community; they reported feeling alienated towards it in describing some negative aspects, *e.g.* lack of street cleanliness. On these occasions, participants reported a sense of exclusion and discontent. Participants used photography to raise awareness of these issues that were not currently addressed by the council,

or for which other residents were responsible (*e.g.* litter in the streets). With advancing age, people are likely to become more emotionally attached to their local community and homes (Government Office for Science 2016). Therefore, if older people live in a supportive environment, they are more likely to experience a sense of belonging, and this can improve their wellbeing and quality of life (Gabriel & Bowling 2004; Finlay et al. 2015). If, instead, older people live in an environment which is perceived as unsafe, neglected, and poorly maintained, they are more likely to experience a sense of exclusion, alienation, and a negative influence on their sense of identity and wellbeing. This can also reduce their social participation within and outside the community (Marmot 2010; Scharf & Keating 2012; Scharf et al. 2005; Buffel et al. 2012; Phillipson 2007).

Another aspect connected with the sense of attachment experienced by older people was the fragmentation of their neighbourhoods that was happening due to a fast population turnover. Older people reported that this was leading to a loss of sense of community and cooperation, and informal social interactions – whereas in earlier times they used to know their neighbours, and they used to mix with each other. Buffel *et al.* (2014; 2012) have also found similar results concerning issues affecting older people's place attachment.

With regard to tackling some of these challenges, older people thought about issues preventing respect and social inclusion not just for themselves, but also for people of all ages. This aspect is very important, and links with what reported by past United Nations (UN) Secretary General Kofi Annan in occasion of the *UN Year of Older Persons* in 1998 (cited in Scharlach 2016 p.237):

“A society for all ages is multigenerational. It is not fragmented, with youths, adults and older persons going their separate ways. Rather, it is age-inclusive, with different generations recognizing – and acting upon – their commonality of interest.”

Initiatives to create AFCs have thereby a considerable role to play in achieving a society inclusive of all ages.

The two most important solutions identified by older people included improving access to technology and IT (Information Technology) skills, and tackling age-stereotypes. Older people reported that being able to use the Internet and computers could enable them to stay connected with family and friends who lived at a distance. More importantly, they considered the Internet as a means to feel integrated in the community and to maintain independence, despite their physical limitations (*e.g.* by online shopping). Consistent findings have been found in previous literature focusing on improving access to technology in older people (Ageing Well Network 2012; Menec et al. 2011; Liddle et al. 2013). The need to overcome the barriers to accessing technology has been identified as a priority for action that may enable older people live independently for longer (WHO 2016b; Government Office for Science 2016).

Furthermore, older people suggested tackling age-stereotypes and negative attitudes towards older people. They reported that the society should (i) improve the terminology used to refer to older people (*e.g.* the use of the term ‘elderly person’ in conversations and newspapers was perceived to be more respectful), and (ii) disseminate positive images of ageing, including the various ways in which older people contribute to the community (*e.g.* volunteering). Older

people also recommended to tackle internalised age-stereotypes affecting older people, and to convey that growing old should not be (perceived) as a barrier to taking part in activities (*e.g.* playing sport). Older people thought that these actions could improve our understanding of growing old. As noted in Chapter 1, challenging age stereotypes has been recognised as a public health priority (WHO 2016b), and the strategies that have been proposed (*e.g.* communication campaigns and fostering intergenerational interactions) are consistent with those expressed by older people in the current study.

- **City stakeholders and older people’s perspectives of respect and social inclusion**

In light of my findings (Chapter 4), it appears important to reflect if the perspectives of city stakeholders operating in different environments and contexts would ever meet the aspirations of older people. As noted in Chapter 4 (Section 5.1.6), the findings from the photovoice and city stakeholders study suggest that there was some degree of mutual understanding between them.

For instance, city stakeholders identified national and local budget cuts as being among the factors that hamper their ability to promote respect and social inclusion in Liverpool City. Older people were concerned about the consequences that they attributed to government budget cuts (*e.g.* limited access to IT training or closure of local shopping areas), but some of them recognised that local policy makers had to make difficult decisions. As argued by Buffel *et al.* (2013), one of the competing aspects which is likely to be a limiting factor in the implementation of AFC initiatives is the pressure to cut funding on health promotion projects, including those designs to strengthen respect and social

inclusion. In the context of economic austerity, the focus seems to be on more ‘immediate’ challenges, including guaranteeing pension funds and provision of health and social care services (House of Lords 2013). Hence, although facilitating opportunities for social interactions are important for community health and wellbeing and can save costs to the National Health Service, other issues are likely to compete for funding (Warburton et al. 2012; Fitzgerald & Caro 2013; Glicksman et al. 2013; Buffel, McGarry, et al. 2013).

The main focus of policy makers and commissioners on addressing health and associated social care implications reflects a well-recognised issue in public health, and previous research has shown that limited financial resources were among the key barriers to (i) prioritising public health, (ii) to partnership working, and (iii) to greater use of available evidence in planning and decision-making (Taylor-Robinson et al. 2012; Orton et al. 2011a; Orton et al. 2011b; Oliver et al. 2014). Hence, the pressure to cut funding that local governments are currently facing will have implications for sustainability of interventions over time of AFC initiatives (UNFPA and HelpAge International 2012). For instance, even if cities have political support and plans to implement AFC initiatives (*e.g.* IT training courses in libraries), local policy makers may have to reduce these plans due to budget cuts (Buffel, McGarry, et al. 2013).

## 7.6 Implications for public health policy and practice

- **Photovoice methods**

Photovoice methods, by adopting a CBPR approach, offer flexible tools to strengthen public health research and action (Minkler 2005). The current study has suggested that images produced through photovoice can provide highly informative and influential material – when presented through a public exhibition – particularly for increasing awareness and for engaging a diverse audience, including key stakeholders in discussion about aspects of the city that are important to older people (Gubrium & Harper 2013).

At the exhibition event for this study, a few attendees questioned whether the findings could contribute to changing policy and, in response, the mayoral lead for older people stated that the findings would inform the Liverpool Joint Needs Strategic Assessment. Whilst it has not been possible within this current study to identify how the research may have impacted on AFC policy in Liverpool – as this develops over the next 12-18 months, Sanon *et al.* (2014) noted that to promote an impact on policy, alongside the photo-exhibition, is important to follow-up with city stakeholders in various ways. I plan to disseminate a report with the findings of older people's views to city stakeholders, and I intend to follow-up to establish the extent to which future AFC strategy includes older people's views.

Given the AFC context, and the need for older people to be involved in shaping their city, photovoice should be considered by policy makers and clinical commissioning representatives as a tool to be used from time to time to maintain

engagement with older people in identifying priorities for action, and ensuring that their views are included in decision making processes affecting their health. Local policy makers should also make a determined effort to include the views of those older people who are marginalised and excluded from the community (Whitehead & Dahlgren 2007; WHO 2016b). To date, I did not find any example of photovoice methods used by cities and local governments to support engagement. From a brief search of grey literature on Google, only one public health report was found that has recommended the use of photographs and photovoice to assess the age-friendliness of a city. However, the report mainly refers to use photographs to offer tangible evidence that some improvements in the city (*e.g.* outdoor spaces) have been made (Public Health Agency of Canada 2016).

- **Systematic review**

Findings from the systematic review have shown that many, though not all, of the interventions were delivered as projects to selected groups of older people, raising important questions about feasibility and impact of wider implementation to secure population benefits (Whitehead 2007). Findings from the review suggest that those older people who were taking part in the interventions may also be those more willing to be involved in the community. Services and other initiatives promoted through AFC (and similar approaches) should be provided to every older person who stands to benefit from these, and good policies in place should remove the barriers that limit people in most need (*e.g.* marginalised groups) in accessing these interventions. In support of this view, the WHO (2016b p.221), in the *World report on Ageing and Health*,

recommends to provide “opportunities for social participation and for having meaningful social roles, specifically by targeting the processes that marginalize and isolate older people”.

In the photovoice study, older people reported how good access to transport, to well-planned train and bus stations, and to suitable public toilets in the city centre, were all important for their social inclusion and wellbeing. Others, identified green spaces as very important to promote intergenerational initiatives and physical activity. The few evaluation studies on these aspects that I found did not emerge from this systematic review, or could not be included in this review, as they did not meet the inclusion criteria (*e.g.* most people were not aged 60 and more). These initiatives included an evaluation of the use of the bus system by older people (Broome et al. 2013) and two transport projects (Ogilvie et al. 2006), and the evaluation of health-promoting neighbourhood interventions to revitalise built urban environments through active engagement of community members (Jalaludin et al. 2012; Semenza et al. 2007).

The lack of studies addressing wider social, community and environmental issues seems to suggest that interventions on transport, public toilets and green spaces – identified as so important by older people in the photovoice study – have not yet been tested as interventions on respect and social inclusion. In testing interventions, researchers have not adequately recognised or represented the important part that these ‘facilitating’ factors (*e.g.* transport, public toilets, green spaces, etc.) can play in achieving the kinds of changes that can strengthen respect and social inclusion for older people in general, and not just for those who happen to already be in, or easily enrolled into, a project or programme.

This implies that evaluation should consider the whole system as this impacts on older people's lives, and their ability to take part in these kinds of activities, or benefit from the services, that will help. The methods for evaluation of interventions in complex systems can achieve this, and logic models can be used to illustrate how these different components interact to support older people (Hawe et al. 2009; Petticrew 2015; Sautkina et al. 2014).

The findings from this research have identified the potential value to conduct needs assessment based on the three steps using here, namely: (i) the involvement of older people, including (potentially) employing photovoice methods; (ii) reporting back their views to stakeholders, with reflection by city stakeholders on what the city is currently doing, and an assessment of the extent to which policy makers can address older people's priorities for action; and (iii) a last step involving relating what is needed (according to older people and city stakeholders) with the evidence base. This will help inform what type of initiatives are more likely to impact on health and wellbeing, and the possible mechanisms through which they can lead to health outcomes (Buckner et al. 2016).

## **7.7 Implications for research**

In this section I consider the directions for future research needed in this field.

- **Systematic review**

Firstly, the current lack of consensus about the definition of social inclusion meant that studies included in the systematic review had a wide variety of conceptual definitions of social inclusion (Scharf & Keating 2012; Wright &

Stickley 2013). Some studies have also shown a lack of clarity regarding the terminology and definition of outcomes that were assessed (*e.g.* physical health and wellbeing). Therefore, strengthening conceptual clarity by using standardised definitions, methods and outcome measures represents a central research direction for this field.

Secondly, findings from the review have highlighted that many of the included studies had moderate and high RoB, particularly regarding sample representativeness. Moreover, most identified studies did not explore differential effects by gender, ethnicity or socio-economic status. When considering implementation of interventions on respect and social inclusion in older people, those involved should explore whether interventions have the potential to reinforce or reduce health inequalities (Whitehead & Dahlgren 2007; Marmot 2010).

Thirdly, this review has shown that many of the projects were implemented through weekly and monthly activities (*e.g.* reading books to children; supporting students in solving math problems; choirs and music making activities). These activities were generally facilitated by professionals, students, peers, or older people themselves, and took place in community centres and schools. However, further research should assess the cost-effectiveness of these interventions (including when applied at greater scale in response to population need), particularly those that have shown a health impact (intergenerational initiatives, singing and music).

In highlighting some of the issues, this review has provided a foundation from which larger, extended, and more robust interventions – using rigorous

methodologies including randomised designs – may be developed. Moreover, in-depth qualitative studies, quantitative, and physiological studies will be useful to better understand the context and the possible mediating factors between the intervention(s) and the health outcomes.

- **Using natural experiments and adopting a systems approach**

As noted in Section 7.6, many of the included studies reported assessments of project-based initiatives that were targeted at specific groups of older people. The lack of studies implemented at city/population-level (*e.g.* interventions to improve green spaces that could facilitate intergenerational interactions) seems to suggest that current research has not considered this yet.

Natural experiments can thereby make an important contribution in addressing some of the challenges related to the lack of evaluative research of AFC initiatives. Natural experiments are projects which are not developed for research purposes. They are implemented in a particular geographical area or community, wherein the researcher cannot control the allocation of a particular intervention, and they are likely to be subject to bias and confounders (Petticrew et al. 2005; Medical Research Council 2008). Because of these characteristics, natural experiments are more challenging to assess if compared with project-based initiatives with RCT designs (*e.g.* applying strong methodologies). However, they can inform the evidence on population-based interventions that is critical to public health and to reduce health inequalities (Petticrew 2013). In fact, one advantage of natural experiments is that the ‘intervention’ may be much more representative of mainstream actions, in comparison with what is typically tested in project-based RCTs. Future research should develop evaluations of

natural experiments of AFC initiatives that are aimed at strengthening respect and social inclusion, and assess their impact on health and wellbeing outcomes.

Moreover, systems thinking in public health evaluation is a potentially useful approach (i) to understand the context in which AFC initiatives operate; and (ii) to develop relevant evidence for AFC initiatives to improve health and reduce health inequalities (Hawe et al. 2009; Petticrew 2015). With regard to urban environments that aim to become more age-friendly, the context includes the positions occupied by key players – *e.g.* community members, policy makers, commissioners, voluntary sector, service providers – and factors that can enable or prevent AFCs – *e.g.* current policies, financial context, competing priorities for funding, and budget cuts (Figure 1, Chapter 1). Furthermore, a systems perspective acknowledges that the impact of interventions can be influenced by dynamic processes (*e.g.* interactions between key players/events/places and non-casual pathways) (Craig et al. 2008; Hawe et al. 2009).

According to the WHO report on *Systems thinking for health systems strengthening* (De Savigny & Adam 2009 cited in Naaldenberg 2011 p.15) “by combining knowledge from different sources and stakeholders, it is possible to reach a broader evidence base that takes the complex context of interventions into account”. In fact, key players are characterised by their own values and perspectives within the context (Naaldenberg 2011). Failing to take this into account risks developing initiatives that are appropriate to create AFCs, but do not meet the views of older people and/or city stakeholders of what they think it is important for promoting respect and social inclusion in the City.

- **Community based participatory research approach**

The current photovoice study has demonstrated the appropriateness of taking a community based participatory research (CBPR) approach in accessing older people to elucidate their views on respect and social inclusion in the City. Although gatekeepers working in grassroots organisations helped me in recruiting some less included older people, future studies should extend these efforts to better represent those older people who are marginalised from the community. This can be achieved through the help of housing associations and fire services who regularly visit older people, or through a snowballing technique (*i.e.* asking one person to identify contacts in his/her networks). Buffel (2015) conducted a CBPR project wherein trained co-researchers – represented by older people – successfully recruited and interviewed ‘hard-to-reach’ older people (*e.g.* those experiencing social exclusion, isolation, poverty, and health problems) in exploring features of age-friendliness in Manchester City (UK).

Lastly, although the findings of this photovoice study did facilitate productive collaboration between older people, city stakeholders, and researchers, further research is needed to explore the impact of photovoice on these partnerships, including how the process of engagement can be sustained in the long term (Catalani 2009).

## **7.8 Conclusions**

To conclude, population ageing and increasing urbanisation represent public health challenges that require priority for action. Creating a supportive urban environment is especially important for older people’s health. This research has

shown that respect and social inclusion is a key domain of an AFC, and one that cuts across most – if not all – other domains identified in the WHO framework for AFCs. It is a subject with considerable importance for the health and wellbeing of older people that warrants further research, although the concept of ‘social inclusion’ requires more consistent definition.

Although using photovoice methods present several challenges, it has been shown to be a valuable method for eliciting views of older people on an important and complex topic such as respect and social inclusion in the context of a large urban setting. It also provides a basis for generating constructive dialogue between older people and city stakeholders through an exhibition. Whilst photovoice provides extensive and ‘rich’ data, it is important to be aware of some limitations. Difficulties may include photography of negative and social concepts, and anxiety when taking photographs due to (i) expectations of what is a ‘proper’ photograph, and (ii) the need to obtain consent from subjects. These issues can be overcome with preparation, training, and discussion of participants’ ideas not expressed through photographs.

By using photovoice methods (in Liverpool as a case study), older people identified a very wide range of factors that enable or inhibit their experience of respect and social inclusion in the City, and ways in which some of the barriers could be reduced. These factors, and their solutions, are linked to how participants react to the spaces in the urban setting (*e.g.* feeling of pride and identity, or feeling of alienation and disregard). They also extend beyond services to include wider aspects of the city’s social and physical environment (*e.g.* parks, rivers, and iconic buildings), attitudes towards older people

(improving the language used to refer to older people, and lack of recognition of what skills and experience they can offer), transport (facilities, passes for older people) and cultural facilities (museums and libraries).

Local policy makers, service providers, and third sector representatives, share many of the same priorities identified by older people, but their perspectives also differ in some important respects. They tend to be more focused on service delivery, and less conscious of the value that older people place on the wider environmental aspects. They are also (understandably) very concerned by how budget constraints are limiting, and will continue to limit, what they can do to promote respect and social inclusion in the City, and note that these pressures tend to lead to short-term planning. On this last matter, there appears to be limited mutual understanding of the respective perspectives of older people and city stakeholders.

While there is a quite substantial body of evidence on the impacts of interventions to foster respect and social inclusion on the health and wellbeing of older people, this tends to be for quite well-defined interventions delivered through community programmes such as inter-generational activities, mentoring, music and dance, art and culture, information and communication technology, and multi-activity programmes. The most effective of these interventions on psychological outcomes, wellbeing, subjective and physical health appear to be intergenerational initiatives and those based on music and singing. Evidence is much weaker for mentoring, dancing information communication technology, art and culture, and multi-activity initiatives. This

body of evidence is, however, generally limited by moderate to high risk of bias, notably in respect of the representativeness of the study sample.

Future evaluation research should address both the methodological weaknesses identified, and should complement the priorities identified by older people and city stakeholders with the current evidence base. Future research should also take more into account the factors which can facilitate older people's involvement in activities and services that can strengthen respect and social inclusion in the city, and thereby benefit health and wellbeing of the older population more widely. These other factors, identified as important by older people themselves, include issues such as a well-preserved environment, accessible and affordable transport facilities, green and blue spaces, iconic buildings, and suitable public toilets. When studying the health impact of AFC initiatives, a systems approach would help structure more inclusive evaluation efforts.

Cities developing AFC (or related) approaches to help promote healthy ageing need to find more effective ways of engaging with older people. The periodic use of photovoice methods (i) to better engage with community members, as well as (ii) to enhance community voice by incorporating older people's views in the planning processes for the city, should be considered as a useful tool for this purpose.

Yet, some questions remain to be answered:

- Is CBPR revealing a path to promote a more age-inclusive society?
- How can we strengthen the use of natural experiments to measure the health/wellbeing impact of AFC initiatives?

- How can we apply and implement a systems approach to the evaluation of AFC initiatives?
- Can photovoice methods be regularly applied in practice to identify priorities for action for AFCs and to encourage dialogue with community members and city stakeholders? What are the challenges and opportunities related to its application in practice?

I hope that the research described here and the above questions can contribute to inform further research as AFCs develop, which in turn, may contribute to improve the health, and the respect and social inclusion of older people living in urban environments.

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# Appendixes

## Appendix A. Overview of the health outcomes and scales used to assess the interventions on respect and social inclusion (34 studies in total).

First author, year, country study, type	Depressive symptoms/ depression	Subjective health/self-rated health/health status	Quality of life	Mental health	Physical health	Wellbeing	Falls	Perceived stress/ anxiety	Other
<b>GROUP N 1: Mentoring interventions</b>									
Dickens 2011, UK QUANT	Geriatric Depression Scale (GDS-10)	Health status (EuroQol EQ-5D)		SF-12 – Mental health component score (MCS)	SF-12 – Physical health component score (PCS)				
Ellis 2004, UK MIXED						Short Form 12 Health Survey (SF12)			
<b>GROUP N 2: Intergenerational interventions (including Ellis 2004)</b>									
Chung 2009, China QUANT	Chinese version of Geriatric Depression Scale (CGDS)		Quality of Life- Alzheimer’s Disease (QoL-AD)						
De Souza 2007, Brazil, QUANT		Self-rated health Questions taken from the Brazilian Old Age Scale							

<b>First author, year, country study, type</b>	<b>Depressive symptoms/ depression</b>	<b>Subjective health/self-rated health/health status</b>	<b>Quality of life</b>	<b>Mental health</b>	<b>Physical health</b>	<b>Wellbeing</b>	<b>Falls</b>	<b>Perceived stress/ anxiety</b>	<b>Other</b>
Hernandez 2008, Spain, QUANT	Yesavage Depression Scale (YDS)								
Hong 2010, USA, QUANT	Centre for Epidemiologic Studies Depression Scale (CES-D)	Non-standardised scale							
Fujiwara 2009, Japan, QUANT	Short version of Geriatric Depression Scale (GDS)	Non-standardised scale							
Gaggioli 2014, Italy, QUANT			The adapted Italian version of the World Health Organization Quality of Life Scale for Older People (WHOQOL)						

First author, year, country study, type	Depressive symptoms/ depression	Subjective health/self-rated health/health status	Quality of life	Mental health	Physical health	Wellbeing	Falls	Perceived stress/ anxiety	Other
Murayama 2014, Japan, QUANT	Geriatric Depression Scale (GDS) - Short Version-Japanese								
Fried 2004, USA, QUANT							Non-standardised scale		
Newman 1995, USA, QUANT	Geriatric Depression Scale (GDS)								
Mendis 1992, USA, QUANT	Center for Epidemiologic al Studies- Depression Scale (CES-D)								
Ellis 2004, UK, MIXED						Short Form 12 Health Survey (SF12)			
<b>GROUP N 3: Dancing interventions</b>									
Houston 2015, UK, QUANT	Dance for Parkinson's' questionnaire (including the Centre for Epidemiologic Studies	Dance for Parkinson's' questionnaire (including questions from SF-36)						Non-standardised scale	

First author, year, country study, type	Depressive symptoms/ depression	Subjective health/self-rated health/health status	Quality of life	Mental health	Physical health	Wellbeing	Falls	Perceived stress/ anxiety	Other
	Depression Scale)								
Hackney 2007, USA, QUANT	The 17-item Philadelphia Geriatric Centre Morale Scale						The modified Falls Efficacy Scale		
<b>GROUP N 4: Music and singing interventions</b>									
Coulton 2015, UK, QUANT (same as Clift, 2012)	Hospital Anxiety and Depression Scale (HADS)			SF-12 – Mental health component score (MCS)	SF-12 – Physical health component score (PCS)			Hospital Anxiety and Depression Scale (HADS)	
Cohen 2006, USA, QUANT	Geriatric Depression Scale–Short Form (GDS)				NS scale				
Clift 2011, UK QUANT								CORE questionnaire	
Davidson 2011, Australia MIXED			Quality of Life – Alzheimer’s Disease (QoL-AD)						

First author, year, country study, type	Depressive symptoms/depression	Subjective health/self-rated health/health status	Quality of life	Mental health	Physical health	Wellbeing	Falls	Perceived stress/anxiety	Other
Creech 2013, UK, MIXED			the Basic Needs Satisfaction Scale  12-item version of CASP						
Davidson 2014, Australia MIXED	Geriatric Depression Scale (GDS)			Medical Outcomes Study Short-Form (SF-36) Health Survey Version 2	Medical Outcomes Study Short-Form (SF-36) Health Survey Version 2				
<b>GROUP N 5: Information-communication technology interventions</b>									
Slegers, 2008 the Netherlands, QUANT	90-item Symptom Check List				36-item Short-Form Health Survey (SF-36)	36-item Short-Form Health Survey (SF-36) (emotional wellbeing)		(Anxiety and sleep complaint) 90-item Symptom Check List	
Woodward 2011, USA, QUANT	Geriatric Depression Scale GDS)		Non-standardised scale						
Woodward 2012, USA, QUANT	Geriatric Depression Scale GDS)		Non-standardised scale						

First author, year, country study, type	Depressive symptoms/depression	Subjective health/self-rated health/health status	Quality of life	Mental health	Physical health	Wellbeing	Falls	Perceived stress/anxiety	Other
<b>GROUP N 6: Art and culture interventions (including Cohen 2006)</b>									
Phinney 2014, Canada, MIXED	Geriatric Depression Scale short (GDS short)	Single item perceived overall health scale						Chronic pain: single item verbal descriptor scale; Daily function: Older Americans Resources and Services Activities of Daily Living Questionnaire (OARS-(I)ADL)	
Cohen 2006, USA, QUANT	Geriatric Depression Scale-Short Form (GDS)				Non-standardised scale				
Camic, 2014, UK, MIXED			Dementia Quality of Life (DEMQOL-4)						
Yuen 2011, USA, MIXED				36-Item Short-Form Health Survey (SF-36)	36-Item Short-Form Health Survey (SF-36)	General Well-being Schedule (GWBS)			
Vogelpoel 2014, UK, MIXED						Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS); an extension of			

First author, year, country study, type	Depressive symptoms/ depression	Subjective health/self-rated health/health status	Quality of life	Mental health	Physical health	Wellbeing	Falls	Perceived stress/ anxiety	Other
						Thiele and Marsden's Dynamic Observation scale			
<b>GROUP N 7: Multi-activity interventions</b>									
Saito 2012, Japan, QUANT	Geriatric Depression Scale (GDS)					The Life Satisfaction Index A (LSI-A)			
Greaves 2006, UK MIXED	Geriatric Depression Scale (GDS)				SF12 Health Quality of Life	SF12 Health Quality of Life			
Gonyea 2013, USA, QUANT	Geriatric Depression Scale (GDS)- Short Form of 15 items							10-item Perceived Stress Scale (PSS)	
Kocken 1998, the Netherlands, QUANT		Non-standardised scale				Short version of the validated Dutch scale for wellbeing			
Ruffing-Rahal 1994, USA, QUANT						Non-standardised scale			

## **Appendix B. PARTICIPANT INFORMATION SHEET (older people)**

You are being invited to take part in a research study that is part of a doctoral thesis in Public Health. Before you decide it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand.

Please also feel free to discuss this with your friends, relatives if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

**Title of study:** How can we make Liverpool a better place to grow old and where people feel valued and part of their community?

### **Who is doing the research?**

Sara Ronzi: doctoral student at the University of Liverpool (Department of public health and policy) – will conduct the research.

Professor Nigel Bruce, Dr Daniel Pope and Dr Lois Orton (Department of public health and policy) - will be supervising the research.

### **What is the purpose of the study?**

The overall aim of this study is to explore the way in which older people themselves view their neighbourhood (and Liverpool) as a place which supports or does not support older people to age healthily. This research study will explore which features/aspects of the city enhance or prevent the opportunities for older people to cultivate social relationships, have access to social, learning and cultural opportunities. **This refers to all aspects of the city of Liverpool which may enable or prevent older people to feel valued and part of their community.**

### **Why have I been chosen to take part?**

We would like you to help us with this study because we are interested in exploring views and experiences of older people. As a person aged 60 or over, your perspectives are very important to us. In total, we aim to work with between 5-9 other older people.

### **Do I have to take part?**

No. It is your choice whether you decide to take part.

If you wish to take part, you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to take part, you are free to withdraw at any time without giving any reason.

### **What will happen if I take part?**

If you decide to participate you will be invited take part in 2 group discussions and 1 interview, and also to take pictures which we will discuss. All group discussions and interview will be audio recorded (with your permission).

### **1st discussion group**

This discussion group should last no more than 2 hours and will be held in a room in the University of Liverpool or within this organisation where you attend to take part in activities. In this 1st discussion group, the research study will be further explained and your views on the aspects in/around your neighbourhood/local area (or city) which enable or prevent older people to feel valued and part of their community will be discussed. You will also be provided with a digital camera to take photographs in/around your own local area (or city), related to the themes the group has discussed, over a period of a week. You will be shown how to operate the camera.

### **Interview**

You will be asked to take part in an interview of 30-45 minutes that will be held in a room in the University of Liverpool or within this organisation where you attend to take part in activities. At the interview you will be invited to give the digital camera back to the researcher to upload the pictures onto the laptop. You will be invited to discuss the photographs you have taken and to select the 4 photographs that are meaningful to you to be shared in the second discussion group, and to explain the reasons of your choices and why those are important for you.

### **2nd group discussion**

This second discussion group will take place one week after the first discussion group and should last no more than 2 hours. At this second discussion group you will be asked to talk about the 4 photographs that you have chosen and what relevance they have for you as an

older person in relation to feeling valued and part of your local area (or city). In addition, you will be asked to share your experiences of taking these photographs with the other participants. Following the choice of the pictures, you will be asked to select 2 favourite photographs according to you that represent a positive aspect in your city that would need to be strengthened, and another aspect that you think should be improved in order to make Liverpool a place which supports older people to age healthily. Later, you will be asked a number of questions about your experiences in the project and how participation has affected your views of your local area /city.

The researcher will write a short summary to accompany each photograph. This short summary, along with the photographs you have chosen will be emailed/sent/shown to you to be reviewed for your comments and permissions, allowing the researcher where appropriate to use it in academic and scholarly publications, and to display those in future photo-exhibitions that we will organise.

At the end of the study, you will be invited to attend an open photo-exhibition that will be held (half day) in a venue in Liverpool, with attendance of University staff, council representatives and others who work with or in various ways support older people in the city (e.g. representatives from Age Concern Liverpool and Sefton, Museums of Liverpool, etc.), and any family or friends that you may wish to accompany you. This represents a great opportunity for us to acknowledge your contribution to this study and also to convey your views to those responsible for supporting older people to age healthily, and where your pictures will be displayed to the public (with your consent).

**Duration of the research:** Three meetings will be arranged over a period of around 1 month, and will involve 4-5 hours of your time in total.

### **Expenses**

At the end of the study, a voucher (£20) for a local store will be given to you to thank you for your time. Refreshments (tea, coffee, fruit, biscuits and cakes) will be provided during the group discussions and interview.

### **Are there any risks in taking part?**

We do not expect there to be any direct risks or discomfort to be associated with participating in this research study.

Being involved in research can, however, have an emotional impact, as you will need to reflect on which features/aspects of your ward (and in the city) you think enhance or prevent the opportunities for older people to feel valued and part of their community. If during or after the group discussions or interview you feel uncomfortable or concerned, you should let the researcher know immediately. If there is anything you wish to discuss with us at any time during the study, please do not hesitate to contact the researcher (Sara Ronzi) and we will be happy to discuss with you.

### **Are there any benefits in taking part?**

You may find the study interesting and worthwhile. You will have the opportunity to express your views about the aspects of your ward (or city) which support or do not support older people to feel valued and part of the community. The findings from this study will be reported back to council representatives and others with

responsibilities for services and other initiatives for older people. Furthermore, your stories and pictures will give a very important contribution to the development of this area of research. Finally, you will meet other people and share your experiences.

**What if I am unhappy or if there is a problem?**

If you are unhappy, or if there is a problem, please feel free to let us know by contacting the researcher Sara Ronzi on 0151 795 0132 or by email: [ronzis@liverpool.ac.uk](mailto:ronzis@liverpool.ac.uk) who will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at the University of Liverpool on 0151 794 8290 or by email: [ethics@liv.ac.uk](mailto:ethics@liv.ac.uk). If you contact the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

**Will my participation be kept confidential?**

All the information that you give us will be kept strictly confidential. The procedure for handling processing, storing and eventually destroying the data will comply with the Data Protection Act of 1998.

All information which is collected about you during the course of the thesis will be kept strictly confidential. At the start of the recruitment, any information about you (e.g. your name, date of birth, telephone and address) will be removed so that it will not be possible to identify you as an individual. The pictures that you will take, with your consent, will be used to promote the purpose of this thesis, make

presentations of the findings at academic meetings, in academic journals, and photo-exhibitions.

All data which is retained on paper (e.g. signed consent forms and printout containing personal addresses, postcodes, faxes, e-mails or telephone numbers) will be kept in in a University locked filing cabinet or drawer in a locked room. All electronic data will be stored on a password protected computer which will have anti-virus software on the University's secure server (M: drive).

At the end of the study all the research data will be kept in locked filing cabinets and/or password protected university computers. As usual practice for research studies, the data will be kept for 5 years to allow time for any possible resubmission or appeal and to make presentations of the findings at academic meetings, in academic journals, and photo-exhibitions.

Please note that if you did tell us something that meant you were in danger or could come to any harm, the researcher would have a duty to tell her supervisor about this.

### **What will happen to the results of the study?**

After the study has finished, the results will be put together as part of the researcher's doctoral thesis and submitted for examination. The research material will be stored at the University of Liverpool. The research will also be presented at academic meetings, in academic journals, publications and photo-exhibitions. If you wish, you will be provided with the final research report at the end of the study.

**What will happen if I want to stop taking part?**

If you decide at any point that you no longer wish to be part of the study, you are free to withdraw at any time without giving any reason. As the researcher will anonymise your information during the recruitment, results may only be withdrawn prior to anonymisation.

**Who can I contact if I have further questions?**

Just feel free to get in touch with the researcher, Sara Ronzi, who will be happy to answer any questions you might have:

Tel: 0151 795 0132

Email: [ronzis@liverpool.ac.uk](mailto:ronzis@liverpool.ac.uk)

**Thank you for reading this.**

**Appendix C. PARTICIPANT CONSENT FORM (elderly people)**

**Title of Research Project:** How can we make Liverpool a better place to grow old and where people feel valued and part of their community?

- |   | <b>Please tick the box</b> |
|---|----------------------------|
| <b>Researcher: Sara Ronzi</b>   |                            |
| 1. I confirm that I have read and have understood the information sheet dated [14.05.2014] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.                               | <input type="checkbox"/>   |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline. | <input type="checkbox"/>   |
| 3. I understand and agree that the information I provide will become anonymised and once this has been done, I will no longer be able to withdraw my data.  | <input type="checkbox"/>   |
| 4. I agree to being audio-recorded during the 2 discussion groups and the interview.  | <input type="checkbox"/>   |
| 5. I understand that my responses will be kept strictly confidential. Any information about me which is shared with others (e.g. in reports, publications or if shared with the research team) will have my name, telephone and                                 | <input type="checkbox"/>   |

address removed so that it will not be possible to identify me.

6. understand the data collected in this investigation (anonymised group discussions and interview transcripts, pictures and notes) will be used for this doctoral thesis, and may be shared to make presentations of the findings at academic meetings, in academic journals, publications and photo-exhibitions.
7. I agree to the researcher taking my contact details (name, telephone number, address, etc.) in order to contact me to arrange the interview and group discussions.
8. The information you have submitted will be published as a report; please indicate whether you would like to receive a copy.
9. I agree to take part in the above study.

Participant Name (BLOCK CAPITAL)      Date      Signature

Name of Person taking consent      Date      Signature

Researcher      Date      Signature

**Thank you for agreeing to take part in this doctoral project for the University of Liverpool.**

## **Appendix D. USE OF THE PHOTOGRAPHS CONSENT FORM**

**Title of Research Project:** How can we make Liverpool a better place to grow old and where people feel valued and part of their community?

Please indicate that you have understood the information by signing after the statements below and ticking the box if you wish that the researcher (Sara Ronzi) uses your photographs for the purposes of this doctoral thesis, making presentations of the findings at academic meetings, in academic journals, publications and photo-exhibitions.

**Please tick the box**

- I agree and consent that the researcher and the University of Liverpool are not responsible for any misappropriation - use of my pictures without my consent - of any photo by the general public or anyone else.
- I acknowledge that I will make no monetary or other claim against the researcher and/or the University of Liverpool for the use of the photograph(s).
- Yes**, you may use the photographs I took during the study to promote the purpose of this thesis, make presentations of the findings at

academic meetings, in academic journals, publications and photo-exhibitions.

**Please tick  
the box**

- Yes**, I understand and agree that the photographs that I took during this study will be accompanied by some brief explanations, based on what I said during the 2 group discussions and the interview.
- Yes**, I understand that the researcher will check with me whether I am happy with the brief explanations accompanying the photographs I took.

**Participant Name (BLOCK CAPITALS) Date Signature**

**Name of Person taking consent Date Signature**

**Researcher Date Signature**

**Thank you for agreeing to take part in this doctoral project for the  
University of Liverpool.**

**Appendix E. ACKNOWLEDGEMENT AND RELEASE  
FORM – PERSON WHO APPEARS IN THE PICTURE**

**Title of Research Project:** How can we make Liverpool a better place to grow old and where people feel valued and part of their community?

**What is the research about?** This research study is part of a doctoral thesis. The overall aim of this study is to explore the way in which older people themselves view their neighbourhood (and Liverpool) as a place which supports or does not support older people to age healthily. In particular, this research study will explore which features/aspects of the city enhance or prevent the opportunities for older people to cultivate social relationships, have access to social, learning and cultural opportunities. This refers to all aspects of the city of Liverpool which may enable or prevent older people to feel valued and being part of their community.

Please indicate that you have understood the information you have received by signing after the statements below.

**I am 18 years of age or older** and hereby grant the researcher designated below from the University of Liverpool permission for publication for the above titled approved doctoral thesis and for other uses such as making presentations of the findings at academic meetings, in academic journals, publications and photo-exhibitions.

**Please tick  
the box**

- I understand that my photograph(s) may be used for the purpose of this doctoral thesis, which is made available for research purposes and for the presentation of the study.
- I recognize that all photographs may be deleted at the discretion of the researcher who is writing this doctoral thesis.
- I acknowledge that my name will not be published on the photographs selected for inclusion in this doctoral thesis, reports or for publication in academic journal and photo-exhibitions.
- I understand and consent that the researcher designated below and the University of Liverpool are not responsible for any misappropriation - use of my pictures without my consent - of any photo by the general public or anyone else.
- I agree that I will make no monetary or other claim against the researcher and/or the University of Liverpool for the use of the photograph(s).
- I have read the above description and give my consent to use my picture as indicated above.
- I confirm that these photographs were taken with my knowledge and consent.

**Thank you for agreeing to take part in this doctoral thesis for the  
University of Liverpool.**

**Location(s) of photo:**

.....  
.....

**Number of pictures taken:**

.....  
...

**Participant Name (BLOCK CAPITALS)**

**Date      Signature**

**Name of person who appears in the photograph(s)**

**Name (BLOCK CAPITALS)**

**Date      Signature**

**If participant who appears in the picture is under 18 years old,**

consent must be provided by the parent or legal guardian:

**Name of guardian: (BLOCK CAPITALS)**

**Date      Signature**

**PLEASE GIVE THIS SLIP TO THE PERSON WHO  
APPEARS IN THE PHOTOGRAPH(S)**

**If you require further information on this study, please contact  
the researcher (below)**

**Title of Research Project:**

How can we make Liverpool a better place to grow old and where  
people feel valued and part of their community?

**Contact details:**

Name: Sara Ronzi (doctoral student)

Contact information : email **ronzis@liverpool.ac.uk**

Phone: 0151 795 0132

Address: Room 3.14, Whelan building, Quadrangle, University of  
Liverpool, L69 3GB

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## **Appendix F. PARTICIPANT INFORMATION SHEET (key informants)**

You are being invited to take part in a research study that is part of a doctoral thesis in Public Health. Before you decide it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand.

Please also feel free to discuss this with your friends, relatives if you wish. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

**Title of study:** Evaluation of complex public health interventions for healthy ageing: the example of respect and social inclusion.

### **Who is doing the research?**

Sara Ronzi: doctoral student at the University of Liverpool (Department of public health and policy) – will conduct the research.

Professor Nigel Bruce, Dr Daniel Pope and Dr Lois Orton (Department of public health and policy) - will be supervising the research.

### **What is the purpose of the study?**

The overall aim of this study is to explore your views on (i) perspectives on needs, (ii) organisation of interventions which promote respect and social inclusion in older people, wider policy and influences and (iii) your views on the challenges associated with making Liverpool a better place to grow old (in relation to respect and social inclusion).

**Why have I been chosen to take part?**

We would like you to help us with this study because you have an interest and/or you work with or in various ways support older people in the city. You may therefore be able to provide a perspective on the elements which influence the way in which older people feel valued and a part of their community and that can be improved and/or strengthened to make Liverpool a better place to grow old in.

**Do I have to take part?**

No. It is your choice whether you decide to take part.

If you wish to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are free to withdraw at any time without giving any reason.

**What will happen if I take part?**

If you decide to participate you will be invited to take part in 2 interviews, which will be audio recorded (with your consent).

**1st interview**

You will be invited to take part in an interview of 30-45 minutes that will be held in a room in the University of Liverpool or within your organisation. In this 1st interview, the research study will be further explained. Information on (i) perspectives on needs, (ii) organisation of interventions which promote respect and social inclusion in older people, wider policy and influences and (iii) your views on the challenges associated with making Liverpool a better place to grow old in (in relation to the domain of respect and social inclusion), will be discussed.

**2nd interview**

You will be invited to take part in a second interview of 30-45 minutes that will be held in a room in the University of Liverpool or within your organisation. This second interview will take place some months after the first interview, once both the evidence review work and the study with older people has been completed by the student investigator as a part of her doctoral thesis. You will be consulted on the findings that

will be found from the evidence review work which is looking at the health impact of interventions which promote respect and social inclusion in older people.

At the end of the study, you will be invited to attend an open exhibition that will include pictures, etc. and will be held (half day) in a venue in Liverpool, with attendance of University staff, those older people who took part in the study, and others who work with or in various ways support older people in the city, and any family or friends that you may wish to accompany you. You do not have to attend this if you do not want to, although it represents a great opportunity for us to convey to you those aspects of the city of Liverpool which may enable or prevent older people to feel valued and part of their community, according to older people's perspectives, and where their pictures together with their views on those issues will be displayed to the public.

**Duration of the research:** Two meetings will be arranged over a period of 6-12 months, and will involve 1-2 hours of your time in total.

**Are there any risks in taking part?**

We do not expect there to be any direct risks or discomfort to be associated with participating in this research study.

If, however, during or after the group discussions or interview you feel uncomfortable or concerned, you should let the researcher know immediately. If there is anything you wish to discuss with us at any time during the study, please do not hesitate to contact the researcher (Sara Ronzi) and we will be happy to discuss with you.

**Are there any benefits in taking part?**

You may find the study interesting and worthwhile. You will have the opportunity to express your views on perspectives on needs (Liverpool), what being done and your views on the challenges associated with making Liverpool a better place to grow old (in relation to respect and social inclusion). Your expertise and experience will be a very important contribution to the development of this area of research.

**What if I am unhappy or if there is a problem?**

If you are unhappy, or if there is a problem, please feel free to let us know by contacting the researcher Sara Ronzi on 0151 795 0132 or by email: [ronzis@liverpool.ac.uk](mailto:ronzis@liverpool.ac.uk) who will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer at the University of Liverpool on 0151 794 8290 or by email: [ethics@liv.ac.uk](mailto:ethics@liv.ac.uk). If you contact the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

**Will my participation be kept confidential?**

All the information that you give us will be kept strictly confidential. The procedure for handling processing, storing and eventually destroying the data will comply with the Data Protection Act of 1998.

All information which is collected about you during the course of the thesis will be kept strictly confidential. At the start of the recruitment, any information about you (e.g. your name, date of birth, telephone and address) will be removed so that it will not be possible to identify you as an individual.

All data which is retained on paper (e.g. signed consent forms and printout containing personal addresses, postcodes, faxes, e-mails or telephone numbers) will be kept in in a University locked filing cabinet or drawer in a locked room. All electronic data will be stored on a password protected computer which will have anti-virus software on the University's secure server (M: drive).

At the end of the study all the research data will be kept in locked filing cabinets and/or password protected university computers. The data will be kept for 5 years to allow time for any possible resubmission or appeal and to make presentations of the findings at academic meetings, and in academic journals.

Please note that if you did tell us something that meant you were in danger or could come to any harm, the researcher would have a duty to tell her supervisor about this.

**What will happen to the results of the study?**

After the study has finished, the results will be put together as part of the researcher's doctoral thesis and submitted for examination. The research material will be stored at the University of Liverpool. The research will also be presented at academic meetings, in academic journals, and publications. If you wish, you will be provided with the final research report at the end of the study.

**What will happen if I want to stop taking part?**

If you decide at any point that you no longer wish to be part of the study, you are free to withdraw at any time without giving any reason. As the researcher will anonymise your information during the recruitment, results may only be withdrawn prior to anonymisation.

**Who can I contact if I have further questions?**

Just get in touch with the researcher, Sara Ronzi, who will be happy to answer any questions you might have:

Tel: 0151 795 0132

Email: [ronzis@liverpool.ac.uk](mailto:ronzis@liverpool.ac.uk)

**Thank you for reading this.**

## Appendix G. PARTICIPANT CONSENT FORM (key informants)

**Title of Research Project:** Evaluation of complex public health interventions for healthy ageing: the example of respect and social inclusion.

Please tick the

**Researcher: Sara Ronzi**

**box**

- I confirm that I have read and have understood the information sheet dated [14.05.2014] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.
- I understand and agree that the information I provide will become anonymised and I will therefore no longer be able to withdraw my data.
- I agree to being audio-recorded during the two interviews.
- I understand that my responses will be kept strictly confidential. Any information about me which is shared with others (e.g. in reports, publications or if shared with the research team) will have my name, telephone and address removed so that it will not be possible to identify me.
- I understand the data collected in this investigation (anonymised group discussions and interview transcripts, and notes) will be used for this doctoral thesis, and may be shared to make presentations of the findings at academic meetings, in academic journals, publications and photo-exhibitions.
- I agree to the researcher taking my contact details (name, telephone number etc.) in order to contact me during the study to arrange the



## **Appendix H. Focus groups guidance (older people)**

### **Initial focus group** (time estimated:2 hours)

*[(original) Research question: how can we define and assess (and improve) the age-friendliness of a city?]*

Elements to be covered: exploring perceptions of the concept ‘age-friendly city’ (in Liverpool), including potential facilitations and barriers to respect and social inclusion in older people; exploring features/aspects which contribute to create a city which is inclusive of older people and where older people feel valued and part of their community; aspects/features of the city would make Liverpool a more socially inclusive place to grow old in and would support older people to age healthily.

### **Schedule:**

Introduce myself.

Thank the group for attending the focus group.

Remind participants that everyone respects each other’s opinions, no-one talks over anyone else, everyone is given a chance to speak, etc.

Give participants the ‘agenda of the day’ and collect signed consent forms.

Start to audio-record the focus group.

Remind participants what is the purpose of the meeting and let them introduce themselves to the group.

Explain briefly:

- What is the research about?
- Why we have chosen this topic
- Define what we mean by ‘respect’, ‘social inclusion’ and ‘ageing well within a city’ (with reference to the concept of an ‘age-friendly city’)
- Review the different phases of the photovoice process (timeline, etc.)
- What participants are asked to do
- Make clear that there are no right or wrong answers. ‘I am interested in your own views’ (Bowling, 2008).

Opportunity for participants to ask questions.

Start asking the open questions: think of your life within the city of Liverpool:

- What things do you think that make your neighbourhood/local community/Liverpool a good place to live in and which may support you in ageing well?
- On the other hand, what things do you think do not make your neighbourhood/local community/Liverpool a good place to live in and which may not support you in ageing well?
- What features/aspects do you like most about living in your neighbourhood/local community/Liverpool?
- What things/features/aspects do you like least about living in your neighbourhood/local community/Liverpool?
- What would you say are the most positive features/aspects in Liverpool that make you feel part of your community?
- What would you say are the most negative features/aspects in Liverpool that do not make you feel you are part of your community?
- Which things/features/aspects of Liverpool do you think that support or do not support older people in taking part in social/cultural/learning activities?
- Which things/features/aspects of Liverpool do you think that support or do not support older people to interact with and to meet, other people in the community?
- Which things/features/aspects of Liverpool do you think that support or do not support older people to go out to places (e.g. hobby, visiting family and friends, shopping, and health checks)
- Respect – to feel valued by the community/Liverpool; exploring attitudes towards ageing and older people.

An age-friendly city is a city committed to social inclusion, ensuring that older people are involved in, are part of and feel comfortable in, and are valued in the city in which they live.

How are older people viewed by people in your neighbourhood/Liverpool (e.g. young people)?

**‘Photography mission’:**

Introduce briefly: ‘I would need your help. As you are older people who live in Liverpool, I would like you to identify and take pictures of any feature/aspect of your neighbourhood/local community/Liverpool that you think (i) can support you (ii) and other older people to feel that you belong to your community, meet friends and family, take part in social/cultural activities that you enjoy and represent an opportunity to go out and do something that will contribute towards making your day. I would like that you think of **any aspect that is there in your community/Liverpool that is a good and helps you in feel valued and part of your community.** Moreover, mention if this aspect/feature is **something that you would like to see all around the city.** It could be any aspect/feature that you find in your neighbourhood/local community/Liverpool. It could be a thing (e.g. a park nearby you live), a person (e.g. a friend or neighbour), a place you go to (e.g. church), an activity that you do in the community (e.g. walking the dog in your local park).

In the same way, for taking pictures of positive aspects of Liverpool, I would like that you think of **those aspects that you think should be improved upon and that may represent a barrier or make it difficult for you and other older people to feel part of their community.** So, for instance, those may be barriers for you to go out and meet friends and family, to attend social and cultural activities that you would like to attend (e.g. lack of a park near where you live or a park very badly looked after). **It could be anything that you think would make it easier for older people to feel valued and part of this community/city.’**

Remind participants what they are asked to do in the following days and explain the **‘photography mission’** (to represent and capture both positive and negative aspects which support or do not support them and other older people to feel valued and part of their neighbourhood/local community/Liverpool).

Photography training + ethics related to taking photographs.

Give participants the ‘photo release forms’ + ‘use of the photographs forms’.

Opportunity for participants to ask questions.

Suggest possible days of the second focus groups.

Thank the group for participating in the focus group.

**References:**

Bowling, A. (2008). Enhancing later life: how older people perceive active ageing? *Aging & mental health*. [Online]. 12 (3). pp. 293–301. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/18728941>. [Accessed: 29 May 2013].

**Second focus group** (elements to be covered: discussion of the pictures; list of top 10 priorities to make Liverpool a socially inclusive place to grow old in).

Schedule:

Thank the group for attending the focus group.

Remind participants that everyone respects each other's opinions, no-one talks over anyone else, everyone is given a chance to speak, etc.

Give them the 'agenda of the day' and collect signed consent forms (if no collected at the interview).

Start to audio-record the focus group.

Remind participants what is the purpose of the meeting.

Contextualising and 'story telling' about the pictures with other participants:

- Why do you want to share this picture?
- Why is it important for you?
- What does it represent in terms of positive and negative aspects which support or do not support you and older people to feel valued and part of your community (e.g. meet friends, neighbourhood and family, attend social and learning activities, going out, etc.)?
- How/in which way do you think that this picture/aspect you portrayed may help to supporting other older people to feel valued and part of your community?
- To identify the top 10 priorities in Liverpool (in relation to respect and social inclusion in older people).

Thank the group for participating in the focus group and in the study

Give to them voucher, thank you card and invitation for them and other people to attend the exhibition.

Probes that will be used during the two focus groups and interviews:

- Can you give me some examples of this?
- What do you mean by ‘...’?
- That’s helpful. Could you say more about that?
- How do you think that this aspect relates to the issues?
- Can you explain how these factors influence each other?
- Is it possible to look at this in another way? Do you think that is a commonly held opinion?
- What do you think this (may) affect you?
- How much does it affect you?
- How did you feel about that?
- Would you change your opinion if ...? Was to happen?
- Can you give me an example where this did not happen?
- Can you give me an example of a different situation?
- In what ways does your opinion differ from the views of other people?

## Appendix I. Interview questions (older people)

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- Tell me why you took this photograph.
- Why do you want to share this photograph?
- Why is it important for you?
- How, in what way does this photograph (name of the building/place in the photograph) make you feel valued and/or part of your community?

### **The SHOWeD technique** (Wang et al. 1998; Wang & Burris 1997)

- What do you See here?
- What's really Happening here?
- How does this relate to Our lives?
- Why does this problem, concern, or strength Exist?
- What can we Do about it?
  
- What does this photograph represent in terms of positive and negative aspects which support support you to feel valued and part of your community?
- How do you think that this photograph/aspect you portrayed may be help to supporting other elder age healthily and feel valued and/or part of their community?
- Think of two challenges within your neighbourhood/local community/Liverpool that you face which constitute a barrier for you to make you feel valued and/or part of the community.
- Think of two aspects within your neighbourhood/local community/Liverpool that support you to feel valued and/or part of the community.
- Think of services/aspects/activities of Liverpool that are inclusive of elder people. Can you give examples of this? What type of services would you like to see/do you think that can be inclusive people in the community?
- Imagine that there was the possibility to make your neighbourhood/local community/Liverpool a better place for elder people to feel valued and part of their community. In this, imagine that you have all the resources to make it possible. What would you do?
- How would like that communicate what is meaningful to you and the results of the projects to people who work in the council and representatives of services for elder people in the city?

### **Exploring photographs not taken:**

- Are there any photographs that you might have wanted to take but you did not? If yes, can you tell about that? (Hodgetts et al. 2007)
-

## **Appendix J. Interview guidance (key informants)**



**University of Liverpool, Department of Public Health and Policy**

**PhD student: Sara Ronzi**

**Supervisory team: Professor Nigel Bruce, Dr Daniel Pope, Dr Lois Orton**

**PhD project title: Evaluation of complex public health interventions for healthy ageing: the example of respect and social inclusion.**

### **Topic overview interview**

Please note: this document that has been designed to give participants a general idea of issues we are interested in. As we will interview participants that come from different organisations which work with or have an interest in older people (*e.g.* public health, social care, culture, art, etc.), some of the topics below might be more relevant to your role than others, and this will be reflected in the interview which will explore aspects that are most relevant to you.

### **First interview**

#### **Definition of social inclusion and respect:**

Elements to be explored:

Social inclusion refers to enhancing the opportunities for older people to cultivate social interactions, have access to resources and support, and feel being a part of their community (Warburton et al., 2012). In this context, respect refers to positive attitudes and behaviours towards older people, and where those feel accepted, valued, appreciated by the community regardless of age (Department of Health, 2001).

- Your organisation and role within your organisation; links with older people and respect and social inclusion in Liverpool city. What is your Organisation's remit, and how this relates to your role, older people and respect and social inclusion in Liverpool city?

- Can you tell me more about the type of services/events/projects delivered by your organisation concerning older people and respect and social inclusion?
- Perspectives on what is being done (planned or implemented) in terms of the organisation of interventions/projects/initiatives designed to increase respect and social inclusion in older people; networks and partnership working around older people and respect and social inclusion. Does your organisation focus on respect and social inclusion (in older people), or carry out work related to respect and social inclusion [or social participation or any type of intervention designed to promote healthy ageing, improve health and wellbeing in older people]? Is there an overview & co-ordination of social inclusion and-related activity in Liverpool and beyond (region, national)? Is your organisation linked with other partners or are there existing partnership working/collaborations around older people and respect and social inclusion or services/projects for older people in general? Are there (Other) key players delivering/implementing interventions/projects in the area of social inclusion in older people locally?
- Use of evidence base: if interventions/projects/initiatives designed to increase respect and social inclusion in older people are carried out in your organisation, how are those assessed? Are standardised tools used? If yes, can you mention some of those? How do you know that the projects delivered work? What would be needed, useful to assess its impact in the most appropriate way? (e.g. type of measures, questionnaires, interviews.)
- Perspectives on needs, priorities, or issues; links with interventions/projects/initiatives designed to increase respect and social inclusion in older people. Extent to which respect and social inclusion in older people is considered a priority in Liverpool city. Based on the definitions that I gave you on R & SI, and our initial conversation, what is your understanding/perception of respect and social inclusion in older people as a priority issue needing addressing in the city? What would it be required to make social inclusion in older people a priority?
- Involvement of older people in interventions/projects/initiatives designed to increase respect and social inclusion in older people in your organisation and

Liverpool city. Have older people been involved in planning & implementation of these interventions? If so, how, in what way?

- Views on wider policy and influences (e.g. budget cuts, competing interests/issues for commissioning services and/or in developing interventions/projects/initiatives designed to increase respect and social inclusion in older people). Can you tell me more about funding of interventions? Are those sustainable in the long term? Are there any competing interests/issues for commissioning services and/or in developing interventions/projects/initiatives designed to increase respect and social inclusion in older people? If yes, can you give me some examples?
- Challenges associated with making Liverpool city a better place to grow old in and where older people feel valued and part of their community. So in summary, what are the main challenges associated with making Liverpool city a better place to grow old in and where older people feel valued and part of their community? (you can refer to your organisation and the city as well).
- Possible solutions/alternatives to those challenges? What may be required to strengthen respect and social inclusion in older people in Liverpool city?
- Brief update on the ongoing study with older participants in Liverpool.
- Opportunity for participant to ask questions
- Brief overview of the second interview (this is planned to be carried out in Spring 2015, at completion of the review work and study with older people).

## Appendix K. Ethics approval (Photovoice study with older people and study with city stakeholders)

**Ronzi, Sara**

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**Oggetto:** I: IPHS-1314-335-Evaluation of complex public health interventions for healthy ageing: the example of respect and social inclusion.

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**From:** IPHS Ethics  
**Sent:** 09 July 2014 11:52  
**To:** Bruce, Nigel  
**Subject:** IPHS-1314-335-Evaluation of complex public health interventions for healthy ageing: the example of respect and social inclusion.

Dear Nigel

I am pleased to inform you that IPHS Research Ethics Committee has approved your application for ethical approval. Details and conditions of the approval can be found below.

**Ref:** IPHS-1314-335  
**PI / Supervisor:** Nigel Bruce  
**Title:** Evaluation of complex public health interventions for healthy ageing: the example of respect and social inclusion.  
**First Reviewer:** James Cruickshank  
**Second Reviewer:** Michael Humman  
**Date of Approval:** 9.7.14

The application was APPROVED subject to the following conditions:

#### Conditions

- 1 All serious adverse events must be reported to the Sub-Committee within 24 hours of their occurrence, via the Research Governance Officer ([ethics@liv.ac.uk](mailto:ethics@liv.ac.uk)).
- 2 This approval applies for the duration of the research. If it is proposed to extend the duration of the study as specified in the application form, IPHS REC should be notified as follows. If it is proposed to make an amendment to the research, you should notify IPHS REC by following the Notice of Amendment procedure outlined at <http://www.liv.ac.uk/researchethics/amendment%20procedure%209-08.doc>.
- 3 If the named PI / Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore please contact the Institute's Research Ethics Office at [iphsrec@liverpool.ac.uk](mailto:iphsrec@liverpool.ac.uk) in order to notify them of a change in PI / Supervisor.

Best Wishes

*Liz Brignal*  
Secretary, IPHS Research Ethics Committee  
[iphs@liv.ac.uk](mailto:iphs@liv.ac.uk)

## Appendix L. MEDLINE (Ovid) search strategy (02/07/2014)

Database(s): **Ovid MEDLINE(R) and Ovid OLDMEDLINE(R)** 1946 to Present

Search Strategy:

#	Searches	Results
1	dementia/ or alzheimer disease/	98180
2	limit 1 to (abstracts and English language and humans and yr="1990 - 2014")	59488
3	Stroke/	59449
4	limit 3 to (abstracts and english language and humans and yr="1990 - 2014")	40994
5	Depression/	76576
6	limit 5 to (abstracts and english language and humans and yr="1990 - 2014")	42881
7	("health*" or "disorder*" or "disease*" or "illness" or "mortality" or "morbidity" or "disability" or "depress*" or "dementia" or "mobility" or "ischaemic heart*" or "stroke" or "cerebrovascular accident*" or "falls" or "Alzheimer's" or "Parkinson's" or "psychological distress" or "psychological disorder*" or "psychological symptoms").mp. [mp=title, abstract, original title, name of substance word, subject	7648068

	heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]	
<b>8</b>	limit 7 to (abstracts and english language and humans and yr="1990 - 2014")	3371321
<b>9</b>	2 or 4 or 6 or 8	3371321
<b>10</b>	("social inclusion" or "community inclusion" or "e-inclusion" or "digital inclusion" or "social cohesion" or "community cohesion" or "neighbo* cohesion" or "social involvement" or "community involvement" or "social integration" or "community integration" or "social engagement" or "civic engagement" or "community engagement" or "intergeneration*" or "social recognition" or "information and communication technolog*" or "social exclusion" or "neighbo* inclusion" or "neighbo* exclusion" or "community participation" or "social participation" or "ageism" or "agism" or "age* stereotyp*" or "age* discrimination" or "digital divide" or "social interaction*" or "social responsabilit*" or "social capital" or "social networks" or "access services" or	32554

	"access information" or "access opportunit*" or "access facilities" or "access volunteer*" or "access learning" or "social exchange" or "solidarity").mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]	
<b>11</b>	limit 10 to (abstracts and english language and humans and yr="1990 - 2014")	21290
<b>12</b>	("old*" or "elder" or "aged" or "senior*" or "pensioner*" or "ageing" or "aging").mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier]	4647454
<b>13</b>	limit 12 to (abstracts and english language and humans and yr="1990 - 2014")	2500260
<b>14</b>	"aged, 80 and over"/ or frail elderly/	619997
<b>15</b>	limit 14 to (abstracts and english language and humans and yr="1990 - 2014")	485303
<b>16</b>	13 or 15	2500264
<b>17</b>	Community Networks/	5458

<b>18</b>	limit 17 to (abstracts and english language and humans and yr="1990 - 2014")	2908
<b>19</b>	Intergenerational Relations/	2918
<b>20</b>	limit 19 to (abstracts and english language and humans and yr="1990 - 2014")	1973
<b>21</b>	11 or 18 or 20	23914
<b>22</b>	9 and 16 and 21	8267

## Appendix M. Criteria for assessing quality of quantitative studies

Pope (2014) adapted from Puzolo et al. 2013; Rehfuess et al. 2014

<b>Liverpool Quality Assessment Tool (LQAT) – Pope (2014)</b>				
Study ID (Author, year and date of extraction):				
Study design:				
	<b>Weak</b>	<b>Moderate</b>	<b>Strong</b>	<b>Reason and implication</b>
<b>SELECTION PROCEDURES</b> (population/sample size, sampling method, selection bias, response bias, follow-up bias, allocation of Intervention)				
<b>BASELINE ASSESSMENT</b> (e.g. type of randomisation, blinding of participants)				
<b>OUTCOME ASSESSMENT</b> (type of outcome measures used; subjective assessment e.g. observations, interviews; objective assessment e.g. validated tool/measures; Validated objective assessment e.g. observed improvement in health)				
<b>ANALYSIS/ CONFOUNDING</b> (how data are analysed/presented. E.g. significance difference, adjustment for known confounders)				

<p><b>CONTRIBUTION FOR</b></p> <p><b>THE REVIEW</b></p> <p>(how much information answers the review question: What is the empirical evidence of the impact on health of interventions which foster respect and social inclusion in older people?)</p>				
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## **Appendix N. Criteria for assessing quality of qualitative studies**

Adapted from Harden et al. (2009) from Puzzolo et al., 2013; Rehfuess et al., 2014) and  
& Pope 2000

Study ID (Author, year and date of extraction):

Study design:

### **1. Quality of reporting**

<b>Context of study</b>
<b>Were the aim and objectives clearly reported?</b>
Yes Partly No
<b>Comments:</b>
<b>Was there an adequate description of the context in which the research was carried out?</b>
Yes Partly No
<b>Comments:</b>

### **2. Methodology**

<b>Appropriateness of the design to the question</b>
<b>Would a different method have been more appropriate?</b>

<p><b>Yes</b></p> <p><b>Partly</b></p> <p><b>No</b></p>
<p><b>Comments:</b></p>
<p><b>Sampling methods</b></p>
<p><b>Was there an adequate description of the sample and the methods by which the sample was identified and recruited?</b></p>
<p><b>Yes</b></p> <p><b>Partly</b></p> <p><b>No</b></p>
<p><b>Comments</b></p>
<p><b>Did the sample include the full range of possible cases or settings so that conceptual rather than statistical generalisations could be made?</b></p>
<p><b>Yes</b></p> <p><b>Partly</b></p> <p><b>No</b></p>
<p><b>Comments:</b></p>
<p><b>Data collection</b></p>
<p><b>Was there an adequate description of the methods used to collect the data?</b></p>
<p><b>Yes</b></p> <p><b>Partly</b></p> <p><b>No</b></p>
<p><b>Comments:</b></p>

<b>Data analysis</b>
<b>Was there an adequate description of the methods used to analyse the data?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments:</b>
<b>Was there enough data presented to allow the reader to verify findings and/or interpretation?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments:</b>

### 3. Use of strategies to increase reliability and validity

<b>Were there attempts to establish the reliability of the data collection tools (e.g. by use of interview topic guides, interview schedules or other attempts)?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments:</b>
<b>Were there attempts to establish the validity of the data collection tools (e.g. with pilot interviews)?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>

<b>Comments:</b>
<b>Were there attempts to establish the reliability of data analysis methods (e.g. by use of independent coders or other described methods)?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments:</b>

**4. Extent to which findings reflected participant perspectives and experiences**

<b>Did the study use appropriate methods for ensuring the data analysis was grounded in the views of the participants? (Validity/trustworthiness)</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments:</b>

## Appendix O. Criteria for assessing quality of policy and case studies

Adapted from Aktins and Sampson 2002 (in Puzzolo et al., 2013; Rehfuess et al., 2014)

**Study ID (Author, year and date of extraction):**

**Study design:**

### 1. Ways and quality of reporting

<b>Context of study</b>
<b>Were the aim and objectives clearly reported?</b>
Yes
Partly
No
<b>Comments:</b>
<b>Was there an adequate description of the context in which the research was carried out?</b>
Yes
Partly
No
<b>Comments:</b>
<b>Was there an adequate description of the study design used?</b>
Yes
Partly
No
<b>Comments:</b>

<b>Was there any information on sampling (sample size and how it was identified)?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments:</b>
<b>Was there any attempt at representativeness and/or to report on different views from stakeholders?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments:</b>
<b>Was there any information on data collection?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments</b>
<b>Was there an adequate description of the methods used to analyse the data?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments</b>
<b>Was there an adequate description of the methods used to analyse the data?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments</b>

<b>Was there enough data presented to allow the reader to verify findings and/or interpretation?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments</b>
<b>Are limitations to the study acknowledged and described?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments:</b>

2. **Bias**

<b>Any risk of bias due to author(s) being closely associated with the implementers/participants?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments:</b>
<b>Are conclusions made well-grounded in the data?</b>
<b>Yes</b> <b>Partly</b> <b>No</b>
<b>Comments:</b>

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**3. Appropriateness**

<b>Did the study use appropriate methods for ensuring the data analysis expressed the views of participants?</b>
<b>Yes</b>
<b>Partly</b>
<b>No</b>
<b>Comments:</b>
<b>Does the study suggest if and how the findings might be transferable to other settings?</b>
<b>Yes</b>
<b>Partly</b>
<b>No</b>
<b>Comments:</b>

**Appendix P. Photographs taken by older participants that were not presented in Chapter 5**

**Green and blue spaces**



**Transportation**



**Famous and elegant buildings, Museums, Community centres**



**Libraries, cultural/learning opportunities**



**Hobbies, interests, sport/leisure centres**



**Hobbies, interests, community centres, theatres**



**IT Skills/training**



**Family, friends**



**Churches**



**Streets, pedestrian paths, benches, home**



**Good memories**



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### Places to eat, drink, health centres



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### Lack of street cleanliness



