1. Background

Almost two million people in the UK are living with sight loss that has a significant impact on their daily lives, and every day approximately 100 more people begin to lose their sight (Fight for Sight, 2013). This phenomenon is increasingly linked to age, with 1 in 9 people aged 60+ in the UK currently living with sight loss. The health and well-being of this growing and ageing population requires attention. Research shows that visually impaired older adults, in general, have poorer general health than the sighted population (Jones et al., 2009). Visual impairment is also a significant risk factor for additional medical conditions as a result of activity limitations, and participation restrictions (Crews & Campbell, 2001).

Physically active older adults have lower risk of disease including dementia and have higher levels of physical and cognitive function, psychological well-being and independence than inactive older adults (Department of Health (DoH), 2011). However, less than 10% of those over 55 years meet the minimum amounts of activity recommended for health (30 minutes of at least moderate physical activity on five or more days per week) (Craig, Mindell & Hirani, 2008; DoH, 2011). Broad scale survey work (not specific to visual impairment) has shown that disabled adults are less likely than non-disabled adults to participate in cultural, leisure or sporting activities (Department for Work and Pensions (DWP), 2013). Sport England (2011; 2013) estimate that only 18% of disabled adults (18+) undertake physical activity for more than 30 minutes a week, and those living with impairments are around half as likely to be active as non-disabled adults. These numbers are slightly worse when broken down by type of impairment, with participation amongst those with a sensory disability being 4% lower than amongst those with a physical disability (Sport England, 2011). In addition, adults with impairments are more likely than those without impairments to experience barriers to taking part in leisure activities (DWP, 2013).

Despite these figures, no systematic research exists concerning physical activity among older people with sight loss. While statistics on physical activity participation by older adults (60+) with visual impairment are unavailable, if we are to consider the broader disability participation rates alongside ageing participation rates, an alarming picture emerges.

The DoH physical activity recommendations are as relevant to older adults with sight loss as their sighted peers. To date, however, both research and policy have had little to say about the involvement of older adults who are experiencing late onset sight loss, nor how their participation can be facilitated. Policy makers, organisations, and so forth cannot assume that what is known about one population (e.g., older sighted people / young physically active / young visually impaired people) can simply be
transferred into recommendations for promoting physical activity for another (e.g., older adults with sight loss). Knowledge on this specific group thus needs developing in order to make meaningful changes in activity levels and subsequent health and well-being.

2. Aims and objectives

The primary aim of this research was to increase the knowledge and understanding of physical activity among older people with sight loss. Specifically, the objectives of the research were to:

- Explore individual experiences of physical activity among older people (60+ years of age) who have acquired sight loss later in life. (See section 4. Findings)
- Identify the ways in which visually impaired older people’s participation in physical activity can be facilitated and/or prevented. (See section 4. Findings)
- Provide an evidence base with examples of good practice, which can be used to inform policy and practice regarding the promotion of physical activity among older people with sight loss. (See section 5. Promising practice)
- Examine the value of novel and imaginative qualitative research methods to understand these issues in more complete and nuanced ways. (See section 6. Methodological reflections)
- Establish areas for future research that will develop knowledge and improve commercial enterprise and service delivery in this area. (See section 7. Conclusions and recommendations)

3. Methodology

A qualitative methodology was used in order to meet the research aim and objectives. Qualitative methods are widely used in research, including within medicine, psychology, and social care (Green & Thorogood, 2009). Qualitative methods allow researchers to identify what is meaningful for people themselves and enables them to produce in-depth knowledge. In so doing, policy and best practice recommendations are informed in deep ways by the very people they are meant for – in this case, older people with sight loss.

Ethics and sample

The research was approved by the Loughborough University Research Ethics Committee. Informed consent was obtained prior to each participant’s involvement in the research. In addition, the research was overseen by a formally appointed Advisory Board made up of members drawn from a range of relevant backgrounds. Meeting quarterly throughout the project, the Board provided constructive comment and advice as the project was being implemented, contributed ideas, advice and support, and helped the research to achieve maximum impact both during and after the project duration.

A purposive sample (Ritchie & Lewis, 2003) was used in order to capture a diverse range of views from
the population of interest. The aim of this strategy was to ensure that a full range of factors, influences, views, and experiences could be investigated, as they pertained to physical activity among older people with sight loss. As part of this, the sample deliberately included individuals with a variety of visual impairment (in type and degree), as well as a range of time elapsed since sight loss was first experienced. Additionally, the study sampled for different ages within the defined range (of 60-75 years of age, and small number aged 75+) to examine any possible age differences, and endeavoured to represent both genders and a range of (self-defined) activity levels.

The final sample consisted of 16 participants from each of three separate geographical locations: the South West, the Midlands, and London (total n = 48). Within each group of 16, the majority of participants were between 60 and 75 years of age (n = 14), and the remaining two were 75+ years of age. Within the final sample, 18 participants were ‘black blind’, a self-reported term used to signify a complete loss of vision. The other 30 had varying degrees of partial sight, with diverse conditions reported including age-related macular degeneration (AMD), cataracts, glaucoma, diabetic retinopathy (DR), and retinal issues such as retinitis pigmentosa (RP) and haemorrhage. In addition, the age at which sight loss was first experienced varied widely within the sample, with 26 participants experiencing sight loss in the recent past (<15 years), and 22 participants who had been living with their sight loss for 15+ years.

The sample also consisted of participants who had a variety of activity levels. Activity levels and participation in physical activity were captured by self-report, and were not measured objectively. From this self-report data, it was evident that participation in physical activity existed on a continuum from inactive to very active, rather than in discrete categories (i.e., ‘active’ vs. ‘inactive’). To capture and represent activity levels in a standardised fashion, the research team combined self-reports with interview data in order to give a better sense of each individual’s level of participation in physical activity (see tables 1 – 3 for key characteristics of the sample, including activity levels). Activity levels refer only to frequency of participation, and not intensity. The first category of ‘rarely/never’ encompasses those participants who self-identified as completely inactive, rarely leaving the house and restricted in terms of mobility. The second category of ‘occasional’ describes those who participate irregularly (i.e., on a monthly basis). ‘Regular’ participants were those who described themselves as moderately active: often leaving the house, relatively mobile with some restrictions, yet interested and engaged in various activities (physical, social and cultural) at least weekly. ‘Frequent’ participants were active on a daily basis, habitually participating in organised physical activities of various descriptions.

By including those who had more recently experienced sight loss, detailed and contextualised information about the sight loss and rehabilitation process was readily recollected, both positively and negatively. Sampling people who experienced their sight loss 15+ years ago also provides longitudinal, reflexive data. It allowed deep awareness of a person’s adjustment to their sight loss and an understanding of resilience and coping strategies developed over time. The type of partial sight remaining, if any (i.e., peripheral, pinpoint, cloudy vision, etc.) was also pertinent to consider, as different types of partial vision can effect engagement in lifestyle activities, including participation in physical activity. To further ensure a robust data sample set, data saturation was sought. This refers
to the point at which the information collected, transcribed, and analysed begins to repeat itself; nothing new is being found.

Table 1: South West participants by key characteristics

<table>
<thead>
<tr>
<th>VI Degree</th>
<th>Age</th>
<th>Gender</th>
<th>Type of VI</th>
<th>Age at onset</th>
<th>Physical activity participation</th>
<th>Type of activity (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Blind</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>male</td>
<td>Retinal haemorrhage</td>
<td>36</td>
<td>Regular</td>
<td>Swimming, walking, sailing</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>male</td>
<td>Retinal haemorrhage</td>
<td>50</td>
<td>Regular</td>
<td>Home-based exercise &amp; rifle-shooting</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>female</td>
<td>Degenerative Myopathy</td>
<td>44</td>
<td>Frequent</td>
<td>Walking</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>female</td>
<td>Glaucoma &amp; AMD</td>
<td>54</td>
<td>Regular</td>
<td>Swimming</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>female</td>
<td>Detached retina</td>
<td>55</td>
<td>Rarely/never</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>female</td>
<td>DR</td>
<td>46</td>
<td>Rarely/never</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>male</td>
<td>AMD</td>
<td>49</td>
<td>Frequent</td>
<td>Home exercise, gig-rowing, skiing</td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>male</td>
<td>Glaucoma &amp; AMD</td>
<td>61</td>
<td>Rarely/never</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Partial Sight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>male</td>
<td>AMD</td>
<td>55</td>
<td>Regular</td>
<td>Rifle-shooting &amp; home exercise</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>female</td>
<td>DR</td>
<td>60</td>
<td>Regular</td>
<td>Rifle-shooting, some walking</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>male</td>
<td>Retinal haemorrhage</td>
<td>54</td>
<td>Regular</td>
<td>Rifle-shooting</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>female</td>
<td>AMD</td>
<td>58</td>
<td>Regular</td>
<td>Walking &amp; dancing</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>female</td>
<td>RP</td>
<td>50</td>
<td>Regular</td>
<td>Gym &amp; swimming</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>female</td>
<td>AMD</td>
<td>50</td>
<td>Regular</td>
<td>Keep Fit, home exercise &amp; dancing</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>female</td>
<td>AMD</td>
<td>41</td>
<td>Frequent</td>
<td>Gym, dancing, bowls</td>
<td></td>
</tr>
</tbody>
</table>
### Table 2: Midlands participants by key characteristics

<table>
<thead>
<tr>
<th>VI Degree</th>
<th>Age</th>
<th>Gender</th>
<th>Type of VI</th>
<th>Age at onset</th>
<th>Physical activity participation</th>
<th>Type of activity (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male AMD</td>
<td>65</td>
<td>Male</td>
<td>AMD</td>
<td>54</td>
<td>Occasional</td>
<td>Gym &amp; home exercise</td>
</tr>
<tr>
<td>Male AMD</td>
<td>74</td>
<td>Male</td>
<td>AMD</td>
<td>63</td>
<td>Rarely/never</td>
<td>N/A</td>
</tr>
<tr>
<td>Male AMD, vein occlusion &amp; Glaucoma</td>
<td>64</td>
<td>Male</td>
<td>AMD, vein occlusion &amp; Glaucoma</td>
<td>58</td>
<td>Frequent</td>
<td>Cricket &amp; gym</td>
</tr>
<tr>
<td>Male</td>
<td>72</td>
<td>Male</td>
<td>accident (1 eye)/ Herpes Simplex (other)</td>
<td>10/20</td>
<td>Regular</td>
<td>Walking</td>
</tr>
<tr>
<td>Male AMD</td>
<td>89</td>
<td>Male</td>
<td>AMD</td>
<td>69</td>
<td>Rarely/never</td>
<td>N/A</td>
</tr>
<tr>
<td>Female RP &amp; cataracts</td>
<td>62</td>
<td>Female</td>
<td>RP &amp; cataracts</td>
<td>25</td>
<td>Regular</td>
<td>Fitness dancing</td>
</tr>
<tr>
<td>Male cataracts</td>
<td>70</td>
<td>Male</td>
<td>cataracts</td>
<td>69</td>
<td>Regular</td>
<td>Walking &amp; cycling</td>
</tr>
<tr>
<td>Male AMD</td>
<td>63</td>
<td>Male</td>
<td>AMD</td>
<td>59</td>
<td>Regular</td>
<td>Gym</td>
</tr>
<tr>
<td>Female AMD &amp; cataracts</td>
<td>69</td>
<td>Female</td>
<td>AMD &amp; cataracts</td>
<td>63</td>
<td>Regular</td>
<td>Walking, gardening &amp; T’ai Chi</td>
</tr>
<tr>
<td>Male AMD</td>
<td>70</td>
<td>Male</td>
<td>AMD</td>
<td>64</td>
<td>Rarely/never</td>
<td>N/A</td>
</tr>
<tr>
<td>Male Pseudoxanthoma Elastica</td>
<td>68</td>
<td>Male</td>
<td>Pseudoxanthoma Elastica</td>
<td>49</td>
<td>Regular</td>
<td>Walking &amp; gardening</td>
</tr>
<tr>
<td>Male AMD</td>
<td>66</td>
<td>Male</td>
<td>AMD</td>
<td>64</td>
<td>Regular</td>
<td>Walking</td>
</tr>
<tr>
<td>Female AMD</td>
<td>77</td>
<td>Female</td>
<td>AMD</td>
<td>74</td>
<td>Regular</td>
<td>Bird-watching/walking</td>
</tr>
<tr>
<td>Female AMD (Sorsby’s Fundus Dystrophy)</td>
<td>69</td>
<td>Female</td>
<td>AMD (Sorsby’s Fundus Dystrophy)</td>
<td>62</td>
<td>Regular</td>
<td>Walking, cycling &amp; skiing</td>
</tr>
<tr>
<td>Age</td>
<td>Gender</td>
<td>Condition</td>
<td>Occasional Activity</td>
<td>Activity Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>--------</td>
<td>------------</td>
<td>---------------------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Female</td>
<td>Hemianopia</td>
<td>55</td>
<td>Walking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>Female</td>
<td>AMD</td>
<td>72</td>
<td>Walking</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 3: London participants by key characteristics

<table>
<thead>
<tr>
<th>VI Degree</th>
<th>Age</th>
<th>Gender</th>
<th>Type of VI</th>
<th>Age at onset</th>
<th>Physical activity participation</th>
<th>Type of activity (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Blind</td>
<td>72</td>
<td>Male</td>
<td>Unknown/infection</td>
<td>18</td>
<td>Frequent</td>
<td>Lawn bowls &amp; swimming</td>
</tr>
<tr>
<td></td>
<td>68</td>
<td>Female</td>
<td>RP</td>
<td>8</td>
<td>Frequent</td>
<td>Running (guided), gardening, skiing &amp; walking</td>
</tr>
<tr>
<td></td>
<td>72</td>
<td>Male</td>
<td>RP</td>
<td>20</td>
<td>Rarely/never</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>69</td>
<td>Male</td>
<td>RP</td>
<td>12</td>
<td>Frequent</td>
<td>Gym, tandem cycling &amp; walking</td>
</tr>
<tr>
<td></td>
<td>93</td>
<td>Female</td>
<td>AMD</td>
<td>68</td>
<td>Rarely/never</td>
<td>N/A</td>
</tr>
<tr>
<td>Partial Sight</td>
<td>72</td>
<td>Female</td>
<td>AMD</td>
<td>59</td>
<td>Regular</td>
<td>Yoga &amp; walking</td>
</tr>
<tr>
<td></td>
<td>72</td>
<td>Female</td>
<td>DR &amp; cataracts</td>
<td>67</td>
<td>Regular</td>
<td>Hospital-based exercise program</td>
</tr>
<tr>
<td></td>
<td>66</td>
<td>Female</td>
<td>AMD</td>
<td>54</td>
<td>Regular</td>
<td>Yoga, gardening &amp; walking</td>
</tr>
<tr>
<td></td>
<td>62</td>
<td>Female</td>
<td>Albinism (genetic - degenerative)</td>
<td>0</td>
<td>Rarely/never</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>67</td>
<td>Female</td>
<td>Macular Dystrophy (Stargardts)</td>
<td>27</td>
<td>Regular</td>
<td>Walking</td>
</tr>
<tr>
<td></td>
<td>67</td>
<td>Male</td>
<td>AMD &amp; cataracts</td>
<td>66</td>
<td>Regular</td>
<td>Walking</td>
</tr>
<tr>
<td></td>
<td>70</td>
<td>Female</td>
<td>Stargardts</td>
<td>10</td>
<td>Regular</td>
<td>Dance &amp; walking</td>
</tr>
<tr>
<td></td>
<td>73</td>
<td>Female</td>
<td>AMD &amp; Glaucoma</td>
<td>56</td>
<td>Rarely/never</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>79</td>
<td>Male</td>
<td>AMD</td>
<td>72</td>
<td>Regular</td>
<td>Lawn bowls &amp; walking</td>
</tr>
<tr>
<td></td>
<td>68</td>
<td>Male</td>
<td>AMD</td>
<td>58</td>
<td>Frequent</td>
<td>Swimming &amp; tandem cycling</td>
</tr>
<tr>
<td></td>
<td>76</td>
<td>Male</td>
<td>AMD</td>
<td>74</td>
<td>Regular</td>
<td>Gym &amp; walking</td>
</tr>
</tbody>
</table>
**Data collection**

In-depth semi-structured interviews with 48 people with sight loss were conducted. Each interview lasted for approximately 1 hour and was organised around the following key themes: visual impairment diagnosis, description, and details; general health and well-being; personal background and participation in physical activity pre-sight loss; participation and engagement following sight loss; barriers and motivations to engage in physical activity; and suggestions and recommendations for physical activity access and provision based on personal experience. Themes that formed the interview guide were employed flexibly throughout the interviews to encourage open-ended responses and rich descriptions of events and participant experiences.

Two additional forms of data collection were also employed with a selection of the sample: audio diaries (n=6), and mobile interviews (n=6). These methods represent a novel, imaginative, and participant-led approach to qualitative data collection. Six participants (two from each geographical location) were provided with a digital recorder and asked to keep an audio diary of their day-to-day experiences of and/or aspirations for physical activity over a two week period (approximately 10 minutes daily duration). This allowed the capture of dynamic individual and social processes of physical activity over time (Monrouxe, 2009). It also provided insight into the participants’ everyday, mundane practices, which may have seemed irrelevant to the participant during the formal interview setting, but can be pertinent in facilitating and/or preventing their involvement in physical activity within the context of everyday life.

A further six participants (two from each geographical location) were approached to take part in a mobile interview. Mobile interviewing involves talking with participants while ‘on the move’ through (disruptive) space (Brown & Durrheim, 2009). For example, in this research, mobile interviews took place while exercising alongside the participant and/or travelling to the places where physical activity occurred. Such an approach provided the opportunity for the participant to show rather than describe the environments and spaces that are significant in terms of their participation in physical activity, and allowed for conversations that were contingent on the surrounding (visual), olfactory, and aural distractions rather than on researcher pre-planned questions. It also placed experiences, stories, and events in their spatial context that, in turn, can stimulate the participant to articulate or elaborate on their thoughts, behaviours, and emotions.

Lastly, this data was supplemented by the identification of examples of promising practice regarding the facilitation and support of participation in physical activity among older adults with sight loss. Promising practice emerged from conversations with participants, and consisted of sites, policies, and facilitators that best reflected a response to the needs of older adults with sight loss. This dimension complemented the first part of the project by providing solutions that go some way to addressing the difficulties of undertaking physical activity as an older adult with sight loss that have been expressed by participants. Case studies of promising practice are presented in section 5, following the findings.
Data analysis
Data was analysed using a thematic analysis (Braun & Clarke, 2006). This involved the systematic organisation, description, and interpretation of the key patterns (themes) within the data set. The thematic analysis involved six steps. These were: 1) transcribing the verbal data and re-reading it for content familiarity; 2) generating initial codes or meanings by highlighting relevant segments of data; 3) searching for and identifying themes within the data; 4) organising themes into a matrix and reviewing these by considering how they fit with the data extracts; 5) defining the themes by identifying the ‘essence’ of what each theme is about, and; 6) writing the report.

Validity and generalisability
Using Tracey’s (2010) extensive review of what constitutes “excellent qualitative work” (p. 837), the study used several criteria to assess the validity of results. These included: the social significance of the topic; rich rigor (e.g., weaving together appropriate concepts); a transparent audit trail (e.g., an independent researcher scrutinised sampling strategies, the data collection process, and the analysis); and credibility through member checking (e.g., selected participants were given their respective transcripts and later a preliminary report to test if the analysis was fair and accurate).

The generalisability of the research was tested using the concept of naturalistic generalisation (Stake, 1995). This assesses if the research resonates or fits with other people’s understanding of a certain event, context, or experience. When it does, this means that research can be transferred across the population (e.g., to other older adults aged 60+ with age-related sight loss) and topic (physical activity engagement, access, and experiences) being studied.

4. Findings

From the thematic analysis, two broad themes were identified:

1) Health characteristics; and

2) Accessibility and opportunity.

Within each theme there are several contributing sub-themes, describing both barriers and facilitators to participation in physical activity among older adults with sight loss. For ease of reference in this report, the sub-themes are presented here separately. It should be noted, however, that in practice these frequently overlap. In the following section, we explicate each sub-theme and in doing so we address our first two identified objectives: to explore individual experiences of physical activity among older people (60+ years of age) who have acquired sight loss later in life; and to identify the ways in which visually impaired older people’s participation in physical activity can be facilitated and/or prevented.

Within the sub-theme descriptions below, participant experiences did not vary by geographical location or by age unless stated otherwise.
Theme 1: Health characteristics

Regardless of their individual level and type of physical activity participation, each older adult with sight loss linked the practice of physical activity to the wider concept of health. Their own personal health and fitness level was variously an incentive, a motivator, or a barrier. Many spoke of how their participation in their chosen activity enhanced aspects of their health, beyond the physiological level. This broad theme considers participants’ holistic conceptions of health, and how or if they perceived or experienced this to be a barrier or facilitator to their participation in physical activity.

Physical fitness

Several participants itemised the physical benefits they perceived to result from their participation in a chosen activity. For these older adults, physiological measures such as weight loss and improved cardiovascular functioning were the markers for progress and/or maintenance, allowing them to do everyday tasks with ease.

Going on the treadmill helps my breathing, obviously. It keeps my weight down. It just helps me keep fit as I get older. I think the more physically fit you are, the more mentally fit you are, the longer you’re going to live. If you don’t keep fit – if I just let myself go and get too overweight, it’s going to affect my diabetes, which then affects other things. Which then shortens my life, or certainly makes my life worse.

Functionality in everyday mobility as well as not being or feeling restrained in life (in general) featured heavily here.

For me, it’s being able to run around with my grandchildren. You know, I can’t see to kick a ball that well but they know that, so they’ll yell: ‘It’s coming granddad!’ And I stop it, and kick it. If I know where it is, bang! Just being able to do that, and enjoy your life. Climb the stairs and not be gasping. Being able to enjoy and embrace everything around you.

A few participants went beyond the idea of function, and referred to the necessity of physical fitness for performance in their chosen sport. These participants tended to be participating on a competitive level, and gauging their personal physical fitness either directly against others or against their previous selves.

Running is such a big part of my life. It makes you feel so much better. It’s just a feeling of well-being. A few weeks ago I did a 10K race, and it went up the steepest hill in the area. It is hard work. People say to me, ‘Well, if it hurts, what do you do it for?’ I don’t know exactly, but somehow or other you want to see how you can push your body. It’s just knowing that you can push your body a little bit further or a little bit faster.
At the other end of the spectrum were those who described themselves as lacking physical fitness, with inactivity the primary contributing factor.

I really don’t do much at all. I’m not fit enough, and I can’t see well enough. I’ve found my perimeters, and I don’t feel I can do any more, or go any further than that. So I’m prepared to accept that and work with it. I’m not dissatisfied. It’s just the driving, more than anything – because I used to drive for a living and for a hobby, I loved it. I miss that.

Whether or not sight loss led, or contributed, to inactivity and poor physical fitness for participants, many spoke of activity loss as a result of their visual impairment. The following sub-theme considers this in more detail.

**Activity Loss**

Each and every participant lamented some form of activity loss that resulted from their visual impairment. For many, it was the loss of a valued leisure activity, like driving or reading, which they felt most impacted their lifestyle. Many tried to adapt the activity to continue their participation for as long as was possible. However, there were limits to the level of adaptation that can take place.

The one thing I can’t do that I did for years and years is sing in a choral society. Obviously, I can’t read music anymore. As my sight dropped, I used to buy my own score. And I would highlight my lines in an orange highlighter, and highlight starting points with blue highlighter. But in the end, it just because too much of an effort. I just had to give up.

Knitting, needlework and woodwork were some other common leisure activities about which participants expressed disappointment with no longer being able to participate. Within this list were also certain forms of physical activities. In particular, several participants explained that the first thing to go was any form of ball sport participation.

I can’t play tennis or those sort of sports anymore. The ball moves too fast for my eyes to send the messages to my brain. My husband plays golf, and possibly if my eyesight weren’t so bad I might have taken that up when I retired. But I haven’t, because I can’t. I don’t feel I can see well enough to enjoy it.

Other physical activities began to carry significant risks due to impaired vision, and the necessity of being able to judge external moving objects, obstacles, or distances.

I used to cycle a lot on the roads. I think that would now be most unwise. I might ride it on a path, but I find riding on the roads now impossible, so I’ve given that up.

Participants for whom the sight loss was more severe (and/or more sudden) often expressed a loss of more general physical activities related to mobility, including walking.

I can’t really do very much at all. Before, two, three, four times a week I would go – we’ve got a big
park nearby and I would walk around the park and along the river, which is just under four miles. And I would do that several times a week. But I can't do that now, I just can't. Never mind get out into the countryside.

Activity loss was also experienced when circumstances changed. For example, for some, activity participation was enabled by a particular source of social support (i.e., partner or friend). If the support was then no longer available, activity participation would often cease.

When I had my husband, it was fine and I didn't have any problems, and used to do lots more different things. But you've just got to cut back, and do what you can, and go from there, haven't you? I mean, I love dancing. My husband was an absolutely fantastic ballroom dancer. So, dancing is my real loss, I'd say. And all these things I do miss dreadfully.

Another common experience of activity loss resulted from the combination of, or interaction between, participant's visual impairment and other existing or concurrent health conditions. This was relatively common, and thus informs the following sub-theme (comorbidities).

**Comorbidities**

A comorbidity is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases. Several participants described the challenges of juggling other chronic conditions alongside their sight loss, many of which they perceived as directly interfering with their participation in physical activity. These included circulation and joint issues which had an impact on their capacity to walk and/or move in general.

I can't do much because of my arthritis, in my knees. I do walk as much as I can with my husband. We park up somewhere and walk. And if we get to a destination and I can't walk back, he'll leave me and go and get the car. Most of the times, I try... It's not a great deal of walking, but it's a little bit of walking. My general health is a bit poorly at the moment. Because I've got Diabetic Retinopathy. I've also got a heart problem. I did have fluid in my lungs... And I've just had an operation, and that's slowed me down a bit.

I can't do it now, because of the neuropathy in my legs. I have no circulation left. I'm alright up to about 20 yards, but then I can't walk any further. So even going into town, I can't walk around town.

In contrast, many participants described using physical activity as part of their broader health care regimen, particularly to help control other chronic conditions.

I have diabetes, so I need to keep fit and healthy and I keep my blood sugar at a really good level. And I have a check-up every six months. They're, they're very pleased with me, because my blood sugar's been quite stable for a long time now, and it's low. And that's only because of my diet and my exercise. It controls it. And the more I do, the healthier I am. I also have arthritis in my hip joints. I've had one hip replacement and the other one needs to be replaced one day. But, exercise
seems to help that as well, just keeping my hips going.

Within this sub-theme, there were some variations according to age. We know that chronic conditions represent a critical health issue facing many older adults in developed countries (WHO, 2010). In England, more than 15 million people have a chronic condition, and this figure is set to increase over the next 10 years, particularly those people with 3 or more conditions at once (DOH, 2013). Our findings suggest that those participants aged 75 and older did report having many concurrent chronic conditions.

I’m 89, profoundly deaf, and registered blind. I’ve got a bit of a bladder problem right now, an infection. And this year it was found that I have bowel cancer, so I’ve recently had an operation for that and just started my chemo on Monday.

However, many of our respondents in their sixties also reported juggling numerous conditions.

We also had some exceptional participants, including one 97 year old who reported very few health complaints and who participated in daily physical activity:

I go walking three or four times a week and do exercises here at home. Floor exercises, to keep my muscles strengthened. I’ve got a stationary bike and a rowing machine that I use every day as well. Some days it’s a job to walk around, and I do find I’m getting slower and a bit more wobbly. I did have some problems with my hip, and my doctor sent me up to the hospital for physio. But he sent me back and told my doctor it was a waste of time because I was too fit.

Of course, the number of adults aged 75 and older within our sample does not allow for a comprehensive comparison between age groups. What is evident within our data, however, is a pattern of how participants referred to their health complaints. For example, those aged 70 and older were more likely to refer to their physical complaints within a larger discussion of their ageing bodies.

But it’s this [points to her body], it’s outside of my control. Your body lets you down a bit. I’ve got bursitis in my hips and I find it difficult to get around. I’ve got varicose veins which cause me pain, ulcers on my legs, and my vision is getting worse and worse. And of course I wish all of that was different, or could get better. But I’m 82, and I’m okay! I’ve had a good run at life. I’ve enjoyed it, I’ve done good work. I’m not unhappy. I’m a happy, fulfilled woman, and I’m still here.

I mean, sometimes I push myself and I think, ‘Slow down woman, you’re 77 not 18!’, you know? But your brain still thinks you can do it, it’s your body telling you that you can’t. And that’s natural as well, that’s part of getting older.

These participants were resigned to the limitations of their ageing bodies, and sight loss was one in a long list of ailments that they were coping with on a daily basis. Further, their activity choices and capabilities were impacted by this perceived inevitability of bodily decline that comes with age.

I’d like to walk more. But even that I can’t do much of because of my heart condition, and the pain in
my knees from the arthritis. So I think maybe I’m past thinking about physical activity. (age 73)

I do go out when I can, but the last couple of years unfortunately I’ve not been able to walk very far. I used to walk a lot. And now, I find that I can only walk for about five minutes and then I need to sit down and have a rest. It is partly my sight, but I think now it’s my age or something. (age 93)

**Mental and emotional health**

Going beyond physical health, the majority of participants acknowledged the link between mental and emotional health and physical activity.

I think that one of the main things is depression, feeling depressed and fed up. I do suffer from that. That can be quite bad at times. I do try to bring myself out of it, but I haven’t found anything that really works for me. I think that probably contributes to not being able to do a lot of activities.

I think on a day to day basis, you know, I definitely feel more mentally fit. So they’re intimately related, aren’t they? Those mental and physical feelings. I definitely feel better in myself when I go to the gym. I don’t ever feel sluggish at all, and I know that if I stop going to the gym I would definitely feel a bit under the weather.

A distinction that continuously emerged was whether or not you were able to ‘get out of the house’.

I know that if people don’t get out from the house then they’ve got a problem. I mean, I know myself, if I’m stuck here and I don’t get out it only takes me a day or maybe a little bit more before I’m feeling quite down. And it’s very true that they say exercise helps depression. It does. There’s a little lane opposite me. If I walk from here and walk up that lane, I’ve only got to do a couple of hundred yards and I start to feel better.

Participants spoke of experiencing depression following sight loss, during bouts of illness, or when side-lined by injury. Importantly, for some older adults with sight loss, participation in physical activity, whether in an organised group or not, offered one means and reason to ‘get out of the house’.

I have a few friends who live on their own. Coming to the shooting club is the one thing that gets them out of the house, the one thing in the week that they do and that they look forward to. You know, and it’s not just the shooting. They’re not particularly good. But you know, meeting a group of people who are similar-minded and who have the same problems… And just the breather, to get out of the house, you know?

For those participants who did participate in physical activity, there was a split: those who preferred to do so alone, and those who preferred to be in a group. Those who did solitary activities spoke positively about the opportunity to engage in self-reflection, contemplation, and escape.

I just enjoy the open countryside, having nothing to do but walk. And walking is a great reflection time, you can reflect whilst you’re walking. And I find that I think of ideas and things while I’m
walking. If you like, the intellectual part of my brain is not busy while I’m walking, but I’m carrying out an activity which allows me to contemplate things, really.

I go to the gym. I do half an hour on the treadmill and then I either go on the cross trainer or the arc thing. One or the other, for half an hour. And then I end up going on a steps machine for half an hour. I finish up on weights. I like it, I’m on my own and it gives me time with my thoughts and makes me feel fit. I feel fantastic afterwards.

Those who preferred group or team exercise cited enjoyment of the activity alongside enjoyment of the social interaction that the activity induced or created.

It’s the camaraderie, you know, the social side of the cricket. Some of the chaps I’ve known for 30, 40 years. It’s like a family really, they’re there for all of the ups and downs. They’re a great bunch. We take the mickey out of each other, we have a good laugh about things.

We just sort of get on together… We talk about absolutely everything and nothing…It’s really wonderful.

You meet people the same as yourself. Whereas, if you don’t go to these groups or do anything, you just think, am I the only one in this world that’s got this problem? It makes you try things you didn’t think you could do. And that’s why it’s so important with these clubs. To get people out of those four walls, to get them to try things they would never dream of doing. I mean, everybody gets different things out of it.

For these participants, the social benefits of participation in physical activity thus emerged as forefront and as contributing to their emotional health.

**Challenge and independence**

Those participants who were keen about the activity itself reported many reasons for being so, such as personal challenge, learning or developing a physical skill, improving scores, and/or winning a competitive match. These varied according to the activity and the individual.

I play bowls competitively. Fortunately I’ve been quite good at it. I’ve been the champion for eight years. And I go to nationals every year, and it’s always held in a different place and people come from all over England for it. Last two years, I’ve not been so good, someone else has come up and beaten me. Let’s see what happens this year!

I swam at the cold water swimming championships. It was at an absolutely massive open lido, and was about three degrees, the water there…And I might go again, because I would like to win a medal, actually. ‘Cause I missed the bronze medal by four one hundredths of a second.

However, others were less motivated by performance measures within the activity and/or sport. For these participants, the activity was secondary to what they perceived the activity as enabling them to
do. For example, keeping fit enough to maintain mobility enabled a welcome feeling of independence. However, this was an ongoing challenge when faced with unfamiliar spaces and/or places.

I see many blind people who totally rely on their partners or their friends just to take them from A to B, and don’t go out on their own. I’m very conscious of my independence and I want to retain that. The cycling that I do makes my legs strong, more stable. So I’m more confident in getting around without help. I like to go out on my own and get to places, and maintain my independent lifestyle.

The thing with losing your sight is the independence is gone. You’re depending on people. So I try and challenge myself. I mean, that’s why today – it’s for me that I came to you [for the interview]. You could have come to me. But I wanted to go and walk down from where I live, cross the road, make sure I got the right bus. You’ve got to have that – I think you’ve got to have a certain amount of independence. If I know the area, I like to go myself. If it’s a strange area, I’m less inclined. But I don’t like to be beaten.

Maintenance of independence through activity, though challenging, was emphasised repeatedly for reasons of freedom and mobility. For those who did not (or felt they could not) participate in physical activity, it was the simultaneous loss of independent mobility that they most lamented. Some remained active or maintained activity in order to retain fitness and what they perceived to be associated independence.

I’m fit. I eat really well, and you can see I’m not overweight. I walk every week, I belong to a walking group. I jive, I used to jive three times a week. For me, being healthy is being active. I always walk down the road, even if I’m in my studio, I always take about an hour and a half off. I walk briskly down the road. I don’t amble, I walk briskly. I do try and keep active. It’s that old phrase I think, if you don’t use it, you lose it. And I’m not ready to lose it yet.

On the other hand, there were also participants who cited their complete lack of independence, and the often direct impact that this had on their physical activity participation.

So now I have to rely on my wife. And I mean, we could drive a bit and go to a swimming pool in town, but it’s just too much hassle. And I mean, she’s as good as gold, she’ll do anything. Take me anywhere. But you don’t want to always be, you know, ‘Oh, can you take me here? Can you take me there?’ Whereas before I would have just jumped in the car and gone, now I can’t.

In summary, within the broad theme of ‘health inequalities’, older adults with sight loss spoke about many aspects of health as they pertain to participation in physical activity (or lack thereof), including: physical fitness, activity loss, comorbidities, mental and emotional health, and challenge and independence. Whilst none of these conceptions of health are new, it is important to acknowledge lived experiences of health in each domain, on an individual level, to best understand the impact of sight loss on health practices of older adults.

**Theme 2: Accessibility and opportunity**
Like health, accessibility is a multi-faceted term. The definition of the term ‘accessible’ demonstrates this well (OED, 2013):

- able (of a place) to be reached or entered;
- able to be easily obtained or used;
- easily understood or appreciated;
- able to be reached, entered, or used by people who have a disability.

The Equality Act 2010 and the Disability Discrimination (NI) Order 2006 (DDO) is legislation aimed at addressing and ending the discrimination that faces many people with disabilities. Of relevance to this research, it requires public bodies to promote equality of opportunity for people with disabilities, and provides them with rights with respect to access to goods, facilities and services.

Accessibility thus covers real and perceived barriers to participation in physical activity, and these can take any number of forms. Each older adult living with sight loss reported various experiences relating to accessibility, including issues, concerns, negotiations, and personal anecdotes. These were primarily practical and/or structural in nature, but also included psychological considerations such as self-esteem and confidence.

**Transport availability**

In the South West, access to transport was a common barrier to physical activity participation. Participants described how public transport was often not very useful because they resided in a rural location (i.e., miles from the closest bus or train station).

The problem down here is transport. Because if you were in a city, if you’re visually impaired like I am and you’ve got a little bit of sight, or if you’ve got a dog, you can jump on a bus. But the other way around, if you live down here – well, my friend lives in a place where the stage coach passes through once a week. It’s just not an option, you have to have somebody to take you.

For those who did have public transport available, there were mixed reviews on its level of accessibility within the South West. For the most part, train travel was rated more highly than bus travel. Indeed, given the rural location of many of the South West participants, doing physical activity often relied upon having someone (i.e., a partner or friend) who could drive, to take them to the location of the activity. Those who had such resources were (self-admittedly) lucky enough to have a spouse or partner that was still driving and not working. Other participants spoke of giving up activities because they felt the time or distance was too much to ask for, and/or were selective about which activities they sought out for the same reason. Similarly, those who had and then lost a partner spoke of how their lives (and activity level) had changed once this support was no longer available (see sub-theme re: activity loss). Community transport schemes do exist in the South West, but are limited in terms of scope and access – particularly in Cornwall.

The biggest barrier down here is getting transport. We have great difficulty with that. The Sight
Centre has volunteer drivers, we contact them and make requests. Bearing in mind that they’re covering the whole county, of course. I usually manage to get a driver, or my husband takes me. But we’ve got people who live further out who often miss out on coming to the shooting club, because they just can’t get a driver. They say there just aren’t drivers available.

In the Midlands and in London, participants expressed different experiences with transport availability. On the whole, it was less of a barrier to physical activity participation. In the Midlands, reports were mixed depending on where participants lived in relation to the nearest urban centre. Many participants reported using public transport without difficulty.

I can walk up the street, get on a bus and go anywhere really, you know? If I want to take the time and trouble. I go to one shop right across the city pretty often, and I can be there in 40 minutes. I go and have a chat with them, get what I’ve got to get and come home. It’s quite simple.

Others explained that transport links were inconsistent and, at times, impeded their participation in physical activity.

I used to go to a gym in town. But in winter it’s a drag, because there’s no bus there. And if the weather is bad, it’s hopeless. So there’s no continuity.

London participants, in particular, remarked at how easy it was to get around in, through, and across the capital – using the network of buses, trains, trams, and the underground.

London is easy for getting about, because there are so many tube stations and a good transport system. The parks have footpaths, and where I live it’s very quiet, but I’m still very close to the tube station and bus service, and all the shops that I need.

I go to one Macular Society group in my area just to help support them. They don’t seem to think that they can go anywhere unless somebody collects them and takes them. I get there on a bus, and go around the long way to make sure I don’t have to cross the road. You know, you plan your route. By getting a different bus, you can go around this way or that way, and avoid underpasses. And all of the buses and the train talk, so you know where you are. I’m quite comfortable traveling on my own.

Of course, as the above quotation demonstrates, a good transport system does not mean that everyone with visual impairment will be comfortable or confident in using it. Those participant’s who were active, but not confident in navigating public transport on their own, spoke of well-organised and convenient community transport schemes in both the Midlands and in London. On the whole, transport availability was reported to be a barrier in all three geographical locations – though most markedly within the South West.

Transport cost

Another commonly reported barrier related to transport was that of cost. For those using public
transport, this was not an issue, as registered blind or partially sighted individuals are entitled to concessionary travel passes.

I’m getting out two or three times a week. I go to central London at least twice a week. Either to London or through London. And having the rail ticket and the bus ticket is great, you just go free.

Public transport outside of London (i.e., in both the Midlands and in the South West), although not free, was available at significantly discounted rates for registered blind or partially sighted individuals. None of the participants cited the cost of these services as a barrier. However, for those using other means of travel, costs could become prohibitive.

Anywhere I want to go from here, it costs at least ten pounds in a taxi if not more. And I don’t get mobility allowance because I’m over 65. So I just can’t afford to get out, unless someone is taking me.

Community transport tended to be run either through the local council or the local sight loss charity/organisation. Costs varied but tended to be a set fee for a there-and-back trip, depending on destination. In Cornwall, if attending an activity or social group put on by the sight loss organisation, costs were subsidised. However, for some, using their money for leisure and/or physical activity was either not an option or not a priority.

It all comes down to money, whatever you do. I’d like to try and go swimming, but it’s just too much hassle. If you could get drivers cheaper… I mean, if I get a driver, it’s £2.50 each way. If it’s a club, like the rifle club, it’s £2.50 each way. You have a voucher and you give the driver a voucher each way. If it’s not for a blind club, then I think it’s double the amount each way. And of course, that makes it expensive if you want to go out two or three times a week, and you have to pay for the activity as well.

However, in all areas, many participants maintained that the available community transport was excellent value, particularly when compared to the alternative option of hiring a taxi. These participants were adamant that the existence of such transport actually made their participation in physical activity possible.

The transport is ridiculously cheap. Five pound for a return trip anywhere. That’s ridiculous. They could double that, and it would still be good value. (Cornwall)

I think with the transport, people tend to be unrealistic. Very often, they don’t realise what it costs to run a car… And you know, when you say to a visually impaired person, “Can you pay me five quid towards that?” They grumble and moan and all sorts of things. But when you think about insurance, tax, deterioration, buying a car. As well as petrol. What is offered is really good value, and that doesn’t get recognised. (Midlands)

This is a good example of how something can be seen as both barrier and facilitator by different
parties, depending on their individual perspectives, circumstances, and perceived capabilities.

**Variety, sustainability and consistency of opportunities**

Several participants praised their local sight loss organisation for the type and variety of physical activity opportunities that they provided.

*When I moved down here, I immediately joined dancing, shooting, bowling, computer classes for the blind, chess for beginners. I’ve always wanted to play chess. And Braille, which I was learning before, anyway, and I started again. I made lots and lots of friends that way.*

*I joined a few things. And I got bored. I used to go to bowls, indoor bowls. And that was fun for a few years. And then I got bored with that. I guess I like the variety, trying new things. Yeah, see what suits. I’d try anything once.*

Indeed, variety of opportunity emerged as important for many participants: some happy with the level provided and some less so.

*At [the local sight loss organisation], they used to have a group for blind people. A social group, and it was meant to be for people a bit younger. It’s finished now, but they had quite a few different activities. We tried pilates, armchair exercises, tai chi, archery, skittles, and bowling. Quite a few different classes, uh, taster afternoons I guess. But that’s all finished now, they don’t offer anything like that anymore. There was no follow up. They do run a social group, but to me it’s more like a day care. You go and have a meal or a cup of tea and just sit there. So they seem to cater for the really old and the really young, but for the middle age bracket there’s absolutely nothing. I mean, nothing’s exclusive – I could go to any of the social groups if I wanted to – but I’d rather do activities and try new things.*

Opportunities for participation in physical activity were somewhat dependent on location and availability of facilities therein – not necessarily across our geographical locations but within them.

*I would like to be able to swim. But I haven’t found a conveniently placed gym to go to. There are some boroughs that have an accessible pool, but it means two or three bus rides. And I think if you’re going to spend an hour getting there and an hour getting back, you won’t do it for very long. It’s just too much time.*

Generally, those less satisfied with available opportunities tended to be less mobile and as such more dependent on others.

*In addition, variety of opportunity was highly dependent on funding. This fact led to important concerns being raised about the consistency and sustainability of leisure and physical activity opportunities in this context.*

*I used to go to quite a few clubs. But because of all the cuts and everything, I’m afraid I can’t go*
anymore. They've either given up completely, or it's too difficult for me to get there. I used to go to one every week, and they had speakers and activities and entertainment. It was very nice – I really miss that one.

The local blind association, they had a lottery fund and their aim was to get social activities going. This area got a bowls club, and a blind rock group. We got fishing, we got archery, and we got art. But then the lottery funded stopped, so archery stopped, art stopped, it all stopped.

I started blind archery, there was going to be a blind archery thing here, but then nothing. I think one of the problems is that some of these charities – and I don't want to be rude about it – but they start these initiatives off and then they seem to fizzle. Archery they started once, never heard of it again. Tandem riding – I went on one ride and I've not heard anything since. Gardening started, and then it stopped. And that's worse than not having it at all, to be honest. It raises people up, and down they come again.

Limited and/or interrupted funding was the main reason cited for a perceived lack of consistency in physical activity opportunities and programming. However, there was also an acknowledgement that these activities were often run by volunteers within the organisation and not paid employees. These volunteers, while laudably dedicated, have their own life interruptions and/or concerns that might affect the delivery of the activity itself.

Death of the activity-leader is an extreme example, but one that demonstrates the fluid nature of program delivery in the non-profit sector. Hence, finding replacement leaders and ensuring the continuation of the activity is contingent on the availability of another qualified and/or willing volunteer.

Marketing of opportunities

Several participants expressed interest in participating in organised physical activities for the visually impaired, but explained that they were unsure of what opportunities existed – and how to go about finding out about them.

You know, I've heard of archery groups for blind people, and I've also even heard of shooting for blind people, but I've no idea how you would get into that or where they are. Or how to find out about it. Yeah, it's difficult not knowing what's going on. I don't even know where to start looking.

Those who had participated in such activities recalled having proactively sought information about available opportunities in their area. Often, this meant being persistent and making several phone calls:

[Local sight loss organisation] don’t offer anything, and when I asked they didn’t know of anything running anywhere. So I rang the local RNIB College to ask about leisure activities, what they had
available. It didn’t seem widely available to people, but because I’d inquired directly I got to know about them. And I did a few things with them in the end, we went rally car driving and a few bits, and they were talking about going horse-riding and then we heard absolutely nothing and now it’s all finished.

However, those in a program delivery or organisational role shared a different perspective. One participant, who was visually impaired and served on the board of his local sight loss organisation, shared their frustrations:

It’s something we’ve talked about here [reaching people], because we’ve got 4000 members from the area. But we know that there are well over 20,000 people in the county with an eye problem and they’re not in contact with us. So how do you get to them? Even reaching our members – I mean, we used to produce a magazine here which went out to every member every two months. And it cost about £10,000 to produce. And like most charities, we’re getting a bit tight on funds and things. And so we did a survey and found out that most members just put it in the bin... But it’s – how do you contact people, then? My perception is they don’t want to be contacted.

There was an acknowledgement that opportunities needed to be marketed using a variety of mediums, and even so this information will not reach everyone to whom it applies. Most importantly, participants expressed that each sight loss organisation needed a leisure coordinator role (paid or volunteer), that could answer questions about opportunities and/or assist clients in accessing them. General enquiries could then be directed to this individual for their attention.

Finally, there was an acknowledgement that even if such opportunities are appropriately advertised and circulated, uptake by visually impaired older adults is not a given:

It doesn’t really affect me, but I think there might be blind people who would like to be involved in sport but they don’t know how to get the initial fitness. When I started running, I could run on my own and my sight was better. And when I couldn’t get out running I used to skip, with a skipping rope. And that’s a really good way of trying to keep fit. But not everybody’s got those sort of facilities, or space, or a garden. And being blind, I think, forces you into quite sedentary occupations because of mobility. So I think it’s quite difficult for people to start getting fit.

This is an important point, as it demonstrates that not only do opportunities need to exist and be appropriately marketed, visually impaired older adults may well need social and emotional support in order to engage.

Social support

Availability of social support had an undeniable impact on participant’s levels of physical activity. This ranged from provision of assistance with respect to mobility and access (see previous sub-theme of transport availability) to reports of shared activities. The latter could be current practice, in that a spouse or family member participated alongside the older adult with sight loss, guiding them through
the activity.

I often play bowls with my wife, and she’s still driving. She drives to all of the tournaments, we usually take a car full. When she’s not playing, she still often drives me to the club, or I occasionally walk.

I think for my age, I’m probably fitter than most sixty-five year olds. We danced to this tribute band for three hours the other night. But I have a very fit seventy-one year old husband. And we walk, well you see how hilly it is round here. We walk down a hill, up a hill, down a hill and then turn round and come back. And it’s about two miles, and we do that every day, or walk further, somewhere else.

Friendships with sighted individuals also offered opportunities, and facilitated participation in physical activity:

I don’t really have any desire to be around other partially sighted people, so I haven’t sought it out. I’m lucky to have such good friends already, and they happen to have their sight and are happy to do things with me, to help me out and also because they enjoy it as well.

I’ve gone tandem cycling with the same friend – we celebrate 20 years of riding together next year. I’ve every confidence in him. I used to like going fast down the hill, but now I don’t. And he – I don’t know whether he thinks the same as me or not, but he doesn’t go down the hills at 40 or 50 miles an hour anymore. We try to get out at least once a week, and in the summer we stop for petrol at a local pub sometimes. So that’s nice – it’s a real pleasure, actually.

These participants were quick to acknowledge how fortunate they were to have such support. Indeed, some expressed fear at the prospect of ever losing this support:

I can pretty well do what I want, providing friends and family help. And they do. I’m such a lucky woman. Without friends and family, I think I would be awfully stuck. But I have a very good support network.

I won’t cycle anywhere without my husband now, with him in front of me, warning me of hazards. He wears a high viz vest, and he leads. Normally on cycle tracks, when we go traveling in Europe… Honestly, I do live in fear of becoming a widow. I’ve often said, ‘I hope I go first’. I am just so lucky, because he is my eyes. He often says he can’t get anything right, but he is incredibly good.

Given that social support is dependent on relationships, issues and occasional conflicts did arise within participants’ experiences. One individual described how his activity tends to fluctuate according to the schedule of others:

Cycling, yeah, I used to go out with my son. But he’s too busy at the moment. He’s trying to get fit for rugby, so he’s got training a couple of nights a week, and playing on a Saturday. So it’s getting the right time to do it.
Another explained that, when he first lost his sight, he had to negotiate with his partner regarding his level and type of activity participation:

At first my wife was unhappy about me going out walking because she didn’t know if I was safe. And alternatively she was unhappy about going out herself and leaving me at home, because she didn’t know that I was safe… I mean, I’ve been registered [blind] for 17 years, and we’ve worked most of the problems out now. But say, like gardening, I can do some things like clipping the odd bush or whatever without her there, but in general we’ve got to make time for the both of us to be out there, so that she can see what I’m doing and tell me whether I’m going it right or wrong or whatever.

In addition, the availability of support did not ensure fulfilling activity participation. At times, the visually impaired individual’s need for support served, in practice, to isolate:

With my husband I’ve been trying to go to Zumba classes. Fitness dancing. It’s very difficult. For a start, it’s a room full of women. My husband is trying to tell me the moves because I can’t see what the instructor is doing. And we’re trying really hard to persevere with this, but it’s very difficult, frustrating, and not easy at all…. I feel I could do this and really enjoy this if I could see what the other ladies are doing. And I could socialise with the other people in the group if I could see. I would feel more a part of it, like one of them. I sort of feel out of it, like I'm on my own.

The above is particularly a consideration for group activities within a mainstream (not visually impaired specific) environment, and demonstrates how social support requirements and experiences differ by chosen activity, social and structural setting, and individual preference.

Picking up on more barriers to physical activity participation, several widowed participants spoke of activities that they used to (be able to) do with their spouse, now no longer an option.

I don’t do anything now. I don’t go out much – well, I always used to drive to get places. And even though I drove, I still did more activity, because I’d park in town and walk around the shops. And when my husband was with us – he passed about six years ago now – we used to go for evening walks, after tea. He used to guide me round, you see? And I was confident that he’d help me round things and keep me from being run over. I can’t go out on my own.

Similarly, those who lived alone expressed a desire for companionship within their potential activity.

[Organisation] are going to do a buddying scheme, but they’re only going to do it for six months. So say, they might match me up with you to go walking round the town, or whatever. But after six months, they’re expecting you to be able to do it on your own, or somebody else would take it over. Your family should be able to do it for you. But after six months, I’d still want the comradeship and the people. If you don’t have anyone else… Like myself, none of my family are anywhere near me. And it’s not very nice to be given something, and then you enjoy it, and have it taken away. Cause then it’s just another loss. Just another thing to make you depressed.
This latter excerpt raises questions about the purpose of buddying and befriending schemes, commonly provided by local sight loss organisations. Are they primarily concerned with social support and companionship or are they an attempt to provide a boost in confidence to do/perform a particular task or activity? Both are, of course, valuable – however, the needs, perceptions, and experiences of the individuals using the service need to be evaluated and considered.

Confidence, fear and safety

Many participants spoke of not having the confidence to participate in activities. Often this lack of confidence was linked to fear associated with their impaired vision.

I’m scared of going out alone, that I might fall down. I don’t want to hurt myself. I’ve tried to go out on my own but I don’t very often. I’m still not ready – I am not confident that I won’t fall down, you see? If I go alone, I don’t have balance.

I am frightened. Because I can’t see the ground. I have fallen down steps. And, believe it or not, up steps. If you don’t know they’re there. And it is frightening.

Participants expressed many fears: falling, getting lost, looking silly, and being a target for crime. Several expressed that holding and using a white cane or having a guide dog made them a visible target.

I don’t go out on my own at night. Because I’ve been stopped a couple of times, and had a close shave with people and things like that. Um, people stop you in the street, and ask you for money. Things like that. You feel intimidated. A friend of mine, he was actually physically assaulted twice by this bloke, trying to grab money off him. So yeah, there’s always that fear. Especially nowadays, you know, they’ve got so many gangs of people around. You know, you’ve got to keep listening all the while. You know, if somebody came up and grabbed you, and ripped your wallet out, you’ve got no chance of defending yourself. And if somebody said, ‘who was it?’ You’ve got no description and things like that. So if I’m going out at night-time, I tend to get a taxi. Purely for safety, more than anything. You know, if you’ve had a bad experience, it can be really, really frightening.

One of my friends, he used to go to the pub once a week, just to give his wife a break from him. He got beat up. Young lads, you know, he’d got a white stick. They took his money and everything. So, there’s such a danger. I really feel it. It’s an abominable feeling. Every time you go out with your stick, it is difficult, I’ve been sworn at, shouted at, all sorts of things.

Specifically referring to physical activity, many participants described feeling frightened within certain environments.

Anything in the water scares me. Because I’ve always got that fear – you know, you go in the water, you come up to the surface – I mean, you might have a life jacket on, but how the hell do you know where the bank is? Or where the boat is? Obviously you’d be with other people. I did try – I started
to take up scuba diving for the blind. And I did a certain amount of the training in the gym, but I found that when I had to spend a lot of time underwater, even with the breathing apparatus, I’d start panicking a little bit. And the leader said, ‘That’s not a good thing’. You know, you either take to it or you don’t. And if you panic, you can’t do it... I don’t know why I reacted like that. I just... it’s hard to explain. Because you know you’re safe, because you’ve got the air tank on and the weights and all that. But I found – I don’t know if it’s claustrophobia so much, being underwater? And knowing there’s that potential of – what would I do if the valve suddenly packed in? Could I get to the surface with all of this weight on me? And, of course, not being able to see around you. So that wasn’t for me.

I know that it sounds absolutely daft, but swimming pools are loud places, aren’t they? Echo-y and loud. And I just get too frightened. Because if I’m trying to swim a width, I can’t see the other end. I just can’t see so much. And then someone will bump into you, so I think no. I suppose it’s not knowing where the other bodies are around me. So I just don’t go anymore. I did try water aerobics, but I found that too frightening as well.

As such, safety was an oft-mentioned term when speaking about potential avenues of participation:

I think it’s so individual, and up to the individual to do what he’s happy with. I mean, when I could see, I played tennis and ten pin bowling, you name it. I was very sporty. Cricket. But, when you lose your sight, all that goes, I’m afraid. So you just have to adjust. And I mean, the only safe thing I do is in the gym. Because I’ve got someone watching over me. And all the stuff in there is safe, you know? For example, I wouldn’t run. Maybe I’d do it on a beach, where it’s safe. But I wouldn’t do it in the streets. Or jogging round a track, no – I couldn’t do that. I like to feel safe. Put it that way. So, all my physical activity is geared around safety. Because I don’t want to injure myself physically.

Confidence, fear, and concerns with safety have obvious implications not just for mobility, but also for the types of physical activity that participants engaged in – and the types of activity that they could imagine themselves engaging in.

**Time**

With a concern for safety, many participants described how the nature of their activity participation had changed as they experienced sight loss. In particular, they referred to each activity – physical and otherwise – now necessitating more time to complete, negotiate, and navigate.

I’ve got a stick, and that’s a wonderful help. But I can’t do as much as I once did. Of course, one slows down. So what I could do in an hour years ago now takes me half a day. I’m not as brave – or I guess, I want to feel the ground before I move.

Indeed, the need to take more time to complete tasks was often expressed. Many participants described it as initially frustrating, but something they had to learn to come to terms with:
I've started preparing the soil, and I've got a little greenhouse at home where I nurture my seedlings. So when it gets warm enough I'll be able to plant those out. Obviously when you can’t see, doing tasks like that take so much longer than if you can see. The friend who came to help me yesterday was sawing down a shrub, an overgrown shrub in my garden. And I thought, ‘oh, this will take at least an hour’. And within ten minutes she’d done it! It amazes me how quickly other people do things, but I just know that it take me a bit longer to get myself organised and I have to be more careful of course.

These participants had learned to enjoy the process and the task itself – and relished performing it independently, if possible – rather than comparing their capabilities to others or to their previous selves.

Others were less accepting of the increased time that tasks may now require. This was particularly enhanced when discussing access to activities, and as such is linked to transportation. For some, no longer being able to drive meant that certain activities were less desirable.

I mean, if my husband’s not here, I walk three miles to town centre and get on the bus to the next town over and walk to their swimming pool. I swim for an hour, get on the afternoon bus home. So I leave at ten and get home at about half past four, for just an hour’s swim.

I mean I could at a pinch – at a pinch – go to town, say twice a week, swimming. But it means a three hour turnaround, to go half hour swimming.

These participants bemoaned that it often took longer to get there and back than performing the activity itself.

Leisure facilities

Facilities, perhaps unsurprisingly, got a mixed review. This was entirely dependent on individual experiences at local community centres or larger gyms. Only six participants were members of local gyms and attended regularly, reporting positive experiences. However, many of these positive stories were coupled with reports of previously poor experiences.

They’re really good at my current gym, compared with my last one which was absolutely dreadful. They just couldn’t care a monkeys. Just weren't interested. But where I am now, the staff has been trained for disabled people. Personal trainers come and help you out. People come over and ask if you’re alright, and help you get set up on equipment.

My current gym is fine. It’s not perfect. Because getting around a gym, you’ve got to be careful. There’s the prospect of walking into a machine that’s moving up and down, or putting your hands on people in the wrong place, that sort of thing. Which, you know, from the point of view of their ignorance of the situation can cause a rather unpleasant reaction.

Many different barriers were encountered. Some included being turned away because of health and safety regulations, or being asked to pay more money (in addition to a membership) to have a
dedicated personal trainer at every gym session. Participants described a range of different reactions to such adversity. One individual advocated tirelessly for his right to attend his local facility, ultimately wearing them down with his resolve:

When I first went to the local gym they were very hesitant to have me join as a member. They were worried about health and safety, and I guess the risks of using the equipment. I had to be very persistent and I kept on at them. I even phoned the manufacturers of the equipment and got them on board. I eventually wore them down until I was allowed. Since then I’ve left and joined a new gym closer to me. They’re brilliant, and the staff are generally helpful – especially as they get to know me. I tend to go in the mornings when everybody has gone to work, so it’s that bit quieter.

Another participant took his business elsewhere, although not without a battle over membership commitments wherein he felt he had to threaten action:

I have had a dispute with one gym. They wouldn’t let me bring my dog, they didn’t accommodate the dog. So I didn’t continue my membership with them, and had a huge dispute because they were trying to charge me for not giving a month’s notice…And eventually they let me off because I threatened them with discrimination, and said I’d go to the local paper with the story.

Several other participants described being completely put off from commercial fitness facilities, and either made alternative arrangements (i.e., built a home gym), or opted for another form of activity.

I did suffer initial prejudice when I joined gyms in the past. In fact, that’s what made me build my own. I had two good personal trainers, who I had a rapport with. But if they were on holiday or unavailable, the attitude was that nobody else would want to touch you. Because you can’t see. You’re doomed, you know? And that I found annoying, that sort of attitude. That it’s not safe to train someone who’s blind. I mean, how you get around this prejudice, I’ll never know. But yeah, that was enough to put me off. That’s why I went independent and did my own thing.

On the whole, participants’ experiences (good and bad) strongly underlined that there are a lot of considerations in making a gym facility accessible:

I think the thing that puts me off with gyms is that the machines are not accessible. Things like the treadmill, the rowing machine, the cross-country. To operate them, you always have to have assistants there, to help you. And navigating around a gym – you get in a leisure centre and because it’s so massive and there’s so many machines and that, you know, I could stumble around there with my white cane and you can end up bumping into somebody. And if you’ve got somebody doing free weights and you bump into them, it’s a bit of a nightmare. And there’s nobody there to watch you, to guide you. Or as they say, they haven’t got enough staff, they haven’t got enough time to do it. And then you’re often waiting – like, there’s always queues waiting to get onto machines. So you can’t spend a lot of time trying to set it up, or getting somebody to set it up…

Six other individuals attended fitness classes at the gym, or used the swimming facilities. These were
also hesitantly recommended.

I do swim in the pool sometimes, but I don't like it. I've bumped into people and you can't relax. 'Cause people just stand around and chat and get in your way, or swim across instead of up and down. There's a swimming club close by and I tried joining that and it was horrible, because they all go in, like a load of minnows and they're all swimming, one after the other, up and down, up and down. And so I can't do it because I either hit the person in front 'cause I'm going too fast, or I thump into somebody coming down.

As in the above quotation, several participants described having issues with the physical space (i.e., the swimming pool) itself as well as the other bodies using the space. Other participants struggled with the accessibility of the space in a different sense, and commented on the restricted times dedicated to disabled users:

They used to have a swimming night down at the leisure centre for handicapped people. I don't know whether that's still running or not, because – You know, but you have to have special nights. Or certain times. But then you'll find, if they offer a special time for the disabled, it's nearly always in the daytime. And then if you’re working, you can’t go.

Linked to confidence, several participants expressed trepidation at negotiating and using leisure and fitness facilities, despite never having tried to do so.

I'd like to do some running on one of these running machines or walking fast. But then, nowadays, it's all setting them up by screens, isn't it? So you need someone to help you set it up and get going and just show you the switch to stop it, that sort of thing.

I wouldn't be able to use any machines, like a treadmill or whatever. Because I should imagine whatever you've got to do is on a small tiny screen... I wouldn't mind going to a Keep Fit class. But there's one thing that's stopped me going, and that's you can't see the instructor, can you? That's one thing…. I do wish people were more aware and you didn't have to ask and feel a nuisance.

Not wanting to feel a nuisance was reported by more than one participant, alongside hesitation to ask for 'special treatment', or what they felt they needed in order to participate. Others, however, were far more strident about requesting and/or advocating for their needs.

I mentioned [that I was having trouble with my Keep Fit class] to my local society, and they said that they should be including blind people. But I don't want to make waves like that. I don't want to stand there demanding anything. You know, yelling 'You should do this, you should do that'. I don't want to ask for special treatment, but I do need it – I do need her to explain things verbally, step by step. And I do need a little bit of extra tuition, compared to the average person who could just watch and follow the movements.

I can’t swim in a public session per se, because I’ve got everybody coming from all different
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directions and I can’t see. And I can swim relatively well, as well. I’m a fairly powerful swimmer. And I don’t want to hit anybody, because if I hit somebody I’m going to hurt them. So if I go swimming now, I bide my time until I can get to the wall. And then I go up and down the wall. Most people should have the common sense not to try to come in on me. You know, some people do and they get thumped. And I really don’t care on this occasion.

For some, encountering resistance and a perceived lack of helpfulness – if not outright discrimination – was enough to turn them away from using public leisure and fitness facilities. Others offered stories of how they had negotiated the inaccessible aspects of leisure facilities in order to participate in physical activity at their chosen level. All of these stories elucidate the multi-faceted nature of accessibility in this particular realm.

Built and natural environment

The built environment can offer numerous barriers to accessibility, as it pertains to physical activity. However, a consideration of the multiple factors that make a built environment more accessible can relieve some of these barriers. These include lighting, signage, permanence/consistency of obstacles, locker and changing rooms, and so on. The following excerpt from one participant encompasses many of these considerations:

I’ve been a member of my gym for three or four years now, and as yet, they haven’t moved the pieces of equipment around. So I go in and I know where something is, which is quite nice. The lighting is just okay. The changing rooms – I suppose really they don’t want it brightly lit for obvious reasons, if people are changing and that sort of thing. But they aren’t too bad. Light in the sauna would be nice. I have to hope if someone’s in there that they’re talking, because then I can work out where they are and not sit on their lap! But there again obviously you don’t want bright lights because it goes against the relaxing experience… It might take me a while to work out where the signs are. I have to go looking for the information. Getting used to lockers, different lockers in changing rooms can be a challenge. And when people leave head-height lockers open. It’s just little things like that. And the fact that you even have to insert a coin, that’s not easy. And then of course you’ve also got the bit of remembering which locker you are, and finding that number afterwards.

Similarly, the built environment outside of buildings and facilities themselves can offer numerous obstacles that require negotiation. Visually impaired older adults have to consider pavement quality and grade, the location of bollards, street signs, rubbish bins, and so on.

I’ve had quite a number of accidents just walking. I mean, I’ve been using a white cane now 40 years. But you’ve only got to miss a post by a fraction of an inch when you’re swinging your stick. I once went out walking down near where we live. And I was following the grass verge. And the next minute, my left eyebrow smacked straight into a concrete lamp-post. And it cut my eyelid right open, like. And that was because I’d just missed the bottom of it with the swing… It’s things like that, you
know? You’re going along, and you’ve only got to get a small hole in the pavement. Your stick can miss it, and you go down and you twist your ankle. You know, kerbs, things like that. And also, people who don’t clean the dog mess up after their dog. That sort of thing you can’t detect with a white cane. You know, it’s all different surfaces.

Participants explained that navigating the built environment took mental as well as physical energy, and this could limit physical activity participation:

It’s not so much the physical strain, but the mental strain of walking. Because you’ve got to think of so many things at the same time. You’ve got to think which side of the path you’re on, where the kerbs are, where the grass is. Listening for other people, traffic, for people on the pavements on bicycles. And coming across unexpected obstacles like the gas board digging the road up, or digging a path up. You always have to be alert. And then just actually moving your hand back and forwards every pace. You know, if you go a mile and a quarter, that’s quite a few hundred swipes of the cane. And you’ve got to hold the cane tight. So you end up getting cramp in your hands, and in your wrist and your elbow and that. And then you can mistime your stepping and walk into something, or over-hanging bushes. So you’ve got so much to think about, so sometimes it’s just easier to jump on the bus and go into town than actually walking, you know? So it’s the environment that puts me off a lot of the time.

For most, unfamiliarity with a built environment was a strong deterrent to physical activity. However, when describing the negotiations involved each time a new environment is encountered, one participant offered the following example:

I went away in December, and our hotel was right on the top of the cliffs by the seaside. And there was a path, it zig-zagged all the way down to the prom, right at the bottom. And, so when I got there, we checked out the promenade and the surface was great, there were no potholes. So I got up really early in the morning, just as it was coming light so there wouldn’t be any other joggers or cyclists out. And, went down this zig-zag. And then, when I got to the bottom, instead of power walking, I jogged. So I jogged all the way to the pier, that side, and then I came back and jogged right down the other side, as far as I could. And then I jogged up the zig-zag, going back up, and back to the hotel. And I thoroughly enjoyed that. But the reason I did it was because the surface, I knew the surface was perfectly alright for me and I wasn’t going to suddenly drop into a hole or something.

The natural environment can offer obstacles of its own. These obstacles are certainly determinants in the type, level, and location of physical activity engaged in by participants.

It’s getting out in the country, that’s a limiting factor. Because of my eyesight, I can’t read a map or a compass, or even see the road to do any walking. If I go over a stile in a field, you can usually see the stile at the other end of the field or the line of a footpath or something, but I can’t. So I need somebody to guide me around, I can’t do it on my own anymore.
I used to belong to a rambling group but it got to the point where I thought, no, I can’t do this anymore. So I stopped. Tree roots, steps, things like that… Because I can’t see the ground, I don’t know if it’s sloped or going up. You don’t half jar your back all the time, if you aren’t expecting a change in ground level. I’ve been whacked in the face with branches.

On a mobile interview with one participant, walking alongside him elicited several observations on the interaction between the built and natural environment, and how each of these affected his walking activities.

There are a lot of factors I have to consider when I go out for a walk, which is why I tend to stick to the same route. Over-hanging branches or slippery leaves are things that I can’t see, and that can be very dangerous. Uneven ground, of course, anything that throws off your balance or that’s unexpected that your cane might not pick up. But it can also help me to know where I am. For example, when I pass this bush here [brushes bush with his jacket], I know I’m right by the post office and I turn left soon. I also have to consider the elements, the weather. If it’s too windy, I can’t hear the traffic very well, so I can’t cross the street that I need to.

Further, many participants expressed that their physical activity participation had at times been stymied by unkempt outdoor spaces. One participant was particularly concerned with the maintenance of pavements and cycle paths:

The most annoying thing I find, which affects me more than anything, is overgrown bushes and things like that. Especially if it’s been raining, over-hanging trees and bushes on pavements are really annoying, because I just get soaked. It’s quite a disincentive to walking. And it’s the same – we very rarely use cycle tracks because often alongside those pavements are overgrown things, and you get thorns and punctures. I’ve been on a few, and just gotten my legs stung by nettles and all sorts as we were going along. Or my front-rider is constantly yelling ‘Duck!’ so I don’t get hit in the head by a branch. So I think the council needs to spend time on maintaining cycle tracks and pavements and keeping them clear to encourage people to walk or cycle.

Similarly, another participant was indignant about the condition of the roads in his local area:

One time – and this was a breaking point for me – I got on the bike to the local Tesco’s near me. And on the way back was a massive pothole, because of the frost this winter. And we’re talking half the wheel went down it. And of course I’ve got two bags of shopping. As I’m going past this pothole, I literally went straight over the handlebars. And I landed on – my chest landed on top of my four cans of cider, which exploded, when I landed on them. And these two women saw it, and came at me. I felt embarrassed as hell. I’d gashed me hand right up on the tarmac. Honestly, I haven’t been on my bike since.

All of these experiences demonstrate that accessibility can vary day by day, and is a constant, shifting, and complex negotiation.
5. Promising practice: case studies

In this section, we present four case studies of promising practice that go some way towards addressing barriers to physical activity participation as identified by project participants. In doing so, we address the third identified objective of the research: to provide an evidence base with examples of good practice, which can be used to inform policy and practice regarding the promotion of physical activity among older people with sight loss.

These case studies of promising practice consist of sites, policies, programs and organisations that best reflect a response to the needs identified within the previous findings section. Case selection was inductive and data-driven, with ideas, recommendations, and positive experiences arising from the interviews with the visually impaired older adults themselves. Data collection for the case studies took the form of observation, interviews with key individuals (i.e., program/activity leaders), and document and website analysis. Once written, the case descriptions were then member-checked with the individuals involved, the research team, and the Advisory Board overseeing the research.

The four case studies of promising practice address different identified barriers, although as in the above section these do overlap. All are concerned with varying ways to facilitate and support participation in physical activity among older adults with visual impairment. They are not perfect or unproblematic, nor will they apply to every older individual with sight loss. They do, however, give us a starting point for engaging with the issue at hand.

For each case, a brief description is first outlined, followed by a rationale for selection, further details on how the organisation/concept/strategy works, and closing with a summary of important considerations.

Case Study #1: The Inclusive Fitness Initiative

Description of case:

The Inclusive Fitness Initiative (IFI) is managed by the English Federation of Disability Sport (EFDS) – see website (http://www.efds.co.uk/inclusive_fitness). EFDS is the national body for disabled people in sport and physical activity throughout England. It leads the way in addressing inequality in physical activity, reaching inactive populations, and raising awareness of the benefits of exercise and creating demand. The IFI has been established for over ten years, with a national coverage of over 400 IFI Mark gym facilities. Since the IFI began the principles of providing accessible fitness for disabled people on this scale has attracted approximately 100,000 new disabled users at their local Inclusive Fitness gyms.

Importantly, the IFI promotes holistic inclusion that encourages a cultural change within IFI Mark facilities addressing the following elements: accessibility, fitness equipment, staff training, marketing and engagement, and sports development.

Every IFI Mark accredited gym facility is required to have a minimum number of pieces of IFI-
accredited fitness equipment that will provide anybody with a full-body workout. The fitness equipment has been adapted to be more inclusive for disabled people and includes, for example: audio feedback, tactile consoles, colour contrasting, and swing away seats. The IFI influences facilities and equipment suppliers and provides support, resources, and expert advice on how they can achieve inclusivity (and accreditation). In addition, there is a tool on the IFI website where disabled people looking for an inclusive gym can enter their postcode to find the nearest IFI Mark accredited facility (see: http://www.efds.co.uk/inclusive_fitness/ifi_gyms).

Why this case:

“I think the thing that puts me off, a lot of times when I go into gyms, it’s that the machines are not accessible. A lot of the things like the treadmill, the rowing machine, the cross-country, things like that. To operate it, you’ve always got to have assistants there, to help you. And it’s navigating around the gym… often there’s nobody there to help you unless you go with somebody sighted. But also, I think at every gym, one of their trainers should be trained in teaching visually impaired people. I’ve come across a few where they say, ‘well, you need to have your own personal trainer’. And that costs loads of money. And they need to be trained in visual awareness… so they’ve got some idea what it’s like for somebody, going on a machine. And taught how to guide… and the right way to explain things.” – participant, aged 63, Age-related macular degeneration

As is evident within the above excerpt, the IFI responds to barriers identified within our findings such as: access to fitness facilities (buildings and equipment), and training of staff so that they have knowledge and awareness of disability. In addition, it employs a holistic approach and considers the entire accessibility journey, including: transport to the facility (i.e., car-parking, public transport), the customer journey in from the entrance, through reception, changing facilities, and the gym itself. Many of our participants encountered resistance at one or more of the above component structural considerations. The IFI not only draws attention to the barriers experienced by many older adults with age-related sight loss when accessing public fitness facilities, but also provides an inclusive platform for disabled and non-disabled people to be active together. Furthermore, the IFI Mark framework encourages continuous improvement to ensure that facilities offer disabled people more choice and opportunities to enjoy the benefits of physical activity.

How it works:
As mentioned above, the IFI addresses inclusion as a whole to encourage cultural change within IFI Mark facilities, by addressing the following elements:

- **Accessible facilities**: physical access and accessible service provision. Facilities that express interest in the IFI receive an access audit, undertaken by an independent audit team. From this, facilities are provided with an audit report and action plan considering all elements of Inclusive Fitness. The action plan identifies ways of reducing risk, enhancing health and safety, as well as improvements to service provision for disabled users at each of the accreditation levels (provisional level, registered level, and excellent level). Facilities are then re-assessed every three years.

- **IFI accredited fitness equipment** Each IFI accredited facility provides a minimum package of fitness equipment, the selection of which ensures that each and every disabled user will be able to complete a full-body workout. The minimum package consists of a treadmill, upright or recumbent bike, an upper body ergometer, leg curl, leg extension or leg press, and a multi-station. Additionally, a range of small body equipment should be provided.

- **Workforce development**: customer service training for all staff and adaptive exercise programming for fitness instructors

Facilities receive customer service training for all front-of-house staff. This focuses on disability equality and awareness, ensuring staff increase their knowledge and awareness about disability and disabled people and above all provide good customer service to disabled users. All facilities are encouraged to have an inclusive induction policy. The IFI also recommends that instructors are qualified to at least level 2 in the discipline(s) that they instruct, are registered with the Register of
Exercise Professionals (REPS), and hold the additional modules at Level 3 (Level 3 Exercise and Disability). This helps to ensure that the instructor has adequate knowledge about appropriate exercise supervision and safe exercise selection for a range of users.

- **Marketing and partnership development** within the local community

Inclusive marketing is about making disabled people feel inspired that a service or product is relevant or accessible to them. IFI facilities are encouraged to ensure that disabled people in the local area learn about the opportunities that are available to them through inclusive fitness, and how they can become physically active. The IFI also emphasise financial incentive for facilities, making the point that by becoming more inclusive to disabled users, they will ultimately sell more memberships and capture a portion of the market that are currently relatively untapped. Doing the recommended marketing will thus also encourage a return on facility investment.

- **Accessible sport and social activities**

Working alongside National Governing Bodies of Sport, Disabled People’s Organisations, and National Disability Sports Organisations, the EFDS has a wider focus upon increasing opportunities and choice for disabled people to participate in physical activity and sport. The emphasis here is on ensuring that other opportunities are available for disabled people to be active for life and engage with sport at the relevant level – from relatively informal local sport and physical activity to competition.

**Important considerations:**

Geographical distribution: While over 400 IFI Mark facilities now exist, there are still some local authorities and County Sports Partnerships which have not yet invested in the principles of inclusive fitness. However, one aim of the IFI is to have an IFI Mark facility within 20 minutes driving time of anywhere within England and the project continues to influence this.

Incentive: It is up to local authorities, leisure providers, County Sports Partnerships and/or individual facilities (or fitness companies) to acknowledge their accessibility issues and seek out the tools and resources of the IFI, and then financial investment might be required for the facility to achieve inclusivity. However, there is a potential return on this investment (i.e., in selling more membership to disabled individuals). In addition, inclusivity has increasingly become part of the competitive tendering process – so newly built facilities are often required by the local authority to be accredited to the IFI Mark standards.

Visual impairment (VI): The IFI has worked alongside British Blind Sport to create a guide to support and attract adults with a visual impairment to use gym facilities (see: http://www.efds.co.uk/assets/0000/5317/BBS_IFI_Guide.pdf). This guide is part of a package of resources made available to IFI Mark facilities. It provides advice for leisure and gym facilities on how to market their service provision to fully engage the VI audience within the local community so that they are aware of activities and how to access them. The resource provides useful tips on how to adapt marketing material and communication to be more inclusive and accessible to adults with a visual...
impairment. It also provides useful information about adapting the environment for visually impaired individuals to ensure that the gym is more accessible to meet customer’s individual needs.

**Case Study #2: Buddying and befriending**

*Description of case:*

Many organisations provide buddying and befriending schemes, wherein the visually impaired client is paired with a volunteer to provide social, emotional and/or physical support. These are offered by sight loss organisations for visually impaired individuals (e.g., RNIB), as well as by organisations endeavouring to improve and support individuals in later life (e.g., Age UK). Befriending services tend to operate primarily on a social level, with volunteers making phone calls and/or house visits to the client and providing social interaction and support. Buddying, on the other hand, extends to the provision of some level of functional support to enable or assist the client in running errands, attending appointments or events, and generally getting ‘out and about’ and ultimately more involved in the community. Focusing on the latter, we considered a range of buddying schemes that create relationships of support for participation in leisure and physical activities. Here, we present a composite case study of promising practice drawing from a number of organisations and services, including but not limited to:

- **Buddying.** Cornwall Blind Association, Cornwall: [http://www.cornwallblind.org.uk](http://www.cornwallblind.org.uk)

*Why this case:*

Existing buddying and befriending services are offered by many organisations. Each has the potential to address several of the barriers to physical activity participation that have emerged from this project, including: social isolation/lack of social support, limited transport, and poor mental and emotional health.

Our findings indicate, however, that participant encounters with such schemes are not always wholly successful. As such, for the purposes of this case study we have collated information from a variety of sources (including participants and service providers) in order to explore strategies and suggestions toward building a more successful buddying scheme – as well as with consideration for lessons learned along the way. In doing so, we provide a set of guidelines of what successful buddying might look like.
– particularly as it pertains to encouraging, empowering, promoting and/or assisting with participation in physical activity by older adults with visual impairment.

“We have one client who admitted, ‘Oh, I’m a bit nervous about going out’. She had asked to go for a walk. She doesn’t go out very much, and she wasn’t very confident. She did a couple of walks, and then was interested in going swimming at her local baths. So the requests that come through can indicate a boost in confidence, or that they’re ready to move on to the next step.” - buddying service provider

How it works:

Each organisation provides their buddying support service in a different manner, but there are common elements that we will now outline for clarity. Firstly, both volunteers and service users are recruited. This is done by marketing and publicising the scheme at, for example, volunteer fairs and centres alongside service user meetings, social events, talking newspapers, mail-outs and so forth. Information is collected from interested parties, including contact information and a list of activity preferences and desires. Volunteers are screened and required to have a criminal record check, as well as – ideally – some form of visual impairment awareness training. Once these checks are in place, volunteers are matched with service users according to shared interests, availability, and geographical location. Volunteers then meet with the service users for their desired activity or event, and their tasks include such things as arranging transport, accompanying the visually impaired individual to the venue or facility, and participating alongside them if appropriate and feasible. Again ideally, there would be a full-time coordinator of the scheme, to gather the necessary documentation, make the connections, and to gather feedback from both volunteers and service users throughout the process.

Many organisations look to match volunteers with clients for regular meetings (e.g., weekly or fortnightly). However, there are some organisations (i.e., Link Up, Changing Lives) that are taking an alternative approach – arranging buddies for short-term or one-off meetings or events to take part in something specific and defined. The idea here is to provide the client with support and confidence – perhaps to try something new – but then to draw upon other existing schemes and support systems (both within and outside of the visual impairment community) should the client want to continue participation.

Important considerations:

“I tried this befriending service, where if you are interested they’ll try and line you up with somebody suitable for you… I put my name down for a befriender, a lady, so she would fit in with the all-women’s Zumba class. And for a long while there wasn’t anyone available, and they said that they were struggling to get volunteers in this area. And then finally there was a lady who was assigned to me. She was 71 I think, she had two new knees and she really was not suitable, she wasn’t really fit enough. And she really wasn’t interested in Zumba fitness dancing anyway.” - participant, aged 62, Retinitis Pigmentosa & cataracts
Matching: The strength of buddying schemes is the companionship and confidence-building within an activity itself. As the above quotation demonstrates, service users and volunteers need to be matched according to activity preferences and interests. An interest in similar activities ensures at least one element of common ground, and frequent feedback and evaluation within a scheme assists in matching personalities, interests, and tastes.

Volunteers: To run a buddying scheme effectively, you need adequate numbers of trained and committed volunteers. Ideally, volunteers would have a wide range of interests and levels of availability, and would be scattered throughout the covered geographic area so as to reduce associated transportation costs.

Sustainability: Linked to recruiting and sustaining a committed volunteer pool, one possible solution to help schemes become sustainable is a short-term buddying scheme. Short-term schemes require less of a commitment from the volunteer, allowing them to dip in and out according to their availability – and thus perhaps making volunteering more attractive. Further, short-term schemes are designed to get clients started on or within an activity, and then provide means or connections for them to continue if desired (i.e., by tapping into existing opportunities). This last point is absolutely crucial, to ensure that participation becomes a habit rather than a ‘one-off’. Such an approach requires collaborative relationships between existing organisations in the public and voluntary sector, and puts the service user at the heart of service delivery.

Funding: Across the board, ‘optional’ services tend to get delivered when there is money, and then cut when there is no more money. We are all aware that funding is limited and unreliable, particularly within the voluntary sector. There is a call for service providers to thus think differently and more flexibly about scheme design, process, and delivery to ensure long-term availability and to escape the culture of flourish then falter.

Case Study #3: Blind and Partially Sighted Saltash (BAPS)

Description of case:

BAPS is a social activity group that operates in the South West of England, with partial support from a sight loss organisation in Cornwall. Meeting weekly, it has been running for over fifteen years. For each meeting, subsidised transport is provided to all members – enabling visually impaired older adults to take part. Activities vary from week to week, and include such things as bowls, skittles, seated chair exercises, excursions, and so on. BAPS also organise group holidays for members at least yearly, and host speakers, pub quizzes, and musical entertainment regularly.

Why this case:

Particularly in the South West of England, transport accessibility and cost was a commonly reported
barrier to participation in physical activity. In addition, across all geographical locations, a lack of consistency of opportunity arose as an important barrier to regular participation. BAPS provides an example of an organisation and social activity group that has successfully addressed both of these barriers. As a result, the group has many long-term members in the local area.

How it works:

BAPS is run by a volunteer leader, and a volunteer committee (i.e., treasurer, drivers, etc.). Members are referred by word of mouth, social services, or the blind association. BAPS covers the meeting hall fee, basic refreshments, activity fees (if applicable), and a portion of the transport costs.

The remaining cost of the transport scheme is divided between the sight loss organisation and member contributions. This cost is not insignificant. Volunteer drivers collect each member from their homes and take them to and from the meeting venue. BAPS draws members from a 70 mile radius and volunteer drivers are reimbursed per mile covered. Vehicle maintenance and repair, storage and insurance add to the transport bill.

BAPS is not unique in offering this type of transport scheme. They are perhaps unique in offering it for a sustained (and uninterrupted) period of time. However, there is no one solution or approach for their success when others have faltered. Doing so has not been smooth sailing:

"Transport – well, the minibus. It’s my biggest worry. It’s always the biggest expense and I’m never sure that we’ll be able to keep it going. But I guess, it’s also my biggest accomplishment – because we have somehow kept it going all these years.”
- BAPS organiser, aged 66, AMD

Keeping the club going is a priority for everyone involved including the leader, committee members, and visually impaired participants. There is a conscious effort for continuous fundraising and sponsorship drives to supplement the running of BAPS. In the past, they have received lottery and grant funding, and are looking to do so in the future. They are persistent, tireless, and creative in their endeavour because they believe in what the club stands for and what it offers to visually impaired older adults.

Important considerations:
Passion: Throughout the project, we encountered numerous social activity groups like BAPS, in all three geographical locations – and likely similar groups exist across the UK as a whole. Involvement in delivering these types of opportunities, particularly on a volunteer basis, takes a special kind of person. For a group to be successful and sustainable, you need a passionate leader and committed volunteers. You need people that are devoted to the cause because of the pleasure it brings to them and those they are providing the service for.

“I am so lucky in that one of my drivers, for the minibus, is my treasurer. I've got five other car drivers. And they don’t just pick people up and drop them off like other clubs. They come in, they take them to toilets if they need to, they’ll make the tea, they’ll help with the dishes. They’re always there for me. So I’m lucky that I’ve got such good helpers because without them, I couldn't do it on my own.”
- BAPS organiser, aged 66, AMD

Funding: Given the current climate of cuts in the public service sector, the issue of funding is more contentious than ever. There is less money in the pot to go around, and more organisations competing for it. However, the bottom line is that a social activity group (and transport scheme) like BAPS costs money to run. Finding this money requires creativity and persistence, and it is an ongoing negotiation. It is important to mind and apply via various sources and avenues: grants, lotteries, sponsorship, fundraising, and partnerships with existing community transport schemes if available. Further, it is crucial that these avenues are explored before the money runs out, so that there is minimal interruption to the service delivery.

Case Study #4: Forums and information hubs

Description of case:

This case study examines the provision of support and information regarding opportunities and resources for visually impaired older adults to participate in physical activity. Most local sight loss organisations distribute newsletters, brochures, magazines, or similar to highlight news and events relative to the organisation that members might find useful and informative. Talking newspapers are another common method of communication, and increasingly there is attention upon sharing information via accessible websites. The reach of each of these avenues varies depending on organisation size and budget, and engagement in them is also variable. Further, these may or may not list or include physical activity opportunities. For the purposes of this case study, we considered several websites, forums and information hubs that focus specifically on publicising physical activity events and activities for the visually impaired community. Here, we present a composite case study of promising practice drawing from a number of organisations and services, including but not limited to:

- London Visual Impairment Forum (LVIF), London: http://lvif.co.uk/
Physical Activity among Older People with Sight Loss

- FitNetUK, national:  http://fitnetuk.com
- Websites of sight loss organisations (of varying size and reach)

Why this case:

Every organisation that provides a service endeavours to ensure that service reaches those who need it most. For many organisations, leisure and physical activity opportunities do not necessarily feature in their promotional or informational material. However, this is not always because such opportunities are unavailable. We speculate that for these organisations, the priority is on communicating what they perceive to be essential services (i.e., home visiting, mobility, welfare rights, counselling and emotional support).

"I would like to do more activity. I don't do much at all. And I’d be interested in trying new things. I’d try anything, if I knew about it. I just don’t tend to hear about things that are going on, and so I probably miss out."  - participant, aged 73, AMD

This speculation is supported by our findings, which indicate that many participants were interested in participating in physical activity, but did not know about available opportunities to do so in their local area. Effective and wide-reaching communication of opportunities has the potential to address several of the barriers to physical activity participation that have emerged from this project, including: insufficient marketing of opportunities, and lack of variety, sustainability, and consistency of opportunity. Further, awareness of, and subsequent engagement in, available opportunities would go some way toward addressing other barriers expressed by participants, including: a lack of physical fitness, activity loss, poor mental and emotional health, a lack of social support, and a lack of confidence (and concern for safety).

By exploring a selection of mediums, organisations and initiatives that purposefully aim to communicate opportunities for physical activity participation, we present several strategies and considerations with the objective of reaching as wide of an audience as possible.

How it works:

Individual sight loss organisations that do emphasise leisure and physical activity participation tend to list opportunities on their websites and in promotional material (i.e., pamphlets). Often listed under ‘Services’ on the accessible websites, these organisations tend to position physical activity participation within larger considerations of wellbeing (as one example, see the MySight Nottinghamshire website: http://www.mysightnotts.org.uk/services/sports-healthy-lifestyle). On these websites, existing activities are listed alongside contact information for getting involved.
A more comprehensive approach is offered by forums dedicated to the topic of leisure and physical activity, which collate opportunities, resources, events, and services into a website, listserv, or newsletter (paper and electronic) format. These tend to exist primarily in larger urban areas (such as London), wherein numerous statutory, voluntary, independent and private sector agencies simultaneously provide services to the visually impaired. News and bulletins are distributed weekly, fortnightly, or monthly to members and interested parties. There is little in the way of production costs, but there tends to be an individual who manages and assembles the bulletins. Forums thus serve to share relevant information about existing activity groups, taster days (to try an activity), and events.

Hubs (i.e., FitNetUK) operate primarily online, and offer a means by which individuals can connect with each other and also provide information on, and links to, fitness and sports resources. Hubs are thus more interactive in nature – allowing visually impaired participants to ask questions, seek or provide advice, and share experiences with their peers.

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**From FitNetUK website:**

We’d like everyone to reach their full potential in terms of fitness, feeling great, staying healthy and trying out new things, in good company. Fitness doesn’t have to mean having a gym membership, but some of the benefits of joining a gym are the social contact, encouragement, advice and support you can get. We aim to provide that virtually, by helping people to connect with each other and also provide information on and links to fitness and sports resources. … A further aim is to encourage the fitness industry to become more inclusive for people who may need additional support. We believe that inclusion is key and that nobody should feel excluded from fitness for any reason, be that to do with a lack of confidence or knowledge, money, location, or physical ability.

**Important considerations:**

**Viability:** To market activities, there have to be available activities. This is not the case in all local authorities within the UK. When persistent in seeking information about possible opportunities for physical activity participation, some participants found that there was legitimately nothing available in their areas. While problematic, this is also an opportunity – and emphasises the necessity of collecting this information in a systematic way, in order to subsequently address shortcomings.

**Engagement & reach:** For forums and information hubs to be successful, you need visually impaired
participants and members to receive and read the information, and to engage in discussions with each other on relevant topics. Bulletins and newsletters of the forums that we looked at all tend to go to pre-existing members. This is a concern, with one provider stating that he was aware that they were ‘preaching to the already indoctrinated’. Similarly, hubs are not useful interactive tools if there are not enough users therein to interact with each other. There must be a conscious effort to publicise the existence of the forum and/or hub, to encourage engagement and increase reach.

Format: One step towards encouraging engagement and increasing the reach of forums and information hubs is an awareness of visually impaired individual’s preferred formats for receiving information. Generally, the more formats available, the better. This includes traditional forms of communication such as newsletters, talking newspapers, and radio, alongside virtual methods such as accessible websites, email, and social media (i.e., Twitter, Facebook). The point here is that all preferences must be accounted and catered for when delivering information.

“There’s no point in me producing something if no one can read it. Before anything, clearly what we need to find out is what format people want the information in. That seems to be the biggest problem that local authorities and organisations, charities, and so on, have. You know, they’re so keen to find out names and addresses and mobile numbers, but they forget to ask, you know, fundamentally – how would you want the information? If I send it to you by email, can your computer read it to you? Can you change the print to large print? Do you want it on a CD? Do you want it in large print, and if so, what size is best for you? And that is really fundamental to a lot of the communication break downs. I mean, some people still want it in Braille. That’s a very small minority now, of people that learn Braille. But it is an important part of an older generation of blind people. And it might be that’s how they want it. And oftentimes we seem to fail in that communication.” – organiser of forum on physical activity

Cultural sensitivity: Linked to the consideration of format, there is a need to acknowledge the language preferences of older adults with visual impairment. Increasingly, the UK is a multicultural environment. Particularly in urban centres, large proportions of the older population may be non-English speaking, or English maybe their second language. To ensure maximum engagement, information should thus be produced in multiple languages according to the cultural make-up of the target population.

Power of positive stories: Information hubs, in particular, are avenues by which visually impaired individuals who are physically active can share their stories of successfully negotiating their chosen activity. Common barriers are thus evident, as are strategies to overcome them. These stories can then serve as inspiration for others. Indeed, exposure to peer success stories is a powerful impetus for
change, and has the potential to be an effective strategy within any number of settings (i.e., the sight loss pathway, rehabilitation services, and physical activity programs for visually impaired older adults).

6. Methodological reflections

Purposive efforts were made to obtain a diverse sample with respect to age, gender, ethnicity, socio-economic, marital and health status, and type and level of visual impairment. On the whole, this sampling strategy was successful despite challenges with recruitment. However, diversity was not sufficiently achieved with respect to ethnic origin. The vast majority of participants were Caucasian and British, and ethnic minorities were not well represented. Only two participants fell outside of this category, (two female participants: one South Asian and one from East Asia). Each of these women spoke English as a second language (ESL), although their level of English was good.

This brief insight demonstrated that a consideration of cultural and ethnic origin has important implications when considering access to resources particularly within multicultural urban centres. While not experiencing any issues themselves, each of these ESL participants explained that language was a barrier to accessing public services for others within their communities.

“Did you see any other Indian family, at all? I tell you, because some Indian people they don’t want to share their feelings, that’s the problem. I think that could be a problem. And some people they can’t talk proper English, I know – that’s difficult for them. They don’t want to ask for help, and they – maybe they don’t know how or feel confident speaking, you see.”

-participant, aged 72, DR & cataracts

Further research is thus necessary to explore how, if, and why perceptions and experiences of physical activity participation differ amongst ethnic minorities in the UK, particularly those who are ESL and/or not English-speaking.

Additional considerations with respect to the methodological approach taken within this research address the fourth identified objective: to examine the value of novel and imaginative qualitative research methods to understand physical activity among older adults with sight loss in more complete and nuanced ways. The novel and imaginative methods employed within the project were audio diaries and mobile interviews, and these were used to complement traditional in-depth interviews.

Audio diaries:

Two individuals from each geographical location were approached to keep audio diaries, for a total number of six. From each location, we approached one active individual and one less so to take part in this aspect of the project. Each of these participants were provided with a digital recorder and asked to keep an audio diary of their day-to-day experiences of and/or aspirations for physical activity over a two
week period. They were asked to record an entry daily, for approximately ten minutes duration. They were provided with verbal and written instructions to operate the recorder as well as the audio diary task.

On the whole, engagement and compliance with this methodology and the associated instructions was poor. Of six collected audio diaries, three were incomplete: with participants stating they have recorded over ten entries, and less than five recordings being present. This suggests errors with the recorder itself, and accidental erasing of existing entries. The other three participants that submitted audio diaries stated that despite the instructions being relatively clear, they found themselves unsure of what to say when recording. Oftentimes, this turned into a straightforward reporting of the day’s tasks, and any physical activity undertaken. In general, the collected audio diaries did not produce the insights and data that the research team had hoped for.

However, we still feel that with a few tweaks, the methodology has potential with an appropriate research design. For example, given that our data collection took place over three disparate geographical sites, the lead researcher was not generally in the same area as the participant. It would be ideal if a member of the research team could regularly check in – in person – with the participant during the two week audio diary period. Doing so would ensure that the digital recorder was being used properly, and perhaps allow for download of entries during the process itself to minimise the danger of accidental erasure. In addition, it would allow the participant the opportunity to check in and/or ask questions about the task itself, what was expected within their entries, and general reassurance.

Mobile interviews:

Mobile interviews were also employed with two individuals from each geographical location. For this task, active participants were approached and asked if the lead researcher could accompany them to their chosen activity. Interviews took place before, during (if feasible), and after the activity itself. For this project, the lead researcher accompanied and interviewed participants as they went rifle-shooting, running, gardening, walking, and cycling, and one as he played cricket.

Supporting the literature, we found this to be a rich methodological technique that stimulated the participant to show rather than describe the environments and spaces that were significant in terms of their participation in physical activity (Brown & Durrheim, 2009). It placed participants’ experiences, stories, and events in their spatial context and inspired each participant to articulate and elaborate on their thoughts, behaviours and emotions while performing the activity that did not arise in the traditional interview setting. In particular, in the act of describing the negotiation of the activity itself, many participants recalled the initial barriers that they encountered when first taking part. Talking the researcher through these, and how they were subsequently overcome, several participants described a feeling of pride and accomplishment in their perseverance.

Further, such an approach captured the complexity of factors that needed negotiating. For example, for something as seemingly simple as a country walk, the walking participant described how navigating
country lanes was dependent on the weather (i.e., if windy, he couldn’t hear approaching vehicles), over-hanging bushes impacted his mobility and enjoyment, and so on. It was in the act of walking – and for example, having his white stick get caught in the hedge – that these barriers and his strategies for overcoming them became apparent. Certainly, the novel methodological approach of mobile interviewing allowed for a more complete and nuanced understanding of physical activity among older adults with sight loss.

7. Conclusions & Recommendations

Older adults with visual impairment describe various barriers, motivating factors, and facilitators to their participation in physical activity. For our participants, the interaction of these had a significant impact on physical as well as mental and emotional health. As a result, attention to this issue has important implications for this population with respect to wellbeing and quality of life. In this section, conclusions of the project are outlined, and the fifth and final objective is addressed: to establish areas for future research that will develop knowledge and improve commercial enterprise and services delivery in the area of physical activity among older adults with visual impairment.

Barriers

Reported barriers to physical activity participation encompassed physical, structural, and psychological realms. The barriers expressed under the broad theme of ‘health characteristics’ (physical fitness, activity loss, comorbidities, mental and emotional health, and challenge and independence) are not necessarily exclusive to those with visual impairment. Aspects of each could easily be seen to apply to all older adults with respect to physical activity participation, with accompanying nuances of managing visual impairment therein.

- Age-related sight loss does not tend to occur in isolation, but as part of the ageing process alongside other age-related illnesses, conditions, and changes. Given the growing proportion of older adults experiencing and living with sight loss, it is essential that visual impairment is incorporated into the larger ageing agenda rather than being addressed in isolation.

Many additional barriers were identified within the broad theme entitled ‘accessibility and opportunity’. These barriers were more specific to older adults with visual impairment, and encompassed such things as: transport availability and cost; variety, sustainability and consistency of opportunities; marketing of opportunities; social support; fear, confidence and safety; time; leisure facilities; and the built and natural environment.

An important conclusion of this project is that each of these barriers has the potential (and likelihood) of overlapping and/or co-existing rather than occurring in isolation. For example, addressing the accessibility of the physical built environment within a fitness facility might need to be considered
alongside the social and psycho-emotional barriers that visually impaired older adults may also face.

- As part of this, then, research needs to extend its focus beyond a structural or social model approach that attends to the socio-structural barriers that serve to exclude and restrict people with impairments.

This is warranted because the psycho-emotional dimensions of disabled people’s lives are not deliberately attended to within the social model (Goodley 2011; Smith and Sparkes 2012; Thomas 2007). As such, we are left with an inadequate understanding of the complex ways in which disabled people are restricted from engaging in physical activity. In light of this inadequate understanding of disability, and recent criticisms of the social model (see Goodley 2011), one possible way forward is to consider the social relational model of disability as described by Thomas (2007). This has not been attended to in terms of visually impaired adults. However, it holds much potential value.

The social relational model describes disability as “a form of social oppression involving the social imposition of restrictions of activity on people with impairments and the socially engendered undermining of their psycho-emotional well-being” (Thomas 2007: 73, italics added). Conceptualised this way, this model uniquely extends the social model by proposing that it is not just the physical environment that restricts people’s physical activity (i.e., structural disablism). The social relational model also deliberately proposes that restrictions of activity arise when a person’s psycho-emotional wellbeing is damaged. One way this damage can occur, and thus activities restricted, is through interactions with other people. For example, an impaired person’s psycho-emotional wellbeing might be damaged when a group of people at the gym aim hurtful words at them or when the gym manager claims that because they are visually impaired they pose a ‘health and safety’ liability. In such social interactions, the potential damage and/or undermining of the visually impaired older adult’s psycho-emotional wellbeing might result in their future avoidance of the gym altogether. Hence, damage to psycho-emotional wellbeing can place limits on what one can do and can become.

**Motivating factors:**

Older adults with visual impairment who were physically active described many motivating factors for being so. These included perceived physical benefits such as improved physical fitness, help in controlling other health conditions, and implications for independence and mobility. In addition, many active participants also cited the mental and emotional rewards of participation. Engaging in activities often also offered the opportunity for social interaction, and this brought immense pleasure.

- Awareness of the variety of motivators for participation in physical activity has the potential to inform public health messages and/or promotion within this population. For example, in addition to highlighting the health benefits of participation, it might be fruitful to emphasise the implications of these health benefits. Across the board, independence was valued by older adults with sight loss. Making the link clearer between participation in physical activity and maintaining independence might be a message that invokes action (i.e., improved balance, decreased incidence of falls, fewer reports of mental health issues, etc.).
• Going one step further, health promotion messages would do well to highlight the social benefits of participation in physical activity, and to underscore the potential for pleasure and social engagement within such activities.

With the above points in mind, another important consideration is the variety of available opportunities for older adults with visual impairment to participate in physical activity. It is crucial to acknowledge that each individual will have different preferences. Some may desire to participate in mainstream activities within the larger community, others will feel more comfortable within groups of other visually impaired individuals performing or engaging in an activity. Preferences for types and levels of activity will depend on previous activity involvement and experiences with physical activity across the life course.

• Endeavour to provide a wide variety of options for participation in physical activity, within local sight loss organisations and in partnership with existing mainstream community activities.

• Provide individualised attention to what activities are valued by the visually impaired older adults themselves. Explore what steps and/or adjustments could realistically be made in order to maintain/continue a chosen activity to reduce activity loss, and provide alternatives and individualised solutions where necessary.

**Facilitators:**

Including visually impaired older adults who considered themselves to be physically active within our sample allowed an exploration of the facilitators of their involvement. These included such things as social support, access to and information about desirable activities, confidence, and accessible transportation enabling their participation. Once again, these facilitators overlap and are important to consider in their interactions rather than individually. However, individual stories about facilitators are excellent examples of what has worked well for some and perhaps could work well for others. These individual stories about facilitated participation provided a starting point – and informed (and were complemented by) an examination of promising practice. The promising practice case studies (see section 5) provide insight into the complexity of designing, delivering, and facilitating physical activity opportunities within this population.

• When designing/conceptualising a physical activity opportunity specifically for older adults with visual impairment, it is most important to ask older adults with visual impairment what they want. More preliminary research followed by targeted marketing of the opportunity will lead to increased engagement. This will limit the start/stop nature of many activity programs.

• Taking the lead of the Inclusive Fitness Initiative (IFI – see section 5, case study #1), there is a need for all service providers to examine their inclusivity practices, and address inclusion as a whole, including: accessible facilities, equipment, staff-training, marketing, and development. It is important that these components are addressed both within and beyond the realm of fitness facilities to encompass other physical activity settings and opportunities.

Currently, many local sight loss organisations are content to offer a ‘one size fits all’ social activity
group, thus fulfilling directives and/or requirements to address the social and leisure needs of older adults with visual impairment. However, there is a danger of a tick-box approach here. No one social group can satisfy the needs and desires of a heterogeneous population. For many participants of this project, existing social activity groups were insufficient and/or too inactive to suit their leisure and activity purposes and preferences. Critical attention to the above points would ensure a range of available opportunities, wherever possible.

All of the above may be too much to ask solely from resource-restricted local sight loss organisations. There is a need to work collaboratively with national sight loss organisations, to pool resources and knowledge, and to ensure development and consistency of opportunity across the country. There is also a need to engage community and commercial stakeholders in the matter of inclusion, to widen accessibility and promote compliance to anti-discrimination laws.

The issue here is that the Equality Act (2010) is not enforced so much as it is softly persuaded. It is up to each individual to take legal action in order to enforce their rights as a disabled consumer. However, not every visually impaired older adult felt willing or able to advocate for their own needs when they encountered barriers to their physical activity participation.

- One possible solution is to develop an independent ‘watchdog’ type organisation, whose purpose would be to advocate for disability rights and address accessibility issues within the realm of physical activity, sport, and fitness. Alternatively, this might be addressed by developing links to an existing organisation such as the Disability Rights Commission, and getting the issue of physical activity access onto their radar. Each sight loss organisation could direct clients to speak to this organisation, and they would mediate and collect relevant experiences of discrimination and take the desired action: be that advocating for the individual affected, and/or to ensure discrimination is addressed and eliminated in future.

Concluding comments

This research represents a first step toward the development of a set of heuristics for decision-makers and health professionals to consider and begin to address physical activity as an important health and leisure practice in the lives of older adults with sight loss. Many decision-makers are seeking academic support and advice in moving forward in this area. Ultimately, the intention of this and future research is to begin to produce best practice guidelines to diminish real and perceived barriers to participation, and to maximize engagement with physical activity among older adults with sight loss. In our view, this can only be done through collaboration between decision-makers faced with real world constraints in designing and delivering activity opportunities, older adults with a visual impairment themselves, and researchers with interests in this important topic area.
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References


