

Active Leisure and Ageing in Rural Ireland: Exploring Perceptions and Motivations to Facilitate and Promote Meaningful Physical Activity

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The life expectancy of the world population is increasing and the art of aging well is of global interest (European Commission, n.d.). In Ireland, the number of people over the age of 60 will increase from 1.1 million currently, to 2.44 million by 2041, constituting nearly one third of its total population (Institute of Public Health, 2018). Despite the benefits of regular physical activity (PA), particularly with the frail (≥ 65 years and requiring a walking aid), rates of participation remain low (Colley et al., 2011). Health concerns raised, such as smoking and weight issues, are more prevalent in this cohort (Witcher et al., 2016). Currently, when they reach a certain age, PA is not seen as beneficial and older adults refrain from participating in PA (Witcher et al., 2016), particularly post-retirement (Chaudhury and Shelton, 2010). Education of the older population concerning the benefits of PA is critical, and PA perceptions and behaviours must be examined both contextually and historically (Witcher et al., 2016) to provide greater clarity and understanding. In order to develop a more comprehensive, inclusive policy for active ageing in Ireland, particularly rural Ireland, we need to reflect on the research to date. This conceptual paper develops a framework of meaning-making to active leisure, focusing on perceptions and motivations of a rural based population. It also examines the impact of being physically active on participating in tourism in this population and how Ireland is targeting this growing older market for various forms of tourism activity. An unhealthy population brings a financial burden to the country. Encouraging a healthier lifestyle which includes more meaningful active leisure, facilitating an engagement with tourism, is required to enable this cohort to age healthily and well and thus reduce the cost associated with an ageing population.

Keywords: ageing population, rural, physical activity, perceptions, motivations, tourism



<https://doi.org/10.26493/2335-4194.15.65-80>

Introduction

Ireland is a small island situated on the north-western edge of Europe on the north-eastern fringe of the

Atlantic. The Republic of Ireland measures 70,273 square kilometres whilst Northern Ireland measures approximately 14,136 square kilometres (Irish Geneal-

ogy Toolkit, n.d.). In April 2021, Ireland had an estimated population of 5.01 million, which is the first time since the 1851 census that the population has risen above 5 million (Central Statistics Office, n.d.b). The industry is broken down into agriculture (0.9%), industry (35.18%) and services (56.72%) (Statista, n.d.) and the current minimum wage is estimated to be €1,755 (Eurostat, 2022).

The State Pension (Contributory), often referred to as the old-age pension, is paid to people from the age of 66 who have enough Pay Related Social Insurance (PRSI) contributions. Most employers and employees (over 16 years of age and under 66) pay PRSI contributions into the national Social Insurance Fund, which is generally accepted as a compulsory contribution, and the weekly State Pension payable to eligible individuals is €248.30 per week (Citizen Information Board, n.d.). In addition, 65% of workers in employment aged 20–69 years have occupational and personal pension cover of some form outside of the State Pension to supplement this income (Central Statistics Office, n.d.a).

The profile of the Irish population is changing and becoming more aged. The number of people over the age of 65, will increase from an estimated one in seven (14%), totalling 696,300 in 2019, to one in 4 (26%), doubling to almost 1.6 million by 2051 (Sheehan and O'Sullivan, 2020).

In the Republic of Ireland, 44% of rural dwellers are over the age of 65 (Walsh et al., 2012), and there is a stark difference in distribution between men (44,040 or 18.8%) and women (190,217 or 81.2%), which contrasts significantly between the general population distribution of 2,354,428 men (49.44%) and 2,407,437 (50.56%) women recorded in the 2016 census (Central Statistics Office, 2017).

Lack of studies of physical activity and older adults in a rural context makes this area of research challenging. The studies to date either focus on active leisure or sports participation of the older adult in an urban context (Etman et al., 2016; Sugimoto et al., 2014) or retirement community (Vaitkevicius et al., 2002), or, where the study takes place in a rural setting, the participants are either not older adults, or over the age of 65 (Mitchell et al., 2014), or the studies do not test or assess leisure and sport activity programmes, tending

rather to focus on factors contributing to exercise or the lack thereof (Boehm et al., 2013). Where studies occur in a mixed population of both urban and rural older adult dwellers, the studies focus on identifying correlates of sport participation (Murtagh et al., 2015; Yamakita et al., 2015).

Definitions differ between the different scientific disciplines and need to be considered. Most research papers refer to the elderly as being 65 years and over (Yamakita et al., 2015), with the Japanese further categorising this group into young old (65–74 years old) (Sugimoto et al., 2014), old (over 75 years) (Ouchi et al., 2017) and those above 80 years of age referred to as old-old (Asher, 2013). In Ireland the term 'older people' was historically applied to individuals of state pensionable age (Walsh & Harvey, 2011), which increased to 66 years in 2018 (Citizen Information Board, n.d.) as a means of coping with the ageing population. As the Central Statistics Office uses 5-year age increments in Ireland we now class those over the age of 65 years as 'elderly,' which is line with the system employed in the rest of Europe (Walsh & Harvey, 2011).

A further classification by the National Council for Ageing and Older People in Ireland describes those over the age of 80 years as 'older elderly' or 'frail elderly' (Walsh & Harvey, 2011). However, studies do vary with definitions of ≥60 years (Roh et al., 2015; Murtagh et al., 2015; Asher, 2013) being referenced. Discrepancy exists as to the definition, with older adults referred to in Australian research (Boehm et al., 2013) as 50 years or over whilst in Finland, Sarvimäki and Stenbock-Hult (2000) describe old age as 75 years and older – a difference of 25 years.

Despite the definition of 'elderly' varying between countries, the World Health Organisation (WHO) uses 65 years of age to describe the older person, and this is the most commonly accepted definition.

Language is also of the utmost importance when describing an older population with terms like 'elderly,' 'old' or 'aged' seen as discriminatory or offensive and alternatives like 'seniors,' 'older' or 'mature' adults recommended (Flinders University, n.d.). Older adults, 65 years and over, will be used to describe this cohort going forward.

Terminology is also a limiting factor with lack of

clear definitions of terms resulting in the interchangeable use of ideas or concepts like physical activity (PA), leisure time physical activity (LTPA) and sport participation. Definition of PA across studies vary which makes comparison of data difficult according to a systemic review of PA in older people by (Sun et al., 2013). The definition and meaning of the term PA need to be clarified in regard to individuals as currently a broad definition is accepted to include a variety of activities outside of the definition of PA, where being active and busy is deemed to be synonymous with PA (Witcher et al., 2016). 'Physical activity is defined as any bodily movement produced by skeletal muscles that requires energy expenditure' and physical inactivity (lack of physical activity) has been identified as the fourth leading risk factor for global mortality (World Health Organization, n.d.).

This definition is purposefully broad to encompass all modes of PA. 'All types of PA are of interest, including active play, walking or cycling for transport, dance, traditional active games and recreational games, gardening and housework, as well as sport or deliberate exercise' (*Get Ireland Active! National Physical Activity Plan for Ireland*, n.d., p. 5). Sun et al. (2013) assert that PA comprises leisure-time PA (LTPA), occupational PA, household PA and transport PA and yet studies in Ireland do not focus on LTPA, focusing rather on participation in sport, recreational walking, cycling for transport and walking for transport (Sport Ireland IPSOS & MRBI, 2019). This makes analysis of PA engagement difficult.

In order to develop a more comprehensive, inclusive policy for active ageing in Ireland, particularly rural Ireland, we need to reflect on the research to date. This conceptual paper, by examining existing data (secondary research), develops a frame-work of meaning-making to active leisure in a rural, older (65 years and older), Irish population, by focusing on perceptions and motivations to exercise. Furthermore, it examines the impact of being physically active on participating in tourism in this population and how Ireland is targeting this growing older market for various forms of tourism. This has been highlighted in a recent report conducted by Golden Ireland (Irish travel website exclusively for the actively retired) ex-

Table 1 Estimated PAFs, Calculated with Adjusted Relative Risks, for Coronary Heart Disease, Type 2 Diabetes, Breast Cancer, Colon Cancer, and All-Cause Mortality Associated with Physical Inactivity, by WHO Region and Country

Disease	Global average	European average	Ireland
Coronary Heart Disease	5.8	5.5	8.8
Type 2 Diabetes	7.2	6.8	10.9
Breast Cancer	10.1	9.3	15.2
Colon Cancer	10.4	9.9	15.7

Notes In percent. Adapted from Lee et al. (2012).

amining the seniors travel market between September 2020 and June 2021; 75% of those surveyed planned to travel in Ireland during this period and 75% take 2–3 leisure trips per annum, 61% in Ireland and 14% abroad (McGlynn, n.d.).

Importance of PA and Irish Participation Levels

Ageing encompasses both the biological changes (molecular and cellular damage) and life transitions (retirement, experience of death) as one advances in age (World Health Organization, 2021). An aging population makes increased demands on the government in terms of healthcare. Prince et al. (2015) have reported that 23% of the total global burden of disease can be attributed to those aged 60 and above and these challenges are heightened by a lack of PA (Murtagh et al., 2015). Being physically active maintains health and reduces the decline in physical function (Etman et al., 2016) which in turn reduces health costs. Disturbingly, Irish statistics are worse than both the global and the European average for coronary heart disease, type 2 diabetes, breast cancer and colon cancer, with lack of PA deemed responsible (Lee et al., 2012). This is highlighted in Table 1, which uses the population attributable fraction (PAF), a measure used by epidemiologists to estimate the effect of a risk factor, in this case lack of PA, on disease incidence in a population (Lee et al., 2012).

Numerous benefits to PA have been explored by The Irish Longitudinal Study on Ageing (TILDA). Irish adults who report high levels of PA have higher levels

of self-rated health, enjoy better quality of life (QOL), display clinically depressive symptoms less commonly, have lower loneliness scores, engage more frequently in active and social activities and volunteer more in comparison to adults with low levels of PA (Donoghue et al., 2016, p. 16). There are also numerous social, physical and psychological benefits to enjoying an active lifestyle and there is a direct link between PA and life expectancy, with physically active individuals or populations living longer than inactive or sedentary ones (*EU Physical Activity Guidelines*, 2008, p. 3).

Participation rates are influenced by age as can be observed by the significant difference in activity levels between those aged 50–64 years classed as highly active (31%) compared to 18% of the ≥65 year olds (Perceptive Insight, 2015). Rural and urban discrepancies in PA have also been highlighted (Van Dyck et al., 2010; Witcher et al., 2016), demonstrating that irrespective of age and life experiences, rural dwellers tend to walk or exercise less than urban dwellers. In rural communities particularly, where PA has been largely shown to be at its lowest in the older population, health concerns are also raised as smoking and weight issues are more prevalent in this cohort (Witcher et al., 2016).

Lack of Knowledge

Despite the benefits of regular PA, particularly with the frail and rural populations, rates of participation remain low (Colley et al., 2011). This could possibly be explained by the fact that despite acknowledging the benefits of PA, when the seniors reach a certain age they feel that there would be limited improvement in their physical strength or ability, and subsequently refrain from participating, feeling that it would be ‘pointless’ for them (Witcher et al., 2016). Broderick et al. (2015) echoed this sentiment, determining that outcome experiences were directly related to age and that those aged between 79 and 85 years deemed exercise to be something beneficial for younger people, rather than for themselves, who were seen to be beyond it. It could also be due to a lack of knowledge on what constitutes adequate PA for their age group.

Guidelines for adults aged 18–64 years are at least 30 minutes a day of moderate activity on 5 days a week (or 150 minutes a week) which is consistent with that

recommended for adults ≥64, with an additional focus to be placed on aerobic activity, muscle-strengthening and balance (The Department of Health and Children, Health Service Executive, 2009, pp. 13, 15). Of concern is that not even half of the Irish individuals (≥50 years) surveyed by Perceptive Insight (42%) had heard of the National Physical Activity Guidelines and of those that had heard of them, only 13% could cite them correctly (Perceptive Insight, 2015, p. 5). There is, therefore, an urgent need to educate the Irish population as to the recommended levels of PA per week and the benefits of this regular engagement to promote and enhance our national PA levels. In wave 1 of the TILDA study (Donoghue et al., 2016, p. 6), 2009–2011 results show that only 33% of the Irish population over the age of 50 are meeting the required levels of high activity with men (41%) achieving substantially greater standards than women (26%). When comparing Ireland’s levels of PA to fifteen European countries, Piątkowska and Pilsudski (2012) determined that Ireland ranked 9th out of 16 countries in high PA levels (29% vs 31.3% European average) and 11th (34.7%) compared to the European average of 31% when examining low PA levels. In both instances Ireland is performing below the European average.

Perceptions of Active Leisure and PA

PA is influenced by our own views and perceptions of ageing and the older adult. ‘Perception is the process by which individuals select, organize, and interpret stimuli into a meaningful and coherent picture of the world’ (Schiffman & Wisenblit, 2015), and differs among individuals as each person processes these stimuli based on their own personal needs, values and expectations. Individuals then carry biased pictures in their minds of the meanings of various stimuli, which are termed stereotypes (Schiffman & Wisenblit, 2015).

The *Oxford English Dictionary* defines a stereotype as a ‘widely held but fixed and oversimplified image or idea of a particular type of person or thing.’ When age stereotypes become directed at oneself in old age, they can be classified as self-perceptions of ageing (Levy, 2009).

Stereotypes and how we perceive ourselves and others influence if and how we exercise. Negative per-

ceptions of the older adult can be internalised from a young age so that these beliefs are seen to be true of themselves as they age. Negative stereotypes originally about others then become negative self-perceptions of ageing in later life (Robertson et al., 2015) and the effect of self-perceptions increases with age (Levy et al., 2002).

How the older adult perceives they are viewed in society also impacts on their PA behaviour. Egan et al. (2014) reported that negative public perceptions of older people, influenced by stereotypical views of ageing, created a barrier to participation.

Misconceptions regarding the effects of PA on illness or functional limitations hinder participation as some individuals deem PA to be contra-indicated for conditions like arthritis and joint or heart problems when actually the converse is true and PA is strongly recommended for older adults with chronic diseases or functional limitations (Nelson et al., 2007).

Sargent-Cox et al. (2012) have provided insight into the dynamic relationship between expectations regarding health and resultant physical function, with general negative perceptions of ageing associated with a decline in physical function. This phenomenon was also observed by Robertson et al. (2015), who determined that middle aged and older people who express stronger beliefs regarding negative perceptions of ageing and lack of control in the process, exhibit a greater decline in walking speed over a 2-year period than those with a more positive outlook. Wurm et al. (2008) take this one step further and demonstrate how an optimistic view of ageing has a positive effect on subjective health and life satisfaction, even in the face of a serious, unexpected health event. The authors explain this observation as a result of the older adult's acceptance of a serious health event. They possibly see it as an inevitable and concomitant part of the ageing process, which thus causes them to be impacted far less by the event than younger individuals may be, for whom a sudden worsening of health may be unexpected.

Burke et al. (2012) found co-morbidity to be a predictor of perceived health status, indicating that subjective health is dependent on physical health, making self-assessed health a good predictor of objective health. Interestingly, in this sample of 60–92 year-old

Irish participants, functional health or instrumental activities of daily living (IADL) was the strongest predictor of self-assessed health. Murtagh et al. (2014), when examining the relationship between PA participation and health status, found that individuals who had poor perceptions of their health and ability to be active were far less likely to meet PA guidelines than those with more favourable perceptions about their health. This has also been observed by Stewart et al. (2012), who noted that the more an individual attributed age to the onset of illness, the less likely they would be to engage in routine health maintenance behaviours (PA, nutritious diet, adequate sleep) and that mortality rates more than doubled (36 vs. 14%) between individuals who ascribed old age to an illness, to those who did not.

Janke et al. (2011) have determined that whilst life events may shape and alter our behaviour with regards to leisure in order to accommodate such events, our actual attitudes and perceptions remain fairly stable over time. However, an adult's life experiences do also have the ability to change perceptions of leisure. Moreover, factors influence perceived freedom in leisure, particularly among women, where reduced responsibility for children as they enter adulthood allows them more time for personal leisure. Thus, it seems that leisure attitudes, both for individuals and society as a whole, are influenced more by life experiences, whilst life structure or interpretation of events is more influential when considering perception of freedom in leisure or perceived ability to engage in leisure (Janke et al., 2011). Previous participation within a plan or structured programme by the frail older adult seemed to influence their current perception of exercise and how they defined exercise, with those taking part in a rehabilitation or exercise-therapy programme having a positive perception of exercise as a result of perceived positive outcomes. However, those who participated in sports or the military when they were younger with perceived high levels of fitness, had negative perceptions of their current exercise levels as they defined exercise in terms of the vigorous activities of the past (Broderick et al., 2015).

In a study exploring the perceptions and expectations of exercise in frail and pre-frail older adults in

Ireland, this theme of exercising for purpose was also highlighted (Broderick et al., 2015). This population felt exercise to be incidental to a particular type of an activity, be it necessary, like manual labour, or for fun, like dancing or riding their bikes. Although PA was acknowledged to have benefits in maintaining one's health, promoting confidence and enhancing moods, exercise was perceived as a by-product of purposeful activities and occurred incidentally rather than being undertaken as a health-related activity (Broderick et al., 2015). The benefits to PA in this generation seem not to be understood and PA was not valued for its own sake. This poses a challenge to promoting exercise in the rural, older adult population as LTPA is completely alien to them.

Motivation to Engage in PA

'Motivation is the driving force that impels people to act' (Schiffman & Wisenblit, 2015). As described by Homans' Rational Choice Theory (RCT), individuals are motivated by personal preferences and goals that express these preferences, and base their decisions on what will provide them with the greatest benefit, satisfaction or fulfilment (De Guzman et al., 2015). Whilst an individual's disposition provides a signature for personality, a motivational agenda is established by one's life goals or strivings and illustrates what a person aims, dreams or hopes to achieve in the future, with purpose and direction (McAdams, 2015).

Gender and age are often considered when exploring motivation to exercise. In later years, goals are more prevention-focused and outcomes are geared towards avoiding negative outcomes such as physical decline (McAdams, 2015). Older men expressed awareness and management of their aging bodies and overcoming physical challenges as motivation to engage in intentional PA, as a result of the value they placed on health (Liechty et al., 2014). Participation in PA was also guided or motivated by the desire to maintain or improve the ability to engage in enjoyable activities or pastimes as well as for the sense of identity acquired through participation and being a physically active person in later years (Liechty et al., 2014). This desire to be independent and not be a burden on family members was also echoed as a prominent mo-

tivator for PA by frail older adults (Belza et al., 2004; Broderick et al., 2015), who also identified a sense of enjoyment and personal fulfilment as a driving force to exercise (Broderick et al., 2015).

Despite the awareness of the benefits of PA and the possible positive physical changes that may have occurred as a result of the exercise, unless an individual has enjoyed the experience, they will be unlikely to continue. Conversely, when a positive affect is experienced, individuals are far more likely to negotiate possible constraints or barriers to exercise, thus ensuring continued participation and the health benefits associated with it. Involvement at a younger age also predisposes people to engage in certain activities as they age, therefore the exposure to PA skills and enjoyable activities is paramount in forming positive attitudes to PA and increasing the likelihood of continued involvement as we age (Henderson & Ainsworth, 2002).

Older adults invest more in intrinsically valued ends, and place greater emphasis on goals focusing on their health and social connections, particularly those related to family and close friends, rather than goals that promise future rewards (McAdams, 2015). They choose activities they enjoy and not those they see as exercise (Liechty et al., 2017).

Breheny and Stephens (2017) explored the concept of time as a motivating factor for PA in the older adult (63–93 year-olds). Although these individuals are encouraged to use their time 'productively' by participating in sports activities in order to age healthily and contribute to society, this form of engagement can be excluding when they can no longer maintain the level of health required. 'Personal time,' in contrast to the productive ageing concept where long-term activity plans promoted health and well-being, constructs the notion of time as short and uncertain and as such activities that brought immediate enjoyment to the individual were prioritised in recognition of mortality and inevitable decline (Breheny & Stephens, 2017). The 'personal time' discourse is 'an available resource that incorporates the inevitability of decline and supports participation and pleasure while there is still time' (Breheny & Stephens, 2017), and this notion can also be broadened to incorporate leisure time and tourism with 'bucket lists' and '30 things to do before

you die' (*The Travel Bucket List: 30 Things To Do before You Die*, n.d.) as an incentive to travel and seek immediate fulfilment. This sentiment of instant gratification has been echoed by Lenneis and Pfister (2017) in their exploration of the motivation of middle-aged (45–55 years) women to play a team sport (floorball), where cooperation with others and experiences of immediate success are motives to participate.

The motivation to initially commence a PA programme and then maintain it, are often quite different. Seekamp et al. (2016) determined that the physical benefits of walking, as well the accountability (reporting back) and pedometers (increasing step count), prompted rural, inactive Australians (40–65 years) to engage in a six-week walking intervention programme, whilst the mental benefits, in conjunction with positive self-talk and focusing on personal goals, motivated them to continue walking. PA self-efficacy and social support are considered to be key factors when adopting and maintaining a PA regime. 'Physical activity and self-efficacy refers to an individual's confidence in his/her ability to engage in physical activity, even when encountering barriers, whereas social support encompasses various types of encouragement and assistance for engaging in PA' (Becofsky et al., 2014). Mode of delivery of an intervention is an important consideration as group programmes foster and increase both self-efficacy and social support, whereas one-on-one feedback merely facilitates an increase in self-efficacy. It is noteworthy that self-efficacy mediates programme effects and is vital in PA adoption regardless of how the programme is delivered (Becofsky et al., 2014).

According to social cognitive theories, the most important factor determining whether an individual will engage in exercise, is whether or not they believe they can perform the activity, even in adversity, and whether they deem there to be sufficient rewards or benefits from participating, e.g. fitness gains or fun (Warner et al., 2011). 'Perceived self-efficacy is defined as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives' (Bandura, 1994). Warner et al. (2011) highlight the synergistic relationship between self-efficacy and social support. Older

(≥65 years) individuals with low self-efficacy were unlikely to be active even if they had social support, and individuals with low social support were less likely to be physically active even if they had high self-efficacy. This emphasizes the need to consider both resources when moderating behaviour change as the likelihood of engaging in exercise is dependent on support from friends, coupled with a strong self-belief in one's ability to succeed (Warner et al., 2011).

Gender Differences

Davis et al. (2012) have determined that gender, age and level of education influence the type and level of participation in rural areas, with women more regularly engaging in social activity, with the exception of sport which is favoured by men.

Kozakai et al. (2012) have noted gender differences in popular activities throughout the life course, with men preferring ball sports and women favouring dance or gymnastics. This gender difference has also been observed by Giuli et al. (2011), who note aerobics as a popular choice of PA in women, with interest or preferences for different activities varying from culture to culture. Whilst running, swimming and exercise are the most popular activities amongst both men and women in Ireland, differences in PA preference then emerge with team based sports (rugby, soccer, hurling and Gaelic football) favoured by men and yoga or Pilates preferred by women. Younger women are also now spending more time indoors, with gym based (weights) and class activities (Pilates) the preference for the 25–34 year-old age bracket. In the older population, golf (men) and dancing (men and women) is the preference for those aged ≥65 years which highlights gender differences in PA throughout the life course (Sport Ireland & Ipsos MRBI, 2015, pp. 18, 21).

Initiatives

Despite numerous national initiatives to promote Active Leisure (AL) and PA in the older population, uptake and participation rates, particularly in the frail and rural populations, remain low (Colley et al., 2011). There is an issue with engagement with this cohort and previous studies examining the barriers and exclusion of older adults in community initiatives noted that the

most commonly cited risk factor was the mind-set of the older people themselves (O'Shea et al., 2012). Local Sports Partnerships (LSPs) work in conjunction with Sports Ireland, 'the authority tasked with the development of sport in Ireland' (Sport Ireland, n.d.a), yet the programmes are not targeted for our older population, but rather geared towards all adults over the age of 55. Communication of programmes is also limited as it is directed online via newsletters or websites which the majority of this cohort would not access, which contributes to the lack of knowledge of, and thus engagement with, local initiatives. Programmes are also often far too generic and aimed at 'older adults of all abilities' (Sport Ireland, n.d.b) rather than catering for a wider range of age groups, fitness abilities and physical health.

Tourism and the Older Adult

Developed by the economist Max-Neef in 1991, the Human Scale Development identifies idleness time or leisure as one of the fundamental needs of human beings (Max-Neef, 1992, p. 32). Leisure has been described as 'activity – apart from the obligations of work, family and society – to which the individual turns at will, for either relaxation, diversion, or broadening his knowledge and his spontaneous social participation, the free exercise of his creative capacity' (Veal, 1992). As we get older, the ability to engage in leisure time is determined by our ability to function both physically and mentally. A physically active older person can engage far more than one who has limitations.

'Individuals become tourists when they voluntarily leave their normal surroundings, where they reside, to visit another environment' (Camilleri, 2018, p. 3). This physical and mental requirement of 'being a tourist' acts as a stimulus, thus providing an adventure and a time for leisure and relaxation in surroundings different to one's own.

Harper (2014) describes future generations of older adults as having 'higher levels of human capital in terms of education, skills, and abilities and better health profiles, and this will enable them to remain active, productive and contributory for far longer'. Patterson and Balderas (2020) assert that travel provides

the means to achieve a better health profile, adjust to retirement and improve quality of life, and seniors, defined as empty nesters (55–64 years), young seniors (65–79 years) and seniors (80+ years), now constitute a prime market segment as they tend to have more spare time, more capital and be more independent than younger adults (Nimrod & Rotem, 2010; Gu et al., 2016; Patterson & Balderas, 2020).

Numerous benefits in an older population can be attributed to tourism. Gu et al. (2016) found while researching an older Chinese population that those that engaged in tourism reported better self-rated health which is a valid indicator of their overall health condition. They advocate that tourism participation may improve cognitive function through new learning opportunities and encourage a positive psychological state with reduced depression, increased social connection and spiritual well-being. The amount of physical activity (e.g. walking) during a trip may also be sufficient to promote and improve the physical health of older adults, highlighting the importance of tourism in promoting healthy ageing (Gu et al., 2016). The participation in nature-based tourism, activities with a focus on enjoying natural attractions (e.g. bird watching, fishing and walking in forests), may promote the health of active tourists as they involve PA (Chang, 2014). They can also promote relaxation, thereby relieving stress, through exposure to natural environments (Chang, 2014) which in turn promotes general well-being.

Nimrod and Rotem (2010) have described the heterogeneity of the older adults' tourism segment, with significant variability between subgroups, based on motivations, in this older cohort. They described associations between destination activities and benefits gained, with the 'physical destination activity factor' (exercise and wellness activities) correlating highly with the benefit of 'relaxation' (restful, healthful and the feeling of being relaxed).

In Ireland, a recent 2021 campaign aimed specifically at the older market, 'Golden Ireland,' seeks to attract the over 55s to various forms of soft (active and passive) tourism. As identified by Patterson & Balderas (2020), the seniors or older adult market is one that in many cases has experienced travel and knows what

they want in terms of experience. This is a growing market, with the Central Statistics Office in Ireland predicting that those aged over 65 will increase to almost 1.6 million by 2051 (Central Statistics Office, 2017). An older person's decision and ability to participate in tourism requires a degree of independence that can be enhanced by remaining physically active. Thus, PA opens up or rather keeps open the world of leisure and tourism, contributing to better quality of life (QOL).

Discussion

Perceived barriers to PA, in terms of motivation (lack of enjoyment), social support (neighbourhood safety, opportunities for socialising) and lack of time (poor time management, access to facilities, lack of family support) have a huge impact on participation levels, and understanding these influences may contribute to more effective strategies in removing barriers in different social groups and modifying PA behaviour, thus increasing participation levels (Cerin et al., 2010). When examining the barriers and exclusion of older Irish adults in community initiatives, stakeholders noted that the most commonly cited risk factor was the *mind-set of the older people* themselves (O'Shea et al., 2012). They offered three possible explanations for the lack of engagement in local activities: older people not wanting to accept what may be construed as charitable assistance due to a negative stigma, feelings of being unworthy of public assistance due to perceptions of having more than previous generations, and simply preferring to live in isolation, all of which combine to keep them marginalised and outside of public and social spheres of influence (O'Shea et al., 2012). It must also be noted that when this population are presented with an opportunity to contribute to research in this area, they choose largely to abstain, as was the experience of the researcher when conducting a refinement exercise with a rural, active retirement group. Only 25% of respondents to a survey, conducted to narrow down a PhD research question, volunteered to be contacted for future research into the respondents' preferred area of research, highlighting their general ambivalence to contributing to a possible solution.

Sargent-Cox et al. (2012) advocate that the ageing

stereotypes informing our expectations surrounding health outcomes in old age tend to be negative, focusing on frailty, disability and dependence, yet normal ageing is not characterised by declining mobility or physical function. When targeting the older adult in terms of interventions to foster and encourage PA, it must be acknowledged that the age-related stereotypes of participants may actually undermine the efforts to modify behaviour, thus necessitating an initial challenge of negative beliefs about ageing in order to optimise the health promotion (Stewart et al., 2012). Programmes that challenge and combat ageing misconceptions may be an important strategy to counteract negative age expectations and self-fulfilling prophecies (Sargent-Cox et al., 2012). Yet Liechty et al. (2014) determined that participation in PA is not undertaken to challenge ageing stereotypes or to change the discourse of ageing, but rather for the individual's own agenda of reducing age-related decline in health and ability.

A study by Witcher et al. (2016) exploring PA perceptions and influences among older, rural adults in Nova Scotia found that patterns of activity were related to participants' earlier life experiences. Activity was confined more to work and productive tasks, with leisure-time activity participation (LTPA) a relatively new concept. People walked for a purpose, not just for 'the sake of things.' A lack of awareness as to what constituted exercise and facilities was also highlighted. Previously no place to exercise existed in this population with walking and running being the norm, although these activities were not perceived as exercise. Historical context is, therefore, a huge factor when considering PA in any given population and seems to determine current experiences and perceptions of exercise (Witcher et al., 2016). These adults placed a value on work-related activity, often continuing this ethic into their current lives, with leisure activity lacking purpose or usefulness. This poses a challenge to promoting exercise in the rural, older population, prompting the exploration of exercise programmes focusing on functional outcomes, such as community gardens and dog walking, as more suitable for this population.

The Local Sports Partnerships (LSPs) categorised

the primary effect of each of their initiatives under the pillars of the COM-B Behaviour Change Model, in order to determine the effect of their programmes in increasing participation in sport and PA (Sport Ireland, 2019, p. 22). This model suggests that an individual should have Capability (Physical and Psychological), Opportunity (Physical and Social) and Motivation (Reflective and Automatic) in order to change behaviour. LSP initiatives to date have largely targeted Physical Capability (skill development – 55%), with Psychological Capability (knowledge development – 6%), Physical Opportunity (facilities, access, discounts, etc. – 13%), Social Opportunity (development of PA culture – 10%), Reflective Motivation (PA goals – 6%) and Automatic Motivation (habit development – 7%) making up the remaining 43% (2% not stated), highlighting the need for increased focus on these latter five pillars if behaviour is to be modified (Sport Ireland, 2019, p. 22).

Despite the success of the LSP initiatives in targeting the correct individuals, with 8 out of 10 participants not meeting the National Physical Activity Guidelines at registration and more than 25% being classed as inactive, the participant figures for our Go For Life (national programme for sport and physical activity for older adults in Ireland – 2,746) and Older Adult Initiatives (9,168) are quite low, yet it must be acknowledged that older adults may have participated in other programmes offered by the LSPs (Sport Ireland, 2019, p. 21). This could perhaps be explained by the difficulties expressed by the LSP network in building awareness of opportunities amongst the hard-to-reach target groups, like the rural, older population. This challenge will be addressed by the provision of Building Awareness and Promotional Guidelines by Sport Ireland to the LSPs and the support to implement them, in order to ensure ‘the broadest possible participation ensuring quality and accessibility for all groups’ in line with the National Sports Policy (p. 67).

Choice has been shown to make activity rewarding and meaningful (Davis et al., 2012), highlighting a need for a range of leisure time physical activities (LTPAs) that cater for a wide variety of needs, abilities and preferences (Nimrod & Rotem, 2010). This has also been highlighted in the tourism literature with

motivations to participate in tourism varying between older adults based on their interests and preferences. According to Rowiński et al. (2017), health conditions associated with aging might be related to disability and lead to decreased independence. PA assists in maintaining independence throughout life as well as improving quality of life. In a study conducted on older people of over 65 years in Poland both with and without disabilities, the most frequently indicated barrier to participation in sport PA and tourism were health conditions. They suggest common strategies and programmes to increase PA among older people may be utilized for both individuals with and without a disability, thus increasing older adults’ independence and ability to participate in both tourism and sport physical activities.

In an Irish context, Egan et al. (2014) highlighted the fact that meaningful PA engagement at both ends of the age spectrum (12–18 years; 65 years and over) as well as for individuals with physical, intellectual and sensory disabilities, is hindered by structural factors and public unawareness of the Irish population’s diversity, emphasizing the importance of tailoring PA to different age groups and specific needs throughout the life course.

Whilst the health benefits of exercise may initially motivate individuals who do not exercise regularly to engage in PA or leisure activities, unless they enjoy the experience they are unlikely to change this inherent behaviour. Negative experiences of PA in the past have resulted in abstinence from leisure time exercise as they age. Facilitating opportunities to find and participate in enjoyable activities is paramount in ensuring that barriers to exercise are negotiated and healthy living for the entire family and community is promoted (Henderson & Ainsworth, 2002).

Liechty et al. (2017) highlighted that whilst retirees valued physically active leisure and intended to be active in retirement, incorporating it into daily life and maintaining routines was not always easy, particularly if the activity was disliked. This highlights the importance of making PA meaningful and enjoyable for older people as preferences for casual, unstructured activities that were driven by goals other than health and fitness (e.g. gardening) were identified. Liechty

et al. (2017) suggested that participants valued PA as part of ageing well and selected meaningful activities that would contribute to physical well-being in later life, provided those activities were enjoyable and did not interfere with other valued activities. Participants require more from leisure than health benefits and will exchange PA activities for less active ones if they are deemed to bring more pleasure and fun, therefore the vast range of personal preferences and sources of meaning and value in leisure experiences needs to be considered (Liechty et al., 2017).

As described by Arnadottir et al. (2009) in Casarino and Setti (2015), location of residence may dictate the type of activity individuals engage in, with urban dwellers participating in more leisure-oriented activity, versus the increased work or manual-related activity, like farming, performed by their rural counterparts. Witcher et al. (2016) and Broderick et al. (2015) have also highlighted the effects of life experiences and exercising for purpose as a challenge to promoting PA in rural populations with a need to either educate this population as to the benefits of LTPA, or instigate initiatives like community gardens where patterns of activity would be work-related or purposeful. Activity would be thus be meaningful for rural adults and they would be far more likely to engage.

The ideology of positive ageing was advocated by the World Health Organisation (WHO) in their Active Ageing Policy framework that embraced the opportunities for health participation and security to enhance quality of life, whilst continuing to be productive members of society through economic, social and cultural contributions (Boyes, 2013).

Active ageing is described as 'the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age' (World Health Organization, 2002). There are 4 pillars of active ageing viz. health (enhancing physical and mental health and reducing health inequalities), lifelong learning (to remain relevant and engaged in society), participation (engagement in work or pursuits that bring fulfilment) and security (physical and social protection) that underlie and guide the definitions and policies (International Longevity Centre Brazil, 2015). It is conceptualised as a multidimen-

sional phenomenon which was supported by Rowe and Kahn (1987) who proposed that successful ageing included not only the physical factors such as lifestyle, habits, age and health but the psychosocial factors like feelings of autonomy and social support.

Active ageing stimulates and promotes the ongoing participation of older adults during the oldest phase of life, rather than equating it with rest (Boudiny, 2013) and is also supported by Liechty et al. (2017) who maintain that 'successful ageing' occurs when older adults engage in a variety of activities, including being a tourist.

Conclusion

Older, rural adults are not aware of the benefits of PA and perceive it as something meant either for younger people or to fulfil a particular function (Broderick et al., 2015; Witcher et al., 2016). Current initiatives to promote PA in this population are not working. Perhaps the focus of future initiatives should rather be placed on the social aspect and enjoyment of the activity rather than the health benefits as enjoyment of PA has been shown to be a primary motivator in engagement (Henderson & Ainsworth, 2002; Broderick et al., 2015) and activities that brought immediate enjoyment to the individual were prioritised in recognition of mortality and inevitable decline (Breheny & Stephens, 2017). Tourism offers a further alternative to promoting activity as it has been shown to improve the health of older adults, even the oldest old, and is thus an effective way of stimulating healthy ageing (Gu et al., 2016). Choice has also been shown to make activity rewarding and meaningful (Davis et al., 2012), highlighting a need for a range of LTPAs that cater for a wide variety of needs, abilities and preferences. It is also important to be aware that the meaning of an active life may change over the life course and that this dynamic process needs to be both adaptable and accessible in order for adults to age actively and successfully (Boudiny, 2013).

The factors that hinder PA in older adults also impact tourism participation. Stereotyping of older adults may prevent them from participating in social activities like tourism as they tend to disengage from society, and rural older adults are less likely than

their urban counterparts to engage in tourism (Gu et al., 2016). Tourism has also been negatively associated with poor self-rated health, which is impacted by PA, as Irish adults who report high levels of PA have higher levels of self-rated health (Donoghue et al. 2016, p. 7) and tourism promotes relaxation (Nimrod & Rotem, 2010) which in turn decreases stress and thus increases self-rated health. Men have also been shown to participate in tourism more than women (Gu et al., 2016) which is consistent with the significantly higher levels of PA reported by older men than women (Sun et al., 2013; Nolan et al., 2014).

Despite differing motivations for travel, older adults seem to choose a combination of activities that yield similar benefits (Nimrod & Rotem, 2010). Due to the growth in the older market, the motivations for travel by seniors will have to be accommodated by all stakeholders in order to meet their travel needs. Further research needs to be undertaken to explore the types of choices senior tourists want in the future, in order to account for these changes in a proactive way and specify practical implications for the industry (Patterson & Balderas, 2020).

Further research and evidence of PA in older people is needed, so that public health sectors can formulate initiatives and strategies to extend the lives and health of this population (Sun et al., 2013). A lack of input from our senior population to date highlights the importance of recommending that awareness and information should precede any future research. This would ensure that this cohort take responsibility for their ageing and willingly participate in the formation of a solution or national framework to guarantee the likelihood of all older adults in rural Ireland participating in PA initiatives, and having the means and ability to age successfully in place.

In order to explore older populations a dynamic approach is required. Future research will be underpinned by Responsible Research and Innovation (RRI): 'a dynamic, iterative process by which all stakeholders involved in the R&I practice become mutually responsive and share responsibility regarding both the outcomes and process requirements' (Kupper et al., 2015). The concepts of meaning-making to leisure, focusing on perceptions and motivations of a rural

based population, is a gap that needs to be explored further. Collaborating with a stakeholder group, the Men's Health Forum in Ireland (an organisation that principally 'seeks to promote and enhance all aspects of the health and well-being of males on the island of Ireland' yet also promotes the education of the general Irish population with regards to health and well-being) and the local community, and using RRI as a methodology, the research outcome will provide engaged depth and realism. The four key themes of RRI are: diversity and inclusion (researching the older cohort that is largely excluded), openness and transparency (communication and dissemination plan to increase involvement, encourage input and inform), anticipation and reflection (reflections from all stakeholders are incorporated to pursue a common goal and potential challenges identified) and responsibility and reflective change (adaptability to changing societal needs and evaluation strategies implemented continuously) (Kupper et al., 2015).

The legacy of the 20th century is the gift of a longer life, an unprecedented privilege that can be viewed in the form of a revolution, a longevity revolution (International Longevity Centre Brazil, 2015). In order to embrace a longer life, it is imperative that older people remain physically active so they may stay independent and productive, which will then enable them to participate in tourism and enjoy the new adventures and experiences it brings, to the full.

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