UNDERSTANDING OLDER MENS’ EXPERIENCES WITH PHYSICAL ACTIVITY – A QUALITATIVE ANALYSIS

by

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Abstract

Mobility disability increases the need for assistance with daily tasks, lowers quality of life, and elevates mortality risk in older adults. Prevention of mobility disability is vital for this expanding population.

Physical activity (PA) prevents mobility disability and chronic disease, improves cognitive function and mental health, and extends life. Adults ≥ 65 years old need 150 minutes of moderate-to-vigorous (MVPA) intensity aerobic PA weekly for health benefits, with balance training and muscle/bone strengthening activities twice weekly. Yet only 13% of Canadian older adults meet the MVPA guidelines. Though community-based interventions increase older adults’ PA, older men are less likely than women to participate in gender-inclusive programs. More research is needed to understand their lower rates of participation.

This thesis aimed to describe older mens’ experiences with PA (barriers and facilitators) and provide insight about the preferred features of PA programs for older men. I reviewed interview transcripts of fourteen older men from a PA intervention study called, Men on the Move, and conducted an additional five interviews with a sample of community-dwelling older men (who did not participate in the intervention but who had similar characteristics). I then described and discussed similarities and differences between these men-only interviews and the literature on older adults (men and women) using content analysis. Socio-ecological perspective and hegemonic masculinity frameworks guided the research.
Barriers to PA included lack of motivation, health, time, interests, finances, knowledge, fear of injury, social influences, lack of convenience, weather, caregiving, built and natural environments, low quality fitness instructors, and program structure.

Facilitators to PA included chores, improved health, interests, time, a motivation to engage in PA, social influences, active transportation, built and natural environment, weather, program structure, and skilled and knowledgeable fitness instructors.

Older men described their preferred features of a PA program as a small group atmosphere, individualized attention and programming, equal gender distribution, sports programming, gym and fitness classes, experienced fitness instructors who make classes fun, and fitness instructors who could take criticism. These findings, specific to older men, can be used to inform PA intervention design and program implementation.
Lay summary

Mobility disability (inability to walk 400-meters) contributes to a lower quality of life and increased mortality.

Adequate physical activity (PA) prevents mobility disability, improves brain function/mental health, and lengthens life. However, only 13% of Canadian older adults achieve the recommended 150 minutes of aerobic PA weekly. Although community-based programs to increase PA exist, few older men attend, and more research is needed to understand why.

Older men were interviewed regarding their barriers and facilitators for PA and preferences for programs. Barriers were motivation, health, time, interests, knowledge, finances, fear, social influences, weather, hills, low-quality fitness instructors, and limited programs. Motivators were health, interests, time, goals, encouragement, walkable areas, places to rest, weather, scheduled PA, and instructors.

Older mens’ ideal programs had equal numbers of men and women, individualized attention, sports programming, and experienced instructors. This information can be used to design and deliver PA programs for older men.
Preface

This thesis is based on a qualitative sub-study using semi-structured interviews with older men who participated in a physical activity intervention, Men on the Move, which was part of a CIHR-funded program of research called Shape the Path. I collaborated with Dr. Joanie Sims-Gould to identify the research topic and design additional interviews with community-dwelling older men who were not part of the Men on the Move intervention. Drs. Joanie Sims-Gould, Dawn Mackey, and Heather McKay all provided guidance toward the research design.

The UBC Research Ethics Board (number H15-01887) approved the Men on the Move study. I recruited and interviewed the additional community-dwelling participants with approval from the UBC Research Ethics Board (number H18-00640). I analyzed data from the Men on the Move interviews and the community-dwelling interviews using Nvivo. Dr. Joanie Sims-Gould and Douglas Race reviewed a subset of my work to ensure rigour. I wrote this thesis with feedback and edits from Drs. Joanie Sims-Gould, Dawn Mackey, and Heather McKay. I have not published any chapters of this thesis.

I did not contribute to the Men on the Move study design or conduct the interviews as the intervention concluded before I commenced my Master’s degree. Men on the Move was designed and conducted by Dr. Dawn Mackey with support from Drs. Joanie Sims-Gould, Heather McKay, and their research team.
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List of abbreviations

**AART**: Active Aging Research Team

**MotM**: Men on the Move participant group

**Non-MotM**: Non-Men on the Move participant group

**PA**: Physical activity

**UBC**: University of British Columbia
Glossary

This glossary contains two categories of terms: 1) literature-based definitions, indicated with references and 2) operational definitions that I used for my research.

Active Aging Research Team: Individuals who plan/assist in the Men on the Move study and who are trained to conduct, collect, and compile data for the Men on the Move study.

Active transportation: any non-motorized mode of transport (Sallis et al., 2004). For this thesis, however, I also include the use of public transit as a form of active transportation due to the walking required to and from the bus stops and participants’ destinations.

Activity coaches: individuals involved in Men on the Move who are trained to counsel older adults to engage in preferred and appropriate kinds of physical activities across different settings (e.g., home, community, recreation centres). They are also trained to deliver group motivational meetings, one-on-one consultations, and weekly telephone check-ins with participants.

Built environments: “buildings, spaces, and products that are created or modified by people” (Rao, Prasad, Adshead, & Tissera, 2007, p. 1111), which include “urban design, land use, and the transportation system” (Handy, Boarnet, Ewing, & Killingsworth, 2002, p. 65).

Caregiving: participants who provide physical, emotional, or developmental assistance to individuals in their social network.

Chores: routine tasks required for daily living.

Convenience: the ease with which participants can access and engage in PA.

Enjoyment: the feeling of pleasure participants receive when engaging in a certain forms of PA.

Environmental level: the geography, temperature, or built and natural environments (Stokols, 1996).

Fear: the feeling that someone or some PA is threatening or dangerous to the participant.
**Finances:** an individual’s ability to pay for goods and services with money.

**Fitness instructors:** individuals who are trained to lead various kinds of physical activity and exercise programs.

**Flexibility:** The ease with which an individual is willing or able to modify a schedule or activity.

**Health:** an individual’s physical, social, emotional, and mental capacity to engage in PA.

**Hegemonic masculinity:** “socially generated ideas, behaviours and practices surrounding the group named men” (Kerfoot & Knights, 1993, p. 661-662).

**Incentives:** benefits that help to motivate and encourage PA in participants.

**Interpersonal level:** the relationships between people, such as family, friends, or coworkers (McLeroy et al., 1988).

**Interests:** participants’ affinity to various types of activities.

**Intrapersonal level:** personal attributes, such as disposition, genes, and the behaviour of the individual (Stokols, 1996).

**Mobility disability:** the inability of a person to walk 400 meters in 15 minutes without sitting or assistance (Fielding et al., 2011; Pahor et al., 2014).

**Motivation:** the inner drive or an incentive to engage in activities.

**Natural environments:** Trees, parks, gardens, oceans, lakes, rocks, and hills (etc.).

**Organizational level:** social/local/national institutions’ (formal and informal) methods of operation (McLeroy et al., 1988).

**Social influences:** the connections or interactions participants have with other people that influence their PA.
Physical activity: “any bodily movement produced by skeletal muscles that results in energy expenditure…measured in kilocalories. Physical activity in daily life can be categorized into occupational, sports, conditioning, household, or other activities” (Caspersen et al., 1985).

Program structure: the way a PA class is organized or led.

Self-efficacy: “a person’s confidence in his or her ability to be physically active on a regular basis” (Trost et al., 2002).

Socio-ecological perspective: explains how individuals are influenced by interactions in their physical, social, and sociocultural environments (Bronfenbrenner, 1977; Stokols, 1992). Every level of the socio-ecological network influences all other levels (McLeroy et al., 1988; Reverby, 1979).
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Thank you to Drs. Joanie Sims-Gould, Heather McKay, and Dawn Mackey. I appreciate all the support, guidance, and feedback you offered throughout this project.

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Thank you to my husband, Johann, and my family who always supported and encouraged me through my endeavours.
Dedication

To my husband, Johann, my daughter, Everly, and my family.
Chapter 1: Introduction

1.1 Mobility disability

Mobility disability is defined as an individual’s inability to walk 400 meters in 15 minutes without sitting or assistance (Connell & Messerschmidt, 2005; Fielding et al., 2011; Pahor et al., 2014). Older adults with mobility disability are at an increased risk for dependence in daily activities, a decreased quality of life, and at a higher risk for mortality (Mackey et al., 2014; Yeom et al., 2008). Therefore, preventing mobility disability is essential in the growing older adult population to extend independence, functional ability, and longevity (World Health Organization, 1998).

1.1.1 Physical activity and mobility disability

Physical activity (PA) is “any bodily movement produced by skeletal muscles that results in energy expenditure…measured in kilocalories. Physical activity in daily life can be…occupational, sports, conditioning, household, or other activities” (Caspersen et al., 1985). Regular PA can prevent mobility disability, reduce disease risk, enhance quality of life, and improve cognitive function, social, and mental health (Bauman et al., 2016; Manini et al., 2006; Pahor et al., 2014; Tremblay et al., 2011; Warburton et al., 2006).

Physical activity guidelines state that older adults ≥ 65 years old should participate in a combination of at least 150 minutes of moderate-to-vigorous aerobic PA per week (in 10-minute increments), along with balance training, and muscle/bone-strengthening activities (twice weekly) to attain health benefits and improve functional abilities (Piercy et al., 2018; Tremblay et al., 2011). Notably, more PA produces more benefits (Tremblay et al., 2011; Warburton et al.,
Almeida and colleagues (2014) highlighted how 65-83-year-old men who engaged in 150 minutes or more of vigorous physical activity lived 10-13 years longer without cognitive or functional limitations compared to men who were not physically active (Almeida et al., 2014).

Despite the known benefits of PA, only 13% of Canadian older adults meet the recommended Canadian PA guidelines (Government of Canada, 2017; Hughes et al., 2011). Furthermore, few older adults ever reach levels of vigorous activity as it is currently defined. In the United States, older adults aged 60-69 achieved only 1.4 minutes of vigorous activity per week (Tucker et al., 2011).

Though few older adults achieve the recommended PA intensity levels prescribed by the Canadian PA guidelines, light-moderate intensity PA also provides health benefits. Thus, it is important to encourage PA at any intensity level in older adults. Spartano et al. (2019) highlighted through accelerometry data and brain imaging that light-intensity PA was associated with the “maintenance of brain structures in older age” (p.1). For those who met the PA guidelines, each additional hour of light-intensity PA was associated with 1.1 years less brain aging. Among those who did not meet the PA guidelines, taking at least 7500 steps per day was associated with 2.2 years less brain aging than those who took less than 7500 steps per day. Moreover, every hour of light-intensity PA were associated with improved brain volume corresponding to 1.4 years less brain aging (Spartano et al., 2019).

Community-based interventions can help older adults achieve more PA (Pahor et al., 2014; Stewart et al., 2001). For example, the LIFE study randomized clinical trial (Pahor et al., 2014)
sought to prevent the onset of mobility disability through a structured PA program geared to increase older adults’ PA over 2.6 years. Sedentary older men and women aged 70-89 years old without lower extremity functional limitations (who were able to walk 400m), from urban, suburban, and rural communities in the United States were randomized into 1) a PA program, or 2) an educational workshop. The PA group participated in a structured moderate-intensity PA program twice per week at a centre, and three to four times per week at home. The structured PA program included flexibility, resistance, and 150 minutes of aerobic training (walking) per week. The educational workshop group attended a weekly workshop for 26 weeks and met once a month thereafter. Older adult health topics included information on the health care system, preventative screenings, and nutrition (etc.) but did not include information on PA. A fitness instructor led a five to ten minute stretching session for the upper extremities at the educational workshop. Major mobility disability was 5.4% lower at the end of the study period in the PA group compared to the education alone group (35.5% versus 30.1%) (Pahor et al., 2014).

CHAMPS was also able to increase participant PA through their community-based intervention. The goal of “CHAMPS II: A Physical Activity Promotion Program for Older Adults” (Stewart et al., 2001) was to increase older adults’ PA levels through an intervention that encouraged participants to choose their own physical activities. Participants were 65-90 years old and were sedentary (people who did not engage in moderate-intensity PA at least 3 times weekly for 20 or more minutes for at least 3 months). Moderate PA intensity levels were determined by metabolic equivalents (METs), which is an indicator of activity intensity. One MET is defined as “the amount of energy expended sitting at rest (3.5 mL of oxygen per kilogram of body weight per minute for the average adult)” (Stewart et al., 2001). Moderate (or greater) intensity PA levels
were defined as activities equal to or greater than 3 METs, indicating energy expenditure is at least 3 times greater than sitting at rest. Participants in the intervention group increased caloric energy expenditure from moderate (or greater) intensity physical activities by 487 calories/week (\( p<.001 \)), and a total of 687 calories/week in activities of all intensities (\( p<.001 \)) (Stewart et al., 2001). Collectively, these two studies highlight that PA programs reduce mobility disability (LIFE) and increase older adults’ PA (CHAMPS).

1.2 Older men are underrepresented in physical activity research

Despite the successes of these programs in helping older adults achieve more PA, men are less likely to participate in PA community groups and healthy lifestyle programs compared with women (Hughes et al., 2011; Sinclair & Alexander, 2012). One reason for men’s lower participation rates in community PA programs may be that these programs are designed using data from studies that included both men and women. More women often participated in these studies and their opinions may have predominated – leading to a lack of data on men (Fennell & Davidson, 2003).

In the LIFE Study Randomized Clinical Trial, 32.8% of participants were men (Pahor et al., 2014). Similarly, in CHAMPS II: A Physical Activity Promotion Program for Older Adults, 34.1% of participants were men (Stewart et al., 2001). In a meta-analysis of 104 studies on PA interventions for older adults \( \geq 65 \) years old, an average of 83% of participants were women, and no studies designed and implemented PA interventions specifically for older men (Chase, 2015). In a systematic review on 44 studies (28,583 subjects) published between 1989 and 2010 on barriers and facilitators to PA participation, there were no men-only studies, in stark contrast to
15 women-only studies (Baert, Gorus, Mets, Geerts, & Bautmans, 2011). Further, in a 2019 systematic review and meta-ethnography on 39 studies, there were no qualitative studies specifically on older men that met their criteria: a peer-reviewed primary study or systematic review, with community-dwelling participants ≥ 60 years old, transitioning to retirement, with reports on leisure-time physical activity, and a rigorous qualitative methodology (Morgan et al., 2019).

The lack of current research conducted specifically with older men limits knowledge about their experiences with (e.g., barriers or facilitators) and preferences for PA (Fennell & Davidson, 2003). PA programs may be designed using data that over-represent perspectives from women – leaving masculine values and perspectives unaddressed. This may contribute to the low attendance and adherence of men in community PA programs (Pringle et al., 2014). It is important to understand older mens’ experiences with PA to inform future PA program design and accommodate their specific needs (Caperchione et al., 2017). Men-specific PA programs may facilitate better attendance and adherence by older men.

1.3 Theoretical frameworks

The socio-ecological perspective (intrapersonal, interpersonal, environmental, and organizational factors) and the hegemonic masculinity framework both provide insight into understanding older mens’ experiences and engagement with PA.
1.3.1 Socio-ecological perspective

Bronfenbrenner created the socio-ecological perspective to explain how physical, social, and sociocultural environments interact to influence individuals’ behaviours (Bronfenbrenner, 1977; Stokols, 1992). This perspective argues that every level of the socio-ecological network influences all other levels (McLeroy et al., 1988; Reverby, 1979). The intrapersonal level refers to personal attributes, such as disposition, genes, and the behaviour of the individual (Stokols, 1996). The interpersonal level describes the relationships between people, such as family, friends, or coworkers (McLeroy et al., 1988). The environmental level refers to geography, temperature, or built and natural environments (Stokols, 1996). The organizational level is the final level relevant to this thesis, which refers to social/local/national institutions’ (formal and informal) methods of operation (McLeroy et al., 1988).

The socio-ecological perspective is a useful framework to understand older mens’ experiences with PA, as many factors, such as mens’ personal attributes, their relationships with people, their environments, and the overarching systems within which mens’ environments operate all interact together to influence their PA behaviours (Dishman et al., 1985; Macniven et al., 2014). The following theoretical example illustrates these multi-level interactions: a community-dwelling man’s ideal PA program is aqua fit. He has rheumatoid arthritis and enjoys this class because it is a ‘joint friendly’ activity (personal preference/health condition within the intrapersonal level). He is often unable to attend the class because he cares for his grandchildren during the day while his son-in-law and daughter work (relationships within the interpersonal level). Transportation to the pool is convenient because the bus stop is close to his home (environmental level), yet he can’t afford the cost of the aqua fit class (organizational level). Due to these multiple factors, he does
not participate in as much PA as he would like. As evident in the example above, understanding older mens’ PA experiences is enhanced through examining multi-person interactions within the immediate setting and the larger social context wherein the immediate setting operates (Bronfenbrenner, 1977).

Although other models such as the Self-Efficacy Model (Bandura, 1977) or the Stages of Change Model (Prochaska & DiClemente, 1984) may provide additional insight to older mens’ PA experiences, I chose to adopt a socio-ecological perspective. Compared with the socio-ecological framework, these other theories do not explore the influences of environmental factors on behaviour to the same degree (Baert et al., 2011). Levels of influence as defined with the socio-ecological perspective provide a framework within which to examine the different influences and interactions that impact older mens’ PA experiences and behaviours. While socio-ecological perspective recognizes that several levels of influence affect older adults’ PA behaviours, hegemonic masculinity may specifically and independently impact older mens’ PA experiences within these different socio-ecological levels. Therefore, I introduce this theory in more detail, below.

1.3.2 Hegemonic masculinity

Masculinity is defined as “socially generated ideas, behaviours, and practices surrounding the group named men” (Kerfoot & Knights, 1993, p. 661-662). The hegemonic masculinity framework suggests that masculinity embodies the “idealized man” and requires all other men to measure themselves against these ideals (Connell & Messerschmidt, 2005). Ideals such as technological skills, adventure, courage, aggression, toughness, inner direction, hardiness of
body and mind, group camaraderie, non-femininity, possession of money or work, denial of emotion, and power over other men and women are a few examples of these masculine ideals (H. Brod, 1987; Donaldson, 1993; Fuller, 1996). However, most men do not necessarily live lives that reflect these ideals (Connell & Messerschmidt, 2005), which may lead to insecurity and the avoidance of certain activities to maintain the appearance of possessing these characteristics (Bredland et al., 2018). These masculine ideals are engraved in the social environment and may influence many aspects of mens’ existence (Connell & Messerschmidt, 2005).

Hegemonic masculinity provides a useful framework for examining older mens’ experiences with PA as these masculine ideals may impact their perspectives regarding PA. For example, some men who require mobility assistance devices may feel like ‘less of a man’ when using them, as they clash with the independence and strength that characterize the ‘ideal man’ (Courtenay, 2000). They may avoid going for walks, which negatively impacts their health, or go without the device, which increases their risk for a fall (Bredland et al., 2018). These masculine ideals may also impact older mens’ participation in community PA groups (Hughes et al. 2011) because health-promoting behaviours are often viewed as feminine or weak, and oppose the masculine identity of independence, self-reliance, and strength (Cohen, Chávez, & Chehimi, 2010; Courtenay, 2000; Gough, 2006; Robertson, 2007). Dunlop and Beauchamp (2013) suggest that mixed-sex PA environments may cause insecurity in men and endanger their sense of masculinity if women who attend have comparable or greater strength.
1.4 Barriers and facilitators to physical activity

Older adults’ barriers and facilitators to PA have been recently investigated (Baert et al., 2011; Bethancourt et al., 2014; Franco et al., 2015; Macniven et al., 2014). A systematic and thematic review of the qualitative literature regarding older adults’ perspectives on PA participation synthesised data from 132 studies with 5,987 older adults (men and women) (Franco et al., 2015). Participants were aged 60-89 years old, in different living arrangements (e.g., community-dwelling or health care contexts) and resided in urban, suburban, and rural parts of the United States of America, the United Kingdom, and Canada (Franco et al., 2015). Another systematic review synthesized 44 studies (30 studies with men and women, 15 women-only studies, and no men-only studies) regarding barriers and facilitators to PA with 28,583 participants who lived in different contexts (e.g., community, care facilities, and rehabilitation centres). Participants lived in the United States of America, Canada, Europe, Australia, Mexico, and Israel (Baert et al., 2011).

In the section that follows, I review findings from these systematic reviews and from original research reports on barriers and facilitators to older adults’ PA from a socio-ecological perspective. My aim is to acknowledge a broad frame of influence that spans intrapersonal, interpersonal, environmental, and organizational barriers and facilitators to PA. Notably, in my review of literature I include data from both older men and women unless otherwise stated. The proportion of men in these studies was 33% to 50%, but not all studies provided this information. The reason for examining studies with older adults (both men and women) in my literature review was due to the limited number of studies on community dwelling older men without specific diseases (Baert et al., 2011; Chase, 2015; Morgan et al., 2019). To date, barriers and
facilitators to PA were explored in older men with HIV (Neff et al., 2019) and prostate cancer (Keogh et al., 2014; Weller et al., 2019). Only one study included community-dwelling older men without specific diseases, and it focused on their transition to retirement (Bredland et al., 2018). Two other men-only studies investigated older mens’ PA engagement and the implications for health promotion, and a case study on a PA program (Dunlop & Beauchamp, 2013; Thandi et al., 2018). Neither specifically addressed the barriers and facilitators to PA.

1.4.1 Intrapersonal

The intrapersonal level refers to personal attributes, such as behaviour, disposition, and genes, which influence individuals’ PA engagement (Stokols, 1996). Lack of time (Macniven et al., 2014), limited motivation (Baert et al., 2011; Costello, Kafchinski, Vrazel, & Sullivan, 2011;), health problems (Macniven et al., 2014), pain, busyness, fatigue, and lack of enjoyment were barriers to older men and women in the literature at the intrapersonal level (Baert et al., 2011; Franco et al., 2015). Injury risk (Franco et al., 2015; Hartley & Yeowell, 2014), the fear of falling, (Bredland et al., 2018; Costello et al., 2011;), physical limitations, decreased endurance, balance issues, (Baert et al., 2011; Hartley & Yeowell, 2014), and finances were also barriers to PA (Franco et al., 2015). A preference for activities that do not require PA (Bethancourt et al., 2014; Costello et al., 2011), and disliking PA indoors or at a gym were also described as barriers for older men and women (Bethancourt et al., 2014). Intimidation (Franco et al., 2015) boredom (Costello et al., 2011), being unaccustomed with PA, embarrassment, and limited exercise knowledge were barriers to older adults’ PA engagement (Bethancourt et al., 2014). The belief that PA wasn’t necessary when older, doubt about the utility of PA (Baert et al., 2011; Franco et al., 2015), feeling too old for PA, thinking older people can’t change, preferring to relax,
depressive symptoms, and lack of discipline were also barriers (Baert et al., 2011). Other barriers for older men and women were the belief that they were already participating in an acceptable amount of PA, lack of flexibility in their daily routine, and being unable to attend when the PA classes were being held (Baert et al., 2011). Apathy and believing PA was harmful to health and pre-existing conditions were also barriers to PA participation (Franco et al., 2015). Many older men avoided walking because they did not want to use the assistance devices they required and risk appearing weak (Bredland et al., 2018).

Facilitators to PA for older men and women within the intrapersonal level were improved health, mental acuity, weight loss, an improved mood (Baert et al., 2011; Costello et al., 2011; Franco et al., 2015), enjoyment of PA, acknowledging the benefits derived from PA, a sense of self-efficacy, and habit formation (Baert et al., 2011). Balance maintenance, strength (Franco et al., 2015), belief in physical activity’s importance, and guilt regarding physical inactivity also facilitated PA in older adults (Bethancourt et al., 2014). Gaining self-confidence, the desire to stay independent (Baert et al., 2011; Franco et al., 2015), feeling a sense of accomplishment, and increased competence (physical or motor) facilitated PA in older adults (Baert et al., 2011). Retirement was described as a facilitator for recreational PA for both men and women as it provided them with more time to be physically active (Barnett, Guell, & Ogilvie, 2012; Hartley & Yeowell, 2014). Stewart and colleagues (2001) described how an older adults’ ability to choose their own activities also facilitated PA. Older mens’ PA was enhanced when they were able to choose enjoyable activities that were useful in daily living (e.g., housecleaning and gardening etc.) (Bredland et al., 2018).
1.4.2 Interpersonal

Interpersonal factors stem from relationships between individuals. A barrier for some older adults to engaging in PA groups was the absence of homogeneity and gender inclusivity within a group (Franco et al., 2015). Hartley and Yeowell (2014) highlighted how participants (men and minority groups) often preferred to engage in PA groups that had members of “similar identity and culture” (p. 1648). Feeling intimidated by group members was also a barrier to participating in PA groups for older adults (Franco et al., 2015). A lack of proper supervision during PA (Baert et al., 2011; Franco et al., 2015), not having an exercise partner (Macniven et al., 2014), and lack of social support were also barriers to PA for older adults (Baert et al., 2011). Older mens’ desire to outperform others sometimes led to overexertion and injury in PA groups, which inhibited their continued participation (Bredland et al., 2018). Time was a barrier to PA, which may stem in part from the various responsibilities and competing commitments in caring for a partner, a sibling, adult children, and grandchildren (Baert et al., 2011; Franco et al., 2015). Family and friends were often a barrier to older mens’ PA, due to their overprotectiveness and continued warnings to be careful. Over time older men questioned their ability, had lower self esteem, and avoided PA (Bredland et al., 2018).

Social connectedness facilitated PA in older men (Dunlop & Beauchamp, 2013). This was illustrated in Lively Lads (Dunlop & Beauchamp, 2013), a PA program designed for men ≥ 60 years old. Demographic homogeneity (for gender and age) influenced high participation rates within this group. Participants described the men-only environment as reminiscent of their youth. Participants encouraged one another, inspired each other, and appreciated the similar age of the other members as they were able to identify with one another regarding “the aches and pains of
the older person” (Dunlop & Beauchamp, 2013, p. 227). Customs and traditions, which involved intragroup banter and interpersonal comparisons also facilitated adherence to the group (Dunlop & Beauchamp, 2013). A sense of community inside and outside of the class was valued and was described by members as protecting them against social isolation and loneliness (Dunlop & Beauchamp, 2013). The feeling of belonging, produced by emotional and social connections, facilitated attendance to PA community groups for both older men and women (Hartley & Yeowell, 2014). Interpersonal motivators such as encouragement, companionship, social contact (Franco et al., 2015), camaraderie, and role modelling facilitated PA adherence in older men and women (Bethancourt et al., 2014). Family and friends also encouraged many older adults to participate in PA. Older adults’ desire to be around for family and friends and accepting their invitations to go for walks also facilitated PA (Bethancourt et al., 2014). Social support, physicians’ advice to be physically active, encouragement from fitness instructors (Baert et al., 2011; Franco et al., 2015), liking the instructor, and peer influence were also facilitators to PA for older men and women (Baert et al., 2011).

1.4.3 Environmental

Environmental factors are external to an individual and not related to people. Bad weather (Baert et al., 2011; Bredland et al., 2018; Franco et al., 2015), an unsafe neighbourhood (Franco et al., 2015), lack of sidewalks (Baert et al., 2011), uneven sidewalks, stairs, hills, an inconvenient and aesthetically unpleasing environment, and parking difficulties were barriers to engaging in PA for older men and women (Cohen-Mansfield et al., 2003). Not having places to rest during a walk also inhibited older men from PA (Bredland et al., 2018). Lack of transportation, heavy
traffic, and a lack of exercise facilities nearby were also barriers for older men and women (Baert et al., 2011; Franco et al., 2015).

Good weather can facilitate PA in older men and women (Baert et al., 2011). Living in a walkable area near shopping centers, having places to rest, even walking surfaces, and PA alternatives in the home motivated several older men and women to engage in PA (Bethancourt et al., 2014). Convenient and easy access to fitness facilities (Baert et al., 2011; Costello et al., 2011), neighborhood safety and ease of transportation were also facilitators to PA for older men and women (Baert et al., 2011). Men-only PA programs hosted in masculine environments such as at golf or fishing clubs and sporting arenas (Barnett et al., 2012; Blunt et al., 2017; Caperchione et al., 2017; Golding, 2011; Gray et al., 2013) and fostering environments of competition and comradery may specifically help older men adhere to PA programs (Barnett et al., 2012).

1.4.4 Organizational

At the organizational level, barriers to PA for older adults included a limited number of exercise facilities and PA programs (Baert et al., 2011; Franco et al., 2015), insufficient information on programs available, programs with several difficult exercises, and inconvenient class times (Baert et al., 2011). Low-quality and unmotivating fitness instructors, being pushed too hard, and unappealing classes were also barriers to PA (Bethancourt et al., 2014). The cost of fitness facility memberships and exercise programs were also a significant barrier to PA (Baert et al., 2011). In a study with 27,894 men and women of all ages, fitness facility membership cost was the most commonly reported barrier to PA (23%) (Kruger et al., 2007).
Organized programs facilitated PA in older men and women (Baert et al., 2011; Cohen-Mansfield et al., 2003). Therefore, interventions or programs organized by the community, government, or other organizations may facilitate greater PA engagement. Ideal PA program features were: free or low-cost programs (Baert et al., 2011; Costello et al., 2011; Franco et al., 2015), flexible class times (Bethancourt et al., 2014), exercises for different fitness levels and physical limitations, and knowledgeable instructors (Baert et al., 2011; Bethancourt et al., 2014; Costello et al., 2011; Franco et al., 2015). Programs that were fun, social, and offered a variety of activities facilitated PA for older men and women (Costello et al., 2011). Offering program content that appealed to men specifically may facilitate older mens’ PA (Barnett et al., 2012; Hartley & Yeowell, 2014). Strong leadership facilitated older mens’ PA engagement in the Lively Lads men-only PA program and contributed to the programs’ success. The leader had impeccable communication skills, provided one-on-one attention, and individualized exercises for members based on their needs and abilities (Dunlop & Beauchamp, 2013).

There are multiple barriers and facilitators to older adults’ PA engagement at all levels of the socio-ecological perspective. However, many of these observations in the literature come from interventions where women were overrepresented, and more information on older mens’ perspectives on PA are necessary.

1.5 Summary of the men on the move study

To meet the need for more research on older men and to address their physical inactivity, the Active Aging Research Team (AART) designed Men on the Move (MotM), a 12-week, choice-
based PA and active transportation intervention designed specifically for men ≥ 60 years old in Vancouver, British Columbia, Canada (Mackey et al., 2019; Mackey et al., 2017). The primary objective of the randomized, controlled feasibility trial was to assess the feasibility of MotM. Secondary objectives were to “(a) estimate rates of participant recruitment and retention, (b) estimate rates of intervention adherence, and (c) obtain initial estimates of intervention effect and variability on health outcomes of interest, including physical activity, active transportation, and mobility” (Mackey et al., 2019, p. 2).

MotM was a choice-based, telephone-assisted, PA promotion, and active transportation model. Trained and experienced activity coaches worked one-on-one with each participant to help them develop and implement a personalized PA and active transportation action plan. Participants were given pedometers to track their daily step counts and had the option to be physically active on their own or join group-based or individual PA programs at a community center. Participants had monthly motivational and educational meetings with other participants and their activity coach, and weekly telephone check-ins with their activity coaches. Participants received public transportation travel planning services and complimentary transit passes to aid with their active transportation goals. Participants were also trained to use iPads, which were used to monitor PA, host questionnaires, and support individualized PA programs (e.g., PA videos, recreation center hours of operation, transit schedules, and weather updates).

1.6 Older mens’ physical activity experiences

Understanding how older men perceive such PA interventions and their experiences with PA may facilitate future PA program design and shed light on a previously underrepresented
population. Thus, the MotM study included an optional qualitative sub-study to understand older mens’ PA perspectives and experiences. All 29 MotM participants in the intervention group were invited to participate in the qualitative sub-study. Fourteen participants agreed to participate and provided consent. At baseline and 12-week follow-up (post-intervention), the AART measurement team conducted semi-structured interviews to assess participant experiences with PA, mobility, social interaction, and transit-use, in addition to their perspectives on the intervention. The AART research team conducted fourteen semi-structured interviews (Appendix A) at baseline and thirteen interviews at the 12-week follow-up in 2015.

While MotM interview data described older mens’ experiences with PA and the MotM intervention, they reflected the perspective of a small subset of motivated older men who were predisposed (volunteered) to participate in MotM. It was therefore important to also assess perspectives of other community-dwelling older men who were not involved in MotM to identify similarities and differences between the two populations. I conducted 5 additional interviews with community-dwelling men, ≥ 60 years old in 2018 who were in no way associated with MotM. Non-Men on the Move participants (non-MotM; Appendix B) were all recruited from an independent living older adult community in Vancouver, British Columbia, Canada.

1.7 Aims and objectives
The primary aim of my thesis was to describe older mens’ experiences with PA. My specific objectives were:

1) to describe barriers and facilitators to PA behavior among older men,

2) to describe preferred features of PA programs for older men.
To address these objectives, I analyzed qualitative interview data from fourteen MotM participants and five non-MotM participants from a socio-ecological perspective. I describe and discuss similarities and differences in the findings between the two cohorts to provide a cross-comparison, and to verify or dispute themes that emerged during analyses of MotM participant data. To specifically address older mens’ experiences with PA, I also discuss the influence of the hegemonic masculinity framework at each level of the socio-ecological model.
Chapter 2: Methods

2.1 A description of both cohorts

I describe and discuss qualitative interview data acquired from two different cohorts of older men: 1) fourteen participants who took part in the MotM qualitative interview sub-study and 2) five older men who did not participate in MotM but who met similar inclusion/exclusion criteria. Both cohorts were community-dwelling, ≥ 60 years old, and lived in Vancouver, British Columbia, Canada. Table 1 outlines the demographics for MotM and non-MotM participants.

<table>
<thead>
<tr>
<th>Demographics</th>
<th>MotM (n=14*)</th>
<th>Non-MotM (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Age</td>
<td>73.5</td>
<td>Average Age: 81.6</td>
</tr>
<tr>
<td>Range</td>
<td>63 - 86</td>
<td>Range: 60 - 94</td>
</tr>
<tr>
<td><strong>Country of Birth</strong></td>
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<td></td>
</tr>
<tr>
<td>Born in Canada</td>
<td>42.9%</td>
<td>Born in Canada: 60.0%</td>
</tr>
<tr>
<td>Born outside of Canada</td>
<td>57.1%</td>
<td>Born outside of Canada: 40.0%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
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<td></td>
</tr>
<tr>
<td>Married</td>
<td>64.3%</td>
<td>Married: 60.0%</td>
</tr>
<tr>
<td>Single</td>
<td>21.4%</td>
<td>Single: 20.0%</td>
</tr>
<tr>
<td>Widowed</td>
<td>14.3%</td>
<td>Widowed: 20.0%</td>
</tr>
<tr>
<td><strong>Education Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completed secondary school</td>
<td>14.3%</td>
<td>Completed university degree: 40.0%</td>
</tr>
<tr>
<td>Some trade/technical school</td>
<td>7.1%</td>
<td>Completed graduate degree: 60.0%</td>
</tr>
<tr>
<td>Had some university</td>
<td>21.4%</td>
<td></td>
</tr>
<tr>
<td>Completed university degree</td>
<td>14.3%</td>
<td></td>
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<tr>
<td>Some graduate education</td>
<td>7.1%</td>
<td></td>
</tr>
<tr>
<td>Completed graduate degree</td>
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<td></td>
</tr>
<tr>
<td>Unknown/participant did not answer</td>
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<tr>
<td><strong>Employment Status</strong></td>
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<tr>
<td>Retired and not working</td>
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<td>Retired and not working: 80.0%</td>
</tr>
<tr>
<td>Did not answer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* There were 14 participants who took part in the first interview and 13 participants who completed the second follow-up interview, as one was unable to complete the follow-up.

Table 1: Description of MotM and Non-MotM demographics.

I aimed to describe themes that emerged from the MotM study and discuss similarities and differences between the PA experiences of men who were enrolled in MotM (motivated older
men who were interested in being physically active) versus those who were not involved in 
MotM (community-dwelling older men who were not necessarily wanting to engage in PA) to 
represent a more general population (Creswell & Miller, 2000). I used Nvivo 11 to extract key 
themes from the qualitative interview data to determine older mens’ perspectives about PA, 
barriers and facilitators to PA, and the ideal features of PA programs. I addressed the following 
questions: What prevented them from engaging in PA? What facilitated their involvement in PA? 
and What did older men consider ideal features of a PA program? Throughout this thesis I use 
pseudonyms to refer to participant level interview data. I describe recruitment in sections 2.1.1, 
inclusion/exclusion criteria in section 2.1.2, the qualitative interviews in section 2.1.3, data 
saturation in 2.1.4, and data analysis in 2.1.5 below.

2.1.1 Participant recruitment

2.1.1.1 MotM

Recruitment for MotM was conducted in August and September 2015 over 6 weeks. Research 
personnel advertised the study in community newspapers, in senior’s centers, public libraries, 
community and health centers, neighbourhood associations, through emails to university alumni 
associations, disease foundations, and by word of mouth through certified fitness instructors. 
There were 58 MotM participants in total, with 29 participants in the intervention group and 29 
participants who were in the waitlist control group. Participants randomized to the intervention 
group received information on the opportunity to participate in the qualitative sub-study. 
Fourteen participants consented to be a part of the sub-study, which entailed one-hour interviews 
conducted at the participant’s baseline assessment and 12-week follow-up assessment.

Participants received a $10 honorarium per interview session for their participation. The UBC 
Research Ethics Board (number H15-01887) approved the Men on the Move study.
2.1.1.2 Non-MotM

Recruitment for non-MotM participants was conducted in May 2018. Based on common practice, I aimed to enrol 5-20 participants (Fridlund & Hildingh, 2001). I advertised the study and shared my contact details in four ways: 1) hanging posters in an independent living older adult community’s mail rooms, at the front desk, and by the elevators, 2) displaying advertisements on TV monitors in the community lobbies, 3) including an advertisement in the weekly newsletters distributed to all residents, and 4) through personal phone calls made by the older adult community’s program director and assistant (the community had events available for residents, planned by the program director and assistant). The program director and assistant utilized purposive sampling and invited individuals who met the inclusion/exclusion criteria to participate. The program director and assistant administered consent forms to five interested and eligible participants and scheduled each of them for a 60-minute in-person interview with me. Each participant brought their signed consent form to their interview. Participants received a $10 Save On Foods gift card honorarium upon completion of the interview. I obtained approval for my study from the University of British Columbia, Research Ethics Board (number H18-00640-A001).

2.1.2 Inclusion/exclusion criterion

2.1.2.1 MotM

Inclusion criteria for the MotM intervention group were: 1) older men who were community-dwelling, 2) ≥ 60 years of age, 3) had the desire to be more physically active; had not been active in the past 3 months, 4) did not have plans to be out of town for ≥7 days during the study period, and 5) were able to be physically active (as demonstrated by the PAR-Q+ questionnaire or a letter of recommendation from their physician). Exclusion criteria were older men who: 1) lived
in a nursing home or an assisted living facility, and/or 2) would be out of town for ≥7 days during the 12-week intervention timeframe.

Of 29 participants enrolled for the Men on the Move intervention, 14 agreed to participate in the optional baseline qualitative interviews. Of these, 13 participated in a follow-up interview (one participant was away and was unable to attend the final interview). Table 1 in the above section outlines the demographics of the participants.

2.1.2.2 Non-MotM
The inclusion criteria for non-MotM participant interviews included people who: 1) identified as men, 2) were aged ≥ 60 years old, 3) lived at an independent living older adult community in Vancouver, British Columbia, Canada, 4) were able to read, write, speak English and have acceptable auditory and visual abilities (i.e., able to read and sign the consent form and hear the interviewer’s questions), 5) provided a signed and dated consent form, and 6) were able to participate in the scheduled interview timeframe.

Exclusion criteria for non-MotM participants were: 1) early stages of dementia (may pose a problem with memory/recall during the interview; staff verified this criteria was met through discussions with the multidisciplinary health team at the facility, 2) did not live in the selected independent living community, 3) were not able to read, write, and speak English or did not have acceptable auditory and visual abilities (i.e., people who were not able to read and sign the consent form and hear the interviewer’s questions), and 4) were not independently mobile (e.g.,
relied on a wheelchair). Program staff had access to this information so they verified that volunteers met entry criteria.

Five individuals met inclusion/exclusion criteria and consented to participate in the study. Table 1 in the above section outlines the demographics of the participants. I met two of the five men who volunteered for the study a year prior, when I worked as a program planner at the facility. I informed participants that I was conducting this study to better understand older mens’ experiences with PA. They were also told that this project was part of my Master’s degree.

2.1.3 Qualitative interviews

2.1.3.1 MotM

The AART research team conducted fourteen semi-structured interviews (Appendix A) at baseline and 13 interviews with the same participants at their 12-week follow-up in 2015. Participants’ feedback on the program, their mobility, and their experiences with PA, active transportation, and social interaction were collected during these interviews. This study analysed data from questions that pertained to participants’ past and present PA, any barriers and facilitators to PA, and any descriptions of their ideal PA programs. Two research personnel conducted a one-hour interview. One asked the questions outlined in the interview guide (Appendix A) and the other took notes. There were five interviewers (2 men) who worked as research coordinators, project coordinators, or research assistants. Interviewers had a Master of Public Health, a Bachelor of Arts, or Master of Science degrees. All had completed graduate methods course work in qualitative methods. Interviewers did not have prior relationships with participants outside of the MotM study. Most interviews took place in an office at the Centre for
Hip Health and Mobility located on the Vancouver General Hospital Campus in Vancouver. One interviewer, one recorder, and the participant were present during each interview. One interview was conducted in hospital, due to a participant’s hospitalization during the study period. The participant’s spouse was present during the interview. Interview audio recordings were professionally transcribed for data analysis. Thirteen of 14 participants attended a 12-week follow-up interview, where interviewers adopted the same protocol. Transcripts and findings were not provided to participants for their review.

2.1.3.2 Non-MotM

After coding MotM participant data which had been collected in 2015, I changed the wording of a few questions on the interview guide for non-MotM participants to facilitate participants’ understanding of the questions and to exclude questions that were not relevant as they were directly related to the MotM intervention (Appendix B). I conducted all interviews and collected field notes in an office at the independent living older adult community located in Vancouver in May 2018. At the time of the interview I was working towards a Master of Science in Experimental Medicine Degree at the University of British Columbia (UBC) and held a Bachelor of Arts in Sociology and Communications. I had previous experience and training in interviewing and conducting interviews from my employment as a UBC research assistant and was the only person beside the participant in the room at the time of the interview. I utilized the adapted interview questions from the semi-structured “Interview Guide for Older Adult Informants. Shape the Path: Targeting the Health and Mobility of Older Men through Key Community Partnerships. The ‘Men on the Move’ Study” (Appendix B). Interviews were audio
recorded and a professional data service transcribed interview data for analysis. Transcripts and findings were not provided to participants for review.

### 2.1.4 Data saturation

There is debate on how data saturation is reached in qualitative studies (Saunders et al., 2018). Some researchers use the quantity of interviews as a rule for how saturation can be achieved. A methodology paper designed to examine how many qualitative interviews are enough for data saturation, determined that data saturation occurs after only 12 interviews at which point they “had created 92% of the total number of codes developed for all thirty of the [interview] transcripts and 88% of the total number of codes developed across two countries and sixty interviews” (Guest, Bunce, & Johnson, 2006, p. 74). If one was to determine saturation based on quantity of interviews, 19 interviews (MotM and non-MotM) should be enough for data saturation to occur. However, strong qualitative research advocates suggest that data saturation does not occur through the quantity of data, but through the quality of data (Saunders et al., 2018). Common practice in qualitative research is to continue adding interviews until the characteristics of the sample and the concepts uncovered have been explored, at which point the researcher perceives that additional interviews will not generate new information relevant to their research objectives (Brod, Tesler, & Christensen, 2009). Glaser and Strauss (1967) state that researchers should stop sampling when “no additional data are being found whereby the sociologist can develop properties of the category. As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated” (Glaser & Strauss, 1967, p. 61). The decision whether or not to continue sampling is “the degree of development of a theoretical category in the process of analysis” (Saunders et al., 2018, p. 1895).
When more themes were not uncovered in the data and the themes that had been developed were not further enriched at 19 interviews, I concluded that we had reached enough theoretical saturation to richly describe the barriers and facilitators to older mens’ PA (Saunders et al., 2018) and more interviews would not add to the overall story (Strauss & Corbin, 1998).

2.1.5 Data analysis

I used NVivo 11 and 12 to manage and analyze MotM and non-MotM qualitative data and to determine broad themes (derived from the data). Preliminary analysis of MotM allowed me to use the data to inform interview questions for non-MotM participants. I used an inductive method of analysis with three analytical phases: 1) preparation phase, 2) organizing phase, and 3) reporting phase (Elo & Kyngäs, 2008). During the preparation phase I became familiar with these data by reading all transcribed interviews and field notes. For the organizing phase, I created categories of similar information using coding nodes in NVivo software. In the reporting phase, I interpreted these data by using themes that represented my research objectives (Elo & Kyngäs, 2008). To ensure rigour, Dr. Joanie Sims-Gould coded a subset of the data (Roberts et al., 2019). We looked for consistency of judgment across themes and categories in a subset of data by examining the number of agreements and disagreements across coding (Miles & Huberman, 1994). There was agreement on the themes in 95% of the coding. I then reviewed the themes that emerged from coding in NVivo from non-MotM participants and the themes from the MotM participants to see if there were any similar or unique themes.
Chapter 3: Results

3.1 Mens’ overall understanding and experiences with physical activity

Participants’ in both groups highlighted their perceptions and experiences with PA across the life course, including any changes that occurred over time. In the following section I outline how men in my study define PA, describe their levels of PA in the past, and conclude by describing current PA habits.

3.1.1 Physical activity as defined by older men

Participants described PA as body movement, breaking a sweat, getting your blood moving, walking, exercise, sports, stretching, chores, and house repairs.

“Any kind of movement...Anything that requires an amount of energy expenditure above me just sitting here...That includes everything from doing household chores, the gardening, to shopping or leisure activity” (Robert - MotM).

“Walking, dancing, [and] chair aerobics” (Gary - MotM).

“Bike riding...walking, swimming...physically active to me means that I get into a program where you break a sweat. That to me is physical activity. Anything else is just sort of more casual. If I go walking with my wife, it’s casual...to me the blood pressure is not moving up. The activity is not there” (Steven - MotM).

“The sports I’m involved with currently, which would be squash and tennis” (Andrew –
non-MotM).

“Using the exercise machine, riding my bicycle, walking [and], jogging” (Daniel – non-MotM).

3.1.2 Past physical activity habits of older men
Participants described past PA as tai-chi, yoga, hiking, attending exercise programs, walking, cycling, going to the gym, using active transportation (e.g., public transportation, walking, and cycling), skiing, running, and sports (e.g., squash, swimming, hockey, tennis). Michael described how he used to play sports twice a week but no longer participated since moving to Vancouver due to limited opportunities for older adults:

“I was playing seniors’ hockey up until I was about... 50... But here there’s no facilities or... senior leagues... In Saskatoon where I lived, they had senior leagues. They’d have probably 10 teams of seniors, and we’d play once or twice every week and have practices... I have yet to find a senior league that’s not playing at two or three o’clock in the morning to get the ice time” (Michael - MotM).

Charles recounted how he used to go swimming but was no longer able to since there was a change in the program schedule:

“I used to go to [the] swimming pool [for] exercise. It was one o’clock in the afternoon. But now [it] is nine o’clock in the morning... so this is a barrier for me” (Charles - MotM).
Steven described how he used to hike each weekend but was no longer able to, due to his reduced mobility.

“Every Saturday we used to go hiking all over...three-hour hikes. But I was having a hip problem...I said...this is not good for me” (Steven - MotM).

Many participants described how they were most physically active during their youth.

“I was very active before I became an adult. But that’s a long time ago...I did a lot of cycling and even some distance cycling. I dropped out of that when my bike was stolen” (Mark - MotM).

“When I was still in high school...I used to play...sports...but that tapered down after I started going to university. And then when I started working... it was very limited” (Timothy – non-MotM).

“I think I was most physically active in my teenage years and in my 20s and 30s...I’d spend my summers at the beach...I was swimming. I was golfing. I was hiking, biking, doing all that kind of fun stuff...I didn’t have Parkinson’s back then, so I had a lot more range of movement. I didn’t have mobility issues. It was a good time” (Edward – non-MotM).
Some participants discussed how their careers impacted PA participation depending on the type of work performed (e.g., sitting at a desk or being physically active at work).

“When I was working, I was more physically active. Because you had to do heavy work...I never did go to gyms for...exercises” (James - MotM).

William discussed walking with a friend and how a stroke inhibited him from continuing this activity.

“Right up until I had my stroke, we used to go walking...a couple of times a week. That was right up until the day before my stroke...he was a good companion for that walking” (William - MotM).

In summary, several participants described their youth as their most physically active years. Participants most frequently mentioned sports and other enjoyable activities as their regular form of PA in the past. When barriers appeared, they stopped participating in these physical activities. This highlights the impact barriers can have on PA participation and the need for support to overcome them.

3.1.3 Current physical activity habits of older men

When participants were asked to describe their participation in PA currently, most described walking or engaging in structured PA programs. This was in stark contrast to sports and other
more intense activities, that characterized their past participation in PA. Other current physical activities included group exercise programs, swimming, walking stairs, chair aerobics, spin classes, walking, hiking, chores, active transportation, stretching, dancing, using a punching bag, walking on a treadmill, riding on a stationary bike, snowshoeing, and yard work.

“There’s the strength and stretch, which we do with hand weights, resistance, then balancing…other things that I do-- exercise at home...some squats and some balance” (Joseph - MotM).

“It’s called Fit and Strong…That’s good because it gives you aerobics...stretching and weights...it moves all your joints...Monday, Wednesday and Friday” (Timothy – non-MotM).

“Walking is what I would typically do. I do some stretching...gardening, doing the lawn myself... If it’s sunny I would walk every day... around the neighbourhood, the library, the shops...I will start ten o’clock...and then have lunch somewhere. And by the time I get home, it’s probably around three, four o’clock” (Richard - MotM).

“Hik[ing] around for maybe an hour and a half or so” (John - MotM).

“My snowshoe trips are always wonderful. My Saturday spin classes are great. Those are two that I would really look forward to” (Robert - MotM).
“I exercise on the bike, on the treadmill. It’s at 2.5 kilometres at a five percent incline...I do that every day” (James - MotM).


3.2 Barriers and facilitators to physical activity

Below I categorize barriers and facilitators to PA that surfaced, across levels of the socio-ecological framework: 1) intrapersonal, 2) interpersonal, 3) environmental, and 4) organizational levels.

3.2.1 Intrapersonal

At the intrapersonal level of the socio-ecological framework, barriers and facilitators impacted the PA of older men. Eight themes emerged from interviews with MotM and non-MotM participants: 1) motivation, 2) health, 3) time, 4) interests, 5) lack of knowledge, 6) finances, 7) fear, and 8) chores.

3.2.1.1 Motivation

Motivation referred to a person’s inner drive or incentive to engage in PA. Several participants noted a lack of desire or ‘laziness’ as inhibiting their PA.

“I am a bit lazy to go for a long walk” (Charles - MotM).

“There’s no physical barriers [to PA]. It’s just not wanting to” (Thomas - MotM).
“Being lazy [and] not being motivated… That’s why I’m in this program. I thought it might motivate me to have to do something… I’m sort of pushing myself a bit” (Michael - MotM).

The motivation to accomplish a predetermined task facilitated PA for older men.

“[I need an] objective [to be physically active] …for example, doing errands or need[ing] to return a DVD to the library” (Charles - MotM).

The commitment to attend a PA program or create a plan for PA (what to do and for how long), helped participants engage in PA.

“I sort of set up little goals for myself, and I keep achieving it” (David - MotM).

A step counting goal also increased several participants’ PA by reminding and motivating them to walk.

“It’s got me to the point where I have to go out and exercise. I have to get in my 10,000 steps a day even though she said I didn’t have to do that many. But my goal is to do 10,000 a day” (Michael - MotM).
“I wear this pedometer... Cause I found that the goal of 10,000 steps was an important thing... I would check my pedometer halfway through the day, oh, I’m going to be short here. I better go out and do a little bit more walking... It was a motivator” (John - MotM)

3.2.1.2 Health

Health referred to an individual’s physical, emotional, social, and mental capacity to engage in PA. Some participants compared men to women.

“Women are more attuned to their health, [and] go to the doctors more often... [Men are] resistant...[they] don’t go for regular checkups ... or don’t take advice about exercise or don’t watch their weight” (Thomas – MotM).

Physical health challenges, such as limited mobility, injuries and chronic diseases (e.g., knee arthritis, Parkinson’s disease) were a barrier for several participants.

“I pulled out of the hiking group... Every Saturday we used to go hiking... Three-hour hikes. But I was having a hip problem” (Steven - MotM).

“I was playing tennis and squash until about the end of November... got to the point where my knees were just not capable of doing any more” (Andrew – non-MotM).
“I blacked out and fell…it paralyzed me from the neck down…I use a cane now…physical activities and going out and stuff like that has been reduced” (Timothy – non-MotM).

“When it’s painful, I feel less motivated to go out” (Charles - MotM).

“I can’t walk as far as I used to. I generally have to take my walker for stability, and I can use the seat if I get tired. Even when I’m driving I can’t drive as far…I have to think twice whether I want to meet a friend in Burnaby for coffee…So it’s basically my Parkinson’s, I get fatigued easily. And-- so that’ll affect what I’m able to do in a day. Sometimes I have to take naps, so I just don’t have the energy or the endurance that I used to have” (Edward – non-MotM).

These stories reflect how several participants who used to be more physically active are unable to participate in their chosen physical activities due to health issues.

Just as health challenges were a barrier to some older mens’ PA, recognizing health benefits also facilitated PA. Increased stability, flexibility, endurance, bone mass, energy, quality of life, weight loss, sociability, the ability to breathe better, living independently, and the desire to live longer motivated many participants to be physically active.

“Exercise is very much the mental stimulus…It makes you feel better…You’re much better off…not only sleep, but you’re better off in your attitude. You’re more social. You’re more attentive to other people” (Steven - MotM).
“Enjoyment from doing it and feel[ing] better for doing it, mentally and physically”

(Dennis – non-MotM).

Edward, who was diagnosed with Parkinson’s disease, explained how the mental and physical benefits of PA motivated him to maintain a physically active lifestyle:

“It helps with the Parkinson’s. Another side effect of Parkinson’s is depression, so [PA] certainly helps. I just feel better and it’s fun engaging with other people” (Edward – non-MotM).

 “[I want to keep] whatever mobility I’ve got. If I don’t exercise, my body just seizes up, and I can’t move” (Edward – non-MotM).

Other participants were similarly motivated to be physically active for pain management.

“I think you feel more mobile...sometimes I lay in bed...[with] pain, and through the exercises it’s gone. I haven’t had [pain] for [a] couple years now...I definitely think that exercise works” (James - MotM).

“[PA is] a requirement for the future. For my own future mobility, for my own prevention from falls or having a knee replaced or a hip replacement...healthy ageing is the key” (Thomas – non-MotM).
3.2.1.3 Time

Time constraints were a barrier to PA within the intrapersonal level of the socio-ecological perspective. Program length prevented some participants from joining classes because they preferred to spend their time on other activities.

“I can give five or ten minutes to a thing like that [referring to a PA program] without feeling I’m wasting the time...Not like the hour in the gym where I’m not doing the things I want to do” (Dennis – non-MotM).

Additional barriers to PA were, less than ideal PA program schedules, the length of time it took to get to destinations using active transportation, and scheduling conflicts.

“I did it [a PA program] for a while and it was okay. But [then there were] conflicts and stuff with time and things” (John - MotM).

“A lot of doctors’ appointments and other things [got] in the way [of a PA program]” (Edward – non-MotM).

Having more time during retirement facilitated some men’s participation in PA. Participants were often motivated to maintain an active schedule in retirement and replaced the time they spent at work with PA. Many participants described how scheduling PA in advance was key to maintaining their motivation.
“I just need activity in my life…I retired five years ago. If it comes down to it, I really miss work. So, I guess it’s me building some structure into my life…I need the routine” (Robert - MotM).

“Because the program is on Monday, Wednesday, Friday, it’s scheduled, so that makes me go. But I can find all kinds of reasons for not going for a walk” (Timothy – non-MotM).

Paradoxically, having more unstructured time during retirement was also a barrier to PA. This was especially true if participant’s previous work involved or provided opportunities to be physically active.

“Getting out of the business [reduced my PA]. Because…I was fairly hands-on” (Henry - MotM).

“I went to a different lifestyle [after retirement] …then it became a nightmare…There’s a void…so I filled the void with reading and being a slug and doing nothing” (Thomas - MotM).

Participants also described how retirement may impact men and women differently.

“Women might keep more active…For example, they’re doing more housework…I don’t think they become as sedentary as older men…They’re not necessarily retiring. They’ve
always kept up to a similar type activity as they get older. Whereas men are retiring, and they seem to...slow...down a lot” (Mark - MotM).

In further reference to work and retirement’s influence on older men, when Robert was asked to describe his history, he outlined his work history. When questioned why he referred to his work when asked about his history, he explained:

“That’s what I thought you meant. What else? I mean, we’re guys, we’re very much tied to our jobs. Our identity is tied to our job” (Robert - MotM).

“Men have a much more difficult time with retirement, and they have a harder time re-establishing or maintaining social contacts...Mens’ identity...[is] tied to their job. And then when they’re cut loose from their job...they have a little bit more of a difficult time adjusting” (Robert - MotM).

“Men define themselves by their work. And when their work is no longer there, they suddenly kind of lose their identity” (Robert - MotM).

Many of the participants’ identities and social connections changed with retirement, culminating in a new lifestyle, that for some was less active.
3.2.1.1 Interest

Several participants described their lack of interest in certain physical activities as a barrier to PA.

“I got so terribly bored with working in a gym... Although you’ve got other people... you can’t really have a conversation with people while you’re exercising” (Dennis – non-MotM).

“I used to do spin cycle twice a week... I think it’s boring. It’s good, but it’s boring” (Steven - MotM).

Enjoying inactive pursuits was also a barrier to PA. When asked why he did not get out and about in his community more, Thomas explained:

“I was enjoying myself...alone and reading...I read probably about a book a day on average.... I enjoyed just doing nothing” (Thomas - MotM).

In contrast, having an interest in activities that involved PA facilitated older mens’ engagement. Hiking, gardening, fishing, walking, cycling, and running were activities that participants enjoyed.

*I love bicycling...Sometimes leisurely, sometimes it’s just more a mode of transportation” (Robert - MotM).
“[Cycling is] something I actually enjoy doing. If I was getting anything out of it, it’s a side benefit (Robert - MotM).

“Since I was a young kid, I enjoyed walking...that is the thing that I have enjoyed and still enjoy” (Dennis – non-MotM).

Participants’ interest in seeing new things, such as visiting landmarks and new destinations in the city, also facilitated PA.


Active transportation was also facilitated by older mens’ interest in seeing new things. Some participants preferred to take public transit, so they could watch people and see the sights rather than concentrate on driving.

“If I’m not in a big hurry, I’ll go on a bus...I like watching the scenery as it passes. I used to try and read on the bus but it’s too interesting-- I’m a people watcher” (Andrew - non-MotM).

Others described how they enjoyed going for walks or bike rides to see what was happening in the community.
“I’m not a fan of treadmills and stationary bikes...I just find it boring...I’m not the kind of person who, when I’m biking or walking...put things in my ear. I like to be aware of what’s going on. I tend to take routes that I haven’t taken before” (Robert - MotM)

3.2.1.2 Lack of knowledge

Many participants described how limited knowledge regarding certain physical activities restricted their PA.

“[Tai Chi has]108 movements. It’s a lot to remember...you need somebody to instruct you” (Gary - MotM).

Not knowing what to do in a gym setting also inhibited several participants from PA.

“I had a community centre pass before, with the idea that...I’d like to use their exercise facilities. But I often found it a little overwhelming. If you walk into an exercise facility and you’ve got all these machines and gadgets...it tends to be a little overwhelming. And I usually just walked out. So, having the benefit of some advice and somebody actually designing a structured kind of program, I found that very useful” (Robert - MotM).

3.2.1.3 Finances

An individual’s ability to pay for participation in PA was another barrier for older men.
“Since my income condition now, I cannot do everything I want... If I find [the] kind of exercise class that suits me and it is... free or very low paid... I’d be happy to go” (Charles - MotM).

“I like football...I used to play...I’d like to play it now but the cost [is too high] ... the equipment is [also] quite a bit for hockey” (Michael - MotM).

The cost of active transportation was also a challenge for many.

“If you need to go two zones, I think it’s $2.50...that’s not cheap for seniors...They want people to take transit...and it’s very expensive. If it was a lot cheaper, a lot more people would be taking it” (John - MotM).

The combination of having a vehicle and the cost for public transportation also inhibited many men from using active transportation.

“[I] paid insurance for [my car, I] may as well use it. Why pay...additional?” (Robert - MotM).

“It’s easier just to go all the way in the car...It’s cheaper actually...because if I go to the SkyTrain, I have to pay for parking. And I have to pay to go on the SkyTrain” (William - MotM).
3.2.1.4 Fear

Fear was another barrier to PA. Fear referred to the feeling that someone or some activity threatened or was a danger to the participant. Fear of injury inhibited several participants from engaging in certain forms of PA.

“I’m scared to ski now...I dislocate[d] my shoulder [and] broke my arm...I was young enough I recovered. But I know that recovery is not guaranteed” (Robert - MotM).

“I would like to play some pickleball [but I am] kind of afraid because I could fall down...and hurt [myself]” (Joseph - MotM).

“Very much a fear of injury...when you’re young...you can just leap over that big puddle. But when you’re older and your legs are not as strong as they were, if I miss...I’m going to break my hip...you get more realistic [and]...should know your limitations (Andrew - non-MotM).

Being the only man in a PA class, not knowing anyone, or having young instructors who were women intimidated some older men. These feelings prevented some men from engaging in certain forms of PA.

“[Being one of only a few men in an exercise class might be a little bit intimidating” (Robert - MotM).
3.2.1.5 Chores

Chores motivated several older men to engage in PA. Chores were described as routine tasks required for daily living that often involved walking to various destinations, utilizing public transit, or moving about while completing a task.

“If we’ve got some shopping we need to do I will go out. I’ll walk up the road to the shops” (Dennis - non-MotM).

“Daily shopping at Shoppers and Save-on-Foods. I’m not one to do a big shop ‘cause I use my walker for carrying groceries...So I usually get out daily or try to” (Edward - non-MotM).

3.2.2 Interpersonal

The interpersonal level within the socio-ecological perspective referred to the social connections or interactions participants had with other people that were either a barrier or a facilitator to older mens’ PA. Social influences were a theme barrier and facilitator to PA and caregiving was a theme barrier to PA.

3.2.2.1 Social influences

Social influences often inhibited active transportation. Individuals not making room on the bus for participants to sit, family members discouraging participants from using public transportation, or the participant’s family or friends living too far away for them to use active transportation also discouraged public transportation use.
“There's a lot of people with mental problems and they get on the bus...[it] can be upsetting...and then they want to talk to you, but you don’t want to talk to them” (Gary - MotM).

“[Public transit is] often very busy...crowded...hard to get off...[and] hard to get on sometimes” (Mark - MotM).

Socializing with people inhibited consistent attendance to PA programs for some older men.

“I keep in touch with people at work and...we get together for lunch or coffee...That’ll cause me to miss an exercise class once in a while” (Edward - non-MotM).

Having a physically inactive spouse, not having a PA partner, and people who monopolized group discussion in PA programs limited participants’ PA. An avoidance of groups, feeling unwelcome in a group, and being the only man in a PA program was also a barrier to PA for several participants.

“I [had been] doing Spin Cycle, but then I stopped...one man and 10 women...Nobody ever greeted me. Nobody said, ‘Hi, nice to see you.’ The women would coalesce together...I just didn’t feel the environment was great” (Gary - MotM).

“I’m working out Saturday morning, I’m the only male there. So I think females are more active than men are” (John - MotM).
Some participants predicted that women gained more from the social context than men, leading to their higher PA program attendance rates.

“My Tuesday class, my Thursday class, my Saturday spin class, they are predominantly women…I have this theory that women…gain from the social context of joining a group…women tend to relate to other women, and they tend to go to these classes…It’s a little bit more difficult to drag men into this sort of program” (Robert - MotM).

This hegemonic masculine ideal of independence may contribute to the lower participation rates of men in PA classes as, similarly, several other participants also described women as more social than men.

“Women are more involved. I’m the only guy in this [PA] group…. There’s about 25 women and I’m the only guy there…there’s one reason that women live seven years longer than men… I think women are more inclined to go together as a group than men” (Gary - MotM).

“I think men are quite different to women…you’ll see women will be chatting…men are always in the peripheral. They don’t get involved in the conversations” (Steven - MotM).

Robert described how women seemed to make and maintain social connections easier than men:
“I really think that keeping your social contacts alive is really important…I just think women naturally do it…they’re able to keep [friends]…they make friends when they’re older. I know men don’t, or it seems to be more difficult…women just seem to be more socially adept than men” (Robert – MotM).

In contrast, social influences were also a facilitator to PA for older men. Supportive family members and friends, along with pleasant social interactions helped older men to become more physically active. Many participants described how their spouses or family members got them involved in PA programs.

“The reason I actually got active is because I’m trying to encourage [my wife] to become more active…She just gives me encouragement. When I do go out, she gives me lots of positive feedback about it” (Robert - MotM).

Socializing with people also facilitated PA.

“I take [my grandkids] to the park…and hike around with them” (John - MotM).

“Kick[ing] a ball or keep[ing] them [grandchildren] occupied somehow [keeps me active]” (William - MotM).

Talking with others about PA helped some participants become more physically active. Thomas’ favourite part of the MotM program was making connections with others.
“Having conversations like this...talking about future goals and doing some exercise, going to the community centre...just talking about it [helps]” (Thomas - MotM).

Older men also often used active transportation to meet up with friends.

“I’m walking to a destination where I’m meeting people. We’re all coming from different directions and so we meet there...it’s the social aspect...That’s a large part of what motivates me to do that walk...in a sense that’s...kind of backdoor support to doing that activity” (Henry - MotM).

Having someone to be physically active with also helped participants engage in PA.

“I have a neighbour who also has a bad heart. We go walking, visiting...about three times a week” (David - MotM).

“In squash it’s the same foursome. We’ve been playing together for...20 years...We have an arrangement that if you can’t play you get a replacement. So you could arrive and find that there’s somebody there that you didn’t know. But [it’s] just a very gross error if somebody does not show up” (Andrew - non-MotM).

“There’s a friend of mine...who also goes to [a PA program], and I kind of dragged her into it...I’ll pick you up at eight o’clock in the morning...So I get up because there’s
somebody waiting for me...we...encourage each other to go. So that's why we never really miss--as much as I really like it, sometimes when you get up on a Saturday morning you don’t feel like going. So it’s kind of a little extra push that gets me out the door, and I never regret going (Robert - MotM).

“If I’m alone I probably wouldn’t do it. It’s...peer pressure” (Timothy - non-MotM).

“[PA with others is] motivat[ing] and it was just a lot of fun...encouraging others and working together as a team” (Edward - non-MotM).

Peer inspiration also helped many participants engage in more PA.

“Knowing that other guys are trying as hard as I am...that’s important...knowing that I’m not alone in the process, there’s other people who are struggling too and wanting to do this for their long-term physical health...Thinking, well, somebody else can do it, I can...[Frank (name changed)], who is 94...swims a kilometre a day. So I say to myself...I’m doing six lengths and he’s doing thirty-two lengths? I think I can try a little harder. So meeting other guys like that...I wouldn’t have had without this program... and meet other people like that who are inspiring” (Thomas - MotM).

3.2.2.2 Caregiving

Caregiving was described as a barrier to PA for older men within the interpersonal level of the socio-ecological perspective and referred to participants providing physical, emotional, or
developmental assistance to individuals in their social network. Accessibility issues that affected the people in the participant’s care, was a barrier to older men who were caregiving.

“Accessibility...as far as my wife’s concerned...limits me just because I’m not the sort of person to walk out and leave her alone” (Dennis - non-MotM).

“[My wife had] mobility problems, so-- I just stayed home” (Joseph - MotM).

Pressure to care for others and the busyness and time associated with caregiving for a spouse, a friend, children, or grandchildren limited participants’ PA.

“[I want to] be doing more but with the constraints of my mother-in-law and some other things that are going on, I don’t have the time for myself that I would really like to have...commitments to children, grandchildren, now mother-in-law...sort of restricts what I can do and when I can do it” (Michael - MotM).

3.2.3 Environmental

Environmental barriers referred to geography, temperature, or built and natural environments (Stokols, 1996). Environmental barriers to PA fell into four main themes: 1) weather, 2) built and natural environments, 3) convenience, and 4) active transportation.
3.2.3.1 Weather

Inclement weather, such as rain, ice, frost, and snow were barriers to PA due to the inconveniences associated with it and the increased risk of falling.

“It may be raining or…frosty or [there] may be a little bit of snow…I’m 83 years old…and you [could] slip and break a bone or something…the weather puts you off for walking…when you’re walking you want to be using your arms. You don’t want to be holding an umbrella” (Gary - MotM).

“If it’s raining and snowing, I’d probably choose another day [to go for a walk]” (Andrew – non-MotM).

Bad weather was also a barrier to PA due to “gloominess,” leading to low motivation. Conversely, the sun inhibited some older men from participating in PA.

“I’ve got to watch the sun for my skin…I had a bit of cancer…I prefer it to be cloudy or even raining. I love the rain” (John - MotM).

The weather was also a facilitator to older mens’ PA. Sunny and warm weather encouraged PA participation outside.

“Sunny days, gardening, doing the lawn myself…If it’s sunny I would walk every day…around the neighbourhood, the library, the shops” (Richard - MotM).
“If I get up in the morning and... if it’s nice weather like today, [it] really makes me want to get out and go somewhere” (Robert - MotM).

“If it’s sunny, if it’s warm...I like to go to the beach, walk a little bit there” (Charles - MotM).

3.2.3.2 Built and natural environments

Built environments referred to human-made surroundings, and natural environments referred to nature in the surroundings such as trees and parks (etc.). Hills, lack of visual stimulation, dangerous or difficult terrain, the distance to a bus stop, or a less than ideal or busy biking route were some examples of barriers to PA.

“[There is] nothing to see. If there was something to see, you know, that’d be fine” (Joseph - MotM).

“It’s quite a struggle if you step out the front yard and have to go up that hill. It’s a challenge. And when you get to the top, it’s not like...you’re anywhere. You’re just at the top of the hill. Then you got another couple of hills to deal with...I don’t walk around the neighbourhood...Because of the hill” (William - MotM).

The temperature in a PA facility can also negatively impact participants’ engagement in PA.

“I feel the water is cold...it keeps me away from it [aqua fit]” (Charles - MotM).
Built and natural environments also facilitated PA for older men.

“I was walking with a friend…it’s about two miles around…I do that most mornings. And got myself into the habit of stopping at many of the exercise stations to do a little…push-ups or sit-ups…I’m gone for about two hours” (Henry - MotM).

Living in a house or an apartment with stairs, a pool, or a gym facilitated PA in many older men.

“I could walk up the stairs…I’m on the ninth floor…it doesn’t take long. It’s not even seven, eight minutes” (Richard - MotM).

“[There is a] pool…where I live…three outdoor pools and an indoor pool. And the water’s warm. It’s not that cold Olympic-type pool…it’s part of the complex I live in” (Michael - MotM).

“I don’t think I’d be as motivated. The fact that they’re right here [PA programs] in the same building is a huge plus. I used to go swimming regularly when I was back in Winnipeg and of course I had to drive to the pool. But I’m not that disciplined, you know, if it takes my driving a car or something like that to some place or walking or taking a bus, I don’t know that I would do it as much. But the fact that it’s right here is a real incentive” (Edward - non-MotM).

Flat pathways with benches available also facilitated PA.
“I think it might be easier [if] I [do] not need to go uphill…if it’s flat is easier for me”
(Charles - MotM).

“There’s a bird sanctuary…Sometimes we go there…The handy thing there is there’s benches every now and again. So I get a chance to sit down” (William - MotM).

3.2.3.3 Convenience

Convenience referred to the ease with which participants could access and engage in PA. Inconvenient processes associated with PA was a barrier to PA engagement. The effort required to get ready for certain physical activities prevented some men from participating. Swimming was a prime example.

“A couple of times I went to the pool to do some pool exercises. I find it…a bit inconvenient going to the pool insomuch as…getting dressed and getting prepared and getting dried and all of those things that can be a bit onerous. It’s hard to put your socks on when you’ve only got one hand” (William - MotM).

3.2.3.4 Active transportation

Public transportation-related challenges prevented several participants from using active transportation. Wait times, limited routes, and buses that were slow, late, and unreliable prevented some from using public transportation.
“The transit system is too slow. The transit system waits, and the buses are not on time.
The transit system doesn’t have enough buses. There are all kinds of issues” (Steven - MotM).

Participants having too many shopping bags or heavy items to carry when walking prevented some from using active transportation and using a vehicle was more convenient for some.

“[Using my vehicle is] quickest and easiest” (Joseph - MotM).

“The automobile gives you versatility and it’s not restricted. It’s not on rails. It’s not on somebody else’s schedule...I like being on my own schedule” (Andrew - non-MotM).

“I’m in a car culture...my parents never took the bus. Never took the Skytrain...when I go grocery shopping, yes, technically I could walk that mile. But then I got to haul all the groceries back, and do I want to haul them back on the bus? No. That’s not going to happen either” (Henry - MotM).

For other participants, PA was facilitated by active transportation. Active transportation is defined as any non-motorized mode of transport (Sallis et al., 2004). However, I also include the use of public transit as a form of active transportation due to the walking required to and from the bus stops and participant’s destinations (Davis et al., 2011). Several participants described walking as their preferred way to travel.
“I walk to [the] Community Centre, which is about a 35-minute walk from my place. And I do a 60-minute fitness class...And then I walk home again” (Thomas - MotM).

“If it’s within a reasonable distance or if I don’t have to haul a lot of things” (Robert - MotM).

“[I] either transit or bike ride...transit is generally to go downtown...or to go to a concert, or to go to an event. We’re not that far from the Canada Line, which is great” (Steven - MotM).

Living close to a bus or transit station facilitated PA.

“I’m not sure...what other people’s reasons are for not liking transit. But maybe it’s because they’re not...in a convenient location...I’m centrally located when it comes to transit. So that is actually one of the main reasons why it’s so convenient for me” (Robert - MotM).

Issues with parking and the frequency and speed of public transit options influenced many participants to use active or public transportation.

“The Canada Line has been a wonderful success. We need more of that so that people can get from places to places quickly...No parking issues. So because of the parking I’ll use the transit, and the fact that it runs quickly” (Steven - MotM).
3.2.4 Organizational

Program structure and fitness instructors were a barrier and a facilitator to older mens’ PA at the level of organizations in the socio-ecological framework.

3.2.4.1 Program structure

Program structure refers to the way a PA class was organized or led. Participants avoided PA programs designed specifically for ‘seniors’ due to the connotation ‘senior’ had with being ‘old’, which opposed the masculine ideal of youth, strength, and independence.

“Maybe I don’t want to be considered an old man yet. I don’t know, maybe that’s part of the reason [for not attending a seniors PA program]” (Robert - MotM).

“Guys don’t like to think that they’re getting old and weak…I don’t think men really accept it, that they are ageing, and not capable of doing stuff that they used to be able to do” (Michael - MotM).

‘Feminine’ program content may also further inhibit some men from attending PA programs.

“What I noticed in the exercise class are much more women than men…Maybe we men should be more brave…some classes…they are afraid because they consider that’s only women’s stuff. Some men, not everybody. For example, yoga” (Charles - MotM).
“My wife is quite active...and she goes to fitness classes whereas I didn’t...I didn’t care for the class. So it was kind of a bridge between yoga and other stuff. It’s not for me” (John - MotM).

Classes that were inappropriate for participants’ ability level also inhibited PA.

“I tried the walking club...but they go out for an hour. It’s too long...for me” (Gary - MotM).

“They all got walkers and canes and oxygen tanks and so we don’t...really get into any kind of heavy exer[cise]...I barely get my heartbeat going above normal...I have to have it if I want to go into the other [class]” (Joseph - MotM).

Similarly, a lack of opportunities inhibited PA.

“Here there’s no facilities or no senior leagues [for ice hockey] ...I have yet to find a senior league that’s not playing at two or three o’clock in the morning to get the ice time” (Michael - MotM).

Conversely, program structure also facilitated PA. Participants were more physically active when they committed to PA at a specific time and place, in a small group or a one-on-one setting with a fitness instructor.
“I’m the kind of person that doesn’t necessarily self-motivate myself to do exercising...I have a treadmill at home...I should go down there and spend 15 minutes... But I don’t. I far prefer having an activity where I’m with people... you sort of feel you have to go. It’s your class” (Steven - MotM).

“If you said to me, well, you’ve got a commitment to go to Spin Cycle every week Tuesdays, five-fifteen, I’ve got it marked down. I’ll go... that motivates me...I’ve got something to go to” (Steven - MotM).

“The Men on the Move program [provided] the motivation to get out and move” (Thomas - MotM).

“The inspiration of this particular program [helped]...I got a lot of benefits. I mean, I got a fitness pass. I got a transit pass...an amazing [activity] coach...everybody’s got a good attitude. So it encouraged me to try and do something ‘cause I was doing nothing. And so as a result of...being involved in the Men on the Move project, I’ve totally changed my lifestyle” (Thomas - MotM).

“If I were to go to the gym, part of it will be routine and part of it is that I will put in the exercise” (Richard - MotM).

“I was basically in a slump. And the program got me out and doing things” (Michael - MotM).
“I really enjoy it. I needed something to give me a kick start, motivate me to do something. And I found it structured ‘cause I come from a structured background...And then after I got into doing it I started enjoying doing it” (Michael - MotM).

“The activity programs here, the fitness programs, they force me to get out. I would have slept in this morning if I didn’t have my class at nine o’clock in the morning. So it forces me to get up and get going. ‘Cause I tend to sleep in if I can, you know, like, on a Saturday or Sunday” (Edward - non-MotM).

Participants also described how they were motivated by programs that involved strength, balance, stretching, dance, yoga, spin, tai-chi, weight training, and exercise videos.

Although some participants were motivated to be physically active by their involvement in a scheduled PA class, others preferred flexibility to attend different programs or engage in less formal methods of PA.

“I’d like the option to be able to just go in for one day and try something versus having to be scheduled to do something for a certain period of time...For example, drop-in curling...Pick-up hockey game. Bowling, just something where you just go and do it, that type of thing versus...having to do it once a week” (Michael - MotM).

Participants were motivated to be physically active when they were able to choose an activity
they enjoyed.

“[MotM] was very good because they allowed a lot of flexibility in that you had to find something that you actually enjoyed” (Robert - MotM).

PA programs with incentives also facilitated PA in older men. Incentives were tangible and intangible benefits that motivated and encouraged participants to engage in PA. Incentives increased in value for participants who were on fixed or lower incomes.

“Cyberspace…took my retirement…we just have the government pension…I have to think of little ways to do things to be active that don’t cost anything” (David - MotM).

“It’s all about the perks when you’re a senior. It’s all about the freebies…If you’re not doing anything and you want to do something, it’s a great [way to start]” (Thomas - MotM).

“[My favorite part of MotM was] being able to go on a bus for free” (William - MotM).

“Receiving the money. The bus pass. The Flex Pass [was my favorite part of MotM]” (John - MotM).

Access to information and activity coaches with a wealth of knowledge and experience was an incentive for MotM participants to engage in PA.
“Having access to...expertise” and “all these wonderful people with all this great knowledge and experience” (Robert - MotM).

“I can send an email to [the activity coach] if I want...I can phone...I can use a computer...the availability of getting information” (Gary - MotM).

3.2.4.2 Fitness instructors

Fitness instructors were a barrier and a facilitator to PA. Fitness instructors were individuals who were trained to teach or lead various forms of physical activities and exercises. Fitness instructors were a barrier to older mens’ PA if they were inflexible, harsh or pushy, were inattentive to individual needs, and allowed certain members to dominate class discussion. Charles explained that (in reference to past experiences with fitness instructors and not in reference to MotM Activity Coaches):

“Some instructor[s]...are very harsh. Some are more flexible and...[some] don’t care if they are dealing with a big group. They don’t look at the individual needs” (Charles - MotM).

Participants described how they lacked confidence in fitness instructors who were inexperienced and who did not account for attendees’ medical conditions. Inconsistent program leaders and a limited number of fitness instructors available to run programs were also barriers to PA.

“They were offering a Parkinson’s class. We were doing boxing. But the instructor left
and they’re working on getting another certified instructor for Parkinson’s” (Edward - non-MotM).

In contrast, fitness instructors facilitated PA if they were competent, knowledgeable, and created a supportive environment.

“I respect [my activity coach’s] expertise. I feel as though she is extremely competent. So I’m wanting to give her a hundred percent” (Joseph - MotM).

“My fitness instructor is] very encouraging...supportive and lots of fun” (Thomas - MotM)

“Having the transit pass, having the fitness pass, having a fitness coach, imperative...Having... yourselves today and anybody I’ve met involved with the program, always very friendly, positive, very encouraging, very supportive. Just having that very supportive environment [is helpful]” (Thomas - MotM).

Other positive attributes of fitness instructors were those who delivered flexible programs, provided individualized attention, sympathy, monitoring, and feedback.

“She [fitness instructor] encourages me. She monitors my progress. She changes the routine and encourages me to exercise on my own. She gives me homework to do. But it’s fun homework... She’s so lively, goes at a good tempo” (Edward - non-MotM).
The gender of the fitness instructor was inconsequential to many participants.

“As long as there’s a respect between the individual and the instructor. That’s important” (Steven - MotM)

“As long as they know what they’re doing” (Gary - MotM).

Fitness instructors helped participants engage in more PA by offering advice, recommending classes, and by providing follow-up, education, and resources.

“[MotM is] the whole package... having the Compass card, having the fitness pass, having the pre and post sessions, having the measurements, the measurable goals, having the plan. But the whole thing comes together by having the activity coach. The activity coach for me pulls all that together” (Thomas - MotM).

3.3 A description of MotM versus Non-MotM participants

Participants who were enrolled in MotM, and men who were not enrolled in MotM, described similar barriers and facilitators to PA (Figures 1 and 2). In the following section, I describe themes that emerged within these two groups of participants across levels of socio-ecological framework (see Table 2 and Table 3).
Figure 1: A description of themes that emerged as barriers to physical activity from interviews with MotM participants (n=14) and non-MotM participants (n=5) across levels of the socio-ecological framework.

Figure 2: A description of themes that emerged as facilitators to physical activity from interviews with MotM participants (n=14) and non-MotM participants (n=5) across levels of the socio-ecological framework.
<table>
<thead>
<tr>
<th>Barriers</th>
<th>MotM (sample size)</th>
<th>Non-MotM (sample size)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Theme</td>
<td># of Participants</td>
</tr>
<tr>
<td>Intrapersonal</td>
<td>Motivation</td>
<td>14</td>
</tr>
<tr>
<td>(Ranked first)</td>
<td>Time</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Health</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Interests</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Finances</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Lack of knowledge*</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Fear</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total Mentions: 63</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Social Influences</td>
<td>13</td>
</tr>
<tr>
<td>(Ranked third)</td>
<td>Caregiving</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total Mentions: 19</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental</td>
<td>Convenience</td>
<td>12</td>
</tr>
<tr>
<td>(Ranked second)</td>
<td>Weather</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Built &amp; natural</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>environments*</td>
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</tr>
<tr>
<td><strong>Total Mentions: 28</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organizational</td>
<td>Fitness instructor</td>
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</tr>
<tr>
<td>(Ranked fourth)</td>
<td>Program structure*</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total Mentions: 10</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Unique themes

Table 2: A description of barriers and themes related to older mens’ participation in PA (both groups). Barriers are listed as per levels of the socio-ecological framework (rank order based on how many participants mentioned themes within each level noted in brackets). Themes are listed in rank order based on how many participants mentioned each theme.
### Table 3: A description of facilitators and themes related to older mens’ participation in PA (both groups). Barriers are listed as per levels of the socio-ecological framework (rank order based on how many participants mentioned themes within each level noted in brackets). Themes are listed in rank order based on how many participants mentioned each theme.

**Facilitators**

<table>
<thead>
<tr>
<th>Intrapersonal (Ranked first)</th>
<th>MotM (sample size)</th>
<th>Non-MotM (sample size)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme</td>
<td># of Participants</td>
<td>Theme</td>
</tr>
<tr>
<td>Chores</td>
<td>14</td>
<td>Chores</td>
</tr>
<tr>
<td>Health</td>
<td>14</td>
<td>Health</td>
</tr>
<tr>
<td>Interests</td>
<td>14</td>
<td>Interests</td>
</tr>
<tr>
<td>Time</td>
<td>9</td>
<td>Time</td>
</tr>
<tr>
<td>Motivation*</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td><strong>Total Mentions:</strong> 59</td>
<td></td>
<td><strong>Total Mentions:</strong> 17</td>
</tr>
</tbody>
</table>

**Interpersonal (Ranked fourth)**

<table>
<thead>
<tr>
<th>Environmental (Ranked third in MotM and second in Non-MotM)</th>
<th>MotM (sample size)</th>
<th>Non-MotM (sample size)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social influences</td>
<td>14</td>
<td>Social influences</td>
</tr>
<tr>
<td><strong>Total Mentions:</strong> 14</td>
<td></td>
<td><strong>Total Mentions:</strong> 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organizational (Ranked second in MotM and third in Non-MotM)</th>
<th>MotM (sample size)</th>
<th>Non-MotM (sample size)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program structure</td>
<td>14</td>
<td>Program structure</td>
</tr>
<tr>
<td>Fitness instructor</td>
<td>14</td>
<td>Fitness instructor</td>
</tr>
<tr>
<td><strong>Total Mentions:</strong> 28</td>
<td></td>
<td><strong>Total Mentions:</strong> 6</td>
</tr>
</tbody>
</table>

*Unique themes

3.3.1 Intrapersonal

Intrapersonal barriers were most often described by participants in both groups. I present barriers to PA in rank order in Table 2 and present a few highlights here. All the men (n=14) in the MotM group cited lack of motivation as a barrier to PA, whereas only 1 of 5 participants in the non-MotM group mentioned motivation as a barrier. This difference may have stemmed from the health status of participants, as some non-MotM participants reported health challenges, such as...
knee surgery, as greater barriers to participation. Therefore, lack of motivation may not have been as prevalent. The biggest difference between groups was that lack of knowledge did not surface at all as a theme in the non-MotM group.

Intrapersonal facilitators (Table 3) were discussed by the highest number of participants in both interview sets. All participants from both groups (n=14 MotM and n=5 non-MotM) described chores (which are routine tasks required for daily living, such as grocery shopping, cleaning, or gardening etc.) and health benefits as PA facilitators.

### 3.3.2 Interpersonal

Interpersonal barriers were discussed less often than intrapersonal and environmental barriers (Table 2). For both groups negative social influences were the greatest barrier to PA, followed by caregiving. Interpersonal facilitators to PA (Table 3) were discussed least often by both groups; positive social influences emerged as the predominant theme that facilitated PA.

### 3.3.3 Environmental

Environmental barriers to PA were ranked second in order of importance for both groups (Table 2). MotM participants noted built and natural environments as barriers to PA, whereas this theme did not surface in the non-MotM group (Table 2). This difference may be due to where the participants lived. Non-MotM participants resided in a newly built independent living community, located in a flat area with lots of benches, even sidewalks, shopping centres, and parks nearby. In contrast, MotM participants lived in a variety of locations throughout
Vancouver, where they may have encountered more barriers to PA within built and natural environments.

Environmental facilitators ranked third among MotM participants and second among non-MotM participants (Table 3). All participants in both groups except for one in MotM described active transportation as the most prominent facilitator to PA.

### 3.3.4 Organizational

Organizational level barriers were discussed least often by participants in both groups (Table 2). Five MotM participants described poor fitness instructors (from their past experiences and not the Activity Coaches from MotM) and program structures as barriers to PA. Cancelled programs, long classes, and harsh or pushy fitness instructors discouraged them from PA. Program structure as a barrier to PA did not emerge in the non-MotM group.

Ideal program structures facilitated PA for all participants in both groups (14 MotM and 5 non-MotM participants) (Table 3). A qualified fitness instructor facilitated PA for all participants in the MotM group (14) but was only mentioned by one participant in the non-MotM group.

In summary, both groups had similar barriers and facilitators to PA. Unique barrier themes for MotM participants was lack of knowledge, built and natural environments, and program structure. Some of these unique themes may be explained by differences in demographics (attributable to participant characteristics and their different living environments) between MotM
and non-MotM participants. Motivation was an additional theme facilitator for MotM participants in the intrapersonal level, though mentioned by the least number of participants (8 of 14). This additional theme referred mostly to the motivation derived from having a step counter. Pedometers were given to MotM participants as part of the intervention and were not available to non-MotM participants, which may contribute to why non-MotM participants did not discuss this theme. Overall, the ranking of themes within barriers and facilitators to PA across levels of the socio-ecological model were similar between groups.

3.4 Ideal features of a PA program

Older mens’ ideal PA program features fell into three categories: 1) program structure, 2) program content, and 3) fitness instructors. Table 4 outlines the themes that emerged among MotM and non-MotM participants.
Table 4: A description of themes related to older mens’ ideal PA program features (both groups). Categories ranked in order based on how many participants mentioned themes within the category. Themes are listed in rank order based on how many participants mentioned each theme.

3.4.1 Program structure

Several participants preferred PA programs in a small group setting. Motivation was one reason why participants preferred a small group setting.

“I prefer them in a group...it gets me motivated, gets me there” (Joseph - MotM).
Individualized attention was another reason why a small group setting was preferred.

“It would be better one-on-one or [in] small groups [so fitness instructors can take care of individual needs]” (Charles - MotM).

Opportunity for social contact was another reason older men preferred a small group PA program.

“I think doing it in a group would definitely be a lot more enjoyable...social contact...that’s one of the things I miss from work...I don’t miss the actual work. But I do miss the social contact that I had at work” (Robert - MotM).

“Cardio, strength building, core strengthening, muscle endurance. It would be a combination and I think it would be fun to do it as a group, as opposed to individually. That way you can encourage each other and it’s just fun to hang out with other people” (Timothy – non-MotM).

A group setting took the pressure off some participants who did not enjoy having to push a partner to be physically active but also provided them the opportunity to socialize.

“I hate to push somebody all the time [to attend a PA program]...I don’t like being put in that role...I find it’s easier to go on my own...If you go on your own, I find that people that I never knew, I meet there...sometimes you end up having a coffee afterwards or
something like that” (Henry - MotM).

Although 12 MotM participants and 3 non-MotM participants preferred a small group setting, others favoured one-on-one programs.

“I prefer to have a fitness coach... [and] one-on-one...coaching... it’ll take the heart attack into [account] and I’ll be doing things which will help to strengthen the heart. And I am a loner. I like doing things by myself. So I’m not crowd-oriented anymore” (David - MotM).

Participants most often described their ideal PA program as a program located outside of their homes.

“[My ideal PA program would] probably be going out to some kind of class or program...community centre...two or three times a week. Continuing to walk. Maybe get back into running” (Thomas - MotM).

One MotM participant preferred to have an equal number of men and women in a program, as opposed to more women.

“Sometimes they’re are all females. I am the only male or one more. So I feel more comfortable when it’s balanced” (Charles - MotM).
A men-only PA program was the ideal PA program structure for another MotM participant.

“I think this program would be ideal just for men, otherwise you [will] have 75 percent women and 25 percent men” (Michael - MotM).

Other participants did not seem to mind if there were more women than men in their PA classes.

“[My PA class was] 90 percent women. But it was a good class. Good hour and a quarter class” (Thomas - MotM).

“I didn’t really care one way or the other but they’re all female. I was the only male [in the PA class]” (John - MotM).

3.4.2 Program content

Six participants from MotM preferred sports programming.

“I wanted to get back to... sports because I played tennis and I played golf. But I can’t play tennis anymore. Well, I haven’t played for a while. So what I’d like to do is play pickleball” (Joseph - MotM).

“I would like to get in with a group of guys that I was friends with, and do pick-up sports. Maybe...soccer. A pick-up hockey game be it ice hockey or floor hockey...that I would enjoy...Bike rides with a group” (Michael - MotM).
“[My ideal PA program would be] some sort of sport that you played two or three times a week...That you’d be letting other people down if you didn’t go...Probably a group program...I found the social aspect of the badminton very good. Because you meet people of the same age group because a lot of them are my age or even a little bit older. And there’s younger people too...it took me a good two weeks to sort of get in and feel comfortable. And now I feel comfortable and know their names. They know my name and we joke and banter back and forth. That’s a nice outlet” (Michael - MotM).

“I’ve had friends that have done that [volleyball] over the years...If you’re talking a sport, I mean, it adds a dimension to it, like when I’m saying volleyball, you have to work with other people, so that makes it more interesting” (Mark - MotM).

Two non-MotM participants also described sports as an ideal PA program.

“It would be one that would...involve a sport...I liked where I had accessibility to a coach for either physical or mental help as to how to play the game, and I had the freedom to have it at an ideal time in the day, week or month...it would have to have other people” (Andrew - non-MotM).

Participants described strength training as ideal program content for falls prevention.

“I want to increase my strength, so in case I fall...I have a chance of
Participants also preferred programs tailored to individual abilities.

“[An ideal PA program would] give you some exercise to your ability” (Gary - MotM).

“Some exercise suitable for my needs” (Charles - MotM).

Dancing, swimming, aerobic fitness, strength, and balance classes were also considered components of an ‘ideal’ PA program.

### 3.4.3 Fitness instructors

A program led by a fitness instructor was also considered an ideal feature of a PA program. An ‘ideal’ fitness instructor was an expert in their field, experienced with older adults, able to take criticism, and offered fun and individualized programming. Some participants preferred an older fitness instructor and explained that instructors were often:

“Young... [they] don’t know what the joint pains are...Where coming from an older individual I think [PA guidance] would be more realistic or beneficial” (Michael - MotM).
Chapter 4: Discussion

There are few men-only studies on PA (Baert et al., 2011; Chase, 2015; Morgan et al., 2019). To my knowledge, there have been only 5 qualitative studies on older mens’ PA. Three utilized focus groups, wherein the emphasis was on participants with prostate cancer (Keogh et al., 2014), HIV (Neff et al., 2019), or transitioning to retirement (Bredland et al., 2018). Only 2 employed interviews. One conducted semi-structured interviews with 4 older men on PA engagement and the implications for health promotion (Thandi et al., 2018) and the other was a case study on a subset of men who were members of a fitness centre-based older mens’ PA program (Dunlop & Beauchamp, 2013). As such, this study adds to the limited knowledge on older mens’ barriers and facilitators to PA.

Barriers to older mens’ PA ranged from health problems to cost of PA programs. MotM and non-MotM participants also described several facilitators to PA, which ranged from chores to knowledgeable fitness instructors who provide exercises tailored to participants’ abilities. It is important to understand older mens’ PA barriers and facilitators, so that interventions and programs can minimize the barriers and maximize the facilitators to help them commence or maintain PA engagement. Older men in my study described many similar barriers and facilitators to PA that have been reported in previous studies of men and women. Below, I apply the socio-ecological framework to highlight similarities among studies. I also peer through the lens of hegemonic masculinity to discuss additional themes that emerged specifically relevant to older men.
4.1 Intrapersonal

Lack of time (Macniven et al., 2014), limited motivation (Baert et al., 2011; Costello et al., 2011), health problems (Macniven et al., 2014), and pain (Franco et al., 2015) were barriers to older mens’ PA in my study and in the literature with older men and women at the intrapersonal level of the socioecological framework. Older men may seek to achieve/maintain the ‘ideal’ masculine image/identity, in which they are perceived as young, non-feminine, and independent. Some older men may view health-promoting behaviours as feminine qualities, opposed to the masculine ideals of independence, self-reliance, and strength (Cohen, Chávez, & Chehimi, 2010; Courtenay, 2000; Gough, 2006; Robertson, 2007). These hegemonic masculinity perspectives may negatively impact older mens’ willingness to seek help for health issues, lower their participation in PA programs/activities due to untreated pain, resulting in more inactivity related health problems and pain.

Physical limitations and lack of balance were also common across studies (Baert et al., 2011; Hartley & Yeowell, 2014). Injury risk (Franco et al., 2015; Hartley & Yeowell, 2014), fear of falling (Bredland et al., 2018; Costello et al., 2011), and limited knowledge (Bethancourt et al., 2014) were previously identified as barriers to PA, which were also described by older men in this study. Knowledge is a key component of self-efficacy – defined as “a person’s confidence in his or her ability to be physically active on a regular basis” (Trost, Owen, Bauman, Sallis, & Brown, 2002, p. 1998). Older mens’ PA was inhibited due to feelings of vulnerability in a gym setting because of a lack of knowledge on exercises and how to use the equipment. Vulnerability avoidance and unwillingness to ask for help is a hegemonic masculinity feature, which may explain why lack of knowledge is a barrier to PA (Thompson & Langendoerfer, 2016).
Lack of finances, intimidation (Franco et al., 2015), the inability to attend specific class times (Baert et al., 2011), boredom, and a preference for activities that do not require PA (Costello et al., 2011) were also common barriers to PA among studies. Lack of interest in physical activities were barriers in my study and others (Baert et al., 2011; Franco et al., 2015). Men commonly avoid activities they view as ‘feminine.’ Many PA programs have garnered such a reputation (e.g., yoga and Zumba), which may, in turn, lead to mens’ dismissal or avoidance. Even the connotation of a ‘senior’s program’ caused some older men to lose interest in an activity as they did not want to be considered ‘an old man.’ These examples highlight the influence of hegemonic masculinity ideals in older mens’ interests.

Distinctive to this study, retirement was a PA barrier. Through the lens of hegemonic masculinity, work plays an integral role in mens’ identity. Employment often provides men with intrinsic and extrinsic rewards by which men judge themselves and others (Lupton, 2002). Several participants noted that once they retired, their identities and lifestyles were impacted. This resulted in fewer physical activities (particularly when their work involved PA) and social connections.

Conversely, retirement facilitated PA for some men, especially if their previous work (e.g., a desk job) did not facilitate PA. This was highlighted in previous multi-gendered studies (Barnett et al., 2012; Godfrey et al., 2014). Ultimately, retirement may drastically alter older mens’ lives, including their PA habits. Depending on their previous vocation (manual labour work or non-manual work), and how they approach their new ‘identity’ in the absence of work, these PA
changes may be positive or negative (Barnett et al., 2014). For example, men who used to work in manual labour jobs often engage in less overall PA after retirement because their leisure time PA is less than their former work PA (Barnett et al., 2012).

Intrapersonal facilitators common among studies were improved health, PA enjoyment, an improved mood (Baert et al., 2011; Costello et al., 2011), and being able to choose ones’ own physical activities (Bredland et al., 2018; Stewart et al., 2001). Older men in this study also identified chores, seeing new things, and goals as facilitators to PA. Hegemonic masculinity may provide a lens through which to better understand the influence of each of these. Chores may reflect mens’ tendency to seek mastery over tasks (H. Brod, 1987). In the early literature, adventure characterized the ideal man (H. Brod, 1987). Seeing new things, a theme in this study, may reflect this characteristic. Finally, accomplishing goals may provide older men with competition (a masculine ideal) similar to that found in the sporting context (H. Brod, 1987).

4.2 Interpersonal

PA was less likely to be initiated and sustained among studies if participants felt unwelcome, uncomfortable, or intimidated in a PA group (Franco et al., 2015). In this study, some older men expressed these negative emotions when they were the only man present in a PA program. This may be due to vulnerability avoidance, a hegemonic masculinity feature (Fuller, 1996). Similarly, gender inclusivity and the absence of homogeneity were barriers to PA (Hartley & Yeowell, 2014). Another hegemonic masculinity characteristic is to “consider all interactions as a form of competition in which [one] must be successful” (Thompson & Langendoerfer, 2016, p. 122). If a man compares himself to a woman in a mixed-sex PA context and feels he is not
successful in surpassing her physically, he may feel like ‘less of a man.’ Since men often avoid anything they view as feminine, PA classes with more women attendees may perpetuate a cycle of fewer men by inducing an environment contributing to ‘un-masculine’ feelings of vulnerability. Since men tend to avoid such vulnerability, this may deter them from attending and further reduce the number of men in PA programs with both men and women (Fuller, 1996).

Caregiving responsibilities (e.g., caring for a spouse or grandchildren) were common barriers to PA in this study and in others, as participants have less time to be physically active (Baert et al., 2011; Franco et al., 2015). Social connectedness facilitated PA in this study and in others (Dunlop & Beauchamp, 2013; Oliffe et al., 2019.). Collectively, this reflects the masculine ideal of group solidarity and comradery. Encouragement, companionship, social contact (Franco et al., 2015), role modelling, having someone to participate in PA with (Bethancourt et al., 2014), and peer inspiration (Dunlop & Beauchamp, 2013) were other common facilitators to PA across studies.

4.3 Environmental

Bad weather (Baert et al., 2011; Bredland et al., 2018; Franco et al., 2015), convenience, and issues with built and natural environments, such as hills, and unaesthetic environments were common barriers to PA among studies (Bethancourt et al., 2014; Cohen-Mansfield et al., 2003). Active transportation promoted PA (Baert et al., 2011), living in a walkable area near shopping centers, places to rest, flat walking environments (Bethancourt et al., 2014), and good weather (Baert et al., 2011) were common facilitators to PA in this study and in others.
4.4 Organizational

Organizational barriers were also common across studies. These included a limited number of PA program options (Baert et al., 2011; Franco et al., 2015), programs not tailored to participant ability, low-quality instructors, and being pushed too hard. Insufficient information regarding available PA programs (Baert et al., 2011) and unappealing options were also barriers to PA (Bethancourt et al., 2014). Some themes may not have surfaced among this study’s participants as they were well-informed (MotM participants through the intervention, and non-MotM participants through the program director and assistant) regarding several quality program options.

Involvement in a structured PA program and the integration of PA into a schedule or routine facilitated PA across studies (Baert et al., 2011; Cohen-Mansfield et al., 2003). Scheduled PA may provide some retired older men with a sense of purpose and responsibility to others, adding structure and routine back into the day that work once provided (Barnett et al., 2012; Lübcke et al., 2012; Morgan et al., 2019). Program incentives, such as free or low-cost programs (Hartley & Yeowell, 2014) facilitated PA involvement as often the cost associated with these programs were a barrier to participation (Baert et al., 2011). Programs that were engaging, flexible (Bethancourt et al., 2014), and appropriate for different fitness levels also facilitated PA for participants in this study and in others (Baert et al., 2011; Costello et al., 2011; Franco et al., 2015).

High-quality fitness instructors, support, individualized attention (Baert et al., 2011; Costello et al., 2011; Franco et al., 2015), and exercises tailored to participants’ abilities were important
skills of fitness instructors and activity coaches in this study and in others (Dunlop & Beauchamp, 2013). Fear of injury and lack of knowledge are often barriers to PA, and having access to trustworthy advice from knowledgeable fitness instructors may help overcome these barriers (Lübcke et al., 2012; Morgan et al., 2019). Offering program content that appealed to older men and creating environments of competition and comradery (a hegemonic masculinity feature) facilitated PA in this study; this was also a way to engage men in PA in other studies (Barnett et al., 2012; Hartley & Yeowell, 2014). Advertising strategies that emphasize masculinity may further increase attendance in PA programs by acknowledging mens’ avoidance of anything feminine and by appealing more to their hegemonic masculine ideals similar to the Movember campaign (men grow mustaches to create awareness about prostate and testicular cancer, as well as mental health and suicide prevention). This campaign has impacted the landscape of mens’ health by normalizing preventative health behaviours among men, and now supports more prostate cancer research than any other non-government agency worldwide (Wassersug et al., 2015).

In summary, many themes that emerged in this study with older men were similar to those that arose in the literature with both men and women (Morgan et al., 2019). When differences existed and additional themes were identified in this study, hegemonic masculinity may provide insight into the PA experiences specific to older men.
Chapter 5: Conclusion

5.1 Engaging older men in PA is complex

Older men face barriers and facilitators to PA at multiple levels. Personal and relational components occur within the individual context but are also influenced by environmental and organizational factors. Together, this complex array of factors contributes to older mens’ PA behaviours.

5.1.1 Too few studies focus on older men – there is a grave need for more

Older mens’ experiences with PA are underrepresented in the literature in comparison to older women. Studies that include both older men and women often include more women than men. Therefore, mens’ masculine perspectives are largely unknown. There is a grave need for more studies on older men to design, promote, implement, and sustain PA in this population.

5.1.2 Customize programs for older men

Older men face barriers to PA that are distinct from those that confront older women. These need to be considered and overcome, especially given that most PA programs and studies focus on women. It may be advantageous to host PA programs specifically for men to eliminate feelings of vulnerability. Programming must consider sex and gender differences if they are to attract and sustain men. The Check-Mate tool may be helpful in tailoring programs to men in the design, implementation, and promotion of programs (Struijk et al., 2019). This tool can assist in “1. Creating a male-friendly space 2. Basing the program on activities that are appealing to men 3. Using masculine ideals to increase the well-being of men and their families 4. Considering aspects of mens’ identities other than gender 5. Encouraging independence and participation”
Choice-based options are also important as some men prefer to exercise in groups while others prefer to exercise alone.

Researchers might continue to examine the impact of sports programming on mens’ participation and adherence to PA programs (Bunn et al., 2016; Caperchione et al., 2017; Gray et al., 2013). Fostering an environment of support, comradery (Mackenzie et al., 2017), and competition may also cater to the unique values that facilitate older mens’ participation in PA. Physical activities that are useful, such as chores, and activities that interest older men, such as seeing new things, and using external motivations, such as having a goal to achieve, might also be included in PA programming to encourage mens’ participation.

5.1.3 Promote and sustain

Healthy, preventative behaviours, such as attending PA programs should be encouraged, normalized, and promoted through careful advertising choices that consider the hegemonic masculine belief that the ‘ideal man’ is young, independent, and non-feminine. These advertisements should seek to promote health behaviours and physical activity as a feature of masculinity (e.g., using models, terminology, and color schemes (etc.) that are masculine) (Caperchione et al., 2017).

Even small costs are barriers to PA. Governments at all levels (municipal, provincial, and federal) need to consider ways to support older mens’ participation in PA by minimizing the barrier of program cost. This is especially important given the escalation of chronic disease in older men.
5.1.4 Prepare older men for retirement

At retirement, men should be provided the training and tools to create an active lifestyle. This transition is pivotal as new routines are instituted and may be more readily accepted, making this an ideal season for PA promotion (Barnett et al., 2012). PA programs should seek to provide older men with a sense of purpose and fulfillment (Barnett et al., 2012) through meaningful activities and create an environment characterized by the social support and comradery that is often found in the work environment.

5.2 Study strengths and limitations

My study had several strengths. First, I presented a novel approach and perspective on older mens’ participation in PA by embedding it within levels of the soci-ecologic model. Second, I was able to describe the barriers and facilitators to PA among older men as there is limited information on this demographic. Third, I was able to support the findings reported for MotM based on similarities in the themes between the two groups. As no additional themes surfaced among non-MotM participants, I am confident that there was enough data saturation within the MotM interviews. Fourth, I was able to describe the ideal features of a PA program for older men – informed by their unique masculine values and preferences.

I also recognize that my study had several limitations. First, purposive sampling instead of random selection in non-MotM recruitment is open to selection bias and error. This may have influenced the types of themes that emerged in the results (e.g., non-MotM participants did not have built environmental barriers as they lived in a location with even sidewalks and benches.
They also lived close to shopping amenities which facilitated walking in that neighborhood). Second, participants knew that this project was a part of my master’s degree, which may have contributed to volunteer bias (e.g., Individuals who value higher education and thus, have a higher education, may have been more willing to participate. This may have influenced the type of themes that emerged in this study). Third, though many broad themes regarding older mens’ perspectives on barriers and facilitators to PA emerged, some participants did not share these perspectives. Individual opinions from different life experiences need to be considered. Fourth, there is inherent subjectivity in coding interview data. Thus, another researcher reviewed a subset of data to ensure there was consistency within the coding. Fifth, this study’s data represent 19 older men (MotM and non-MotM participants) who live in Vancouver, British Columbia, Canada. All men in the non-MotM participant group lived in the same independent living residential facility, which limited heterogeneity in my sample. Therefore, my findings cannot be generalized to older men in other environmental, social, and cultural settings or of different ethnicities.

5.3 Future research

More research is needed to learn how to engage older men in PA. Scalable, flexible programs customized for and by older men may be one solution – but they need to be strategically designed from research specific to older men. Older mens’ barriers, facilitators, and ideal program features may differ among subgroups of older men (such as those who are currently exercising versus those who are not and those who live in rural areas) (Weller et al., 2019). Moreover, more research is needed to understand gender role norms in various subgroups of older men to better tailor PA programs to their unique masculine values and preferences in the
design, implementation, and promotion of programs for these older men (e.g., older men with various ethnicities) (Sharp et al., 2018). Future studies should encompass intersectionality and multi-component analyses, as whether older men choose to engage in PA lives at the intersection between barriers and facilitators. To facilitate this, mixed methods approaches that incorporate qualitative and quantitative aspects would help unpack these associations (e.g., why some men with more time at retirement are physically active and some men with more time at retirement are less physically active). Multivariable modeling approaches would allow researchers to examine how several factors contribute to older adults’ PA. For example, healthy older Australians who considered a ‘lack of people to exercise with’ as a barrier to PA, were less likely to meet physical activity guidelines when demographics and health status with their multivariable logistic regression were controlled (Macniven et al., 2014). However, social support did not predict PA in older Australians who had poor health. Thus, multiple factors may interact to effect PA in older adults (Macniven et al., 2014). Studies that examine the impact of removing barriers like program cost on men’s health are also needed. Understanding older men’s barriers, facilitators, and their ideal PA program features can inform future interventions, programs, and policies. Including older men’s values in these sectors may increase their PA engagement, help prevent mobility disability, and empower older men to achieve a better quality of life.
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Appendix A  Interview guide for older adult informants

INTERVIEW GUIDE
FOR OLDER ADULT INFORMANTS

SHAPE THE PATH: TARGETING THE HEALTH AND MOBILITY OF OLDER MEN
THROUGH KEY COMMUNITY PARTNERSHIPS

“MEN ON THE MOVE” STUDY

Purpose
This first section of this document outlines the questions that we will ask each participant in the qualitative interview. Questions do not necessarily need to be asked in order but can be covered with the natural flow of information the participant would like to share.

The subsequent ‘field notes section’ will be completed by the interviewer as soon as possible (ideally within 2 hours of the interview, or at least within 24 hours). This is a standard field notes template used for in-depth interviewing and ethnographic studies to track the interviewing process (e.g., it tracks the length of the interview, interruptions, technical problems, etc.). Tracking things such as the weather, cleanliness of the location, who was present at the interview, and body language are necessary for crafting the “complete picture” of the interview (e.g., family member in another room, may impact how the participant answered some questions). This comprehensive tracking is an essential component of ethnographic research, and enhances to overall rigour of the study. These field notes are a product of the chosen methodology, not necessarily the research question.
Daily Mobility

1. Starting with when you get up, can you please talk me through a typical day for you – explain it to me like a story.
   Probes: tell me - what do you do, where do you go, how do you get there, and who do you see?

2. What activities do you like to do in your daily life?
   Probes: Where do you like to go? Who do you like to go with? How often do you engage in these activities? Out of these, which do you prefer? Thinking about all of these activities together, are you mostly sitting, or mostly moving about?

3. How often do you get out and about in your community?
   Probe: How often do you leave the house? Every day? Once a week?

4. Are you happy with how often you currently get out into your community?

5. When you get out and about in your community, do you typically go by yourself, or with other people?
   Probes: Does anyone help you get around? Does anyone drive you places? Walk with you? Do you help others get around or accomplish daily tasks?

6. If given the opportunity, what if anything would you do differently?
   Probe: What do you hope for in your day?

7. What are some of the things that encourage you get out and about in your community?
   Probe: What people or services or programs help you get out and about?

8. What are some of the things that get in the way from you leaving your home more often?
   Probes: lack of transportation, no one to go with, weather, health-related challenges? [If yes to health challenges: How does your diagnosis affect your ability to get around? Could you tell me about how your mobility affects your ability to manage this diagnosis/health challenge?]

Transportation Patterns

9. When you leave your home, how do you get around?
   Probes: Do you walk? Use public transportation (what kind)? Do you drive a car? Are you a passenger in a car?

10. What is your preferred/ideal way to get around (if you had it your way)?
    Probes: If this is different than how you mentioned getting around, why is your preferred way not feasible? What could work better? If you were no longer able to get around by your preferred mode, then what would you do? Do you own a car or have you ever? In the past or present have you ever drove? Can you describe the time that you went from having your license to not? What was challenging about that? What do you think are the advantages for you not driving—if any?
11. Do you ever take public transit?
Probes: Tell me more about that?
If yes, what kind of transit do you take and where do you go? How often? How do you plan your route and get information about transit times, stops and routes? Do you have to walk to a stop? How far? What do you like about transit? What makes it challenging? Are there reasons that some days your take transit and others not?
If no, would you consider it an option for you? Why or why not? What challenges do you have? Would you be interested in receiving training to ride transit?

Social Environment

12. Do you have someone who you live with or interact with who supports you in being active?
Probes:
If yes, who is this person? How do they support you in being active?
If no, would you find it useful to have someone in your life who supported you in becoming active? How would that work?

Physical Activity

Present

13. When I say physical activity, what comes to mind?
Probes: What does it mean to you to be physically active? What do you see as physical activity? What do you see as the benefits to being physically active?

PHYSICAL ACTIVITY DEFINITION: Any bodily movement (produced by skeletal muscles) that increases heart rate and breathing and requires energy expenditure (Canadian Society for Exercise Physiology, 2011.)

14. Do you consider yourself a physically active person? Why or why not?

15. How are you physically active?
Probes: What do you do? What do you like about being physically active? Do you prefer to be alone or with others when you are active? How do you get to your physical activity (walk, drive, bus)?

16. What are your favourite ways of being physically active? What do you like about this?
Probes: What motivates you to keep up your activities?

17. What are your least favourite ways of being physically active?
Probes: Does this contribute to your inactivity? Do you prefer to be inactive? IF so, doing what? Do you think there’s anything that might make [this activity] more enjoyable for you?

18. How do you feel about your current level of activity?
Probes: Are you happy with your current level of physical activity? If ‘yes’: What is it that keeps you motivated to keep up your activities? If ‘no’: How would you like to be more active (or less active)?

19. What keeps you from being more physically active?

20. What types of support or assistance would help you to start regular physical activity?
Probes: Would it help to have a coach to help you plan your activities and check in with you occasionally? Would it matter if this person was male or female, young or older?

Past/Changes Over Time

21. Think back to the time in your life that you felt most physically active. Can you describe it to me?
Probes: How old were you? What activities were you involved in? What made it possible at the time to do those things?

22. What has changed over time that has had the biggest impact on your physical activity?
Probes: Since last year, are there any activities that you can no longer do or that have changed? If yes, please tell me a bit more about that. Because of health issues or caregiver responsibilities? Are there any new activities that you do now, based on your current ability level and circumstance?

23. Do you participate in any regular physical activity programs? How did find out about them? If you don’t participate, are you aware of any (or any more) that you may consider participating in?
Probe: What are the biggest attractions and/or turnoffs?

24. If we were to design a physical activity program that was ideal for you, what would this look like?
Probe: Where would it take place (In your home? In the community?) What sorts of activities would it involve? Where would you like to find out about such a program?

Influence of Aging & Masculine Identities

25. When it comes to getting older, do you think it is different for men and women?
Probes: How is this different? Can you tell me more about what you mean about that?

26. When it comes to changes in physical activity as people age, do you think it is different for men and women?
Probes: Can you give an example from your own life? Do you feel as strong as you once were? How do new or certain types of activities differ?

Men on the Move Program Feedback
27. Why did you decide to join this program?
Probes: Did you see an advertisement? Did someone recommend it to you? Where you looking for a way to become more active?

28. How is this program working for you?
Probes: Are you enjoying the program? Do you find it easy to continue with the program?

29. What are your favourite parts of the program?
Probes: Which parts of the program worked best for you? Which parts do you look forward to?

30. Do you have any suggestions for how we could improve the program?
Probes: What would you like to change about the program? Are there any parts you’d like to see added or removed?

31. How do you think we could get more men involved in this program?
Probes: What aspects of the program were most appealing to you? If you were telling a friend about this program, what parts would you highlight?

32. How do you feel on a daily basis now, compared to before you started the program?
Probes: Do you find yourself using public transport more or less? Do you find yourself participating in physical activity more or less? Do you find yourself feeling better or worse in terms of your mental or physical health?

33. How easy do you think it will be for you to maintain the changes to your physical activity and active travel habits after the program?
Probes: Which parts of the program will make maintaining your new habits easier? Which parts will make it harder?

Closing

34. When we came to this interview today is there something that you thought we were going to ask that we didn’t? Is there anything else that you would like to add to our discussion today?

Thank you so much for your time and insights.
Field Notes Guide

** To be completed by the interviewer within 24 hours of the interview **

Participant ID:

Prepared by:

Interview Date:  
Starting Time:        Ending Time:

Participant chose to illustrate some answers by drawing on paper [yes/no]:

Location of interview (e.g., participant’s home, community center, etc.):

Description/your impressions of the neighbourhood:

Technical Problems (e.g., timing of interview, tape recorder):

People present:

Description of the home environment (include 5 senses):

Content of Interview (e.g., use key words, topics, focus, words or phrases that stand out):
Interviewer’s impressions (e.g., discomfort of participant with certain topics, emotional responses to people, events or objects)

Nonverbal behaviour (e.g., tone of voice, posture, facial expression, eye movements, forcefulness of speech, body movements, and hand gestures):

Preliminary Analysis (e.g., interviewer’s questions, tentative hunches, trends in data and emerging patterns, insights, interpretations, beginning analysis, working hypotheses):
Appendix B  Non-MotM interview guide for older adult informants

NON-MOTM INTERVIEW GUIDE
FOR OLDER ADULT INFORMANTS

UNDERSTANDING OLDER MENS’ EXPERIENCES WITH PHYSICAL ACTIVITY
A QUALITATIVE STUDY

Purpose
This first section of this document outlines the questions that we will ask each participant in the qualitative interview. Questions do not necessarily need to be asked in order but can be covered with the natural flow of information the participant would like to share.

The subsequent ‘field notes section’ will be completed by the interviewer as soon as possible (ideally within 2 hours of the interview, or at least within 24 hours). This is a standard field notes template used for in-depth interviewing and ethnographic studies to track the interviewing process (e.g., it tracks the length of the interview, interruptions, technical problems, etc.). Tracking things such as the weather, cleanliness of the location, who was present at the interview, and body language are necessary for crafting the “complete picture” of the interview (e.g., family member in another room, may impact how the participant answered some questions). This comprehensive tracking is an essential component of ethnographic research and enhances to overall rigour of the study. These field notes are a product of the chosen methodology, not necessarily the research question.
Daily Mobility

1. Starting with when you get up, can you please talk me through a typical day for you – explain it to me like a story.
   Probes: tell me - what do you do, where do you go, how do you get there, and who do you see?

2. What activities, whether they involve physical activity or not, do you like to do in your daily life?"
   Probes: Where do you like to go? Who do you like to go with? How often do you engage in these activities? Out of these, which do you prefer? Thinking about all of these activities together, are you mostly sitting, or mostly moving about?

3. How often do you get out and about?
   Probe: How often do you leave the house? Every day? Once a week?

4. Are you happy with how often you currently get out?

5. When you get out and about, do you typically go by yourself, or with other people?
   Probes: Does anyone help you get around? Does anyone drive you places? Walk with you? Do you help others get around or accomplish daily tasks?

6. If given the opportunity, what if anything would you like to do differently?
   Probe: What do you hope for in your day?

7. What are some of the things that encourage you get out and about?
   Probe: What people or services or programs help you get out and about?

8. What are some of the things that get in the way from you leaving your home more often?
   Probes: lack of transportation, no one to go with, weather, health-related challenges? [If yes to health challenges: How does your diagnosis affect your ability to get around? Could you tell me about how your mobility affects your ability to manage this diagnosis/health challenge?]

Transportation Patterns

9. When you leave your home, how do you get around?
   Probes: Do you walk? Use public transportation (what kind)? Do you drive a car? Are you a passenger in a car?

10. What is your preferred/ideal way to get around (if you had it your way)?
   Probes: If this is different than how you mentioned getting around, why is your preferred way not feasible? What could work better? If you were no longer able to get around by your preferred mode, then what would you do? Do you own a car or have you ever? In the past or present have you ever drove? Can you describe the time that you went from having your licence to not? What was challenging about that? What do you think are the advantages for you not driving—if any?
11. Do you ever take public transit?
Probes: Tell me more about that?
If yes, what kind of transit do you take and where do you go? How often? How do you plan your route and get information about transit times, stops and routes? Do you have to walk to a stop? How far? What do you like about transit? What makes it challenging? Are there reasons that some days you take transit and others not?
If no, would you consider it an option for you? Why or why not? What challenges do you have? Would you be interested in receiving training to ride transit?

Social Environment

12. Do you have someone who you live with or interact with who supports you in being active?
Probes:
If yes, who is this person? How do they support you in being active?
If no, would you find it useful to have someone in your life who supported you in becoming active? How would that work?

Physical Activity

Present

13. When I say physical activity, what comes to mind?
Probes: What does it mean to you to be physically active? What do you see as physical activity? What do you see as the benefits to being physically active?

14. Do you consider yourself a physically active person? Why or why not?

15. How are you physically active?
Probes: What do you do? What do you like about being physically active? Do you prefer to be alone or with others when you are active? How do you get to your physical activity (walk, drive, bus)?

16. What are your favourite ways of being physically active? What do you like about this?
Probes: What motivates you to keep up your activities?

17. What are your least favourite ways of being physically active?
Probes: Does this contribute to your inactivity? Do you prefer to be inactive? If so, doing what? Do you think there’s anything that might make [this activity] more enjoyable for you?

18. How do you feel about your current level of activity?

PHYSICAL ACTIVITY DEFINITION: Any bodily movement (produced by skeletal muscles) that increases heart rate and breathing and requires energy expenditure (Canadian Society for Exercise Physiology, 2011.)
Probes: Are you happy with your current level of physical activity? If ‘yes’: What is it that keeps you motivated to keep up your activities? If ‘no’: How would you like to be more active (or less active)?

19. What keeps you from being more physically active?

20. What types of support or assistance would help you to start regular physical activity?

Probes: Would it help to have a coach to help you plan your activities and check in with you occasionally? Would it matter if this person was male or female, young or older?

Past/Changes Over Time

21. Think back to the time in your life that you felt most physically active. Can you describe it to me?

Probes: How old were you? What activities were you involved in? What made it possible at the time to do those things?

22. What has changed over time that has had the biggest impact on your physical activity?

Probes: Since last year, are there any activities that you can no longer do or that have changed? If yes, please tell me a bit more about that. Because of health issues or caregiver responsibilities?

Are there any new activities that you do now, based on your current ability level and circumstance?

23. Do you participate in any regular physical activity programs? How did find out about them? If you don’t participate, are you aware of any (or any more) that you may consider participating in?

Probe: What are the biggest attractions and/or turnoffs?

24. If we were to design a physical activity program that was ideal for you, what would this look like?

Probe: Where would it take place (In your home? In the community?) What sorts of activities would it involve? Where would you like to find out about such a program?

Influence of Aging & Masculine Identities

25. Do you think getting older is different for men and women? Why or why not?

Probes: How is this different? Can you tell me more about what you mean about that?

26. When it comes to changes in physical activity as people age, do you think it is different for men and women?

Probes: Can you give an example from your own life? Do you feel as strong as you once were? How do new or certain types of activities differ?

Closing
27. When we came to this interview today is there something that you thought we were going to ask that we didn’t? Is there anything else that you would like to add to our discussion today?

Thank you so much for your time and insights.

**Field Notes Guide**

**To be completed by the interviewer within 24 hours of the interview**

<table>
<thead>
<tr>
<th>Participant ID:</th>
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</thead>
<tbody>
<tr>
<td>Prepared by:</td>
</tr>
<tr>
<td>Interview Date:</td>
</tr>
<tr>
<td>Starting Time:</td>
</tr>
<tr>
<td>Ending Time:</td>
</tr>
<tr>
<td>Participant chose to illustrate some answers by drawing on paper [yes/no]:</td>
</tr>
<tr>
<td>Location of interview (e.g., participant’s home, community center, etc.):</td>
</tr>
<tr>
<td>Description/your impressions of the neighbourhood:</td>
</tr>
<tr>
<td>Technical Problems (e.g., timing of interview, tape recorder):</td>
</tr>
<tr>
<td>People present:</td>
</tr>
<tr>
<td>Description of the environment (include 5 senses):</td>
</tr>
<tr>
<td>Content of Interview (e.g., use key words, topics, focus, words or phrases that stand out):</td>
</tr>
<tr>
<td>Interviewer’s impressions (e.g., discomfort of participant with certain topics, emotional responses to people, events or objects):</td>
</tr>
<tr>
<td>Nonverbal behaviour (e.g., tone of voice, posture, facial expression, eye movements, forcefulness of speech, body movements, and hand gestures):</td>
</tr>
<tr>
<td>Preliminary Analysis (e.g., interviewer’s questions, tentative hunches, trends in data and emerging patterns, insights, interpretations, beginning analysis, working hypotheses):</td>
</tr>
</tbody>
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