Title: Defining, profiling and locating older people: an inner city Afro-Caribbean Experience

Authors: \*Moorley Calvin R and \*\*Corcoran Nova T

Senior Lecturer, School of Health, Sport & Bioscience, University of East London.

\*\*Senior Lecturer, School of Health, Sport and Science, University of South Wales.

The group labelled ‘older people’ has attracted various definitions, opinions and perspectives across the globe (Victor 2010). The main reason for this is the way different cultures view ageing and the ageing process. The predominant opinion is that being ‘old’ is a biological and social context, for example a calendar age is used to mark ageing linking ‘old’ to biological ageing. There are also commonly held markers of old age for example retirement age, state pension age, or becoming a grand-parent. There is no consensus of what it is to reach old age. In the UK the term is often used to describe those of retirement age, the default age being 65. Even this has been phased out and the legal retirement age has been removed (UK Government Retirement Age 2013). Whilst this might be a positive step in terms of ageing, it further blurs the definitions of ‘old age’ and ‘older people’.

Demographic characteristics of older people in the UK have been previously identified (Tomassini 2005) and now form categories of ageing that are used as standard in the UK. These are the ‘young old’ aged between 65 and 74 years. The ‘old old’ aged between 75 and 90 years and the ‘very old’ those over 90 years. For older adults ageing may be measured in terms of physical and psychological changes predominately focussing on deteriorations. There are three main approaches to defining ageing. The chronological approach, which takes into account the number of years lived. The social meaning of age which takes into account subjective perceptions, for example how the individual feels about themselves, what their age means to them and the social meanings attached to age. The final approach is based on a social construction or structural approach; this is where the social representations of ageing in institutions (e.g. hospitals, prisons, universities etc.) and Government departments’ interest and ideologies define age. For example guidance may be set around the minimum age to retire. It is important to acknowledge these approaches when working with older people, as different age groups and institutions will have varying perspectives on ageing and therefore expectations and stereotypes of older people.

Locating and profiling older people

As individuals age and reach the point where active contribution is no longer possible they may begin to fade out of the fabric of society. This makes it difficult to locate older people particularly in inner cities. Inner cities are generally characterised as vibrant communities with young working populations. Whilst this is true in some areas, for example in Tower Hamlets (London, UK) only 6% of the local population are over 65. However, this still means there are a small proportion of older people living within this area (Office for National Statistics 2012). Cities are fast paced, with services and facilities aimed and marketed at a younger population often with little emphasis on older people. The difficulty in locating older people within this context is predominately linked to the macro (structural and societal) and individual (personal) perspectives. A number of factors contribute to older people’s invisibility within inner cities. Some of these include disability, reduced functional status, personal desire to withdraw from society, accessible transportation, affordable and appropriate housing, lack of community cohesiveness, perceptions of safety in the home and neighbourhood, lack of understanding or support from community services and loss of meaningful relationships (Moorley 2012, Moorley et al 2013).

There are a variety of ways that older people can be located for participation in planning and creating health promotion opportunities. Evidence based guidelines for older people (Lis et al 2008) identify a range of locations where older target groups could be reached. These include using key persons, such as community leaders, and using existing groups associated with older people.

Community context shapes how health promotion works including demographics, economic conditions, values and norms within a community (Kegler et al 2011). As older people tend to rely more on local services, health promotion may be more sustainable if a target group can both be located and offered opportunities within the same context. The relationship between health behaviours and variables such as access to facilities can act as barriers to health promotion. By combining a settings based approach in the targeting of older people access to services are acknowledged. Other advantages to utilising a settings based approach include incorporation of a multidisciplinary stance to health that acknowledges the wider determinants.

Within an inner city context social spaces such as cafes, hairdressers, barbers, local clubs, post offices, convenience stores, places of worship or libraries present opportunities to reach older people. These areas usually already have elements that are catalytic in a settings based approach. These include partnerships, a community focus, availability and access to services or facilities and supportive relationships (Peterson et al 2002). A settings approach may also capture those who are isolated or not participating within formal groups. For example convenience stores have potential to offer a range of healthy food initiatives in inner city areas, or barbers have the potential to offer blood pressure checks (a scheme already in existence in the US) (BBHOP Back Barbershop 2013). Groups of older people may already exist within a setting. This includes organised groups such as craft groups or leisure groups and more informal groups for example monthly get-togethers. Settings also offer access to community gatekeepers (i.e. church leaders) and influential peers who can potentially encourage healthy behaviours. They may also have access to groups who are less visible such as housebound or specific ethnic groups. Key opinion leaders within communities may be helpful in encouraging others to participate and engage within health promotion opportunities.

The most effective health promotion programmes have accurate information about the health determinants and needs of their target group (Corcoran et al 2013). As older people are not a homogenous group identifying key target groups is imperative. The health status of older people is linked to multiple influences and some may experience changes in their health status in a relatively short period of time. In an inner city context there may be complexities linked to experiences of poverty, migration, culture and ethnicity which impact on the design and delivery of health promotion. Involvement of the target group within the planning of health promotion helps to address these issues and fosters participation and sustainability.

To capture a demographic picture of the older population the World Health Organization have produced guidance on healthy ageing profiles (Kanstrom et al 2008). This is a comprehensive plan with 22 indicators suggesting profiling in three sections; a population profile, information about access to health and social support services, a socioeconomic portrait and identification of vulnerabilities and strengths. The population profile includes structure of households and health status indicators such as morbidity and mortality. Access to health and social support services includes values, responsibilities and city delivery. The socioeconomic portrait includes economics, transport and participation of older people. This is a useful technique but may miss the fundamental realities of day-to-day life for older people and the health promotion opportunities available in different inner cities. A hands-on profile compiled by older people could supplement this profile. Standard methods could include community based visits to inner city areas and accessing existing older people groups and services. Data could be collected using interviews, focus groups and other feedback mechanisms. Situating a local spokesperson in a local community setting where feedback can be sought may also highlight health concerns. Less traditional data-collection techniques may also suit older people for example photo or video voice which could also be a means of health advocacy, health promotion and communication (Catalani et al 2012).

Inner cities have potential to be drivers of change for older people as they have a wide range of facilities and resources that can be utilised to improve health. As a society we frame older people based on the biological markers of old age but we neglect to consider the individuality of older people; yet a city is a perfect location to celebrate this diversity. Inner city areas are in a prime location to engage and encourage older people to participate and facilitate a wide range of health promotion opportunities. Locating and profiling older people within these areas offers the catalyst to activate age friendly cities and capitalise on what an inner city can offer to everyone.

Authors note

This editorial originates as a result of Moorley’s experience while undertaking his doctoral studies which examined life after stroke, personal, social and cultural factors – An inner city Afro-Caribbean Experience. In a quest to recruit participants for his study considerable problems were encountered locating older people within an inner city area.

References

 BBHOP Back Barbershop (2013), available at [www.blackbarbershop.org](http://www.blackbarbershop.org) (Accessed on 17 07 2013)

Catalani CECV, Veneziale A, Campbell L, Herbst S, Butler B, Springgate B & Minkler M Videovoice (2012) Community assessment in post Katrina New Orleans *Health Promotion Practice* 13 (1) 18-28

Corcoran N, Bone A & Everett C (2013) Using settings In Corcoran N (ed) Communicating Health 2nd edition 2013, Sage, London.

Government (UK) Retirement Age 2013 available at <https://www.gov.uk/retirement-age> (Accessed on 17 07 2013)

Kanstrom L, Zamaro G, Sjostedt C & Green G (2008) Health ageing profiles. Guidance for producing local health profiles for older people available at [www.euro.who.int](http://www.euro.who.int) ( Accessed on 17 07 2013)

Kegler MC, Rigler J & Honeycutt S (2011) The role of community context in planning and implementing community based health promotion projects. *Evaluation and Program Planning* 34 246-253

Lis K, Reichert M, Cosack A, Billings J & Brown P (ed) (2008) Evidence based guidelines on health promotion for older people Austrian Red Cross, Vienna

Moorley C, (2012) Life after stroke: Personal, social and cultural factors – an inner city Afro-Caribbean experience PhD thesis, University of East London

Moorley C, Goodfellow B & Corcoran N (2013) Reaching unreachable groups and crossing cultural barriers In Corcoran N (ed) Communicating health strategies for Health Promotion 2nd edition, Sage, London.

Office of National Statistics (ONS) Census first results: London boroughs’ populations by age and sex 2012 available at <http://data.london.gov.uk/datastorefiles/documents/2011-census-first-results.pdf> last (Accessed on 17 07 2013)

Peterson J, Atwood JR & Yates B (2002) Key elements for church based health promotion programs: Outcome based literature review. *Public Health Nursing* 19 (6) 401-411

Tomassini C, (2005) The demographic characteristics of the oldest old in the United Kingdom. *Population Trends* 120 (Summer) 15 -22

Victor C, (2010) Ageing, health and care Policy Press, Bristol