The Application of Salutogenesis for Social Support and Participation: Toward Fostering Active and Engaged Aging at Home

25

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Introduction

The world population is growing older; one person in five was aged 60 or over in 2017. According to projections, this proportion will be one in four by 2050 (United Nations, 2017). The majority of older adults reports living with chronic illnesses. Almost half have or will have disabilities at one point during their aging (Turcotte and Schellenberg, 2007), limiting their mobility within their home and community. Maintaining or improving the aging populations' health and well-being is an important challenge that can be addressed by targeted interventions on health determinants. It is important to plan and implement innovative and cost-effective population health interventions tackling modifiable determinants of health, including social support, participation, and mobility. Because it aims to generate, maintain, and promote health, rather than solving illness and pathology issues, a salutogenic framework is promising for healthy and active aging at home. Social support and participation are important factors that help older adults cope with stressful events and everyday life challenges. This chapter defines social support and participation, in contrast to social isolation and loneliness. Policies and programs are discussed to demonstrate the contribution of interventions using a salutogenic framework. Finally, opportunities and challenges in planning and evaluating policies and programs are addressed.

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Salutogenesis and Older Adults

From a salutogenic perspective, a person's health can be represented as a point on a continuum, located between illness and healthiness, or health "ease and dis-ease", using Antonovsky's terminology (1993b). Moving in the healthy direction of this continuum requires a person to have a global understanding of their individual and contextual situation and possess the capacity to know and use the available resources to help them cope with adverse life events and still move forward (Eriksson, 2017). Such understanding of one's situation is the sense of coherence (SOC) and, according to Antonovsky (1993a), is a global orientation a person has to the world, allowing them to perceive it as comprehensible, manageable, and meaningful. In other words, it is about feeling confident that life events that may negatively or positively impact health and well-being are worthy of investment and engagement and that there are resources that can be used to cope with them. The latter are referred to as generalized resistance resources (GRRs), found at the personal (e.g., material resources, personality traits, knowledge, experiences) or the community level (e.g., social support, culture, religion; Horsburgh and Ferguson, 2000). Research showed that GRRs, including social support, were associated with older adults' SOC and their location on the health continuum (Wiesmann and Hannich, 2010). If GRRs are available, individuals developing a stronger SOC can maintain or improve their health.

As it stabilizes by the end of young adulthood, shaped by personal and work experiences, social class, gender, and culture, Antonovsky (1993b) nevertheless suggested that older adults might be limited in developing their SOC. Reporting that "*those of us who are less fortunate will increasingly see the world as incomprehensible, unmanageable and meaningless*" (Antonovsky, 1993b; p. 9), such belief is not particularly optimistic for older adults with a lower SOC. Too many adverse late-life events could even worsen such perspective, as they were associated with a decreased SOC (Lövhem et al., 2013). Still, subsequent research showed that the SOC

could be maintained or even developed, even at a very late age (Koelen et al., 2017).

From a health promotion point of view, maintaining or developing the SOC is important because it was associated with better physical health in young-old and old-old Canadians (Forbes, 2001). Antonovsky also believed that the retirement from employment is such a unique and radical transition that the person cannot rely solely on preexisting GRRs, but has to change previous mechanisms to cope with new challenges (Sagy and Antonovsky, 1994). For the Israeli cohort studied by Sagy and Antonovsky (1994), family ties and informal interpersonal engagement became the most meaningful life domains post-retirement. Indeed, older adults still have access to GRRs to cope and shape meaning for possibly very impactful later life events, such as retirement, death of loved ones, and disabilities. The promotion of social relationships could thus positively influence the development of SOC, especially for life meaningfulness (Wiesmann and Hannich, 2010). Allowing a person to benefit from experiences, family ties, or close and supportive relationships would provide meaning to the challenges and contribute to an inner strength to cope with late-life challenges (Tan, 2015). Social support and participation can help older adults in this coping.

Social Support and Participation

Social support and participation are important factors of active and engaged aging associated with favorable health outcomes (Bowling, 2005), notably because it allows older adults to stay integrated with their community. **Social support** can be defined as “*the social resources that persons perceive to be available or that are provided to them by non-professionals in the context of both formal support groups and informal helping relationships*” (Cohen et al., 2001, p. 4). This definition distinguishes perceived support (the belief that support is available from members of one’s network) and received support (mobilization and expression; Gottlieb and Bergen, 2010). Antonovsky (1979) highlighted that social support and network contribute to the person’s sense of coherence because it influences how one views the world and how the environment is perceived as meaningful and comprehensible (Eriksson and Lindström, 2005). Social support was identified as a GRR because relationships of trust can provide the right resources to meet older adults’ specific challenges (Bryant et al., 2001). While sometimes mentioning social ties, Antonovsky mostly addressed the role of family ties when transitioning between labor and retirement (Antonovsky et al., 1990; Sagy and Antonovsky, 1994). More recently, researchers investigated social relationships and their contribution to the SOC among older adults. For example, higher levels of social support in older

adults were found associated with superior self-efficacy and problem-solving (Trouillet et al., 2009), which was linked to the manageability domain of the SOC by Antonovsky (1993a), helping a person cope with stressful life events. Although not exclusively in older adults, the strengthening of social support was also shown to contribute to improving or restoring the SOC for people with mental health problems (Langeland and Wahl, 2009). Social support contributes to a person’s social integration and provides opportunities to assist others, improving self-esteem.

Additionally, different forms of social support were also found to be associated with health and well-being. Greater perceived social support was associated with better self-perceived health (Smith et al., 2013). Received support also influences older adults’ self-esteem and community belonging (Krause, 2007). Still, it could revive conflicts with close ties or be interpreted as a threat to older adults’ sense of independence and control, which is possibly detrimental to their health and well-being (Uchino, 2009). In addition to the number and quality of social ties, active involvement in community activities was shown to be linked to health and SOC.

Social participation can be defined as the “*person’s involvement in social activities that provide interactions with others in society or the community*” (Levasseur, Richard, Gauvin, and Raymond, 2010, p. 2144). These social activities can be formal, such as volunteering or being engaged in a community organization, or informal, such as helping a neighbor, visiting friends, or attending a cultural event (Couton and Gaudet, 2008). Social participation is associated with many health-protective effects, notably fewer disabilities (Lund et al., 2010) and depressive symptoms (Glass et al., 2006), greater well-being (Gilmour, 2012), and self-perceived health (Lee et al., 2008), the preservation of cognitive functions (Glei et al., 2005), shorter hospital stays (Newall et al., 2014), and lower risk for all-cause mortality (Holt-Lunstad et al., 2015). Social participation fosters the development of relationships and engagement with others in the community, which were shown to be associated with the feeling of attachment to others (Grewal et al., 2006). When older adults have regular interactions with younger people, they report better self-reported health, plausibly because they feel more valued, included, and appreciated (Ronzi et al., 2018). When social activities enable the sharing of resources and expertise within a group, they are meaningful and contribute to providing purpose in the older person’s life, which is a fundamental domain of SOC (Antonovsky, 1993b).

Social Isolation and Loneliness

Social support and participation, including their associations with positive health outcomes, are different than social isolation and loneliness. Older adults in a situation of **social**

isolation have fewer fulfilling social ties, social interactions of inferior quality, and a weaker sense of belonging and social engagement (Nicholson, 2009). Older adults are at higher risk of being isolated when living alone, having a low income, presenting poorer health or restricted mobility, and having no children or close family members (Keefe et al., 2006). Life events were also found to be associated with social isolation, such as the loss of a loved one, retirement, driving cessation, or relocation to a long-term care facility (Keefe et al., 2006). Although it was found to be associated with limited social support (Tomaka et al., 2006), fewer social interactions, and lower participation in social activities (Cornwell et al., 2009), the association of social isolation to adverse health outcomes differ from those of low social support and participation. Older adults in a situation of isolation often report more health-risk behaviors such as smoking and being physically inactive than those who are socially integrated (Cornwell et al., 2009). Social isolation has been associated with poorer self-rated physical and mental health (Cornwell et al., 2009), as well as a greater risk of dementia (Fratiglioni et al., 2000), cardiovascular disease in response to stress-related events (Grant et al., 2009), and suicide (Rapagnani, 2002). From a salutogenic and health promotion perspective, reducing social isolation can have different outcomes than fostering social participation, which is more likely to be regarded as a GRR, potentially contributing to the SOC (Ronzi et al., 2018).

Loneliness is a negative subjective state experienced when a person's social ties are not sufficiently fulfilling (Cornwell et al., 2009). Because some people may prefer to be alone without experiencing negative feelings, it is recommended not to study social isolation independently of loneliness. Loneliness was more common in older women than men and was associated with living alone or being widowed (Victor et al., 2006). However, men were less likely than women to report being lonely, plausibly because of the risk of stigmatization (Borys and Perlman, 1985). Compared to reduced social support, loneliness was more strongly associated with lower self-perceived mental health and the presence of depressive symptoms (Cornwell and Waite, 2009). As for social isolation, loneliness is associated with adopting multiple health-risk behaviors, such as physical inactivity and smoking (Shankar et al., 2011). Both social isolation and loneliness may contribute to adverse health effects through these health-risk behaviors.

In summary, higher social support and participation do not only diminish the risk of illnesses associated with social isolation and loneliness. Indeed, social support and participation have a distinct and positive contribution to the older adults' sense of coherence and health. Aging at home allows older adults to keep relationships built over the years within their community and facilitate the preservation of their SOC.

Environment and Salutogenesis for an Active and Engaged Aging at Home

Inspired by Antonovsky's salutogenesis and Lawton's ecological model of aging (Lawton and Nahemow, 1973), researchers showed that SOC, health, and well-being are associated with several characteristics of the local environment, which facilitate mobility and participation in community activities (Stokols, 1992; Wister, 2005). For example, safer environment, urban revitalization programs, accessible and safe public transportation, reduction of noise and air pollution, and availability of walking pathways influence the health and well-being of aging adults (Wister, 2005). According to the ecological model of aging (Lawton and Nahemow, 1973), the person, including his cognitive, physical, and mental competencies, interact with the environmental characteristics, facilitating or hindering these competencies. This interaction provokes an adaptive behavior and emotion (satisfaction if successful, stress otherwise). Lower competence increases the likelihood that the person's behavior will be dependent on the environmental factors and may not be able to operate within the environment without assistance (Lawton, 1990).

Environments that promote health can be developed or encouraged through **aging at home** strategies. Wished by most of them (Farber et al., 2011), strategies related to aging in place can help older adults remain in their homes, despite increasing difficulties (Fry, 2012; Iecovich, 2014). An aging at home strategy promotes important environmental characteristics such as physical accessibility, service proximity, security, recreational resources, housing, and transportation (Plouffe and Kalache, 2010), aimed at improving the mobility, health, and well-being of older inhabitants and their communities. The SOC may be stronger in older adults living in their homes than in communal-care facilities (Haak et al., 2011; Tan, 2015). Aging at home may provide a sense of security, help preserve memories, and provide better proximity to friends, neighbors, and kin (Rowles and Bernard, 2013). Aging at home contributes to all three domains of the SOC, that is, meaningfulness, comprehensibility, and manageability (Koelen et al., 2017). For example, attachment to a place might help individuals maintain a sense of control (Rowles, 1983), which is important for comprehensibility and manageability. Maintaining access to GRRs, such as social support and participation, increases the likelihood of a stronger SOC and health and well-being (Tan, 2015).

Aging at home is partly about providing access to GRRs, notably the retention of social support within the community (Iecovich, 2014), which helps older adults cope with stressful events and contribute to their SOC. To participate socially and maintain social network and support, older adults must be able to move within their community,

regardless of their physical disabilities. Understood as a cornerstone to the social integration of the persons into their community, **mobility** is defined as “*the ability to move oneself (e.g., by walking, by using assistive devices, or by using transportation) within community environments that expand from one’s home, to the neighborhood, and regions beyond*” (Webber et al., 2010, p. 1). Older adults with reduced mobility reported lower participation in social activities (Rosso et al., 2013), which put them at a higher risk of social isolation. Limited mobility restricts the life space, that is, the “extent of travel into the environment, regardless of how one gets there” (Stalvey et al., 1999, p. 472). Mobility is affected by factors such as physical abilities, gender, culture, and income (Webber et al., 2010) and can deteriorate with driving cessation in areas with limited alternative transportation options (Marottoli et al., 2000). Also, an inferior SOC in older adults was found to increase the risk of reduced mobility (Avlund et al., 2003), suggesting the importance of providing equal access to GRRs within a community. Because the life space encompasses the potential GRRs that older adults can rely on, it has strong SOC and health implications.

Mobility is important in enabling social participation, especially for adults with a disability (Verdonschot et al., 2009). Accessibility in the physical neighborhood environment is also essential for older adults with a disability (Richards et al., 1999; Verbrugge et al., 1997) or frailty (Fairhall et al. 2011). In Canada, rural women that wished to participate more were more likely than rural men to be constrained by transportation problems (Naud et al., 2019), illustrating that mobility options are not equally distributed across the aging populations. In general, older adults in rural areas are more dependent on private car use or on informal support (Davis and Bartlett, 2008), which may be a limiting factor in their social participation within the community.

Older adults’ SOC, relying notably on GRRs made available through their social support and participation, is thus associated with the local environment. By modifying factors that can foster social support and participation and decrease social isolation and loneliness, SOC, health, and well-being could be enhanced (Bowling, 2005). Moreover, because they are associated, interventions targeting one dimension could potentially affect others (Dickens et al., 2011). For example, social isolation is associated with reducing social support and participation (Hombrados-Mendieta et al., 2013). These interventions, provided with a relatively modest cost compared to health infrastructure and equipment, could reduce healthcare spending (Kaye et al., 2009). Thus, policies and programs should be planned, implemented, and evaluated to facilitate aging at home. Improving older adults’ ability to identify and use the community’s GRRs may also strengthen their sense of meaningfulness, manageability, and comprehensibility.

Aging in Place Policies and Programs Fostering Mobility and Social Support

Over the past decades, aging in place policies and programs addressing social support, participation, isolation, loneliness, and mobility have shown varying degrees of effectiveness. On the one hand, policies are defined as contextual interventions, coming from consensus-based negotiations between multiple actors, intended to be implemented into practices that create conditions in which the scope of options available in deciding what to do is reduced or altered (Ball, 1993). On the other hand, a program can arise from policies and an organized and planned effort to ameliorate social conditions (Rossi et al., 2018). Considering that the SOC is a disposition orientation that can be developed over time (Read et al., 2005), the following sections introduce examples of policies and programs that had an objective of increasing the levels of SOC in older adults by promoting social support, participation, and mobility, which facilitate aging at home.

Policies

Over the last three decades, health promotion policy frameworks were elaborated using an ecological model to facilitate social participation and reduce the risk of isolation. Evaluating policy trends, Lui et al. (2009) found that the current discourse on aging has redirected the major determinants from economic or welfare issues to matters of social inclusion, engagement, and community development, which are in line with salutogenesis. In their policy review, Eriksson and Lindström (2008) showed that before the 1980s, health promotion was mostly about reducing risk behaviors by health education. Although not explicitly addressing older adults, the seminal *Ottawa Charter for Health Promotion* (World Health Organization, 1986) aimed at providing individuals and communities more control over the health determinants (Eriksson and Lindström, 2008), notably by promoting supportive environments, community action, and leisure as a source of health and well-being. More extensive than the Charter, the WHO’s *Active Aging Policy Framework* (World Health Organization, 2002) emphasized the process of active aging as a multidimensional key mechanism for healthy aging, aimed at “continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labor force” (p. 12). The framework promoted environments that contribute to increase older adults’ autonomy, by alleviating environmental barriers (e.g., inaccessible transportation, discontinuous sidewalks, and heavy traffic) and increasing opportunities for resource acquisition, such as social participation. Most importantly, it recommended that decision-makers strengthen community initiatives, voluntarism, peer

mentoring and visiting, family caregivers, intergenerational programs, and outreach services. Finally, the framework introduced mobility as a key factor for a full participation in the community, regardless of the person's abilities and highlighting specifically the contextual differences between rural and urban environments (World Health Organization, 2002).

More recently, the guide *Global Age-Friendly Cities* (World Health Organization, 2007) proposed a framework to implement easily applicable age-friendly policies and programs at the national and regional levels, which was recognized by many governing bodies (Rémillard-Boilard, 2018). Defining mobility as a key factor for active aging, the framework highlights the importance of available and affordable transportation options. This is especially vital for older adults with a disability or frailty, allowing them to reach their chosen destinations and participate in community activities. Indeed, mobility allows older adults in the formal and informal life of their communities. Universal accessibility, affordability, and diversity of the activities are also highlighted in the framework. Simultaneously, the framework addressed the various reasons that could lead older adults to social isolation and recommends outreach programs to provide them with social connections with the community. The implementation of social programs may be facilitated and oriented by the models of governance suggested by policies (i.e., top-down or bottom-up) and emphasizing either the physical or the social environment (Lui et al., 2009).

Programs

Several health promotion programs aim to develop access and knowledge to resources, notably by facilitating social interactions and mobility for older adults living in their community. Although not necessarily developed from a salutogenic theory, the programs can plausibly enhance the SOC and, subsequently, older adults' health and well-being. The following paragraphs present: (1) three programs relying on passive social involvement; (2) five programs relying on active social involvement, and (3) two programs targeting the community rather than the individuals. These programs provide opportunities for social activities and build social support within the older adults' communities, aiming to maintain or improve health and well-being.

Some programs encourage older adults to gather outside the participants' homes but mostly in passive social gatherings, such as educational programs promoting healthy behaviors. Such programs may enhance SOC by improving the knowledge and use of local resources available to older adults. Still, these programs do not necessarily increase social participation or decrease social isolation. For example, Tan (2015) evaluated a Resource Enhancement and Activation Program, a self-care program facilitating aging at home or in the community, helping older adults develop resilience

and use resources optimally to maintain health. The 12-week program involved 64 aging Singaporeans, who participated in 24 group activities about nutrition, physical activity, mental health, social capital, preventive health services, injury prevention, and environment, contributing to all three domains of the SOC (Tan et al., 2014). Following the program, the participants reported a better knowledge of available resources, developed new skills, and enjoyed sharing their experiences with others. Compared to a control group that did not receive an intervention, the participants improved their overall SOC, specifically in the comprehensibility and manageability domains, but did not differ in loneliness (Tan, 2015). In a sparse rural area in Galicia, Spain, older adults were recruited for 9 months to participate in three weekly mobility workshops: cognitive stimulation, craft with others, and exercise (Dumitrache et al., 2017). After the intervention, the participants considered they had more opportunities for leisure activities than before. Additionally, older participants showed lower risks of cognitive impairment, which contributed to a more positive perception of their quality of life and mental health (Dumitrache et al., 2017). The *University of Queensland Driver Retirement Initiative*, in Australia, held weekly meetings for 6 weeks with urban older adults that stopped driving (Liddle et al., 2014). The meetings involved information sharing, group discussion, speakers, practical exercises, and outings. Compared to a control group, the participants had more activities outside the home, regardless of their self-perceived health (Liddle et al., 2014). They also used alternative transportation options (e.g., walking, public transit, volunteer driver programs, and paratransit) more often than adults in the control group and were more satisfied with their transport situation. The participants to the meetings felt more confident of staying involved within their community and in meaningful activities without driving (Liddle et al., 2014), which demonstrates that informing and providing relevant practical mobility exercises can plausibly positively influence the manageability domain of SOC.

Other programs emphasize an active social involvement of older adults through social activities and workshops. While such programs are not aimed at increasing knowledge about available local GRRs, they help older participants build social support and increase their social participation, improving their sense of manageability and meaningfulness, two domains of the SOC. For example, the *Volunteer Friendly Visitor Program* in Ontario, Canada, paired voluntary undergraduate students with older adults in a situation of isolation, to socialize for about 3 hours every week (MacIntyre et al., 1999). Activities mutually chosen included short walks, talking or listening, assisting with care activities, reading aloud, and writing letters. Compared to a control group receiving no visitor, the program was shown to foster health promotion in many aspects, notably the participants' self-worth, social support, and life satisfaction increased. In the Canadian province of Quebec, the

Personalized citizen assistance for social participation peered a trained volunteer with an older adult with a disability for 6 months (Levasseur et al., 2016). The volunteer assisted the older adult with social and leisure activities self-reported as challenging to accomplish (such as walking inside or outside the home or playing games requiring cognitive abilities). Their participation in social and leisure activities was improved, in addition to their mobility, and they perceived fewer barriers in their social environment (Levasseur et al., 2016). The *Men's Shed* is a growing social activity intervention, providing a communal space for older men to meet, socialize, learn new skills, and participate in practical activities with other men (Milligan et al., 2016). In Winnipeg, Manitoba, a Men's Shed program housed in a seniors' center recruited older male participants to engage in activities such as woodcarving, cooking, game playing, or gardening (Reynolds et al., 2015). The program successfully increased the participants' social network, improved their mental health, and generated stronger bonds with other men. The Finnish initiative *Volunteering, Access to Outdoor Activities, and Well-being in Older People* assigned retired trained volunteers with older adults with severe difficulties accessing the outdoors independently (Rantanen et al., 2015). Together, they had weekly out-of-home activities (e.g., running errands or recreational activities) for 3 months. The intervention effectively improved the participants' satisfaction with their physical capacity, notably by identifying, facing, and solving barriers for outdoor activities, making the outdoors more accessible (Rantanen et al., 2015). Lastly, in a Japanese intergenerational program, older trained volunteers were recruited for reading picture books every week to children at school or kindergarten (Murayama et al., 2015). Such activities allow older adults to care for others by transferring knowledge and wisdom to a younger generation, positively affecting their meaningfulness. After the 3-month program and compared to a control group that did not engage in intergenerational activities, participants reported higher levels of their overall SOC and all three domains. Additionally, superior meaningfulness was found to mediate lower levels of depressive mood (Murayama et al., 2015).

Finally, some programs target the community rather than the individual. These programs provide older adults with new resources or increase their accessibility to improve their SOC. In a rural region in Quebec, Canada, a community development initiative combined with an action research program was instigated by local community partners (Clément et al., 2018). Public consultations were held to identify the needs of the community's older residents at risk of social isolation and define the most relevant initiatives. They developed the *Benevolent Community*, aimed at locating older adults in a situation of social isolation and assisting them in developing social connections. A website was created to provide information on social activities and services, and transportation opportunities were increased for older adults with disabilities and lacking transportation options (Levasseur et al., 2021).

The American *Naturally occurring retirement communities (NORC) supportive services program* (Bedney et al., 2010) promotes age-friendly transformations of housing developments not planned for older adults (e.g., apartment buildings, condominiums, neighborhoods, small towns, or rural areas). In hundreds of housing developments across the United States, older residents, building managers, and community partners cooperated to create a network of services and volunteer opportunities that promote aging in place. For example, building managers and community partners coordinate the efforts of voluntary support systems, promote social support among older residents, and enhance the accessibility and affordability of existing services (Greenfield et al., 2013). Bedney et al. (2010) surveyed the residents of the NORC. They found that the majority of them talked to more people and increased their participation and social network than before their participation. The NORC program also increased older residents' engagement in out-of-home activities and used of community services. Asked to self-rate their health, almost three residents in four reported that they felt healthier than before their participation in the program (Bedney et al., 2010).

In summary, individual or community programs aimed at increasing access or knowledge to local GRRs, notably through mobility, social support, and participation, can positively impact older adults' SOC, health, and well-being. By improving older adults' capacities and knowledge of GRRs, these programs can help them cope more easily with challenges of the daily life within their community, which can be facilitated by a stronger SOC (Tan, 2015), but simultaneously also contributes to strengthening the SOC (Koelen et al., 2017). An active and socially integrated aging allows older adults, with or without disabilities, to continue to live in their community and gain benefits from their long-standing assets. Still, intervening on older adults and their communities requires researchers, community partners, and decision-makers to tackle several challenges.

Opportunities and Challenges Related to Planning and Evaluation

The current policy trend, which targets health promotion, social inclusion, and engagement within the community (Eriksson and Lindström, 2008; Lui et al., 2009), offers many opportunities to plan and implement salutogenic programs for older community dwellers. Challenges have nevertheless to be addressed, notably the scarcity of evaluated salutogenic programs aimed at older adults, the adaptation of health promotion interventions to their geographical context, and the elaboration of a more inclusive discourse about aging in place.

There is an abundance of recent studies interested in aging populations, using a salutogenic framework, which provides the theoretical grounds required to plan and evaluate such initiatives. Indeed, longitudinal studies have demonstrated

that older adults' SOC can be improved, even at later ages (Lövheim et al., 2013; Murayama et al., 2015). Such demonstration and potential replications are essential in justifying future interventions. Other studies have found associations between superior SOC and positive health outcomes in older adults (Borglin et al., 2006; Eriksson and Lindström, 2005; Koelen et al., 2017), but mostly cross-sectionally (Tan, 2015). Tan's (2015) synthesis of published salutogenic empirical evidence showed the scarcity of literature evaluating older community dwellers' interventions. Using the lenses of salutogenesis, such evaluations are important to provide measurements of the SOC and access to GRRs (Antonovsky, 1993a). Consequently, evaluations measuring the impacts of the intervention on health outcomes and well-being are also needed. Fortunately, there are promising community-based research protocols published (Levasseur et al., 2017; Seah et al., 2018), which could provide further evidence for the effectiveness of the salutogenic framework.

Programs well-tailored to their environmental context, for example, rural neighborhoods, could be effective for health promotion. Rural older dwellers may be further at risk of social isolation due to a lack of transportation options and resources (Keefe et al., 2006). Indeed, rural communities' declining resources reduce older rural community dwellers' access to GRRs because they are less mobile (Milne et al., 2007), which can limit their SOC's level and lower their capacity to cope with daily life activities and stressful events. The improvement of social support and the promotion of social participation for older adults living in a rural setting is particularly important because they can increase GRRs accessibility, health, and well-being. As evidence of policy and program effectiveness is still equivocal and fragmented, improved knowledge on adapted interventions may help facilitate aging in place strategies, especially in rural context (Milne et al., 2007). Unlike rural areas, suburban municipalities are not addressed in the World Health Organization's frameworks (World Health Organization, 2002, 2007), and very few ecological interventions were held in this setting (Lord and Luxembourg, 2007). As American suburbs have the most rapid growth in adults aged 65 and over, growing by 39% since 2000 (Igielnik and Brown, 2018), the lack of interventions for these areas could be a challenge in the following decade. Indeed, suburban areas have specific characteristics (e.g., high rates of car ownership, neighborhoods designed for families) that may be constraining to older adults' mobility without a driving license (Brook Lyndhurst Ltd, 2005). The private car's reliance increases the risk of mobility limitations and social isolation for older suburban dwellers (Stjernborg et al., 2015). Aging in place strategies should be promoted regardless of the living context.

Aging in place strategies were shown to be compatible with salutogenic and health promotion approaches, mainly by improving GRRs accessibility through social support and mobility options. A better comprehension of the person-

environment interactions and the development of indices to predict potential mismatches (e.g., older adults with mobility limitations living in resource-scarce neighborhoods), notably in relation to social needs (Oswald et al., 2005), could provide further opportunities for health promotion interventions. However, aging at home strategies have been criticized as not well adapted for all aging populations, notably low-income and frail older homeowners (Golant, 2008). Discourses about aging and healthcare strategies should be more inclusive of older adults with limited abilities or lower socioeconomic status. Home maintenance in older adults may incur considerable financial costs and increase stress and risk of injuries (Coleman et al., 2016). There are promising avenues for effective communal-care facilities, such as the NORCs and the Green Houses program (Greenfield et al., 2013; Kane et al., 2007). Tan's (2015) review showed that older adults in communal-care facilities had a lower SOC than those living in the community. Because living in the community is not accessible to all, salutogenic interventions aimed at improving the SOC for older adults living in communal-care facilities should also be of interest to researchers.

Conclusion

The current health and aging policy context are favorable to applied salutogenic research, especially for older adults living in the community. Indeed, interventions targeting both the individuals and the communities can enhance the SOC of older adults by providing them opportunities for social interactions and increasing their life space with new mobility options. By increasing their SOC, which predicts health and well-being, older adults can cope more easily with daily life activities and adverse life events, such as retirement, deaths of loved ones, and disabilities. Better coping strategies can allow older adults to live longer at home, surrounded by their peers, and maintain meaningful activities. Opportunities to increase accessibility to GRRs through social interactions and mobility options are numerous. Still, challenges need to be addressed to provide evaluated and effective interventions, regardless of their abilities, environmental context, or culture. Researchers, decision-makers, and community partners can apply a salutogenic framework to policies and interventions by improving knowledge and access to social resources that help seniors cope with everyday life challenges.

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