

Building the Foundation for a Health Education Program for Rural Older Adults

Abstract

We explored rural older adults' perceptions of health to inform health promotion program development, using social marketing as our framework. Participants in seven focus groups viewed independence and holistic health as indicators of health and identified healthful eating and physical activity as actions to promote health. Barriers to these actions included physical limitations, social factors, financial considerations, motivation issues, and information confusion. Participants desired education that improves knowledge and skills, provides socialization opportunities, and occurs in familiar, affordable locations. Our findings can be useful to others developing health programming for rural-residing older adults. Also, we show that applying social marketing principles during formative assessment can be helpful in tailoring programs to audience interests and concerns.

Keywords: [rural health](#), [aged](#), [health promotion](#), [holistic health](#), [social marketing](#)

Seung Eun Jung

Assistant Professor
Department of Human
Nutrition and
Hospitality
Management
The University of
Alabama
Tuscaloosa, Alabama
sejung@ches.ua.edu

Stephany Parker

Associate Research
Professor
Department of
Nutritional Sciences
Oklahoma State
University
Stillwater, Oklahoma
steph.parker@okstate.edu

Janice Hermann

Nutrition Specialist
Oklahoma Cooperative
Extension Service
Department of
Nutritional Sciences
Oklahoma State
University
Stillwater, Oklahoma
janice.hermann@okstate.edu

Joshua Phelps

Assistant Professor
University of Arkansas
for Medical Sciences
College of Health
Professions
Department of
Dietetics and Nutrition
Little Rock, Arkansas
japhelps@uams.edu

Yeon Ho Shin

Assistant Professor
Department of Human
Nutrition and
Hospitality
Management
The University of
Alabama
Tuscaloosa, Alabama
yshin9@ches.ua.edu

Introduction

The population segment "older adults," those 65 years of age and older, is the most rapidly increasing segment in the United States (Population Reference Bureau, 2015). The Administration on Aging (2016) has estimated that the proportion of older adults will reach nearly 22% of the population by 2040. Furthermore, approximately 20% of older adults reside in rural areas (Administration on Aging, 2016). Rural older adults often experience a

disparate prevalence of chronic disease, decline in functional independence, and reduced quality of life (Baernholdt, Yan, Hinton, Rose, & Mattos, 2012). Oklahoma, in particular, has a large percentage of older adults with poor health statuses living in rural areas (Oklahoma State Department of Health, 2014; Oklahoma State University Center for Rural Health, 2008).

Maintaining optimal health greatly improves older adults' successful aging (Bishop, Martin, & Poon, 2006). In addition, programs promoting healthful aging can improve older adults' health and well-being. (Friedmann, Shah, & Hall, 2015). Conducting formative assessment to gain an understanding of a target audience's needs, concerns, and preferences before implementing a program has been identified as a way to enhance relevance of health promotion programs (Bandayrel & Wong, 2011). Additionally, social marketing has been widely used as a framework for guiding such formative inquiry (Grier & Bryant, 2005). Applying social marketing principles (SMPs) to the formative process of program development provides a means of exploring audience-specific perspectives. Related to development of health programming for older adults, there has been an increase in qualitative studies investigating older adults' health perceptions (Song & Kong, 2015), but few studies have focused on *rural* older adults' health perceptions.

Our purpose in undertaking the study reported here was to conduct formative assessment using SMPs to explore rural older Oklahomans' perceptions of health and health education to inform development of a program to promote health among rural older adults. SMPs, as described here, can be applied to a wide array of Extension disciplines to tailor programs to audience needs and interests.

Methods

Framework

Our study was qualitative and involved the use of focus groups as the means for formative assessment. The four principles integral to social marketing are known as *product*, *price*, *promotion*, and *place* (Grier & Bryant, 2005). We applied relevant operational definitions to those principles. *Product* refers to benefits older adults experience as a result of maintaining health, as well as actions that could lead to those benefits. *Price* refers to barriers older adults experience performing the actions that lead to benefits. *Promotion* refers to channels through which health promotion programs could be effectively delivered to older adults. *Place* refers to locations where older adults could access health promotion programs. We framed our focus group questions with the idea of using the SMPs to guide inquiry; that is, for each SMP, we developed questions to elicit responses specific to that principle (Table 1).

Table 1.

Social Marketing Principles and Associated Focus Group Questions

Principle

Question(s)

Product

- What does being healthy mean to you?
- What are some major health concerns of older adults?
- What are some things older adults can do to be healthy?

- | | |
|-----------|---|
| Price | <ul style="list-style-type: none">• What are some reasons older adults may not eat as healthy of a diet?
• What are some reasons older adults may not be as physically active? |
| Promotion | <ul style="list-style-type: none">• What are some ways older adults like to get information about eating healthy and physical activity?
• If you could imagine the ideal program that would encourage older adults to eat a healthy diet and be physically active, what would it look like?<ul style="list-style-type: none">◦ What people do older adults listen to regarding healthy eating and physical activity?
◦ What would older adults like to learn?
◦ What would motivate older adults to attend a healthy eating and physical activity program? |
| Place | <ul style="list-style-type: none">• Where would be the best place for older adults to have programs about eating healthy and physical activity? |
-

Participant Recruitment

Oklahoma Cooperative Extension Service (OCES) family and consumer science county educators recruited adults 65 years of age and older via news releases and flyers to participate in the focus group sessions. Recruits were from Oklahoma towns meeting U.S. Department of Agriculture Economic Research Service rural definition #1, areas with 2,500 to less than 10,000 people, or rural definition #2, areas with 10,000 to less than 50,000 people (U.S. Department of Agriculture Economic Research Service, 2016).

Focus Group Sessions

Our team conducted seven focus group sessions, four in towns with populations less than 10,000 and three in towns with populations of 10,000 to less than 50,000. Focus group sessions were held in the OCES county office in each town and ranged in size from four to eight participants. Prior to beginning a focus group session, participants were asked to read and sign an informed consent. A trained moderator conducted and audio recorded the focus group sessions, and an assistant moderator took notes. The Oklahoma State University Institutional Review Board for Human Subjects approved the research protocol.

Data Analysis

A member of our team transcribed the focus group audio recordings verbatim. Following initial transcription, a second team member conducted quality checks on the transcripts. We used a comparative method to analyze the

data (Charmaz, 2014). Two team members independently analyzed verbatim transcripts at a line-by-line level and assigned initial codes. Initial coding consisted of identifying relevant themes and subthemes. Afterward the team members reviewed their independent coding together and discussed any discrepancies until consensus was reached. Team members compared quotes across focus group sessions and included themes if quotes supporting a theme were identified in three or more focus group sessions. After consensus was reached on initial coding, team members conducted focused coding. Focused coding consisted of organizing consistent themes into categories according to the SMPs of product, price, promotion, and place.

Results

Demographics

Forty-seven adults, 65 years of age or older, participated. The majority of participants were female (85%). Eighty-one percent of participants were White, 11% were Native American, 6% were Hispanic, and 2% were Asian American. Forty-three percent of participants were 65–74 years old, 40% were 75–84, and 17% were 85 or older. Similar percentages reported living alone (53%) and living with others (47%). Comparable percentages also reported having incomes of \$22,000 or less (55%) and above \$22,000 (45%). Additionally, comparable percentages reported living in communities with populations less than 10,000 (45%) and communities with populations of 10,000 to less than 50,000 (55%).

Qualitative Findings: Product

To determine the product for older adult health education, the moderator asked participants a series of questions exploring their perceptions of being healthy. Two themes emerged in relation to older adults' perceptions of health. First, participants consistently discussed the importance of being independent throughout the life course. Second, participants described a holistic orientation to overall health. Participants identified healthful eating and physical activity as actions older adults could take to maintain independence and overall health.

Independence

The importance of independence was conveyed through phrases such as "do for yourself" and "not having people wait on me." Many participants stated that they wanted to be able to do things for themselves and avoid relying on others. In terms of general health, functional independence was conveyed as important. Participants wanted to continue doing things they enjoyed throughout life; maintaining health was considered essential to completing day-to-day activities without seeking help from others. Independence was also expressed in terms of enjoyment—that is, being "able to enjoy [one's] life to the fullest to the last minute." Maintenance of familial roles and responsibilities was also related to independence, as participants shared the importance of continuing in their family roles for as long as possible. Some participants had active roles with grandchildren, and continuing in these roles was a priority. For example, one participant stated, "I enjoy getting out with them [grandchildren]." Participants also associated mobility with having independence. They described mobility as being physically mobile, being able to drive, and being able to "go anywhere you want to go." Staying mobile also helped participants have a sense of fulfillment in their lives. They indicated that remaining active, mobile, and independent would help them feel they had roles that were recognized and valued by others.

Holistic Health

Holistic health, the second theme related to the product for health education, was associated with the theme of staying independent. Participants described aspects of physical, cognitive, emotional, and financial health as being essential to quality of life and independence. Specifically, they identified hearing, vision, and bone and muscle strength as important components of physical health and mentioned age-related declines and chronic diseases as concerns. They conveyed a desire to "not have aches and pains" and cited the importance of not being "ruled by pills." In addition, they identified cognitive health or being of "sound mind" as another important component of health. Participants wanted to remain mentally alert, and some had concerns about dementia. Participants also mentioned emotional health as being important and expressed concerns about financial health in relation to health care costs and their ability to "be able to afford to go [to the doctor]."

Qualitative Findings: Price

As previously stated, participants identified healthful eating and physical activity as actions older adults could take to promote independence and holistic health. To identify the price of these actions, the moderator asked participants a series of questions exploring barriers to healthful eating and physical activity.

Healthful Eating Barriers

Participants emphasized a variety of physical limitations affecting their abilities to eat, shop, and cook for themselves. They mentioned common declines such as difficulty walking and standing, difficulty chewing and swallowing, and loss of appetite and thirst when reflecting on eating and asserted that social isolation issues such as living alone and cooking for oneself were barriers related to shopping and cooking. One participant reflected, "It is just harder to fix good meals for yourself." Further, some participants shared a lack of motivation related to cooking for themselves because of perceptions that cooking for oneself is "not worth the trouble." Additionally, participants discussed financial barriers to healthful eating and perceptions that the costs of healthful foods "have gone out of sight." Many were enmeshed in a cultural ideal of "saving for a rainy day." Participants also conveyed concern about waste when discussing purchasing options not conducive to shopping and cooking for one, with one participant stating, "You have to really manage so that you are not wasting." Social ramifications related to navigating food costs and available resources were discussed. Participants described pride as a reason for not taking advantage of food assistance and other social services that they considered to be "handouts." Food choice sabotage was a social ramification in that participants perceived eating as a social situation where healthful food was less accepted as part of the social scene. One participant noted, "If you are with friends that want to eat someplace unhealthy, then it's hard to say no." Participants also conveyed that changing and conflicting nutrition and health recommendations promulgate information confusion because, as one noted, "one day they tell you it's horrible and gonna kill you [and] the next day, they say, 'Oh no, it's alright.'"

Physical Activity Barriers

Participants perceived physical age-related limitations as impeding the adoption of activity or continuance of activity in advanced years. They mentioned fear of falling and aches and pains as barriers to engaging in physical activity and conveyed sentiments such as "I would probably fall down" and "it will hurt too bad." Participants stated that physical conditions such as overweight, bad knees, brittle bones, and arthritis were reasons for aches, pains, and limited mobility. Some shared that they had difficulty motivating themselves to be active, with one participant noting, "It's hard to get yourself to do it [exercise]." They also conveyed lack of motivation as a

challenge precipitated by social isolation and/or depression. Social factors mentioned as barriers to participating in physical activity included time, safe locations, and costs associated with attending scheduled exercise opportunities. Although mentioned less frequently, social acceptance of activity for women as an issue, with participants perceiving that physical activity was not "ladylike."

Qualitative Findings: Promotion

To gain insight into the most effective and meaningful ways of promoting healthful behaviors, the moderator asked a series of questions exploring desired aspects of health promotion programs.

Expertise and Familiarity

When the moderator asked who older adults would listen to, participants predominantly responded that they would listen to people with expertise in the area of health because such people were "knowledgeable about what they were talking about." Participants felt that credentials were important for establishing confidence in the reliability of information being shared. In addition, participants shared a preference for learning from individuals who had successfully made healthful changes. They identified familiarity relative to age, experience, and behavior change success as important because older adults would be able to relate to such individuals and it would be good to see "examples of healthy seniors."

Information for Improving Knowledge and Skills

As previously stated, participants identified information confusion as a barrier to healthful eating. When the moderator asked what type of information older adults would like to receive, participants emphasized a desire to receive "accurate information," particularly related to chronic disease prevention or management. Participants also expressed a desire to learn skills that could empower them to incorporate healthful behaviors into their daily lives and conveyed sentiments such as "I don't know how to do that, but teach me, and I will do it." They expressed an interest in learning "proper ways to do physical activities to avoid any injuries" and in learning about "making healthful food choices, preparing healthy food and food safety."

Program Delivery

When the moderator asked how older adults would like to receive information, participants predominantly expressed a preference for receiving information in the form of printed materials, especially materials targeting older adults. They noted that older adults like to receive printed materials in the mail, such as newsletters, and referred to mail as something older adults "look forward to." Participants perceived handouts as beneficial because they could take them home and have them "to look at and make use of on a daily basis, rather than a single event." They also indicated that older adults often receive information through traditional educational programs and expressed that even at such programs they like to receive printed material in the form of a handout.

Motivators for Attending Programming

When the moderator asked what would motivate older adults to attend health promotion programs, many participants indicated that older adults like to go to programs that provide opportunities for active participation,

socialization, and fun. Participants speculated that older adults may attend programs more for socialization aspects than educational content and conveyed sentiments such as "they [older adults] just wouldn't think of not going because of the socialization." Participants identified fun as a motivator for program attendance, with one participant effusing that a particular program involved "unbelievable fun things." Ideas for making education fun included audience interaction, music, and group socialization time. Incentives also emerged as a desired program feature. Participants cited food, door prizes, and free health screenings as examples of incentives that would attract older adults to participation in health promotion programs. One participant emphasized that "when [there are] door prizes at something, people just flock to it."

Qualitative Findings: Place

To identify where older adults would be able to access education, the moderator asked participants to share their views on best places to have programs. Participants stated that older adults would be most likely to go to familiar and easily accessible locations "where older adults already go." Participants also indicated that health promotion programs need to take place at affordable locations, particularly in reference to sites for being physically active, because "a lot of people can't afford to belong to [a fitness center]." Locations commonly mentioned included senior centers, Extension sites, and community centers, parks, and walking tracks.

Discussion

Using SMPs as a framework for doing so, we aimed to gather data that would allow for the development of relevant and meaningful health education for older adults. Findings from our study point to the need to develop programs focusing on independence and holistic health as interrelated beneficial aspects of health maintenance. Older adults viewed quality of life into advanced age as essential to overall well-being. Important elements of quality of life, including physical, cognitive, emotional, and financial health, should be incorporated into programs developed to meet their needs. The findings of Kang and Russ (2009) also underscore the need to develop holistic wellness programs for older adults in rural communities. The Seniors CAN program is an example of an older adult health promotion program that focuses on enhancing older adults' independence by increasing their ability to interpret the vast amount of available health information and improving their skills related to incorporating healthful behavior changes into daily life (Collins, 2001). The Seniors ALIVE program is another example of an older adult health promotion program that resulted in improvements in various domains, including physical, mental, and social health (Buijs, Ross-Kerr, Cousins, & Wilson, 2003).

Social factors represented a common thread throughout the focus group discussions. Participants emphasized the importance of fostering social well-being so that older adults can feel that they are functional and contributing members of society. Declines in health might be synergistically related to social declines, whereby older adults find "health for one" not worth the effort. Moreover, feelings of isolation can exacerbate health declines (Bisschop et al., 2003; Ellwardt, Aartsen, Deeg, & Steverink, 2013). Programs including opportunities for socialization are recommended as ways to keep older adults holistically healthy. Seniors ALIVE participants reported that social interaction was an essential component of that program (Buijs et al., 2003).

Entertainment education has emerged as an important way to address behavior change (Ellwardt et al., 2013). Participants in our study recommended fun and entertaining education as a way to engage older adults. Buijs et al. (2003) reported that the enjoyment and fun of the Seniors ALIVE program was a reason participants attended.

Programs engaging SMPs to promote health behavior changes have produced positive results. DiGiuseppi et al. (2014) observed that using SMPs in program promotion—emphasizing program benefits (e.g., reducing falls, staying independent) and lessening barriers to participation (e.g., through implementation of convenient locations, small classes, and low costs)—resulted in significantly increased enrollment of older adults in balance and strength classes. Thus, SMPs can enhance the design of effective health promotion programs by leading to tailored messages based on the target audience's needs, concerns, and preferred delivery methods (Grier & Bryant, 2005).

Small sample size is a limitation of our study. Because the study focused on older adults living in rural Oklahoma communities, participant responses may not represent the views of all older adults. Additional research comparing older adults living in different rural population areas as well as those living in urban areas is recommended to see how and whether responses differ.

Implications for Extension

Our findings support other research showing that health promotion is a complex process that should be addressed through tailored programs for older adults living in rural settings. We determined that older adults living in rural Oklahoman communities would benefit from health promotion programs that focus on holistic health, improve their knowledge and skills related to healthful eating and physical activity, allow for social interaction, and take place in familiar locations. Others in Extension intending to develop health programming for older adults living in rural areas can benefit from considering this information.

Additionally, we have shown that use of SMPs during formative assessment can be an effective means of determining how to tailor Extension education programs and processes to participant concerns and interests. Participant interests and concerns vary across the lifespan and in relation to different program areas. We recommend using SMPs as a first step toward enhancing the relevance of Extension programming.

Acknowledgments

Our study was funded in part by Oklahoma Supplemental Nutrition Assistance Program Education. We would like to thank the older adults who participated in the focus group sessions and the OCES county educators who recruited them.

References

- Administration on Aging. (2016). *A profile of older Americans: 2016*. Retrieved from <https://www.acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2016-Profile.pdf>
- Baernholdt, M., Yan, G., Hinton, I., Rose, K., & Mattos, M. (2012). Quality of life in rural and urban adults 65 years and older: Findings from the National Health and Nutrition Examination Survey. *Journal of Rural Health, 28*(4), 339–347.
- Bandayrel, K., & Wong, S. (2011). Systematic literature review of randomized control trials assessing the effectiveness of nutrition interventions in community-dwelling older adults. *Journal of Nutrition Education and Behavior, 43*(4), 251–262.
- Bishop, A. J., Martin, P., & Poon, L. (2006). Happiness and congruence in older adulthood: A structural model of life satisfaction. *Aging and Mental Health, 10*(5), 445–453.

- Bisschop, M. I., Kriegsman, D. M., van Tiburg, T., Penninx, B. W., van Eijk, J. T., & Deeg, D. J. (2003). The influence of differing social ties on decline in physical functioning among older people with and without chronic diseases: The longitudinal aging study Amsterdam. *Aging Clinical and Experimental Research*, *15*(2), 164–173.
- Buijs, R., Ross-Kerr, J., Cousins, S. O., & Wilson, D. (2003). Promoting participation: Evaluation of a health promotion program for low-income seniors. *Journal of Community Health Nursing*, *20*(2), 93–107.
- Charmaz, K. (2014). *Constructing grounded theory*. Los Angeles, CA: Sage Publications Inc.
- Collins, C. (2001). Seniors CAN: Enhancing independence for older adults. *Journal of Extension*, *39*(6), Article 6IAW4. Available at: <http://www.joe.org/joe/2001december/iw4.php>
- DiGuseppi, C. G., Thoreson, S. R., Clark, L., Goss, C. W., Marosits, M. J., Currie, D. W., & Lezotte, D. C. (2014). Church-based social marketing to motivate older adults to take balance classes for fall prevention: Cluster randomized controlled trial. *Preventive Medicine*, *67*, 75–81.
- Ellwardt, L., Aartsen, J., Deeg, D., & Steverink, N. (2013). Does loneliness mediate the relation between social support and cognitive functioning in later life? *Social Science & Medicine*, *98*, 116–124.
- Friedmann, S., Shah, K., & Hall, W. J. (2015). Failing to focus on healthy aging: A frailty of our discipline? *Journal of the American Geriatrics Society*, *63*, 1459–1462.
- Grier, S., & Bryant, C. A. (2005). Social marketing in public health. *Annual Review of Public Health*, *26*(1), 319–339.
- Kang, M., & Russ, R. (2009). Activities that promote wellness for older adults in rural communities. *Journal of Extension*, *47*(5), Article 5RIB2. Available at: <http://www.joe.org/joe/2009october/rb2.php>
- Oklahoma State Department of Health. (2014). *2014 state of the state's health*. Retrieved from <https://www.ok.gov/health/pub/boh/state/SOSH%202014.pdf>
- Oklahoma State University Center for Rural Health. (2008). *State of the state's rural health*. Retrieved from <http://www.healthsciences.okstate.edu/ruralhealth/docs/SOSRH%20-%202008%20Edition.pdf>
- Population Reference Bureau. (2015, December). *Population bulletin*. Retrieved from <http://www.prb.org/pdf16/aging-us-population-bulletin.pdf>
- Song, M., & Kong, E. H. (2015). Older adults' definitions of health: A metasynthesis. *International Journal of Nursing Studies*, *52*(6), 1097–1106.
- U.S. Department of Agriculture Economic Research Service. (2016, June 6). *Identifying nine rural definitions: Three definitions based on census places*. Retrieved from <http://www.ers.usda.gov/data-products/rural-definitions/data-documentation-and-methods.aspx>

Copyright © by Extension Journal, Inc. ISSN 1077-5315. Articles appearing in the Journal become the property of the Journal. Single copies of articles may be reproduced in electronic or print form for use in educational or training activities. Inclusion of articles in other publications, electronic sources, or systematic large-scale

distribution may be done only with prior electronic or written permission of the *Journal Editorial Office*, joe-ed@joe.org.

If you have difficulties viewing or printing this page, please contact [JOE Technical Support](#)