



Health Knowledge

The asthma knowledge and perceptions of older Australian adults: Implications for social marketing campaigns

Uwana Evers^{a,*}, Sandra C. Jones^a, Peter Caputi^{a,b}, Don Iverson^c^a Centre for Health Initiatives, University of Wollongong, Wollongong, Australia^b School of Psychology, University of Wollongong, Wollongong, Australia^c Illawarra Health and Medical Research Institute, University of Wollongong, Wollongong, Australia

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ABSTRACT

Objective: The purpose of this research is to gain an understanding of the asthma perceptions of older adults and identify gaps in their asthma knowledge.**Methods:** In regional New South Wales, Australia, a stratified, random sample of 4066 adults, aged 55 years and over, both with and without an asthma diagnosis, completed a survey based on the Health Belief Model about asthma knowledge and perceptions.**Results:** Almost half of the sample had experienced symptoms of breathlessness in the past four weeks. Breathlessness was a predictor of lower health ratings and poorer mood. Older adults reported low susceptibility to developing asthma. The sample demonstrated poor knowledge of key asthma symptoms including shortness of breath, tightness in the chest and a cough at night.**Conclusion:** There is a general lack of asthma awareness in this age group. This could result in not seeking medical help, and thus a reduced quality of life.**Practical Implications:** Older adults should be made aware of key symptoms and the prevalence of asthma in the older adult population, and be empowered to take control of their respiratory health. Audience segmentation for an intervention should be based on recent experience of breathlessness and asthma diagnosis.

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1. Introduction

Asthma is a chronic disease characterized by inflammation of the airways. This inflammation causes recurring episodes of breathlessness, coughing, tightness in the chest, and wheezing that are typically coupled with narrowing of airways [1]. Despite the general perception that asthma is a childhood disease, it does develop in older adults [2,3].

1.1. Asthma in older adults

There are approximately 420,000 Australian adults aged 55 years and over with a diagnosis of asthma, that is, at least 1 in 10 older adults live with the condition [1]. However, the Australian Centre for Asthma Monitoring believes that there may be many more older Australians living with undiagnosed, and therefore

uncontrolled, asthma. One study found that over 25% of Australian older adults reported shortness of breath, and more than 20% experienced wheezing; however, only 14% had been diagnosed with asthma and 8.2% were self-managing with medication [4]. The literature demonstrates that asthma is under-diagnosed, often misdiagnosed, and under-treated in the older adult population in Australia [2,5–7] as in other countries [8–11].

The risk of dying from asthma increases with age [12]. Asthma has a negative impact on quality of life, with years lost due to disability accounting for approximately 70% of the asthma burden in older adults [12]. While undiagnosed or uncontrolled asthma poses significant health consequences for older adults, their knowledge and beliefs about asthma are largely unknown.

1.2. Asthma knowledge and perceptions of older adults

Little is known about the asthma knowledge of older adults in the general community. While studies have measured community-wide asthma knowledge [13,14], they have not specifically focused on older adults. Small-scale, qualitative studies have examined the asthma knowledge of older adults with [15] and without [16] asthma, though these findings have limited generalizability. It

* Corresponding author at: Centre for Health Initiatives, University of Wollongong, ITAMS Building 233.G14, Innovation Campus, Squires Way, Fairy Meadow, NSW 2522, Australia. Tel.: +61 2 4221 5441; fax: +61 2 4221 3370.

E-mail addresses: uwana@uow.edu.au, uke983@uowmail.edu.au (U. Evers).

appears that older adults tend to associate asthma with childhood [16]. They form their perceptions about asthma from the experiences of their children or grandchildren who have had the disease, or from their own experience of having had it as a child. This association leads to the perception that adults cannot get asthma without having had it as a child. Furthermore, there is the perception that the health consequences for children with asthma are more serious than those for adults [16].

Asthma-related health promotion has been primarily aimed at children and their caregivers. However, there is a demonstrated need for community-focused asthma awareness campaigns targeting older adults [17]. Health communications aimed at changing health perceptions and knowledge are often the first step in enacting health behavior change for individuals and the wider community [18]. In this way, a focus on changing the current asthma perceptions and attitudes of older adults has the potential for eliciting future health behavior change. Recent reviews on health promotion programs directed at older adults provide valuable insight into how to best change their health perceptions and, subsequently, their health behaviors [19,20].

1.3. The Health Belief Model (HBM) and social marketing in health promotion

Over the past few decades, the Health Belief Model (HBM) [21] has been widely employed in health promotion efforts with varying degrees of success [22,23]. The HBM integrates components that impact on behavior: perceptions of susceptibility to and severity of a disease, cues to taking recommended action, perceptions of barriers to and benefits of taking action, and self-efficacy [24]. The combination of perceived susceptibility and perceived severity indicates the threat an individual perceives that a particular disease poses to their health. The cumulative effect of self-efficacy, and the barriers to and benefits of taking a prescribed action, represents an individual's expectations about the outcomes of taking action, and signifies the likelihood of that individual undertaking a specific health behavior. The HBM has shown particular usefulness when applied in the formative stages of program development to better understand the beliefs of a target population [22,23].

Social marketing provides a framework to develop, implement and evaluate health promotion efforts [25]. It has been utilized effectively in public health [26] and specifically with older adult populations [27,28]. French and Blair-Stevens [29] outline eight essential elements for social marketing programs: segmentation, insight, methods mix, customer orientation, behavior, theory, exchange, and competition. Many of these elements are aligned with the constructs of the HBM. For example, the exchange element in the social marketing framework which refers to valued benefits gained versus costs incurred by the target audience relates directly to the HBM concept of barriers and benefits of undertaking a prescribed behavior. In combination, the HBM constructs and the social marketing framework are well suited to underpin a health promotion program directed at older adults.

A recent study integrated the components of the HBM with the social marketing framework to better understand the beliefs and behaviors of older adults [16]. Participants perceived that asthma was not very serious and that it would not impact their daily activities. Their perceived susceptibility was low; they believed that asthma was a childhood disease and that respiratory difficulties were a normal sign of aging. Barriers to action centered on their lack of understanding about asthma. There were no clear benefits perceived by the participants for seeking an asthma diagnosis or treatment. Cues to action were media campaigns, and advice from GPs, pharmacists and credible health organizations. The marketing mix synopsis highlighted the key role of GPs and

pharmacists in terms of place, price, and promoting the product of respiratory health and achieving a higher health-related quality of life. Thus, the combination of psychological theory and social marketing techniques has the potential to guide the design of effective campaigns; this combination provides the foundation for the current research.

1.4. The current study

The aims of this study were to describe the asthma perceptions, and identify gaps in the asthma knowledge, of older adults in a regional Australian community. Two specific research questions underlie these aims:

- (1) What are the asthma perceptions and knowledge of older Australians?
- (2) How do these perceptions relate to the HBM and the social marketing framework?

2. Methods

2.1. Survey development

A survey was developed to examine asthma knowledge and perceptions, asthma-specific self-efficacy, experience of breathlessness, general health ratings, and use and perceived credibility of health information sources. Relevant demographic data were also collected. These variables were chosen to provide data on the asthma perceptions and knowledge of older adults, and to enable an adequate description and subsequent segmentation of the target population. Asthma knowledge was measured using a modified version of the Chicago Community Asthma Survey (CCAS-32) [13]. Previous studies have demonstrated the discriminant validity of the CCAS-32 in detecting differences between sub-populations [14]. As the CCAS-32 was validated using US data, three items were removed as they were deemed to be not relevant to an Australian sample (e.g. "People without medical insurance do not get asthma care"). The modified questionnaire contained 19 true/false or yes/no knowledge items, and 10 Likert-scale items assessing attitudes about asthma. Five items were developed on the basis of HBM constructs to measure perceived susceptibility to and perceived severity of asthma, general barriers to and benefits of visiting the doctor, and reasons for going to see the doctor. Two items on physical and emotional self-efficacy for coping with asthma were adapted from the Self-Efficacy for Managing Chronic Disease 6-Item Scale [30]. These two self-efficacy questions were prefaced with the statement "Please try to imagine what it would be like to have asthma. If you have asthma, please answer from experience". Two subscales from the Asthma Quality of Life Questionnaire (AQLQ) [31], measuring breathlessness and mood on a 5-point Likert scale from "Not at all" to "Very severely", were included in the questionnaire. The ten AQLQ questions were worded in a general sense, and were not asthma-specific. Cronbach's alpha coefficient for these subscales was determined to be 0.86 (breathlessness) and 0.87 (mood). One question assessed asthma diagnosis: "Have you ever been told by a doctor or nurse that you have asthma?", one question examined perceived general health, and two questions on the use and perceived credibility of health information sources. The final questionnaire was reviewed by an expert panel. Ethics approval was obtained from the University's Human Research Ethics Committee.

2.2. Sample and data collection

The survey was pilot tested with adults aged 55 years and over qualitatively ($n = 13$) to maximize readability and ease of use, and

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