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Author(s)	Hodgins, Margaret M.; Clerkin, Pauline; Kelleher, Cecily C.
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# ADULT HEALTH EDUCATION MATERIALS

*Hodgins, M., Clerkin P. and Kelleher C., Department of Health Promotion,  
National University of Ireland, Galway*

## INTRODUCTION

In this article we report the results of a survey of adult health education materials currently available and in use in Ireland, conducted as part of an EU collaborative project<sup>1</sup> aiming to identify health education materials used with adults, outside of the formal framework of the institutional learning process (i.e. mainstream educational settings), in five EU member states.<sup>2,3</sup>

## ADULT HEALTH EDUCATION

Adults are an important target for health promotion, insofar as they may be keen to reduce their own health risk behaviour as a result of health education (Kelleher and Solan, 1995) and interested in promoting health within their own communities. Adult health education is also important in the context of health promotion given the imperative within health promotion to reduce health inequalities. Those who experience poorer health status, for example, those in lower social classes, those on lower incomes, ethnic minorities and unemployed persons (Abel-Smith, 1994), also may be more likely to have left mainstream educational activities at an early stage. There are direct correlations between low educational attainment and low health status (Abel-Smith, 1994; Marmot, 1996). The best way to reach such groups, in terms of health education, is through the adult education sector.

Further, the ideological underpinnings of health promotion, radical health education (Tones, 1997) and adult education overlap substantially. Empowerment is a key concept in health promotion, radical health education and adult education. Tones describes radical health education as facilitating choice by providing people with empowering competencies and support (Tones, 1997, p. 35), and health promotion is frequently defined as enabling people to increase control over, and to improve, their own health (WHO, 1984), through the process of self-empowerment. The Euro-Delphi Report (1995) describes adult education as involving holistic enrichment and empowerment of all people and describes adult learners as co-partners with educators and agencies.

Health education can clearly contribute to health gain. Materials developed through or in conjunction with the

adult education sector are likely to particularly useful, given the close correspondence between the philosophical underpinnings of adult education and of health promotion, health promotion being the recommended way to improve health. Hence, the importance of identifying adult health education materials as part of the process of health improvement or health gain. Conducting a survey on existing adult health education materials allows us establish what gaps exist and where to focus scarce resources.

## METHODOLOGY

### *Sampling*

In the absence of a national data base of published or developed adult health education materials, a snowball sampling procedure was used. The objective was to secure a full population sample of Irish organisations that had produced and developed adult health education materials according to the following criteria;

- materials should be replicable/transportable, a pack
- more than just a simple publication i.e. not leaflets or booklets
- permit involvement, e.g. interactive materials
- new, innovative materials (this was interpreted as to exclude old media campaigns for example, or sets of materials currently under revision)

An initial core data base of relevant organisations was compiled. This list drew on voluntary and statutory health service organisations with an educational function who were likely to have developed materials.

The data base included;

- health promotion/health education officers in each of the eight Health Boards
- adult education officers in VECs and third level colleges
- voluntary organisations involved in delivery of health services or health education

Each organisation/individual was contacted by telephone, and asked whether they had developed adult health education materials, and on that basis would agree to take one or more of the project questionnaires<sup>4</sup>. The list was expanded as some individuals suggested other possible organisations who may have developed materials. Using this procedure, a population of

56 organisations or agencies was identified. It was intended that one questionnaire would be completed per health education material or pack. The questionnaire was intended to assess the quality of adult health education materials and ensure that they met project criteria.

## RESULTS

Of the 56 organisations contacted, 25 accepted questionnaires i.e. agreeing that they had adult health education materials that may conform to our criteria. Of these 25 organisations, returned one or more questionnaires, a response rate of 76%. This resulted in 38 questionnaires and accompanying sets of materials. Questionnaires and materials were then screened for inclusion in the survey, i.e. meeting project criteria.

Twenty six of the questionnaire replies and materials (i.e. 68 %) were deemed to meet project criteria. Those that were not included were rejected for a variety of reasons e.g.

- intended for use in mainstream secondary education system
- not containing any interactive component - i.e. booklets or leaflets, or non-innovative
- education or training courses

The set of materials included was then scrutinised in relation to, topic/subject matter, target group and the degree to which they were potentially participative. Results can be seen in Table 1.

## DISCUSSION

### *Topics*

This survey has yielded important information for those working to improve health in Ireland. Twenty six sets of innovative materials which were replicable/transportable and permitted involvement and interaction were identified. Materials were chiefly resource packs (e.g. information with structured activities), videos, and material for educational/training workshops. In relation to the topics that materials dealt with it is clear that most resources to date in Ireland have

1. Funded by Socrates programme  
2. Belgium, France, Ireland, Portugal and Spain.  
3. We wish to acknowledge the expert assistance of Owen Mercalf in this project  
4. Questionnaire devised by Steering Group of Socrates project

Table 1

TOPICS/SUBJECT	MATERIALS	TARGET GROUPS	POTENTIAL FOR PARTICIPATORY ACTIVITIES
AIDS/HIV information and education and drugs awareness/preventing drug abuse	11 (42%)	Disadvantaged Youth (4) General adult population (2) Parents (4) College students (1)	High (4) Medium (4) Low (3)
Adult lifestyle, for prevention of cardiovascular disease/cancer (e.g. smoking, exercise, nutrition)	9 (35%)	Disadvantaged Youth (1) General adult population (5) Women (2) Older people (1)	High (3) Medium (3) Low (3)
Personal Development	2 (8%)	Disadvantaged youth (1) Gen. adult population (1)	High (2)
Other (e.g., breast-feeding, accident prevention, infection control)	4 (15%)	Health professionals and breast-feeding mothers (1) Travellers (1) Parents (1) Teachers (1)	High (1) Medium (1) Low (2)
<b>TOTAL</b>	<b>26 (100%)</b>	<b>26</b>	<b>26</b>

been directed towards prevention of drug mis-use and the spread of AIDS/HIV. Given the level of drug abuse, especially in Dublin and the expectation that the prevalence of AIDS/HIV will increase (*Shaping a Healthier Future*, 1994), this is a positive finding.

Only 35% of the materials dealt with lifestyle issues, a matter for concern given that cardiovascular disease and cancer are the two leading causes of premature mortality in Ireland (*Shaping a Healthier Future*, 1994). Together, these account for 56% of deaths in persons under 65 years of age, much of which is preventable. Of more concern again, only one set of materials dealt with accident prevention, the third main cause of death in Ireland. Only two sets of materials emerged in the survey dealing with personal development, and there were no specific mental health promotion materials developed. This is a notable gap in the collection of materials, given the current emphasis on mental health issues, particularly suicide.

#### Target groups

The survey has revealed that very few of the adult health education materials identified are in fact targeted at sub-groups of the population who are known to have poor health status. Only one set of materials has been developed for the Travelling community, a group whose health status is dramatically lower than the rest of the population (e.g. Barry, Hericy and Solan, 1987). Much higher rates of smoking and alcohol use have been reported for Travellers, co-existing with lower rates of preventative health service utilisation and lack of information on health issues

(O Donovan *et al.*, 1995). While health education materials can realistically be considered to only represent one part of the larger and multi-sectoral policy required to promote health within the Travelling community, they can play a vital role in improving health. This is reflected in the finding that 20% of a sample of Travellers reported attending a health education programme, many commenting positively on the experience. Additionally, over half of the sample reported taking positive action to improve health (O Donovan *et al.*, 1995) indicating good potential for the development of culturally sensitive adult health education materials.

Recent publications have highlighted the fact that older people in Ireland are in poorer physical health when they reach age 65 than their counterparts in the UK and continental Europe. Life expectancy for older people in Ireland is lowest in the EU, the principal causes of death being cardiovascular disease, cancer and respiratory disease. Accidents, many of which are preventable, are also a significant cause of death (Adding Years to Life Life to Years, 1998). A large study on morbidity of older Irish people found almost half to describe themselves as having health problems and almost a quarter reporting significant psychological distress. This study also predicted that receptiveness to health education programmes is likely to be high, as 80% of the sample reported engaging in activities to improve or maintain their health (Fahey and Murray, 1994). Despite this, and the fact that the importance of developing health education materials for older people has been high-

lighted previously (The Years Ahead, 1988), only one set of adult health education materials was found targeted specifically for older people. No mental health education materials were found for older people, despite the finding that the suicide rate for older men has doubled since 1980.

#### Potential for Participatory Activities

Participation is a concept central to both health promotion and adult education. Of the 26 adult health education materials identified in this survey, only 10 (38%) could be described as being highly participatory. Almost the same amount (8) were best described as having low potential for participatory activities, indicating that a lot more attention needs to be given to this aspect of adult health education. Health education, traditionally, would not have been a participatory activity, but have centred around expert health professionals, imparting information or advice to passive recipients. It is interesting to note that of the 9 highly participatory sets of material, 7 were produced in partnership with voluntary organisations, yet of the 8 designated low, 5 were produced by the health sector alone. It appears from this survey that the field of adult health education is still influenced by the expert imparting information approach.

Finally, it must be noted that a paucity of adult health education materials for any of the target groups mentioned above does not necessarily imply a lack of activity. Particularly within the adult education sector many adult health education activities may be occurring. There is great diversity, energy and creativity within the sector (Bassett *et al.*, 1989; Coolahan, 1994), despite (or perhaps because of!) this lack of written or formalised sets of materials. The modest yield of transportable materials for this project should not be taken as a reflection of the extent of adult education activities. The range of materials discovered can only partially reflect the true energy and creativity in the sector. Many enthusiastic and committed individuals and organisations have worked for many years with the people of marginalised communities, often with poor resources especially in relation to the formal development of educational materials. Any discussion on adult health education in Ireland is not complete without reference to these activities. Indeed, more integration of such activity with the more traditional health education activities could afford be a giant step forward for health gain.

*References available on request from  
The Office For Health Gain*