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LITERACY As A Barrier To HEALTH

And

HEALTH As A Barrier To LITERACY

The Population Health Approach and quality learning environments

by **Cheryl Brown**
and **Wendell Dryden**

The second *Health of Canadians* report pointed out that

> Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy...Canadians with high levels of education have better access to healthy physical environments and are better able to prepare their children for school than people with low levels of education. They also tend to smoke less, to be more physically active and to have access to healthier food. (Kirby)

Literacy as a barrier to health

Literacy workers and researchers understand that low literacy is a direct barrier to health because they see people with poor literacy skills who find it hard or impossible to access written health information. As an indirect barrier, poor literacy skills and low levels of education are linked to low fixed incomes, limited employment opportunities, and so on. Burt Perrin, in his 1998 landmark study, *How Does Literacy Affect the Health of Canadians? A Profile Paper*, sets out both ideas.

Literacy workers know of adult learners who have difficulty accessing health information for themselves and their families. Many literacy programs and organizations have become committed to improving health literacy, people's ability to understand and use health information (Rudd; National Library of Medicine). As health professionals work to make pamphlets and admission forms easier to read and to sensitize frontline employees about literacy issues, literacy professionals work to improve Canadians' access to health care and self-care by helping learners improve those literacy skills directly applicable to deciphering the instructions on a prescription or looking up information online.

All this has been a positive step forward. Improving the readability of health information and the literacy skills of patients does indeed improve access to health information. However, both of these approaches have very real limits. Improving readability "...tends to benefit most those with higher skill levels who report that they prefer such materials" (Rudd et al.). In addition, some individuals with limited literacy skills who face health issues themselves or in their family, either do not enrol in literacy programs or cannot stay long enough to improve their skills.

Based on literature we have read and our field experience over the last three years, we would like to advocate a complementary approach to health literacy. We believe it is possible to positively and directly influence the key determinants cited in the Population Health Approach. We would like to suggest some things literacy practitioners can do to directly support the health of learners and their families.

TRACEY MOLLINS

Health as a barrier to literacy

Improved literacy becomes a receding goal when a learner's poor health acts as a barrier to learning. It is hard to learn when you are hungry or when ingredients in the food you have eaten interfere with your thinking. It is difficult to focus when you are in chronic pain or when you are taking medication. It is hard to maintain regular program attendance or to demonstrate a commitment to learning when you are making frequent trips to a doctor's office or the emergency ward. It is almost impossible for an organization to show funders that their program is viable and effective when learners are out for a week or more at a time as illness moves through their families.

Practitioners and administrators discuss barriers wherever there are adult and family literacy programs. Barriers are those internally or externally located factors that learners cite for not being able to start or finish a program and/or reach their learning goals. Barriers to learning are complex by nature. They are based in each learner's perception and may be as individualized as learners themselves. Yet, several authors have classified barriers into three categories: situational, institutional and dispositional (Thomas; Centre for Family Literacy).

Situational barriers include family and work responsibilities, time constraints and personal problems (Centre for Family Literacy). Childcare and transportation are the situational barriers most commonly cited by administrators and practitioners in Canadian Family Literacy Programs (Skage; Thomas and Skage; Centre de récherche et de développement en éducation; Human Resources Development Canada; Whitty et al.). Other situational barriers include: community and cultural orientation (Human Resources Development Canada); isolation (Skage; Thomas and Skage); lack of support from other family members and friends; lack of time to learn and engage in literacy activities at home; and low self-esteem (Thomas and Skage). Situational barriers may also include domestic violence and concerns about nutrition, housing and other social needs (Skage).

Institutional barriers are those imposed by administrators or practitioners and include lack of program signs, unclear forms, inconvenient class times, poor instruction and unfriendly staff (Centre for Family Literacy). Thomas and Skage cite as institutional barriers to program access "inappropriate advertisement, offering programs at inappropriate times, and offering pre-determined programs that do not interest parents" (p. 34). In Skage, other institutional barriers are "recruitment policies and procedures that do not match the outcome objectives of the program and lack of financial resources and personnel allocated to recruitment" (p. 82). We would add program eligibility and attendance policies to this list. Anderson et al. took a liberal approach to attendance issues, recognizing that parents have busy lives and that they attend sessions when they can. Critics, including other learners in the program, rebuked their practice and stated that people only benefit when they attend. This less liberal approach to attendance requirements can make it difficult for programs to offer flexibility and equity to all participants.

Dispositional barriers are related to the attitudes and perceptions that adults bring to the learning environment and may include a negative or limited experience in education, or placing low priority on the program, sometimes described as "low motivation"

(Centre for Family Literacy). In a New Brunswick study, twelve family literacy focus groups were held in seven health regions. Administrators and practitioners cited "parental attitudes, parents feeling intimidated or afraid to take part in activities, and parents' belief that it is up to the schools to teach their children how to read" as dispositional barriers to family literacy participation (Centre de récherché de la développement en éducation, p. 12). Personal stigma attached to attending groups has also been cited (Skage), as well as locations being perceived as intimidating (Thomas and Skage).

In our own practice in family literacy in New Brunswick, we began by identifying transportation and childcare as the main barriers to adult participation. The provincial government was willing to subsidize bus travel and daycare arrangements fully or in part but this was only partly successful. Not all learners lived on or near a city bus line. Many learners viewed private daycares as unwelcoming and unsafe for their children. When we tested a family literacy program with an on-site children's program and expanded transportation subsidy (taxi fare), the situation improved only slightly. We quickly encountered other barriers that we needed to deal with on an individual basis. These barriers included poor health and lack of appropriate health information, low expectations of success, poverty and program practices such as strict attendance policies and limited staffing (Saint John Learning Exchange).

CHERYL BROWN

Susan Lewis, reading to her children Katie and Dominic in the Storytent (Summer, 2003). The Storytent is a community literacy project in partnership with the Crescent Valley Community Tenant's Association and the Saint John Free Public Library.

Integrating health and literacy: *A Population Health* Approach

Thirty years ago, *A new perspective on the health of Canadians: a working document* (Lalonde), introduced Canadians to a new health paradigm. The approach was preventive rather than reactive. It defined health in positive terms, as an asset everyone possessed in some degree, rather than negatively as the absence of illness or disability. It looked at health holistically and related it to a constellation of different concepts and contexts. Moving beyond the paradigm of hospital and medical professionals, the report spoke of the individual's responsibility for determining their own health, and of a family, community and societal responsibility we share for each other's well-being.

Not all of these ideas were well explored or understood in 1974. Initially, there was an emphasis on personal choice and individual actions, and a downplaying of collective action or the role of local, physical environments (McKay). This led to rather limited social marketing campaigns such as ParticipAction and the Canada Food Guide (Kirby). However, it also led to Health Canada's broader Population Health Approach, a paradigm for health care that has won worldwide respect. The 2004 Population Health Approach lists twelve determinant factors that work alone or in concert to influence our state of health.

The determinant *Education and Literacy* is within the reach of any program or project that supports individual learning. Education "contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and...improves people's ability to access and understand information to help keep them healthy" (Health Canada). A literacy program can support participants' acquisition of health-relevant skills and information simply by ensuring that the curriculum content is

For a useful introduction and description of the Population Health Approach go to **www.hc-sc.gc.ca/hppb/phdd/approach/index.html**. This site also has a very clear description of the Key Determinants of Health in Canada.

relevant to each learner's interest in and perception of effective self-care and health care. A recent document by Heart Health Nova Scotia demonstrated success with this approach, embedding literacy within the context of learners and tutors researching and learning about health issues. In our practice, we provide basic information, from a variety of sources and in both print and audio format, on topics from the link between food and health to the importance of breastfeeding. We sometimes provide recipes for using alternatives to wheat or milk as part of a class project or in a more individualized, door-to-door manner. We have offered information on food additives and the benefits of organic fruit and produce, and, in some cases, provided learners with small amounts of buckwheat flour or unsalted organic butter so that they could experiment on their own before deciding whether or not to spend money on admittedly more expensive products. Meanwhile, we would continue to integrate health information directly into the curriculum, helping learners and families take more control over their own health by reading and writing about the health issues most important to them.

The determinant *Social Support Networks* begins from the underlying premise that support from families, friends and communities is related to improved health. "The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems" (Health Canada).

Closely related to this is the determinant *Social Environments*, which refers to "the institutions, organizations and informal giving practices that people create to share resources and build attachments with others." Factors like "social stability, recognition of diversity, safety, good working relationships, and cohesive communities" provide both "a supportive society that reduces or avoids many potential risks to good health" and the ingredients for a need-satisfying learning environment. Any small class setting or gathering of adults or children around some learning project can provide a degree of social support. However, "caring and respect" do not necessarily appear in "social relationships" (Health Canada). What makes a difference is precisely a "social environment" where all the participants feel safe and valued, and a program or project flexible enough to allow appropriate opportunities for personal sharing. As well, the environment needs to be free of criticism, bullying and blaming (Glasser).

The determinant *Personal Health Practices and Coping Skills* refers to "actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health" (Health Canada). Health Canada's prescription is blunt: "Interventions that support the creation of supportive environments will enhance the capacity of individuals to make healthy lifestyle choices in a world where many choices are possible" (Health Canada). Literacy programs that are individualized, learner-centered, self-paced, and empowering will enable learners to become self-reliant and self-confident. Programs that offer sound, relevant information presented when and in ways learners request will help them make informed choices about the betterment of their health and the health of their families. So long as choices are possible, learners can develop the skills and confidence to choose well.

The determinant *Physical Environments* refers to "levels of exposure, contaminants in our air, water, food and soil" and "factors related to housing" (Health Canada). In the context of a program or project, this raises questions about site suitability, the use of harsh cleaners or insecticides, the quality of air, water, light and so on. Is it a smoking environment? Are mold or mildew present? A positive physical environment will support improved physical and emotional health. With this in mind, we use non- or low-allergenic cleaning products and we monitor the quality of the air and light. When working outside, we choose locations with fresh water and shade. We strive for a safe, low-stress environment. Where appropriate, we integrate this kind of health information (alternatives to chemical cleaners, the dangers of second-hand smoke, the virtues of relaxing) directly into the curriculum to help families take more control over their own health.

Of the determinant *Employment/Working Conditions*, Health Canada notes that people "who have more control over their work circumstances and fewer stress-related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities." Though the focus is on paid employment, there is a link to the work students or learners undertake in the course of their education. Again, the question is: Is the program or project environment itself healthy? "Conditions at work (both physical and psychosocial) can have a profound effect on people's health and emotional well-being" (Health Canada). Does the program allow learners appropriate opportunity to control those conditions? Does the program minimize stress by offering self-paced, individualized learning? Does it offer "a sense of

identity and purpose, social contacts and opportunities for personal growth" (Health Canada)?

How we can influence other determinants is less clear-cut.

Health Services as a determinant means access to services "designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health" (Health Canada). A literacy program might contribute here through empowering learners to write letters or otherwise campaign actively in support of continued funding for local services. Or a program may be a venue for direct interaction with health professionals like nutritionists or optometrists.

Biology and Genetic Endowment, *Culture* and *Gender* are determinant beyond the direct control of a literacy program. However, staff and learners can take the opportunity to think creatively and critically about these determinants. How and why does society offer the sexes different roles, values, and relative power and influence? Is it truly inevitable that someone with a certain physical make-up will suffer worse health than his or her neighbours? Is it necessary that people continue to suffer from "dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization... and lack of access to culturally appropriate health care and services" (Health Canada)?

Income and Social Status is the final determinant. The fact that health status "improves at each step up the income and social hierarchy" (Health Canada) can also be said to be beyond the control of a literacy program. While some literacy programs may offer full employment as a successful outcome for some learners, others may look to literacy as a tool for the application of local and broader political action not far from Paulo Friere's vision of literacy instruction as emancipation (Friere).

Will It Work?

What we have been describing is a way to directly support the health of learners and their families. Does this approach work? Although we have not engaged in formal research, we have gathered qualitative and anecdotal evidence to suggest it may make a positive difference. When learners in a family literacy pilot program were asked about the fresh, organic food the program provided, responses were positive:

"I think it's good! Because [my child] sometimes lacks in eating nutritional foods at home, so it's a good idea."

"Good. Good food. I notice there is no candy, no junk food here".

"It is good. You can't always provide theses things because it's too expensive."

When asked if the food provided led to any changes in eating habits or attitudes toward food in general, learners said:

"My daughter eats more, which is good 'cause I've always had a hard time with her eating."

"Yeah. We've changed a lot of our foods that we ate before. We use to eat just anything. Now we eat pretty much organic."

Responses to a question about changes in their families' health, elicited the following responses:

"Yes. The change is with me. I'm more happier."

"I usually catch a flu [or] something every year, but not this time."

"My daughter hasn't been as sick. This is the first winter she hasn't been hospitalized."

"Yes, because I always used to be tired. The baby was always sick. He's usually in the hospital every few months. He's only been sick once since March. For sure it's linked to eating better."

Learners also valued the information provided around health and nutrition:

"I've learned a lot about nutrition. I learned to cook with buckwheat and that not all organic food tastes awful."

"Yes, at the allergy clinic we went to they showed what he was allergic to. I found out about allergies for my daughter too. Here they provide books to read about healthy stuff."

"It has been good for me and helped my kid gain back his weight. I learned a lot about how to be a parent."

Learners attested to improved family health during this particular program. Though the origin and nature of this improvement is difficult to confirm, what we can conclude is that learners perceived and demonstrated changes in attitudes toward health and nutrition, and a sense of empowerment around their own and their families' health (Saint John Learning Exchange).

In other contexts, we have seen similar results. In an adult classroom, the daily presence of free, fresh fruit was accompanied by a shift in what learners chose for their snacks. Donuts, chips and chocolate bars appeared far less often, and providing healthy food was perceived by some learners as nurturing on the part of the facilitator. The provision of fresh fruit in an outdoor reading program equally shifted eating habits. There, some children met their first orange, melon or dulse, and quickly began looking for fruit each day. In this

same program, our organization of space and learning created a low-stress atmosphere—a social support network, healthy social environment and safe physical environment—which, parents claimed, reduced violence and raised the quality of life for several children in the community (Brown and Dryden).

Despite all the evidence showing that health improvement is linked to living conditions rather than medical intervention, "no jurisdiction in Canada and no country in the world has designed and implemented programs and policies firmly based on a population health approach" (Kirby). Health Canada's limited social marketing of good health practices and information is daily overwhelmed by the far more aggressive marketing of pharmaceutical companies (Healy), with the result that population-health activities "do not claim anything like the close focus and high status that health care has" even though "the non-medical determinants of health have far greater impact on the health of the population than health care" (Kirby). In contrast to drugs and surgery, low-invasive holistic and alternative approaches remain under-promoted, expensive and under-covered by private and public medical plans. In this climate, it is all the more important that local communities and organizations look for creative ways to overcome health barriers and support learners and families through innovative, holistic and self-reflective literacy projects and programming.

We believe this approach to health literacy deserves further support and study. Collaborative research and information sharing between family and adult literacy organizations could be one way to investigate its impact. Another framework could be ethnographic or other longitudinal research where public and private funding supports longer-term programming that deliberately incorporates a Population Health Approach. An alliance between a community organization and university, with graduate students or research friends supporting practitioners is also possible. No matter which method of formal investigation is chosen, it is important for practitioners to be self-reflective. By listening to learner's voices and reflecting on their own experience, practitioners can uncover the methods and materials that directly support the health of learners and their families. ■

Wendell Dryden is a Community Literacy Worker in Saint John, New Brunswick. His background is in Early Childhood Education, Family Resource work and Choice Theory/Reality Therapy. Wendell has co-developed family literacy and community literacy programs. He currently facilitates two adult literacy classes and a community literacy project.

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Cheryl Brown is a Community Literacy Worker in Saint John, New Brunswick. She has worked in the adult and family literacy fields for twelve years and is a certified Reality Therapy Practitioner. Cheryl is currently a researcher in practice with several family and community literacy projects.