Formal submission in response to the Child & Youth Wellbeing Strategy.

Health Literacy and Equity Research Group (College of Health & Medicine, University of Tasmania)

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The **Health Literacy and Equity Research Group** (UTAS and partners) would like to thank the Tasmanian Government for providing the discussion paper and inviting community and stakeholder input.

Founded in 2016, **HealthLit4Kids** has received local, national, and international recognition; published in three World Health Organisation (WHO) reports, seven academic papers, one book chapter, received five awards, and presented on nine occasions at local, national, and international conferences. Our team is multidisciplinary and has grown rapidly to include practitioners and researchers from seven universities nationally.

HealthLit4Kids offers all Tasmanians with a solution to each of the Domains in the Child and Youth Wellbeing Strategy.

Background

Health and wellbeing are interconnected, context dependant, and informed by our culture, thus, mean different things to different people. Three main domains relating to the definition of health are that: (1) health is not being ill, (2) health is a necessary prerequisite for life's functions and (3) health is a sense of well-being expressed in physical, social, mental, emotional, spiritual, cultural, and environmental terms (Baum, 2008). We acknowledge the importance of a broad definition of health.

The Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development identified health literacy as a **critical determinant of health** and **urged for global investment** to **enhance health literacy <u>throughout the life-course</u> and <u>in all educational settings</u>** (World Health Organisation, 2017).

Health literacy **supports <u>health and wellbeing</u>** across people's lives (Australian Commission of Safety and Quality in Health Care, 2014), the foundation of which begins optimally in childhood.

Health Literacy (HL) for **children and young people is defined** as *a social and relational construct. It encompasses how health-related, multimodal information from various sources is accessed, understood, appraised, and communicated and used to inform decision-making in different situations in health (care) settings and contexts of everyday life, while taking into account social, cognitive, and legal dependence. As such, health literacy is observable in children's and young people's interaction and practices with health-related information, knowledge, messages in a given environment (so called 'health literacy events or interactions'), while encountering and being promoted or hindered by social structures (in micro, meso, and macro contexts), power relationships, and societal demands* (J Bröder et al., 2019)**.**

Health literacy includes three essential and interacting elements:

1. Health literacy assets of the individual person (child/parent) (D. Nutbeam, 2008)
2. Distributed health literacy (family/social supports/others) (Edwards, Wood, Davies, & Edwards, 2015)

3. Health literacy responsiveness of community and health services (Trezona, Dodson, & Osborne, 2018)

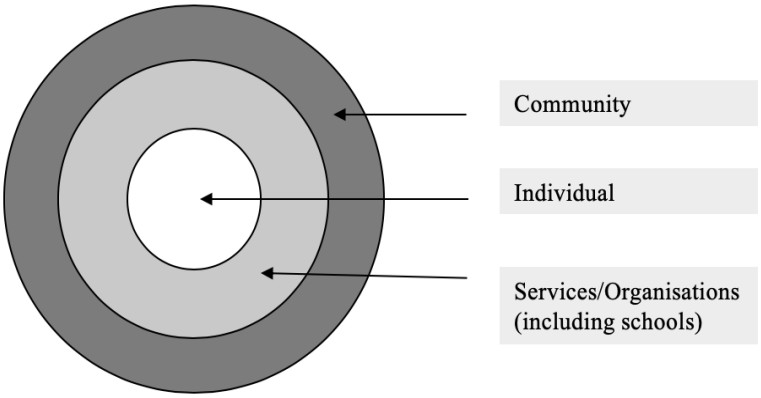


Figure 1. The interconnected elements that influence the health literacy of children and youth.

Tasmania was the first state in Australia to develop a Health Literacy Action Plan (2019-2024). This is to be commended. The Action plan is strengthened by the Government's commitment to a Health in All Policies approach through the adoption of the Tasmania Statement (14th August 2019).

Unfortunately, health literacy (HL) is only referred to once throughout the Child and Youth Wellbeing Strategy under the Domain of **Learning**. HL is referred to under CURRENT TASMANIAN GOVERNMENT INITIATIVES (page 44):

> *Health Literacy*
> *Initiative to improve the health literacy environment of health settings, making information more accessible.*

The current "initiative" refers to increasing the accessibility of information. However, it should be made clearer whether this constitutes a review of print materials or a more comprehensive review of how all health information and services are currently delivered to recipients. We hope it would be the latter.

We acknowledge that making a reference to health literacy is a positive first step. However, the current strategy does not recognise that **health literacy is a health, education and community issue.** This is a **missed opportunity** to develop an integrated strategy that supports the development of health literacy across settings and across the life course for all Tasmanians. This will be essential if we are to successfully redress the social determinants that we are each born into, play, learn and grow.

A health literacy priority is imperative to meeting the visions outlined in the TCYWS discussion paper; Tasmania urgently requires meaningful investment in evidence-based HL programs which can tangibly contribute and cultivate the wellbeing of children and adolescents in Tasmania.

To be successful, this will require a **whole-of-government strategy;** whereby **education**, **health,** and **community** work collaboratively to ensure health literacy is supported across the life course. This is consistent with the overarching aim for Tasmania's Child and Youth Wellbeing Framework *to ensure that everyone, in all parts of Tasmania's service system, as well as in the broader community, has a strong, common understanding of child and youth wellbeing.*

We would like to see explicit mention and consideration of developing the child's health literacy assets, as well as ensuring that children have adequate social supports (distributed health literacy) in their parents and family structure. Further, the services that children are accessing should be cognisant of their own contribution and how they can respond to each child's needs.

HealthLit4Kids across the life course to include: Child Health and Parenting Services (CHAPS) (for new and expectant parents), early learning (parents with young children and the children), primary schools (children, parents and teachers), and high schools (children/adolescents).

The facts:

- A bidirectional relationship exists between HL and educational attainment (Cummings & Obel-Omia, 2016; Pérez-Rodrigo et al., 2001)
- HL develops across the life-course (Maindal & Aagaard-Hansen, 2020)
- HL can determine adult health outcomes (DeWalt & Hink, 2009)
- HL is a predictor of productivity (Batterham et al., 2014)
- Education is an important social determinant, HL has been defined as a social determinant in its own right (Janine Bröder et al., 2018)
- HL can redress inequities that exist in health and society (Batterham et al., 2014; Paakkari & George, 2018)
- Tasmanians report more challenges associated with HL than people in other Australian states (Australian Bureau of Statistics., 2018)

The Health Literacy & Equity unit (UTAS & partners) is currently engaged in the following research:

- Co-designing health literacy solutions with Tasmanian mothers to reduce intergenerational impact of non-communicable diseases.
- Developing health literacy responsive Child & Maternal Health Services (in partnership with Tasmanian Health Service).
- Uncovering best practice pedagogy for developing children's health literacy assets.
- Building health literacy from the school ground up.
- Co-designing health literacy mediators for Tasmanian schools and their communities.
- Tackling suicidal behaviours– an adaptable framework for evidence-based guidelines in children and adolescents.

The findings from this research will have important implications for the Child & Youth Wellbeing Strategy.

HealthLit4Kids responds to a gap in the delivery of HL programs for communities and schools by working at a local level with children, their schools, families, and communities to develop new approaches to learning and health.To date, it has been evaluated in five Tasmanian schools (reports and papers available on request from Dr Rosie Nash rmcshane@utas.edu.au).

From international, national and HealthLit4Kids research, we make four recommendations that we would encourage you to consider.

Recommendation 1: Give greater emphasis to HL in the Child & Youth Wellbeing Strategy, given the importance of Health Literacy to Child & Youth Wellbeing in Tasmania.

In 2021/2022 we plan to **broaden our scope** beyond the primary school to work with CHAPs nurses and school nurses state-wide to ensure more Tasmanians are equipped with the asset of HL and more services (community/health) are health literacy responsive.

Health literacy is embedded across the following domains (circled in red):

EXPLANATION: positive and trusted **relationships** with other people support children to find information and form decisions about their health and wellbeing. Health literacy is fundamental to children participating and having a **voice** about their own health, the health of others, and the health of the planet. Health literacy assets will enable children to enact their **citizenship** for the benefit of themselves and others.

EXPLANATION: Health literacy is defined as a **social determinant** in its own right, as well as a contributing factor to other social determinants (education, housing, etc.). For children and young people this is about forming healthy food **choices**, **navigating** health and social services to access activities that support their health and wellbeing, as well as **developing their own assets.** Developing HL will be instrumental in achieving **intergeneration change**.

Consider adding here: Access to health literacy responsive services, distributive health literacy (community and social supports/family) and opportunities to develop their own health literacy assets.

EXPLANATION: Being healthy is an outcome of being health literate and being supported by health literacy responsive services and health professionals. The health literacy of children and young people accumulates through daily activities, social interactions, and across generations. The central mechanisms for their health literacy development are their day-to-day experiences and the conversations they have about health with their family, neighbours, peers, teachers, as well as with health professionals. These experiences and interactions enable children and young people to access, understand, appraise, remember, and use information about health and health care for the health and well-being of themselves and those around them. Health literacy is an essential life-long skill and is highly transferable to multiple health challenges (mental health, chronic conditions, vaccination) and contexts.

Initiatives in this domain must develop knowledge, motivation and competencies of children, parents and teachers concerning health (e.g., nutrition, oral health, basic hygiene, anatomy, vaccination, healthy behaviours, health services) to promote, access, and maintain health throughout the lifespan.

An explicit focus on health literacy development will assist in supporting children to make positive everyday health-related decisions. It will also empower them to demand the enabling environment that will lead to good long-term health and avoid risk factors for chronic conditions (stroke, diabetes, heart disease), especially resisting and managing commercial determinants of health (for example junk food advertising which is targeted at children). Health literacy development within, as well as outside of the school environment, also leads to distributed health literacy, whereby, the health literacy skills of the children is passed on to their families and communities.

Schools are key settings where children's and young people's health literacy needs to be systematically developed.

Recommendation 2.

All school nurses be provided with HealthLit4Kids Professional Development (for implementation in each of their schools).

All teachers in DoE school be provided with the opportunity to participate in HealthLit4Kids Professional Development (for implementation in each of their schools).

Consultation questions addressed: Q7, Q8, Q11

EXPLANATION: Health attitudes and behaviours formed during childhood influence adult health patterns. Children require support to become knowledgeable and critical consumers of health information. It is, therefore, critical that their environment provides them with appropriate resources to facilitate this development.

The **first 1000 days and early years** are critical because by the time children enter formal schooling, the foundations of their health information and knowledge have been gained from their communities social norms and practices. Furthermore, school curriculum, including language and numeracy skills, is usually delivered within and alongside accumulating family, community, and cultural information and knowledge.

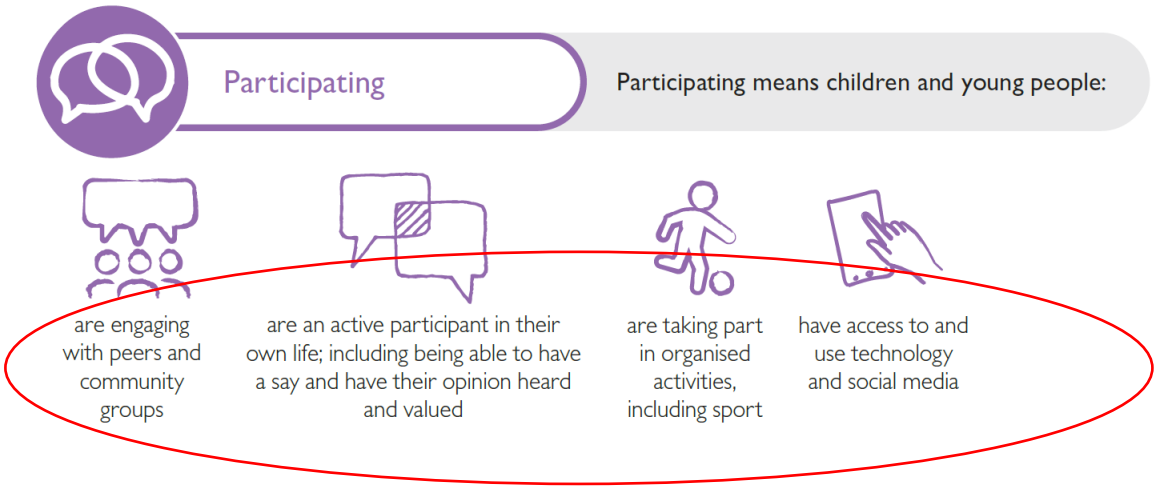
When the skills of reading and understanding information are applied to health, they are often called **functional health literacy**. Basic understanding of biology (e.g., germ theory, blood sugar and obesity) and anatomy (e.g., body parts and how they work) assist people to make sense of information that is provided by health workers and found on the internet. Formal education may also equip people with the confidence and skills to ask questions about health, to critically appraise information, and to understand the health risks and determinants associated with chronic conditions, as well as the slow onset and chronic nature of these conditions.

Early childhood learning about health is accumulated from parents, formal, and informal childcare settings, as well as family and educational networks where children are socialized and educated in social practices. As young people develop and enter adulthood, the information they gain from formal education, and their experiences and interactions with peers, work colleagues, and especially with healthcare providers, contribute to the development of their health knowledge.

School children may come to understand the potentially dangerous long-term impacts of exposure to common chronic condition risk factors (e.g., how tobacco products cause cancer, the physical and social harm of harmful consumption of alcohol, diets high in salt and fats), and **they transfer this knowledge to their family and broader community.** This may lead to action that improves their own and their family's health. School education is therefore, one of the most important health literacy activities available and needs to be systematically developed (Nash, Cruickshank, Flittner, et al., 2020; Nash, Cruickshank, Pill, et al., 2020; Nash et al., 2018).

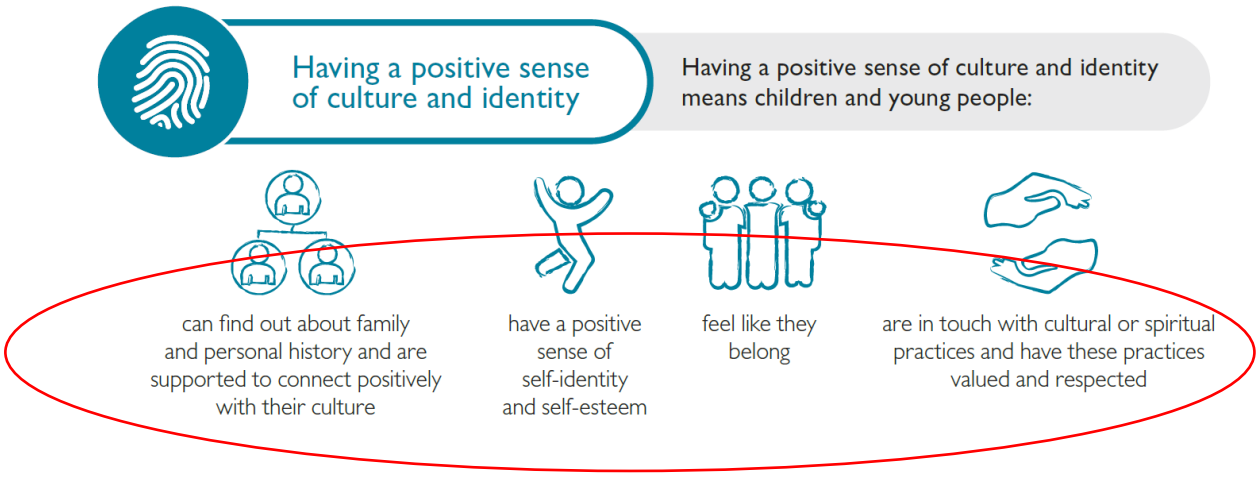
Recommendation 3. All CHAPS nurses receive professional development to support the provision of HealthLit4Kids to Pregnant Mums and Families in the Tasmanian Community.

Consultation Questions Addressed: Q7, Q8, Q11, Q22, Q23, Q24, Q25



EXPLANATION: Health literacy is a strategy for **empowerment** and **enablement** of all Tasmanians, capable of **redressing inequities** that exist in our communities. In the context of children and young people's participation, this requires they possess functional health literacy[1], interactive health literacy[2] and critical health literacy[3] assets (D Nutbeam, 2000).

We need to **build the capacity of children and young people** to participate in decisions about health. As active citizens we need to first develop their functional health literacy and interactive health literacy assets. This will support the further development of critical health literacy skills, essential for broader community participation as the progress across the life course.



EXPLANATION: Health literacy is developed over time through social practices. Health knowledge is developed from birth through the social practices of the communities and environments in which people grow up. Early **health knowledge development is a shared process**, especially through mothering and family networks where children are socialised and take on cultural health practices. Knowledge is held within communities and shared through stories and experiences with family,

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[1] **Functional** health literacy: Basic health literacy skills that are sufficient for individuals to obtain relevant health information and apply that knowledge to a limited range of prescribed activities.
[2] **Interactive** health literacy: Advanced literacy skills that enable individuals to extract information and derive meaning from different forms of communication; to apply new information to changing circumstances; and to interact with greater confidence with information providers such as health care professionals.
[3] **Critical** health literacy: Most advanced cognitive skills which, together with social skills, can be applied to critically analyse information, and to use this information to exert greater control over life events and situations.

friends, peers, community leaders, and teachers. Social practices influence how health information becomes health knowledge. For children and young people we must understand and support the physical and social environments in which people and communities accumulate knowledge about health beliefs, health behaviours, and developing health literacy (Levin-Zamir, Leung, Dodson, & Rowlands, 2017; Papen, 2009; Samerski, 2019).

In light of the information presented above, our Health Literacy and Equity Research Unit would like to **request that the Tasmanian Government consider HL as a cross-sectoral priority** for Health, Education and Community. Increasing the presence of HL in this strategy and considering allocation of budget to support capacity-building amongst CHAPS nurses, school nurses, teachers, and carers in Tasmania would represent an important pathway to achieving the objectives of Child and Youth Wellbeing Strategy.

Recommendation 4: Include health literacy in all domains as indicated. Health literacy fits within all six domains; there is potential to develop aspects of the HealthLit4Kids program to the services relevant to each of these domains.

HealthLit4Kids across the life course becomes the vehicle for embedding health literacy into all of these existing services.

For example, CHAPS nurses work with HealthLit4Kids to assess the health literacy responsiveness of their services and develop site specific action plans. In addition, there is the opportunity to co-design context relevant health literacy development opportunities for the mothers and families attending their services. The outcomes of this approach can be measured using the HeLLOTas Tool, OrgHLR, and HLQ.

Consultation Questions Addressed: Q7, Q8, Q11, Q22, Q23, Q24, Q25, Q41, Q42, Q43, Q44

Response to Consultation Questions

7. If additional initiatives are required to ensure the wellbeing of Tasmanian children and young people in your community what are they and why have you made that suggestion?

HealthLit4Kids across the life course is an initiative that will help to identify and manage issues relevant to children and adolescent and provide connections between health, social and educational services (a more wholistic approach to wellbeing) by embedding health and wellbeing within schools, community services and health systems. This will support the development of Health literacy responsive community services, health services, and schools. This will foster interagency understanding and lead to upskilling across these agencies; this can help those who work with children and adolescents to ensure that they understand how to navigate appropriate referral pathways and help to ensure children and families have access to the support and services that they require.

8. Are you able to identify any barriers to Tasmanian children and young people accessing initiatives aimed at improving wellbeing for your community?

Children in Tasmania are impacted by the social determinants they are born into, and by which they grow, live, learn and play. Our social determinants (the causes of the causes) create barriers for some people who wish to access initiatives designed to improve wellbeing. The social determinants include education, housing, social supports, access to food, transport, environment, and employment. More information here: http://www.instituteofhealthequity.org/about-our-work/action-on-the-social-determinants-of-health-

11. What is one thing we can do to address each of these issues?

Health literacy is an important social determinant and has the potential to serve as an equalizer in the Tasmanian community. Health literacy has been shown to redress inequity and overcome many of the other social determinants that have the potential to negatively impact one's life. By supporting the development of health literacy in our community, we are empowering individuals to have agency. Unfortunately, any wellbeing initiative that doesn't place health literacy at the forefront will continue to disadvantage our most disadvantaged. We must ensure all initiatives prioritise health literacy or implement programs that have been designed with health literacy as a primary priority.

23. If additional initiatives are required to ensure Tasmanian children and young people are healthy what would they be and why?

A cross-sector initiative such as HealthLit4Kids has the potential to improve care pathways and understanding of services available (for children, parents, educators, and health service providers) and consequently, aid in reduction of access barriers for children who would otherwise fall through the gaps in service. It will be important that we work with existing services (CHAPS nurses, school nurses, schoolteachers, etc.,) to provide opportunities to build the health literacy capacity of whole communities and ensure that wellbeing initiatives have health literacy forefront of their approach.

41. How do we know we are making a difference?

The current research demonstrates that early intervention and education established in childhood support the foundations of lifelong wellbeing (including mental health). From routinely collected data (DoH, DoE, DoC) we will see improvement in health outcomes, educational attainment, and health literacy of the Tasmanian community. Health literacy can be measured using the Health Literacy Questionnaire (HLQ). The Health literacy of organisations can be measured with the HeLLOTas tool or OrgHLR. Longer term, wellbeing could be assessed with a sample of individuals using the AQoL8D.

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