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# HEALTH LITERACY IN THE HILLS
## HOW A CALIFORNIA COMMUNITY RESHAPED ITS WELL-BEING

This case study examines how a small, rural school district in Northern California mobilized to increase community health literacy over a four-year period beginning in 2001, incorporating health literacy into programs for disadvantaged, homeless, and Spanish-speaking families. Using an outcome model for health promotion as a means of measurement, the project followed the 1,300-student school district over four years as it: 1) adopted a curriculum model to build health literacy capacity; 2) integrated health literacy into after-school services for disadvantaged youth; 3) partnered with public and community-based agencies to sponsor family health literacy; and 4) specifically targeted health issues of historically underserved populations such as the homeless and non-English speaking groups. This study suggests an effective community model is achieved through intensive collaborative networking with shared communication strategies to help people understand, embrace, and act upon health information.

*Keywords:* health communication, knowledge transfer.

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Teachers are noticing it more and more: sixth-graders snoozing in class because they have been given a double dose of cold medicine; kindergarteners rubbing their aching ears and sobbing because Mom stopped their antibiotic too soon; and families too embarrassed to confess that they lack the personal skills to help their children live healthier lives.

U.S. Surgeon General Richard Carmona defines health literacy as "the ability of an individual to understand, access, and use health-related information and services" (Carmona 2005). Recent studies note that literacy skills are a stronger predictor of health status than factors such as income, age, or race, and that nearly half of all American adults struggle to understand and use health information (Partnership 2005). As a result, schools are learning environments for writing, reading, and listening skills for family well-being (Tappe & Galer-Unti 2001). Such teaching with real life content is a pedagogically relevant mode of knowledge transfer, including cultural practices of health literacy (Muro 2001).

To address such issues with a new community program, Placerville Union School District (PUSD), a small, rural district in Northern California, formed a collaborative in 2001 of over 20 members which included the research team and representatives from homeless shelters, churches, youth groups, health agencies, and California's State Department of Education. This case study analyzes PUSD's efforts as measured by an outcome model for health promotion (Table I), which includes categories of health literacy, social action and influence, and public policy and organizational practice, all of which work together for intervention impacts (Nutbeam 2000).

*Table I: An outcome model for health promotion measures*

| **Health literacy:** | **Social action/ influence :** | **Public policy/ organizational practice:** |
|---|---|---|
| health-related knowledge, attitudes, motivation, behavioural intentions, personal skills, self-efficacy | community participation, community empowerment, social norms, public opinion | policy statements, legislation, regulation, resource allocation, organizational practices |

## 1. Methods

The research team includes: PUSD teachers and administrators; representatives from the local library, the Boys & Girls Club, a hospital's health library; and a PhD student, the author of this article. Research methods are quantitative and qualitative, including textual analysis of public documents and an electronic survey of community collaborative members which reinforced the study's findings. In addition, researchers analyzed notes from a qualitative social research framework informed by participation-action research (Deshler & Grudens-Schuck 2000). This replicable design followed steps such as definition of the research problem, use of multiple methods, and representative sampling (Hansen et al. 1998).

This study also examined events for homeless and Spanish-speaking families which included focus groups of adults and children. All sessions were observed by research team members and written up in reference notes. Researchers focused on these questions:

1. How does a school district undertake a health literacy effort?
2. Does a school-based program display measurable health outcomes for marginalized groups in the community?

## 2. Description of health literacy program

Approximately 40% of Placerville's school children qualified for free-or reduced-cost lunches and one school reported that one-third of its families were Spanish speaking, mostly migrant workers. Such assessments resulted in four programs: adult education; after-school enrichment; family literacy; and health communication for homeless and Spanish-speaking families.

### *2.1. Adult education*

To service adults within a community-strengthening model, the collaborative accepted an invitation to pilot the El Paso Community College/Community Education Program, a five step framework which involves activities of:

1. critical discussion;
2. reading;
3. writing;
4. group work; and
5. action (El Paso 2001).

Adult learners helped select appropriate materials for classroom culture, language abilities, and knowledge levels. For instance, one activity about food and drug labels taught the differences between tubes of toothpaste, antibacterial ointment, and hemorrhoid cream, an example of how adult education may address everyday needs. Application of the outcome model for health promotion showed measurable results in health-related knowledge, personal skills, and motivation, especially in activities about raising children.

### *2.2. After-school enrichment*

PUSD was awarded a five-year grant in 2002 to help elementary students with math and reading lessons which included health topics. After assessments of student progress, the after-school program was modified in 2003 to reflect learner-driven activities for health-related knowledge. For instance, a student garden was created with the five-step framework:

1. discussion of desirable flowers and foods;
2. reading to research the suitability and characteristics of the plants;
3. writing activity including garden chore charts;
4. group activity to finalize planting plans; and
5. action activity to harvest and prepare the foods.

In addition, a dental lab gave free exams and taught about avoiding tooth decay. This program produced all health literacy outcomes of health-related knowledge, attitudes, motivation, behavioral intentions, personal skills, and self-efficacy.

### *2.3. Family literacy*

This grant-funded component began in 2002 and proved to be the most successful in following the five-step El Paso model, given that families chose topics which often included lifestyle and environment areas such as tobacco use prevention, environmental health, and physical activity. Free family events featured bilingual health providers and activities such as blood pressure screenings. This program satisfied health literacy measures of knowledge, motivation, and personal skills, as well as social action measures of community participation.

### *2.4. Communication to homeless and Spanish-speaking students*

This final component was organized by the PUSD homeless education liaison who coordinates educational, medical, and mental health services for

homeless and migrant families. She concentrated on training school personnel about how to document not only homelessness but also health trends. This program was successful in all three health promotion outcomes: health literacy measures of knowledge, attitudes, motivation, and behavioral intentions of PUSD staff; social action measures of community empowerment, social norms, and public opinion; and public policy measures of policy statements, resource allocation, and organizational practices.

## 3. Conclusion

Evaluations of PUSD efforts appear to fit the outcome model for health prevention with some variations: for example, while all four programs demonstrated health literacy outcomes of health-related knowledge, motivation, and personal skills, adult education was not successful in achieving changed attitudes, behavioral intentions, or improved self-efficacy in relation to defined tasks. This deficiency resulted from the local high school's financial inability to continue sustained health literacy efforts, thus removing a critical element of the mobilization of adult skills and resources.

However, these four programs reached thousands of community members: PUSD records from September 2003 to June 2005 document that 80 families joined the family literacy program, 773 students received after-school health literacy instruction, and over 1000 Spanish-speaking and other needy students and parents were served through the homeless education program. In addition, over 1000 community residents attended open events.

Final evaluations from interviews, surveys, and grant assessments reveal that although the adult education program was not sustained, the community looked for new substitutions for such services. In January 2005, PUSD began to offer classes for Spanish-speaking parents after they dropped their children off at school which indicate refocused organizational practices. As evidence of the program's replicability, many measures such as family literacy and communication to homeless families have been implemented county-wide. According to PUSD officials, the success of such expansion depends upon each locality tailoring programs to fit local cultural practices.

The story of health literacy in Placerville is an unfolding drama. A recent federal call for action declared that communities must "mobilize public and private resources to make sure that the question of how

healthy we are is determined by disease and science, not by race or gender, income or address, or any other characteristic" (USDHHS, 2005). As indicated in this case study, school districts may influence community leaders to acknowledge that health literacy is not simply about medical materials but rather how materials are organized into human relationships. In seeking to create connections between people and knowledge, PUSD shifted its collective focus to interventions enmeshing all levels of literacy, economics, and ethnicities. This concentration highlights the role of reciprocal learning in the sharing of knowledge at home and at school, as seen when children become communicators of knowledge with their families. In short, this health literacy case study is a cornerstone example of community partners working closely together to ensure that healthy communities begin at home.

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