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Article

Making health information meaningful: Children's health literacy practices

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ABSTRACT

Children's health and wellbeing is high on the research and policy agenda of many nations. There is a wealth of epidemiological research linking childhood circumstances and health practices with adult health. However, echoing a broader picture within child health research where children have typically been viewed as objects rather than subjects of enquiry, we know very little of how, in their everyday lives, children make sense of health-relevant information.

This paper reports key findings from a qualitative study exploring how children understand food in everyday life and their ideas about the relationship between food and health. 53 children aged 9-10, attending two socio-economically contrasting schools in Northern England, participated during 2010 and 2011. Data were generated in schools through interviews and debates in small friendship groups and in the home through individual interviews. Data were analysed thematically using cross-sectional, categorical indexing.

Moving beyond a focus on *what* children know the paper mobilises the concept of health literacy (Nutbeam, 2000), explored very little in relation to children, to conceptualise *how* children actively construct meaning from health information through their own embodied experiences. It draws on insights from the Social Studies of Childhood (James and Prout, 2015), which emphasise children's active participation in their everyday lives as well as New Literacy Studies (Pahl and Rowsell, 2012), which focus on literacy as a social practice. Recognising children as active health literacy practitioners has important implications for policy and practice geared towards improving child health.

1. Introduction

1.1. The significance of child health

A wealth of epidemiological research links childhood circumstances, practices and health status with adult health outcomes and children are frequently positioned as 'represent[ing] the future' (World Health Organisation (WHO), 2015). It is not surprising, therefore, that improving child health and wellbeing is high on the research and policy agendas of many nations. There are over 2.2 billion children (aged 0-15 years) worldwide and in some countries children comprise nearly fifty percent of the population (UNICEF, 2014). While recognising the value of this life course perspective in underscoring the importance of child health, a number of commentators have highlighted the need to focus on children's present time health and wellbeing as an important end in itself (Blair et al., 2010; Parton, 2006). Indeed, the United Nations Convention on the Rights of the Child (UNCRC), adopted by all but two of the UN member states, outlines children's right to enjoy their childhood and their right to health (United Nations Convention on the Rights of the Child (UNCRC), 1989).

1.2. Health promotion and health education geared towards children

Alongside strategies which aim to influence the social determinants of health (for example, reducing child poverty and improving educational outcomes (United Nations (UN), 2015)), health education is viewed as an important element of child health promotion. The extent to which health education embodies children's right 'to be heard and listened to' (United Nations Convention on the Rights of the Child (UNCRC), 1989), however, is a contested issue. St Leger (2001), for example, argues that in the majority of schools in many countries, health education is characterised by a focus on conveying knowledge and developing

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competencies and acceptable attitudes (p. 1999). Such critiques echo Freire's (1993) conceptualisation of a 'banking' approach to health education: didactic teaching which characterises recipients as empty vessels waiting to be filled with knowledge and attitudes. Evans et al. (2011), go further, arguing that school-based teaching about healthy eating, a key contemporary focus in health promotion, positions children as mere 'vectors to carry information on "healthy lifestyles" from educational spaces back to more responsible actors within the home (parents)' (p. 324).

This framing of health promotion in relation to children's lives echoes broader, adult perspectives in child health policy and research where children have typically been viewed as objects of health promoting inputs (Christensen, 2004; Wills et al., 2008). This adult or adultist perspective has emphasised the role of adults in shaping child health to the exclusion of multiple other factors which may also have relevance to their lives. It underwrites a preeminent focus on objective measures of child health to the neglect of the underlying processes and complexities, which might explain these, including children's own contributions to their health (Christensen, 2004; Graham and Power, 2004; Wills et al., 2008). This view of children and its consequences for the research agenda in child health reflect what has been termed the 'dominant framework' for understanding children. With its roots in both sociology and developmental psychology, the dominant framework focuses on children's lack of competence. Children are portrayed as needing to be socialized to gain awareness of cultural values and conventions and as repositories for information 'deposited' by adults (Christensen, 2004).

1.3. Locating 'the child' in child health

In sharp contrast to this deficit approach, a Social Studies of Childhood (James and Prout, 2015) framework depicts children as competent social actors who have informed and informing views of the social world. Attention is focused on positive notions of competence recognising that age-based, adult-determined contexts can constrain children's agency and undermine their competencies. Researchers working within a Social Studies of Childhood framework have explored the sense that children make of their worlds and demonstrate that children are not merely passive recipients of socialisation but, rather, are active and reflective and can exhibit competencies that challenge a rigid ages and stages approach to understanding (Corsaro, 2003; Buckingham, 2000; Adler and Adler, 1998). Acknowledging Prout's (2005) criticism that a purely social constructionist perspective of childhood risks underplaying the materiality of life (access to resources, technology, and the physical body), the Social Studies of Childhood implies a commitment to exploring the variety of childhoods and children's lived experiences and motivates researchers to describe the diversity of children's lives within their social contexts (Matthews, 2007).

Alongside a wealth of research describing how children experience ill health and disability, over recent decades a small but growing body of research within the Social Studies of Childhood has begun to explore how, in their everyday lives, children are active in and reflective upon their own health. In Negotiating Health, for example, a qualitative study of primary school children's health behaviours, Mayall (1998) characterises children as 'embodied healthcare actors' (p.278) as she demonstrates how they carry out health-related activities at home and school. Christensen (2004) goes further; echoing Freire's assertion that through education people can be 'subjects and actors in their own lives and in society' (Wallerstein, 1988, p. 382). Christensen (2004) argues that children can be agents for health, 'health promoting actors' (p.328), within the family. Christensen suggests that children should be seen as actors in their own right and that research should ask how children become involved in and, indeed, proactive in health practices while growing up (Christensen, 2004, p. 379). She outlines some key ways in which children have the potential to be health-promoting actors including self-care, keeping fit and active, developing and maintaining relationships and developing knowledge, skills, competencies, values, goals and behaviours conducive to good health. Indeed, a recent anthology of work in this field demonstrates the importance of research 'with children and from a child's perspective, in order to fully understand the meaning and impact of health and illness in children's lives' (Brady et al., 2015, p. 1).

However, despite this fertile ground for research and despite the fact that more assets based approaches from the children's rights literature are beginning to inform health policy at an international level (UNICEF, 2014; Search Institute, 2016) very little work has taken a child-centred approach to explore how, in their everyday lives, children construct health-relevant understandings. In particular, the ways in which children interact with health information and how this does or does not become meaningful remains under-researched and under-theorised.

1.4. Understanding health: health literacy

One way of thinking about how people learn about and make sense of health-relevant information is through the concept of health literacy. Although sometimes confined, in the medical literature, to very narrow definitions relating to how people process and understand basic health information (Institute of Medicine (IoM), 2004), including their ability to comply with therapeutic regimens (AdHoc Committee on Health Literacy for the Council of Scientific Affairs AMA, 1999), the concept of health literacy can encapsulate much broader ideas about how individuals interact with health messages. Recognising that it remains a highly contested concept (Bankson, 2009), Nutbeam's (2000) definition has been very influential: 'The personal, cognitive and social skills which determine the ability of individuals to gain access to, understand, and use information to promote and maintain good health' (p.263). Nutbeam (2000) also differentiates different dimensions of health literacy, including functional, interactive and critical. Harris et al. (2015) summarise this neatly:

> Functional literacy is the ability to understand written information and numeracy; interactive literacy is the ability to communicate health needs and interact to address health issues; and critical literacy is the ability to assess the quality and relevance of information and advice to one's own situation (p.3).

However, the vast majority of health literacy research has focussed on promoting functional health literacy, conceived of as ensuring that information is presented to people at a level which corresponds to their reading and numeracy skills and this narrow conceptualisation is 'reinforced by a health education model that emphasises information giving' (Harris et al., 2015, p. 4). Moreover, the concept of health literacy has received very little attention in relation to children. The very small body of research that is available echoes the wider literature in its tendency to focus on functional health literacy (Brown, Teufel & Birch, 2007; Schmidt et al., 2010; Abrams et al., 2009); (for exceptions see St Leger, 2001; Jain and Bickham, 2014; Paakkari and Paakkari, 2012). Borzekowski (2009) critiques this narrow focus in relation to children specifically:

> Although a child or adolescent may be unable to read and define medical texts, that same person might understand healthy behaviors or medical management in his or her home environment and actively participate in decision-making regarding his or her own health care (p. S283).