

Literacy Partners
of Manitoba



Literacy and Health

Defining Links
and
Developing Partnerships

by Charles Moody

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Introduction

The Problem

- Low literacy levels and poor health are directly linked
- Four million adult Canadians have low literacy skills
- Health Education/Promotion relies largely on print materials that low-literacy adults Cannot Understand

The Consequence

- Therefore, few of the 4 million people most in need of health education/promotion benefit from current health education practice about prevention and early detection

The Solution

The Ideal

- Raise the literacy levels of the hard-to-reach population so that they can understand health education materials
- Write the health education materials in plain language so that they can be understood by the hard-to-reach population

However,

- Only 2% of the low literacy population are attending adult literacy programs
- Many of the hard-to-reach population are not reading even simple materials

Therefore,

Health and Literacy practitioners need to work together in a variety of ways on different strategies to reach the hard-to-reach population.

Literacy

Definition

The definition of literacy is constantly evolving.

A current definition holds that

Literacy is the ability to understand and employ printed information in daily activities, at home, at work and in the community to achieve one's goals, and to develop one's knowledge and potential. *(As defined in Appendix D of Health Canada. Health Promotion and Programs Branch. Policy Development and Coordination Division. Report of the August 1997 roundtable on literacy and health, December 1997, p. 16.)*

Levels of Literacy

The International Adult Literacy Survey (IALS) (OECD, 1995) provided comparable data on the literacy skills of adults from eight Western countries including Canada. IALS represents the notion of literacy (as in the definition above) as a skill continuum divided into five levels:

Level	Reading Ability	Percent
1	Persons with very poor skills, where the individual may, for example, be unable to determine the correct amount of medicine to give a child from information printed on the package	22
2	Individuals can read, but not well. They can deal only with material that is simple, clearly laid out, and in which the tasks involved are not too complex. It denotes a weak level of skill, but more hidden than Level 1. They may have developed coping skills to manage everyday literacy demands, but their low level of proficiency makes it difficult for them to face novel demands, such as learning new job skills.	26
3	Individuals can read well but have some problems with more complex tasks. In many countries, this is considered to be a basic skill level. Some occupations require higher skills.	30
4/5	Individuals can meet most reading demands. This level is considered a high level of literacy.	20

Links between Literacy and Health

Dozens of studies have confirmed the link between low literacy and health. A good place to begin for the Manitoba picture is Rob Sarginson's paper, *Literacy and Health: A Manitoba Perspective* at <http://www.mb.literacy.ca/publications/lithealth/ack.htm>.

Burt Perrin summarises the direct and indirect impact of literacy on health in *How does Literacy Effect the Health of Canadians*, 1998, found at <http://www.nald.ca/nls/ials/introduc.htm>

Direct Effects

- Persons with low literacy skills cannot read medication labels and sometimes take medication incorrectly. This applies to both prescription and over-the-counter medications.
- Persons with low literacy skills have problems complying with medical directions (e.g., a diabetic following a prescribed treatment).
- Persons with low literacy skills cannot prepare formula correctly and may improperly feed infants.
- Persons with low literacy skills may not understand safety precautions in the workplace.
- Persons with low literacy skills cannot read written instructions for preventative care, self-care and follow-up care after an illness or injury.
- Persons with low literacy skills have problems understanding appointment slips, informed consent forms, discharge information and oral instructions.

Indirect Effects

- Persons with low literacy skills are more likely to live in low quality housing and in unsafe areas, with higher rates of pollution and environmental hazards. They are less likely to have safety features such as smoke detectors.
- Persons with low literacy skills are less likely to request care early in the course of their illness.
- Persons with low literacy skills smoke more, have poorer nutrition and exercise less.
- Persons with low literacy skills are less likely to have had a PAP test, to practise breast self-examination, or have a blood pressure check.

Anecdotal Reports from Literacy Practitioners

Literacy Practitioners have reported difficulties that their students have had with the health system, including

- Patients needing a personal explanation of the instructions on non-prescription medicines to determine the dosage for their child.
- A patient who was hospitalized because she couldn't read the instructions on the bottle and misconstrued 4 times a day to mean four pills at a time.
- A diabetes patient who failed to show up for an appointment because she couldn't read the information she had been given. Nor could she read the instructions about what to eat and what not to eat.
- A woman bringing in the fasting instructions prior to blood work who was unable to read them.
- A woman working at a group home for mentally challenged adults who was not able to comprehend the language the doctor had used to describe the client's medical needs.
- Students who have complained about the small size print on the packaging or on the inside enclosure of over-the-counter drugs.
- Patients who feel rushed in a doctor's office – they're still trying to come to terms with the diagnosis and they miss what the doctor is saying regarding the treatment required.

Diabetes

People with diabetes who have trouble reading appear almost twice as likely to have poorly controlled blood sugar and serious long-term complications [as] diabetics who have no difficulty reading.

“Diabetes patients rely on a number of tools to manage their disease and prevent serious health problems. For patients with low literacy, it's as though they have received the tool kit, but not the operation instructions.” (Dr. Dean Schillinger, author of paper in Journal of American Medical Association, July 23, 2002, reported in HealthScout News, Yahoo! Health)

The Determinants of Health

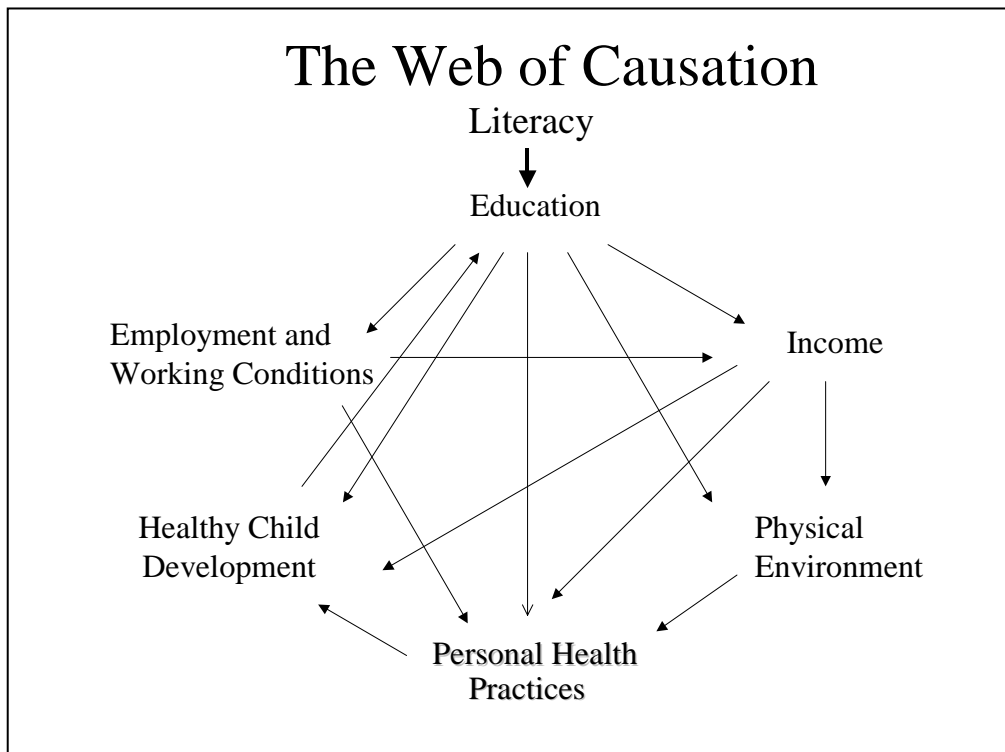
Literacy clearly has a major impact on health. Other factors do as well. These are called the determinants of health. The determinants of health are the basic factors which determine the health of individuals and communities.

Population Health looks at improving the health of the whole population by anticipating and preventing health problems through Health Promotion. Health Promotion seeks to improve health by acting on the determinants of health.

The Determinants of Health

- Income and Social Status
- Social Support Networks
- Education
- Employment and Working Conditions
- Physical Environments
- Biology and Genetics
- Gender
- Culture
- Personal Health Practices and Coping Skills
- Healthy Child Development
- Health Services

Some of these health determinants are related in what has been called the web of causation. Literacy is a prime cause of poor health.



Education has an impact on employment, income, working conditions, physical environment, housing, personal health practices, all of which determine health. Good literacy skills are a prerequisite for a sound education.

Health Promotion needs to focus on literacy:

- Low literacy is a prime cause – directly, and through the other determinants – of poor health.
- Low literacy is also the barrier to health intervention that might forestall the onset of poor health.

How Can Health Care Workers Recognize Low Literacy Clients?

Low literacy people develop strategies to hide their problem, often variations on

- “I’ve hurt my wrist,” (or “You won’t be able to read my handwriting.”) Could you fill that in for me, please?
- “I’ve left my glasses at home. Could you read that for me, please?” (One man was so desperate that he deliberately broke his glasses so that he would be “unable” to read.)

Low literacy people may develop a routine, making sure they deal with people they can trust or keep to places where they feel comfortable.

- One man always goes to the same restaurant and orders the same meal
- Another always deals with the same bank teller, who knows his problem. (Of course, he can’t use the ATM)

Watch for signs of fear or frustration or embarrassment in your clients, as they find themselves in a situation where they may be asked to read or write.

In a brochure for doctors called “If Your Patient Can’t Read”, The Adult and Community Education Board, Leon County Schools, Florida, suggests other signs to look for, in the waiting room and during a consultation.

In the waiting room

Alert your office staff to watch for persons who

- Have difficulty signing in
- Ask for help even when directions are written down
- Rapidly page through magazines without stopping to read text
- Do not pick up a magazine to read, even during a long wait
- Bring someone who signs in or answers questions for them

During a consultation

Notice if your patient does any of the following:

- Misunderstands what you have said
- Hesitates to answer questions
- Speaks with a limited vocabulary
- Doesn't look you in the eye when you speak
- Doesn't pay attention
- Doesn't quite respond to the question
- Seems hesitant or distant

These may be signs of something else altogether, but they may also be signs of the lack of confidence associated with low literacy.

How Can Health Workers Overcome Literacy Barriers?

As a long-term policy, since Literacy is a prime determinant of health, and since low literacy is a barrier to the promotion of good health practices, Population Health must support the efforts of adult and family literacy programs to raise literacy levels in the community.

In the short term, health providers need to overcome literacy barriers to promote good health practices. Here are some suggestions:

- Create an environment accessible to low literacy clients. Do they find it easy to get health care? Do they feel at ease in a health care facility?
- Review all written documents to make sure they are written in plain language and clear format.
- Use good teaching strategies when orally presenting important information to clients. Do not assume that your message has been understood, even if the patient says so.

Create an environment accessible to low literacy people

1. **Make your service easy to find**

- Have a live person available on the phone. Let your message give clear directions on how to get to your building. Give bus stop numbers, landmarks.
- Post clear signs, logos to identify the building
- Use symbols, footsteps, arrows within the building
- Place signs logically, e.g., at the same position or height on a wall

2. **At the reception area**

- Look for signs of low literacy among your clients (See page 8)
- Have a more private place for people who need help filling in forms
- Advise the doctor and others, if you suspect their patient may have low literacy skills
- Use plain language forms

3. **Help clients prepare for treatment**
 - provide easy-to-read or audio-visual materials while they wait
4. **Talk with your clients and make sure they understand**
 - Take time
 - Ask questions to make sure they understand
 - Reinforce message with easy-to-read handouts
 - Offer help *discreetly* to people who may need it. Refer them to a literacy program

Present Your Print Materials in Clear Format and Plain Language

Does your letter, pamphlet or brochure meet the following criteria?

1. Content

- Is the purpose clear and relevant to the audience?
- Is the content limited and related to the purpose?
- Is the material interactive?

2. Organization

- Is the material arranged in manageable chunks?
- Do headings and subheadings help the reader understand and digest the material?
- Do the illustrations enhance rather than detract and distract from the message?

3. Language

- Is the text written in plain language: Personal, Active, Short and Simple (PASS)?
- Is the level appropriate for the audience and purpose?

4. Layout

- Large font. Non-Serif for legibility, Serif for Readability?
- Only two or three different types of font?
- No ALL CAPS?
- Left flush, right ragged?
- Adequate white space?
- Colours enhance rather than detract and distract?

ClearDoc Index

Required Elements (1 mark each) Check

- | | |
|------------------------------------|-------|
| 1. Simple words | _____ |
| 2. Short sentences | _____ |
| 3. Short paragraphs | _____ |
| 4. Active voice | _____ |
| 5. Personal tone | _____ |
| 6. Clear message | _____ |
| 7. Clear organization | _____ |
| 8. Font size of 12 or more | _____ |
| 9. Text left aligned, right ragged | _____ |
| 10. Adequate white space | _____ |

Bonus Marks (+ 1 for each)

- | | |
|--|-------|
| 1. Personal greeting in a letter | _____ |
| 2. Bullets | _____ |
| 3. Question and answer format | _____ |
| 4. Bold for emphasis | _____ |
| 5. Sub-headings as signposts | _____ |
| 6. Effective illustrations or graphics | _____ |
| 7. Place on brochure for name | _____ |
| 8. Preference for Canadian spelling | _____ |
| 9. Serif font for body text | _____ |
| 10. Any other attractive feature | _____ |

Penalties (-1 for each)

- | | |
|--------------------------------------|-------|
| 1. Unexplained terms | _____ |
| 2. Unnecessary information in text | _____ |
| 3. All caps or underlining | _____ |
| 4. Body text in italics | _____ |
| 5. Reverse type | _____ |
| 6. Low contrast | _____ |
| 7. Distracting colours | _____ |
| 8. Too many fonts | _____ |
| 9. Lack of parallel structure | _____ |
| 10. Spelling or grammatical mistakes | _____ |
| 11. Any other detracting feature | _____ |

Notes on the ClearDoc Index

Required Elements

1. Most of the words should be of one or two syllables.
2. Most of the sentences should contain fewer than 16 words.
3. Paragraphs should be as short as possible
4. In the active voice, the subject does the action: “*The doctor sees her patient.*” Not, “*The patient is seen by her doctor.*”
5. Use the 1st and 2nd person, wherever possible, rather than the third person: “*We will phone you.*” Not, “*The hospital will phone the patient.*”
6. Is the message loud and clear?
7. Is the material presented in logical order? Is the arrangement of headings and subheadings consistent in font, size, and alignment? Is the variation in size and type of font purposeful and consistent?
8. A small font will put off a poor reader. If it’s not possible to use size 12, try size 11.
9. Left-aligned is more readable than justified text. Body text should never be centred.
10. Leave enough white space so that the text is not too dense.

Bonus Marks

1. In a letter, address the recipient by name. This establishes a personal rather than formal tone and respects the recipient.
2. Use bullets wherever there is a list.
3. The question-and-answer format is interactive and reinforces learning.
4. Bolding text can emphasize important information or can indicate a subheading.
5. Subheadings, like signposts, break the journey and help the reader to the destination.
6. Are the illustrations relevant to the message, or are they distracting?
7. People are more likely to keep a pamphlet with their name on it.
8. Don’t let your word processor override Canadian spelling.
9. Body text is more readable in serif font. Sans-serif headings make an effective contrast.

Penalties

1. It’s easy to forget that your audience may not be familiar with the professional terms you use everyday.
2. What does the reader really need to know? Unnecessary information increases the density of text, detracts from the message, and forces the writer to use a smaller font.
3. All caps or underlining is difficult to read.
4. Extended text in italics is difficult to read.
5. Body text in reverse type (white on black or colour) is difficult to read. It may be effective in headings or slogans.
6. Black type on white or light paper is easiest to read.
7. Too many colours or clashing colours may put off the reader.
8. Maximum of 3 sizes and 3 styles of font.
9. Lack of parallel structure and other awkwardness of style do not impress the reader.
10. Similarly, spelling and grammatical mistakes cause you to lose credibility.

Follow Effective Teaching Principles during Oral Instruction

In a recent Quebec study of the ways hard-to-reach patients receive their health information (See page 34), 94% of the respondents said they wanted to learn about health in a verbal explanation from a health care worker. Many of them, however, were not satisfied with the verbal explanations they got.

In communicating orally with patients, follow sound teaching principals.

1. Audience

- Adapt the material and adjust the level to the audience.
- Put yourself in the place of the audience and imagine how you would respond.
- Consider how the content, tone and reading level will differ, depending on whether your audience are:
 - men or women
 - adults or children
 - the elderly or the general population
 - patients facing an operation or patients recovering from one

2. Purpose

- Limit and define the objectives. What and Why?
- Relate the objective to the patient. Ask what outcome you want for the patient?
 - To seek help to obtain treatment?
 - To change behaviour to stay in good health?
 - To carry out a procedure to treat a condition?
 - To learn information to ease worry?

3. Unity

- Have one overall theme and purpose. Cast out inessentials. Less is more!
- Other interesting topics can be developed separately.

4. Relevance

- Not, “To lower cholesterol”
But, “To reduce the risk of a heart attack or stroke”

5. Context

- Begin with a context familiar to the patient, when using examples, illustrations, or even sentences. For example,
Not, “Broccoli, carrots, sweet potatoes, peas, spinach, cabbage, carrots, beets and squash have many nutrients.”
But, “Vegetables with many nutrients are broccoli, carrots, sweet potatoes, peas, spinach, cabbage, carrots, beets and squash.”

The Applicator

Audience
Purpose
Participation
Limit
Interaction
Chunking
Active Learning
Testing
Organization
Relevance. Repetition

6. Chunking

- Regroup a longer list of items to be learned into smaller groups, as we do when we learn a seven- or ten-digit phone number.

7. Interaction

People learn more rapidly when they interact with what they learn. Here are some forms of interaction:

- The question-answer delivery (the Socratic Method)
- Simulating the question-answer technique on a pamphlet
- Asking patients how they will do what you want them to do when they get home
- Asking questions to *find out* if patients understand, instead of asking *if* they understand
- Asking the reader to fill in blanks, circle items, rank items in order on a pamphlet

Other Strategies

Minimal-Text Brochures, Posters and Storyboards

A recent study at Montreal General Hospital (See page 34) showed that only 40% of the low literacy patients found written material a useful source of health information. In response, the Quebec Centre for Literacy is developing a series of minimal-text “storyboards” in which the picture illustrates the essential information

Audio-visual materials

Research has shown that low literacy seniors get most of their information about the world from television rather than books and magazines. This is likely true of low literacy people in general. Literacy Partners of Manitoba’s most successful literacy advertising campaign was a series of public service announcements on Global Television. Following their showing each evening, local programs were flooded with calls from potential learners. After the airing of the LPM-sponsored MathWorks, an educational program for low literacy adults, the program website has been receiving 1000 hits a day.

Only government and large organizations can afford the cost of television advertising, but health facilities can build up a library of health videos designed for low literacy patients.

Drama

Drama has been used as a preparation for nervous low-literacy students going to see the doctor. The interview has been acted out an advance to give the patient practice in asking important questions. For other ideas on the use of drama in the literacy classroom, see the texts reviewed on pages 35 and 37.

Health Education Centres

One of the recommendations of the Montreal study (See details of the Health Literacy Project on page 34) is the setting up of Health Education Centres. This might be practical in some Manitoba centres. These informal settings in the hospital would offer plain language written information, audio-visual material for borrowing, and space for small classes or one-to-one meetings.

Community Development Approaches

A review of the literature suggests that low literacy adults often get their health information from peers, rather than health workers (See details of the Health Literacy Project on page 34). Health promoters need to work in partnership with community organizations where low literacy adults might be found. Community Literacy Programs are obvious potential partners.

Partnerships and Participation

Partnerships between Literacy and Health

Literacy and Health organizations need to plan together and teach together.

Invite a literacy person to sit on the health education committee. Invite a health person to sit on the Literacy Program Board of Directors.

Plan health education together. Health providers are the experts on health. However, a common complaint about presentations from health educators has been: “She used big words and talked too fast.” Literacy instructors know the teaching strategies to use with their students. They can also provide an audience of low literacy adults, anxious to learn about health, or a focus group, ready to test-read new documents

Participatory Education

In participatory education the students choose what and how they want to learn. They are motivated because they choose the topic. They learn more effectively because they participate in the process. They are empowered because they are taking control of their education, and in the case of health topics, to some extent, their lives. Empowerment builds self-confidence. Certain health topics, such as nutrition, stress, and even cancer, are popular.

Here are some of the features of participation education:

- Ground rules are laid down at the beginning to establish a democratic process and the role of the teacher (facilitator)
- The students discuss possible topics and vote for their preference
- The students, with the help of the facilitator, plan their lessons and their timetable
- The students share their own stories. This is important in building self-confidence
- The students share the responsibility of consulting resources: the internet, the library, the health authority for low literacy pamphlets. They report back to the class.
- The students invite a health expert to talk to the class, someone used to working with low-literacy adults.
- The students may teach the topic to the class or to other classes.
- The students reflect on their learning
- The whole class may be involved, or a smaller group acting as a “health action team”.

This process is fully explained in a report (reviewed in the Appendix on page 35 and available on the web) by Dr Marcia Hohn: *Empowerment Health Education in Adult Literacy: A Guide for Public Health and Adult Literacy Practitioners, Policy Makers and Funders*. She worked with a group of students at Operation Bootstrap, an adult education program in Massachusetts. Her students devised, developed, and taught a cancer education program: Early Detection of Breast, Cervical and Testicular Cancer. Her advice to literacy practitioners is to start small.

Another example of participation education, in Edmonton Alberta, is described in *Learning for Our Health*, by Mary Norton and Pat Campbell. Women at the Learning Centre conducted their own classes on such topics as Stress, Exercise, Healthy Weight, Eating for Our Health, Menopause, STDs, and Living Healthy on a Low Budget. (See page 37)

Recommendations/Suggestions

For Adult Literacy Practitioners

- Try to make students conscious of health. If your class reacts favourably, make low-literacy health brochures available in the classroom.
- Display some more interesting health or medical posters on the wall to provoke discussion of health topics.
- Go on a field trip to medical facilities and try their forms as a writing exercise.
- Incorporate health topics into the Stages reading and writing portfolio activities in the classroom.
- Invite guest speakers to the class on important health days, such as World AIDS day, on International Day of the Family.
- Consider Participatory Health Education as a means of making your students take more control over their own health.

For Health Educators

- Make sure the health facility is “friendly” to low literacy clients.
- Consider setting up a Health Education Centre where low literacy patients may go to get easy-to-read health information, borrow audio-visual materials, and meet one-on-one with people to answer their questions.
- Continue to develop and use education materials in plain language, so that some of the hard-to-reach population may understand them.
- Develop alternative strategies for reaching the hard to reach population.
- Post the LEARN line referral number in your office.
- Discreetly refer patients to the adult literacy program.
- Visit your local adult upgrading program.
- Include adult educators in your program planning, events, and professional development plans.
- Check with real learners before developing material aimed at them. Use a literacy class as a focus group.
- Conduct your business face to face as much as possible. This is the means of communication preferred by patients.

Appendix 1. Documents Revised in Plain Language

Letter from a Public Health Nurse

Dear Participant,

The Regional Health Authority Diabetes Program will be having a complication risk assessment session in late November. To prepare for this session, please visit your doctor to have the attached information and lab work done. I will then contact you with the exact date and time of the session. In the meantime, should you have any questions, please contact myself, Jane Doe at 123-4567.

At your complication risk factor session we will:

1. Review your lab results to assess your risk for complications
2. Provide you with up-to-date information about diabetes and complications
3. Screen your body mass index and blood pressure
4. Do a complete foot assessment
5. Help you create your diabetes health plan

Sincerely,

Jane Doe,
Public Health Nurse,

[Flesch-Kincaid reading level: 10.3.]

Comments

- Notice the effect of rewriting the letter in very short paragraphs. Don't be afraid to write a paragraph of only one sentence, particularly if that sentence contains important information
- One of the simplest and most effective ways of warming the tone of your letter, and getting a positive response, is to address the recipient by name.
- Make sure that your information is presented in the most logical order.
- You may wish to increase the size of the font. This will not only make the letter easier to read, but also, in the case of a short letter, fill up the page. For this purpose, size 13 (in the case of a document normally written in 12 font) or size 11 (in the case of a document normally written in 10) can be very effective.

Letter from a Public Health Nurse (Revised in plain language)

Dear Mr. Smith,

The Regional Health Authority Diabetes Program will be having a complication risk assessment session in late November.

At this session we will...

1. Review your lab results to assess your risk for complications
2. Provide you with up-to-date information about diabetes and complications
3. Screen your body mass index and blood pressure
4. Do a complete foot assessment
5. Help you create your diabetes health plan

To prepare for this session, please visit your doctor to have the attached information and lab work done. (See separate form.)

I will let you know the time and date of your session, when I get the form back from your doctor.

Please phone me at 123-4567, if you have any questions.

Sincerely,

Jane Doe
Public Health Nurse

[Flesch Kincaid grade level: 7.5]

A Letter to Parents of a New Baby

Dear Parents,

Congratulations on the recent addition to your family.

As parents, you will probably be interested in making all aspects of your baby's life as happy and as comfortable as possible. To assist you, we have enclosed some information that you might find useful.

If you are interested, we have further information available on post-partum adjustment, immunization, child development, communicable disease, family nutrition, and parenting. Please feel free to contact us on any of these or other topics.

Sincerely,
Your Community Health Nurse

[Flesch-Kincaid reading level: grade 12]

Comments

- Again, notice the benefit that comes from turning a form letter into a personal letter.
- Little expressions such as “the recent addition to your family” may prove difficult to the person with low reading skills.
- The third paragraph with its long list of topics is formidable! It begs to be bulleted. This alone accounts for much of the drop in reading level.
- Always follow George Orwell's wonderful rule: “If it's possible to cut a word out, always cut it out.”

A Letter to Parents of a New Baby (Revised in Plain Language)

Dear Mr. and Mrs. Carter,

Congratulations on your new baby.

We know that you will want to keep your baby happy and comfortable. We have enclosed some information that may help you.

We also have information on

- Post partum adjustment (getting used to having a baby in your life)
- Child development (how your child grows)
- Communicable diseases (diseases your child can catch)
- Immunization (protecting your child against those diseases)
- Family nutrition (healthy eating)
- Parenting

Please call us if we can help you.

Sincerely,

Jane Doe,
Your Community Health Nurse

[Flesh Kincaid grade level: 4.3]

A Letter from a Specialist (with comments)

I am writing to you at this time [*redundant*] to advise [*formal*] you that I have received [*formal*] a referral [*noun cluster*] for you/your child [*impersonal*] to have a hearing test. The referral was dated [*passive voice*] upon receipt [*formal*] and is being held [*passive voice*] on the waiting list accordingly [*formal*].

There was a four-month service disruption [*elevated*] caused by the relocation [*elevated*] of audiology to the new Primary Health Care Centre, so my waiting list is presently 5 to 6 months due to the backlog. [*long sentence. Is this information necessary?*] In accordance with our mandate [*elevated*], children are given a prioritized status [*elevated*]. Every effort will be made [*passive voice*] to see people as soon as possible. Your patience is greatly appreciated [*passive voice*].

The schedule is booked [*passive*] in 6-week blocks, so it may be a few months before you hear from us regarding an appointment booking [*formal*]. When your name comes up to be booked, we will contact you. Please contact us if your address or phone number changes (Audiology Reception 123-4567). In the event that [*circumlocution*] you are unable to make your appointment, I would appreciate it [*formal*] if you call in advance to cancel. If you do so, you will be given the next available appointment. In fairness to all who are waiting, anyone who does not show for their appointment and who have not called in advance will be moved to the end of the waiting list. [*long sentence, a little negative. Is it necessary?*]

There are waiting lists at all of the other regional centers where hearing testing is funded by the government. For anyone wishing to obtain service more quickly, there is the option of [*formal*] being seen by one of the audiologists in a private clinic (see listing on back page). Please note that there may be charges for testing at private clinics and not all clinics are set up to test young children, especially young children. For questions regarding costs and services you must contact the private clinics directly.

I hope that you will find this information helpful and I look forward to meeting you.

Sincerely,

[Flesch-Kincaid reading level: 9.5.]

Letter from Specialist (Revised in Plain Language)

Dear Mrs. Brown,

Doctor Smith has referred your son Bobby to me for a hearing test. I have put him on the waiting list.

We are behind due to the movement of our clinic to the new Primary Health Care Centre. I hope to see your son in about five months' time.

In about three months we will let you know the date of Bobby's appointment. Please tell us if you change your address or phone number.

Please tell us if Bobby cannot keep the appointment. I will then see him on the next available date.

You may wish to set up an appointment with another audiologist who can see you sooner. Unfortunately, the other regional centers have waiting lists as well.

In case you wish to visit a private clinic, I have given you a list on the other side of this page. Please contact them directly and ask if they can test children and what you will have to pay.

Please phone our office at 123-4567 if you have any questions.

Sincerely,

[Flesch-Kincaid reading level: 5.8]

Discharge Instructions Following Dental Surgery

- 1) *Do not rinse or use mouthwash for rest of the day. The following day, rinse with warm water and salt several times daily for several days. Stitches usually dissolve within 10 days. Keep tongue and fingers away from operative site.*
- 2) *Eat soft, nutritious foods and plenty of cold fluids for first few days. Rest and avoid excessive activity for several days. Smoking is not permitted for 24 hours. No straws for the first 24 hours as sucking increases potential bleeding.*
- 3) *Some pain is quite normal following dental surgery, If medication has been given or prescribed, take as directed. Sharp edges of bone may occasionally be noticed. These usually disappear within 2 weeks and unless very annoying are rarely removed.*
- 4) *Avoid spitting and rinsing if bleeding occurs. It is normal for the saliva to be lightly streaked with blood for about one day. If bleeding occurs bite down on clean gauze for about 20 minutes.*
- 5) *Swelling may occur, reaching its maximum in about 48 hours. This may attain great proportions, occasionally extending under the chin and down the neck. There is no cause for alarm and will disappear spontaneously in about one week. With impacted teeth a hard lump may be felt on the side of the lower jaw after the visible swelling has disappeared. This may last about six weeks.*
- 6) *Discolouration of the skin sometimes occurs and may extend down into the neck under the eye, and even down into the skin of the chest. This will disappear spontaneously within ten days.*
- 7) *Bad taste or odour in the mouth may be due to stitches and can be alleviated by using a mouthwash. The offensive taste will disappear when stitches dissolve.*
- 8) *Do not drive or operate machinery for 24 hours. Do not consume alcohol, tranquilizers, sleeping medications or any non-prescriptions for 24 hours. Do not make important decisions or sign any important papers in the next 24 hours. You must have someone with you tonight at home.*

If you have any questions or concerns after you arrive home, contact your doctor or the emergency department, 123-4567.

[Flesch-Kincaid Reading Level: 12.3]

Comments

Continuous italics are very difficult to read. Never use for body text.

- 1) Headings are signposts which help the reader find her way through the text.
- 2) Changing passive sentences into the active voice will make the passage easier to read.
- 3) **You may choose to bold text that is very important. *Bold italics give greater emphasis.*** Use sparingly!

Discharge Instructions Following Dental Surgery (revised)

Activity

As you will be a bit groggy after your surgery, you must have someone with you at home on the first night. Do not make any big decisions or sign any papers for 24 hours. Do not drive, or work with machinery. Rest and take it easy for several days.

Rinsing

Do not rinse or use mouthwash for the rest of the first day. Then, for the next few days, rinse with warm water and salt several times daily. Keep your tongue and fingers away from the site of the operation. Stitches usually dissolve within 10 days.

Don't spit and rinse if your mouth starts bleeding. Instead, bite down on clean gauze for 20 minutes. It is normal for your saliva to be lightly streaked with blood for the first day.

Pain

Some pain is quite normal after dental surgery. Take your pills as directed.

You may feel sharp edges of bone. These usually disappear within 2 weeks. We don't remove them unless they are very annoying.

Swelling

You may notice swelling, reaching its peak in about 48 hours. The swelling may be very large and may extend under your chin and down your neck. Don't worry. The swelling will go down in about a week.

With an impacted tooth, you may still feel a hard lump on the lower side of the jaw, after the swelling has gone down. You may feel the lump for up to four weeks.

Bad Taste or Odour

A bad taste or odour in your mouth may be due to the stitches. Try using a mouthwash. The taste will disappear when the stitches dissolve.

Discolouration

Your skin may change colour, extending into the neck, under the eye, and even down onto the skin of the chest. This will disappear on its own within ten days.

Diet

Eat soft healthy foods and drink plenty of cold fluids for the first few days. Do not drink through a straw for the first 24 hours as sucking makes the bleeding worse.

Smoking, Alcohol and Drugs

Do not smoke, drink alcohol, or take tranquillizers, sleeping pills, or non-medical drugs for 24 hours.

If you have any questions or concerns after you arrive home, please contact your doctor or the hospital at 123-4567.

[Flesch-Kincaid level: 4.8.]

A Fact Sheet about a Home Care Program

What is Home Care?

The Home Care program was established in 1974 to help people live at home, remaining independent for as long as possible, thereby avoiding or delaying the need for individuals to go into long-term care facilities.

The mandate of the program is to provide effective reliable and responsible care services to support independent living, develop appropriate care options with clients and/or family and facilitate admission into long term care facilities when living in the community is no longer possible.

What Home Care programs and services are offered in Townsville?

Home Care programs include:

- Long Term Programs (more than 60 days)
- Short Term programs (less than 60 days)
- Dialysis and Ostomy (provincial-basis handled by Townsville)
- Community Intravenous Therapy
- Self and Family Managed Care
- Specialty services such as respiratory, children's and palliative care programs.

Home Care services include:

- Personal care
- Nursing
- Counseling/Problem Solving
- Respite/Family Relief
- Occupational Therapy Assessment
- Physiotherapy Assessment
- Referral to other agencies
- Coordination of internal and external services in the community
- Assessment for long term care and specialty services such as the Adult Day program, Companion Care program and Supportive Housing program.

Key activities of the program are: intake, assessment, care planning, service coordination and delivery, after-hours response, case management, referral, health information, education and community development.

Who is eligible for Home Care?

To be eligible for Home Care, individuals must be a Manitoba resident, registered with Manitoba Health, require health services or assistance with activities of daily living, require service to remain safely in their home and require more assistance than available from existing supports and community resources.

[Flesch Kincaid grade level: 12]

A Fact Sheet on Home Care Program (Revised)

What is Home Care?

Home Care is helping people live at home as long as possible, so that they don't have to go to a long-term care facility.

In the program we will provide community health care services

- To support independent living
- To help clients and family choose the right kind of care
- To arrange for the client to go to a long term care facility when necessary

What Home Care programs are offered in Townsville?

Home Care programs include:

- Long Term Programs (more than 60 days)
- Short Term programs (less than 60 days)
- Dialysis and Ostomy (provincial-basis handled by Winnipeg)
- Community Intravenous Therapy
- Self- and Family-Managed Care
- Specialty services such as respiratory, children's and palliative care programs.

What Home Care programs are offered in Townsville?

Home Care services include:

- Personal care
- Nursing
- Counseling/Problem Solving
- Respite/Family Relief
- Occupational Therapy Assessment
- Physiotherapy Assessment
- Referral to other agencies
- Coordination of internal and external services in the community,
- Assessment for long-term care and specialty services such as the Adult Day program, Companion Care program and Supportive Housing program.

Who is eligible for Home Care?

Manitoba residents registered with Manitoba Health may receive Home Care if they need more help to stay safely in their homes than existing services can provide.

[Flesch-Kincaid reading level: 7.9]

Comment

It is important to be clear about your audience and purpose. As a fact sheet, the original document seems to be aimed at the general public, which would include people wishing to find out about home care for themselves or family members. The language, however, is elevated, as if to impress a board of directors or a funding body. The original document includes more information than the audience needs to know.

A Hospital Consent Form

Authorization for Surgeon to Operate

This is to certify that the surgical procedure known as _____ (name of operation), the reason why it is considered necessary, its advantages and possible complications, as well as possible alternative methods of treatment have been explained to me by _____ (name of Physician or Surgeon), and in light of the information the undersigned authorizes _____ (name of Surgeon) to perform, under any anaesthetic deemed advisable, the operation stated above and also to perform such additional procedures as may be held to be therapeutically necessary on the basis of findings in the course of the operation. Any tissues surgically removed may be disposed of by the surgeon or the hospital in accordance with their accustomed practice.

I _____ realize that when the consultant surgeon is no longer available to continue to follow the recovery of _____ that the care will be assigned to the attending physician. The consultant surgeon will be available for further consultation if deemed necessary by the attending physician.

Witness _____

Signed _____
(PATIENT OR NEAREST RELATIVE)

Witness _____

(RELATIONSHIP)

(Authorization must be signed by the patient, or by the nearest relative in the case of a minor; or when the patient is physically or mentally incompetent.)

Flesch-Kincaid grade level:12

Permission to Operate

I give permission for the surgeon, Dr. _____, to operate on me.

During the operation, he/she

- May perform any other surgery that may be necessary
- May use any anaesthetic that may be necessary
- May dispose of any tissue that is cut out

Dr. _____ has explained to me

- Why I should have this operation
- What could go wrong with the operation
- What treatment I could have instead of the operation

I understand that another doctor will be in charge of my treatment when the surgeon is no longer available.

Signed _____
(Patient or Nearest Relative)

Witness _____

(Relationship)

Witness _____

[Flesch-Kincaid level: 7.3]

Comment
 As one study pointed out, “When low-literate patients are involved, it is vital to make sure that consent is truly informed. A signed consent form does not necessarily mean that you have obtained consent.” (See page 39). A low-literacy patient may have signed a consent form, written by lawyers to cover every loophole, but will it stand up in court?

Appendix 2

A Review of Selected Literacy and Health Materials

These materials will be helpful to health educators who wish to reach “hard-to-reach” patients, and literacy instructors who wish to teach health topics in the classroom. All these materials are, or will soon be, available at the Library of Literacy Partners of Manitoba, 947-5757 or 1-866-947-5757. Some of them are available on the web.

Four of them are highly recommended as rich resources.

- With its review of current practices and its needs assessment of hard-to-reach patients, *Health Literacy Project, Phase 1: Needs Assessment of the Health Education and Information Needs of Hard-to-Reach Patients* is a good place to begin for both literacy and health workers.
- *Empowerment Health Education in Adult Literacy: A Guide for Public Health and Adult Literacy Practitioners* will provide an inspiration to literacy instructors wishing to have students learn about health in their classroom.
- *Working with Low Literacy Seniors: Practical Strategies for Health Providers* is a clear and comprehensive guide to communicating with low-literacy patients.
- *Teaching Patients with Low Literacy Skills* should be in the staff library of every health facility.

Bedford, J & Pepper, L. (1992). *Women Together: A Health Education Training Handbook for Ourselves and Others*. London: Health Education Authority. [327 pages. ISBN 1 85448 346 3]

Developed in response to training needs expressed by women, this handbook is a wealth of resources for women wanting ideas for working on health issues for themselves or for training others. It covers teaching strategies, activities, health topics, planning, publicity, and running training sessions. The title is apt. As a training handbook, it anticipates and provides everything the facilitator might need to organize and deliver a training session. It recognizes that the participants may have low literacy skills. Although this is a handbook for women’s groups, one of its aims is “to show how ideas, activities, and frameworks associated with women’s health education can be applied to other areas of adult education (p. 1)”. The use of 18 teaching strategies employed through hundreds of activities attests to this claim.

Beyond the Brochure: Alternative Approaches to Effective Health Communication. (1998). AMC Cancer Research Center. Denver. [69 pages. This is also available on the web at <http://www.cdc.gov/cancer/nbccedp/bccpdfs/amcbeyon.pdf>]

This guidebook was developed by the AMC Cancer Research Center to encourage health educators to produce materials that do not rely solely on the printed word.

Sections 1 and 2 discuss the importance of getting to know the literacy levels and cultural characteristics of an audience and involving them before developing the materials.

Section 3 provides detailed checklists to determine whether in fact existing materials are suitable in content, visuals and format for a low literacy audience. It suggests useful ways for cutting costs when producing written materials.

Section 4 discusses effective use of non-print materials such as visuals (posters, flip charts, talk boards, real objects and models, display boards, fotonovelas), action-oriented exercises (role play, theatre, song, story-telling, games), and audio-visual materials (videotapes, slide-tape programs, interactive multimedia programs).

Section 5 emphasizes the importance of pre-testing materials.

Doak, C., Doak, L., & Root J. (1996). *Teaching Patients with low Literacy Skills* (2nd ed.). Philadelphia: J.B. Lippincott Company. [212 pages. ISBN 0-397-55161-4]

This is an indispensable text for health educators. It illustrates the link between literacy and health. It looks at the educational theories which provide a basis for particular health interventions. It discusses ways of testing literacy skills, measuring readability, and assessing the suitability of materials. Most important, it provides, with examples, the best practices for health education, in written, oral, and alternative means of communication. Throughout the chapters, it reinforces sound strategies: limit the objectives, group the material, reinforce the main points, begin with the familiar context, make the content relevant, make the lesson interactive, test the patient for understanding.

Health Literacy Project, Phase 1: Needs Assessment of the Health Education and Information Needs of Hard-to-Reach Patients. (2001). Montreal: The Centre for Literacy of Quebec. Part 1: Background Document on Literacy and Health. [46 pages. ISBN 0-9681034-9-9 Printed copies of these documents may be purchased at \$ 10.00 for single copies or \$ 15.00 for the pair (Parts 1 and 2), including shipping & handling, from the Centre for Literacy of Quebec, 3040 Sherbrooke St. West, Montreal, QC, H3Z 1A4. Phone (514) 931-8731 ext. 1415, Email: literacyctr@dawsoncollege.qc.ca. This is also available on the web at <http://www.nald.ca/PROVINCE/QUE/litcent/health/Execsumm/Promo.html>]

This document (Part 1) establishes the rationale for conducting a needs assessment for the information and education needs of hard-to-reach patients at Montreal General Hospital.

Section 1 gives an overview of health literacy. It gives the IALS statistics, and mentions the concern raised by Thomas Sticht that the arbitrary criteria used for separating individuals into different levels may have led to an overestimation of the percentages of adults at levels one and two. It discusses the links between literacy and health, focusing on the work of Burt Perrin. It then records the progress made in recognizing the need to produce health documents in plain language. It summarizes the currently recommended techniques to improve oral communication. “These techniques typically include:

- Limiting teaching objectives
- Giving many examples that have meaning to the patient
- Demonstrating procedures such as measuring dosages and counting pills
- Making learning participatory. Ask patients to restate instructions in their own words
- Repeating the information several times
- Organizing your instruction so the most important messages are presented first and last
- Including family members or other caregivers in the education process (p.10).”

Section 2 looks at key issues arising from the review. Especially important is the emerging evidence that questions “an over-reliance on plain language in health education to address the issue of low-literate patients (p.13)”. The report reviews the patient education strategies “beyond written material (p. 14)”, including community development approaches, participatory health education, drama, and learner patient empowerment. It applauds the important work of Dr Marcia Hohn at Operation Bootstrap in Lynn, Massachusetts.

In discussing the growing number of examples of partnerships between health and literacy organizations, the report summarizes the findings of Dr. Hohn:

In classroom practice, joining the two appears to bring about positive outcomes. Introducing health topics in literacy classes brings out potential for effective learning and retention. Health is a subject of study that draws learners’ interest and is a vehicle for teaching basic skills. It is in fact a two way process. Language

and literacy development facilitates the dialogue about health, while the topic of health stimulates the motivation for literacy learning (p.18).

For more effective health education, partnerships are important at the organizational and decision-making levels as well.

Section 3 is a summary of all the health literacy projects or programs, past and present, in Canada. This is a valuable resource for health authorities as many of these projects are working on plain language education materials.

This review of the research both justifies and focuses the Needs Assessment to be carried out at Montreal General Hospital. Three of the report's conclusions will be of great interest to health educators and literacy instructors:

- Although the emphasis in health education has been on producing material in plain language, it is necessary to look beyond this to oral communication and other strategies.
 - Partnerships between the health system and community organizations may provide the right leadership and expertise for planning the effective health education.
 - Participatory learning with its emphasis on empowerment is a promising teaching strategy.
-

Health Literacy Project, Phase 1: Needs Assessment of the Health Education and Information Needs of Hard-to-Reach Patients. (2001). Montreal: The Centre for Literacy of Quebec. Part 2: [100 pages. ISBN 0-9689593-0-X. Printed copies of these documents (Parts 1 and 2) may be purchased at \$ 10.00 for single copies or \$15.00 for the pair, including shipping & handling, from the Centre for Literacy of Quebec, 3040 Sherbrooke St. West, Montreal, QC, H3Z 1A4. Phone (514) 931-8731 ext. 1415, Email: literacyctr@dawsoncollege.qc.ca. This is also available on the web at <http://www.nald.ca/PROVINCE/QUE/litcent/health/Execsumm/Promo.html>]

This careful, well-documented study determined the health information and education needs of hard-to-reach patients at Montreal General Hospital, as expressed by the patients themselves, their family members/caregivers, and health care professionals. It then made recommendations for a Health Literacy Centre to improve health education at the hospital. It is an excellent model for other facilities to follow.

Among the key findings were the following:

“Patients identified their primary needs as medical information about the illness; information about daily living: diet, exercise, activity level; and teaching about tests and taking medication (p. 6).” A majority (60%) felt that the written material they were given was not useful, as they did not read or had a language barrier. Most were dissatisfied with oral communication with staff as well. Few received education from other sources. They were not interested in learning by computers. Nor were they interested in drama as a means of learning about health (p.37).

The report recommends setting up health education centers (not “literacy” centres, because of the connotation of the word), as a place where patients would go as part of their orientation, or before, after, or during treatment. They should be warm and attractive places, free from the associations of a hospital room. Intimacy is key.

The pilot Health Education Centres should use and offer different learning tools, including better designed written materials in plain language; printed resources such as newsletters, journals, publications from patient support groups, etc.; visual material: posters, pictograms, etc.; health videos for patients to borrow and watch at the centre; and games, Q&A, booklets with cartoons, etc. The activities in the Centres should...include one-to-one meetings with health care workers; small classes and workshops on specific topics; oral presentations by health care workers and other participatory group processes (p.36).

Other recommendations suggest the practical means of setting up and staffing the centres, both with health professionals and volunteers.

This report is essential reading for health authorities interested in reaching their “hard-to-reach patients and setting up a place for low literacy patients to learn and feel at home.

Hohn, M., *Empowerment Health Education in Adult Literacy: A Guide for Public Health and Adult Literacy Practitioners*, National Institute for Literacy, 1998. [141 pages. The text is also available on the web at <http://www.nifl.gov/nifl/fellowship/reports/hohn/HOHN.HTM>]

This is an important book for the literacy instructor who wishes to practise “participatory education” in the classroom.

First, Marcia Hohn identifies the “big problem” for health educators who recognize that literacy is a determinant of health.

1. Studies show that low literacy levels and health are directly linked
2. 45% of US adults have limited literacy skills.
3. Health Education relies on print materials that low literacy adults cannot understand.
4. Therefore the 90 million people who are in greatest need of health promotion/education do not benefit from current health education practice about prevention and early detection (p.12).

She then outlines current approaches to solving the problem:

1. improving literacy levels in the whole population
2. developing low literacy materials
3. developing new ways to communicate health education, including audio-visual techniques

Dr. Hohn, herself advocates a “learning together” approach, consistent with the work of education philosophers Malcolm Knowles, and Paulo Freire. Participation and empowerment are the key words in her approach, and participatory action research, her methodology.

She describes her work at Operation Bootstrap, an adult education program in Lynn, Massachusetts. She recruited a health action team of seven members to teach health topics to other students at the school. The team let the students vote on the topics to be presented, and then proceeded to learn about the chosen topics themselves.

They gathered resources, viewed videos, and asked questions. In their preparation several concerns emerged. Some of them expressed fears “about being poorly treated in a social sense at health care facilities and not knowing their rights and responsibilities in seeking medical care (p.48)”. They developed a skit called “Going to the Doctor” which they thought would provoke discussion of these fears. Their prior experience with outside health educators had also been poor (“they... talk real fast and use a lot of words nobody can understand” p. 47) so they determined to make their material accessible to their classmates. They also realized the importance of making information relevant to their peers. (“You can’t just tell people something and expect them to change as a result. You have to...connect to things that mean something to them.” p.50.)

In response to these concerns, the team concluded that their approach must include:

1. direct teaching by peers
2. a safe and respectful atmosphere to ask questions
3. creative and inclusive methods
4. simple, easy-to-read materials (p.50)

They began with “The Cancer Education Program: Early Detection of Breast, Cervical and Testicular Cancer (p.47)”. In three sessions with each class, they posted a list of vocabulary, gave a true and false quiz to promote initial discussion, did agree-or-disagree exercises to talk about feelings, attitudes and beliefs. With a health educator committed to the process, they demonstrated the process of self-examination. Finally, they presented the drama, “Going to the Doctor”.

In keeping with the Participatory Action Research model which she espouses – problem identification, action, reflection, and learning from action – Dr. Hohn concludes by reflecting on the health action team’s learning.

Health is introduced during the process of literacy development as a crucial life topic that motivates literacy development in adult literacy students. It is a two-way process. Language and literacy facilitates the dialogue about health, while the topic of health simulates (sic) the motivation for literacy learning (p.111).

She ends with a series of valuable suggestions for practitioners on “getting started with linking health and literacy education (p. 116)”.

Mayeaux, Jr., E.J., Murphy, P.W., Arnold, C., Davis, T.C. Jackson, R.H., & Sentell, T. (1996). Improving Patient Education for Patients with Low Literacy Skills. *American Family Physician* 53(1), 205-211.

In this article, the authors – a group of academics and doctors – acknowledge that patients often do not understand their physicians, and that many, especially low-income, low-literacy patients, may be too embarrassed to tell them so. They argue that “to enhance patient understanding, physicians must speak in simple language, repeat key points and avoid giving too many directives. In a detailed table, they list other “techniques that improve oral communication with patients” such as “giving many examples that have meaning to the patient”, making learning participatory “by asking patients to restate instructions in their own words”, and demonstrating “procedures such as measuring dosages and counting pills”(207).

The authors maintain that “written materials should reinforce oral instructions, not replace them”, and that the physician should review the written instructions with the patient. In another table, they give a detailed list of “techniques to improve patient information brochures”(210).

Norton, M & Campbell, P. (1998). *Learning for Our Health: A Resource for Participatory Literacy and Health Education*. Edmonton: The Learning Centre Literacy Association. [110 pages. ISBN 0-9698539-6-3]

This booklet is a report on a Participatory education literacy and health project with a group of women at the Learning Centre, a community-based adult literacy and education centre in Edmonton. It provides an interesting Canadian comparison to the participation action research project at Operation Bootstrap in Lynn, Massachusetts. The authors give the background to the project, the educational philosophy behind it, and the outlines of ten participatory workshops with ideas for implementing them. Like the facilitator of Operation Bootstrap, they see participatory education as a means of empowerment.

Abandoning the teacher's power for the facilitator's role in the democratic process would sometimes produce dilemmas. What does the facilitator do when a student brings wrong information to the classroom?

The facilitators followed a spiral model of participatory education: Start with experiences -> Build on/Analyze experiences -> Plan for action -> Reflect on Action. The women chose the topics for their workshops: Stress, Saying No, Exercise, Healthy Weight, Eating for Our Health, Menopause, Anger, STDs, Living Healthy on a Low Budget, Living on Welfare.

The report concludes with a bibliography of easier-to-read resources about health and related topics.

Oliver, D. (1997). *Literacy Theatre*. Concord: New Hampshire State Department of Education. [66 pages]

This manual may be helpful to literacy instructors wishing to use drama in the classroom to raise awareness of health or other issues, or simply to develop fundamental skills and confidence. Students develop scenarios, which may be scripted or improvised, on provocative literacy or social issues, and present them to an audience of fellow students or the public. A facilitator stops the action and promotes dialogue on the issue between audience and actors who remain in character. The theatre may be used in the same manner as learner speakers to promote literacy awareness to prospective funders and policy makers.

Plimpton, S. & Root, J. (1994). Materials and Strategies that Work in Low Literacy Health Communication. *Public Health Reports*, 109(1), 86-92.

The authors describe their response to the problem of the gap between the high reading level of health pamphlets and the low literacy skills of the target audience: a series of training sessions on how to produce low-cost, easy-to-read, easy-to-reproduce documents.

In 1994, the authors found a virtual absence of, but universal need for, easy-to-read materials. Certainly much progress has been made since then, but the article is still interesting for its list of things to avoid, such as

- information overload
- unclear message
- long words, complex sentences
- technical language
- uninviting tone
- disregard for culture or literacy level of target audience
- solid print without graphics
- cluttered page with graphics overload
- small font
- irrelevant illustrations (p.88).

Sissel, P & Hohn M. (1996). Literacy and Health Communities: Potential Partners in Practice. *New Directions for Adult and Continuing Education*, No.70.

The article refers to “a paradigm shift in health promotion theory and practice that provides an additional base for the linking of health and literacy education (p.62)”, i.e., the movement from a focus on individual lifestyles to an emphasis on “the concept of empowerment”, as individuals and communities are urged to take some responsibility for recognizing and solving health problems. This recognition of the “participatory approach” leads to a discussion of the Massachusetts Health Team, its successor, Project HEAL (Health Education and Adult Literacy), and Project HEAL at Operation Bootstrap. The latter is discussed fully in Marcia Hohn’s *Empowerment Health Education in Adult Literacy: A Guide for Public Health and Adult Literacy Practitioners*. (See above.)

Women's Network Inc. (1997) *Beyond Prescriptions: Meeting Your Health Needs – A plain Language Workbook about Health*, Charlottetown, 1997. [91 pages. ISBN 0-9695419-1-0. Available by mail from Women's Network Inc. Box 233, Charlottetown, PEI C1A 74K, Phone 902 368-5040, Fax 902 369-5039]

This workbook was written by the Health Education in Plain Language Project of Women's Network. Other materials made during the project were

- Health Board Game
- *Is It Hot in Here?* A Handbook on Menopause for Women and Their Families
- *Health Information: Where Can You Get It?* – A Guide to Health Information

This workbook for people in classroom or support groups contains 35 activities in four chapters, You Are a Whole Person, What Makes You Healthy, Making a Health Plan, Supporting Your Health. The book encourages students to think about determinants of health and health promotion. The varied activities relate directly to the students' own lives and will promote thought and provoke class discussion.

Working with Low Literacy Seniors: Practical Suggestions for Health Providers. (1998). Canadian Public Health Association. National Literacy and Health Program. Ottawa. [44 pages. ISBN 0-919245-99-4]

Part 1 explains the impact of low literacy on health. Part 2 discusses the IALS results and points out that of the 48% of Canadians with low or very low literacy skills, very many of them are seniors. In a section entitled "Your Legal Liability as a Health Provider" it warns of the importance of making sure that patients really understand what they are signing when they give consent to an operation:

When low-literate patients are involved, it is vital to make sure that consent is truly informed. A signed consent form does not necessarily mean that you have obtained consent (p.12).

Part 3 offers important practical strategies for health providers in serving low-literacy clients. It emphasizes the importance of clear oral and written communication, since "almost half the general population, and 80% of seniors, have trouble understanding some health information (p.13)." It gives a plain language check list for written materials and a place of pointers for clear verbal communication. It also suggests a holistic approach to seniors' health, citing studies which have shown that people live longer if we bolster self-esteem, promote independence, and reduce isolation. It concludes with additional strategies for working with low-literacy seniors, including a useful checklist for determining whether "your office is welcoming to low-literacy students (p.29) ".

Appendix 3: Literacy and Health Resources on the Web

This is only a sampling of the many resources available on the web. Please send any interesting resources that you find to health@mb.literacy.ca. This list of resources is published on the Literacy and Health website at <http://www.health.mb.literacy.ca>

Health Sites

- **The American Medical Association.** Enter "literacy" in their search engine to find articles on literacy and health. <http://www.ama-assn.org/>
- **Harvard School of Public Health, Health Literacy Studies.** This site offers powerpoint and video presentations and research reports on literacy and health. <http://www.hsph.harvard.edu/healthliteracy/>
- **Health Canada.** This site contains a wealth of reports and resources. <http://www.hc-sc.gc.ca>
- **Health Literacy Consulting.** This private site contains articles on "helping health organizations communicate in ways people can understand". Health Literacy Tips is a useful section. <http://www.healthliteracy.com>
- **The Manitoba Centre for Health Policy.** This research centre of the University of Manitoba's Faculty of Medicine Carries out research on the health of Manitobans. It looks at the factors that affect health, such as income, education, employment and social circumstances. It has a contract with the Government of Manitoba to produce six major reports a year, which are published, along with other educational information, on this site. <http://www.umanitoba.ca/centres/mchp/>
- **The National Literacy and Health Program.** The Canadian Public Health Association's (CPHA) National Literacy and Health Program (NLHP) promotes awareness among health professionals of the links between literacy and health and contains some excellent resources. <http://www.nlhp.cpha.ca/>
- **The Resource Center of the Center for Health Care Strategies.** This site offers a series of *Facts about Health Literacy* on such topics as "Provider Strategies to Help Low-Literate Patients" and "Strategies to Improve Patient Educator Materials". <http://www.chcs.org/resource/hl.html>

Literacy Sites

- **The Centre of Literacy for Quebec.** This important site contains the centre's current research on literacy and health. <http://www.nald.ca/Litcent.htm>
- **International Adult Literacy Survey (IALS)**
<http://www.nald.ca/nls/ials/introduc.htm>
- **Literacy Partners of Manitoba (LPM).** LPM supports adult and family literacy programs in Manitoba. <http://www.mb.literacy.ca>
- **National Adult Literacy Database (NALD).** NALD is the host of hundreds of Canadian literacy websites, the source of up-to-date news, and the repository of important Canadian literacy reports and papers. <http://www.nald.ca>.

Full Text Documents

- *Beyond the Brochure: Alternative Approaches to Effective Health Communication.* A guidebook published by Cancer Prevention and Control to adapting existing materials for hard to reach audiences, and developing new materials such as posters, display boards, fotonovellas, role-play, songs, storytelling, games, etc.
<http://www.cdc.gov/cancer/nbccedp/bccpdfs/amcbeyon.pdf>
- *The Captain's Log. The Proceedings of the First Canadian Conference on Literacy and Health: Charting the Course for Literacy and Health in the New Millennium.*
(http://www.nlhp.cpha.ca/conference/c_log_e.pdf)
- *Clear and Simple: Developing Effective Print Materials for Low Literate Readers.* A publication of the National Cancer Institute, this guide presents a process for developing publications for people with limited-literacy skills. With helpful examples, it outlines the following steps: 1, Define the target audience; 2, Conduct target audience research; 3, Develop a concept for the product; 4, Develop content and visuals; 5. Pretest and revise draft materials.
http://oc.nci.nih.gov/services/Clear_and_Simple/HOME.HTM
- *The Directory of Plain Language Health Information.* This document, available in HTML and PDF, tells health educators how to find excellent examples of plain language health information on a variety of subjects. It also contains plain language and clear design tips and the SMOG readability formula.
<http://www.pls.cpha.ca/english/directry.htm>
- *The Health Literacy Project, Phase 1: Needs Assessment of the Health Education & Information Needs of Hard-to-Reach Patients Part One* reviews current research and practices; Part Two reports on a Needs Assessment conducted at the Montreal General Hospital. The health information and health education needs of hard-to-reach

patients were determined through individual interviews and focus groups.

<http://www.nald.ca/PROVINCE/QUE/litcent/health/Execsumm/Promo.html>

- Hohn, Marcia Drew. *Empowerment Health Education in Adult Literacy: A Guide for Public Health and Adult Literacy Practitioners, Policy Makers and Funders* This report explores one option for health promotion with low literacy audiences: embedding health education directly in adult literacy programs. It details a Participation Action Research (PAR) project in partnership with a student action health team from Operation Bootstrap, an adult learning program in Massachusetts: “Together we identified and investigated the problems around health education for low literacy groups, designed and took action to address these problems, collectively assessed what we learned in the process, and what we needed to share with others (Marcia Hohn).” <http://www.nifl.gov/nifl/fellowship/reports/hohn/HOHN.HTM>
- *Literacy and Health Promotion: Four Case Studies*. In this Nova Scotia project, learners and students worked together in pairs to research a health topic and share their findings with others in their community. By participating in the health promotion process, students gained a better understanding of their own health and improved their literacy skills at the same time. This report contains many lesson plans and other useful information of interest to health educators and literacy practitioners. <http://www.nald.ca/fulltext/4case/cover.htm>
- Perrin, Burt. *How Does Literacy Affect the Health of Canadians* <http://www.hc-sc.gc.ca/hppb/healthpromotion/development/pube/literacy-health/literacy.htm>
- Sarginson, Rob. *Literacy and Health: a Manitoba Perspective*. A good place to begin for the Manitoba picture of the link between literacy and health. <http://www.mb.literacy.ca/publications/lithealth/ack.htm>
- *Toward a Healthy Future: The Second Report on the Health of Canadians* <http://www.hc-sc.gc.ca/hppb/phdd/report/toward/eng/index.html>
- “When Learners Become Teachers: How Students Can Teach Other Students about Health”. This is an article in *Learners in Action*, a publication of Movement for Canadian Literacy. Written by members of the student action team mentioned in report by Marcia Hohn, the article describes how the learners used health materials to teach themselves what they wanted to know about certain health topics. Literacy instructors will find these teaching strategies interesting. Literacy and health people could work together on this model. <http://www.literacy.ca/public/action/feb01/page4.htm>

Resources (Materials for Use with Low-Literacy Adults)

- **AskEric.** This section of the Education Information site contains lessons on health topics that may be of use to the literacy practitioners. <http://www.askeric.org/cgi-bin/lessons.cgi/Health>
- **Current Bibliographies in Medicine, National Library of Medicine.** This section of the site contains a health literacy bibliography. <http://www.nlm.nih.gov/pubs/cbm/hliteracy.html>
- **Easy-to Read Publications** This section of the U.S. Food and Drug Administration site provides easy-to read health brochures. <http://www.fda.gov/opacom/lowlit/englow.html>
- **Facts for Life.** This online version of a UNICEF text contains 13 chapters, each dealing with a major cause of childhood illness and death. Each chapter has three parts: an introduction, several key messages, and supporting information. The key messages are written in very simple language, and will be interesting to health and literacy educators. <http://www.askeric.org/cgi-bin/lessons.cgi/Health>
- **Health and Literacy Compendium.** An annotated bibliography of print and Web-based materials of use with limited-literacy adults. <http://www.worlded.org/us/health/docs/comp/index.html>
- **Patient Education Resources for Clinicians.** This resource of the Oregon Health and Science University offers hand-outs for low-literacy patients. <http://www.ohsu.edu/library/patiented/>
- **Publications of the Office of Elder Health.** This series of Elder Health Tips is published by the Massachusetts Department of Public Health. <http://state.ma.us/dph/bfch/chp/oehehp.htm>
- **Staying Healthy at 50+.** A publication of the Agency for Healthcare Research and Quality, this is a large print, easily readable document in question and answer format in the broad categories “What You Can Do to Stay Healthy” and “Ask Your Doctor about Checkups, Tests, and Shots You Need”. <http://www.ahrq.gov/ppip/50plus/index.html>
- **Talking with Your Doctor: A Guide for Older People.** This publication of the National Institute on Aging covers such topics as Choosing a Doctor You Can Talk To, Tips for Good Communication, What Should I Say, etc. <http://www.nia.nih.gov/health/pubs/talking>

- **UCSF Homeless Clinic.** This site offers health pamphlets written in plain language on topics such as "How to Treat a Cold", "What is Aspirin", and "How to Deal with Lice". <http://itsa.ucsf.edu/~hclinic/>

Appendix 4: Some Winnipeg Health Statistics

Death Rate per 1000 population by Income Quintile

Sex	Q1	Q2	Q3	Q4	Q5
Male	13.7	10.2	8.7	7.8	6.2
Female	9.4	8.0	7.3	6.7	6.6

Life Expectancy by Income Quintile

Sex	Q1	Q2	Q3	Q4	Q5
Male	65.3	70.5	72.8	74.3	76.6
Female	74.4	77.8	79.5	80.0	82.1

Short Term Hospital Stay per 1000

Q1	Q2	Q3	Q4	Q5
5.8	5.2	5.0	4.8	4.7

Physician visits per year

Q1	Q2	Q3	Q4	Q5
5.8	5.2	5.0	4.8	4.7

Source 1986 Census, Slides, Roos and C Mustard (Founder's Network)

Appendix 5. Low Literacy Levels in Manitoba Communities

(Taken from the Manitoba Literacy Atlas to be found on the website under Literacy Links at www.health.mb.literacy.ca)

Town, RM, LGD VL or First Nation	RHA	Pop	% of pop over 15 with < grade 9	Un-employment Rate %	% of income from transfer payments	Average Family Income \$
Alexander LGD	Brandon	2,555	11.7	6.8	17.7	48,643
Arborg VL	Interlake	1,012	26.6	9.8	29	37,397
Brandon C	Brandon	39,175	8	7.4	15.3	49,065
Brochet 197 R	Burntwood	242	50	0	0	0
Cornwallis RM	Brandon	4,279	6.6	2.7	8.5	49,631
Cross Lake 19R	Burntwood	1,529	29.2	28.9	32.6	32,742
Cross Lake 19AR	Burntwood	1,456	42.5	28.4	38.2	30,554
Cross Lake 19ER	Burntwood	506	33.9	28	29.2	32,940
Dauphin T	Parkland	8,266	21.1	8.8	23	48,129
Dauphin RM	Parkland	2,488	15.9	5.5	16.9	46,936
De Salaberry RM	South Eastman	3,067	17.9	5.5	17.8	44,577
Elton RM	Brandon	1,406	11.3	3	16.1	44,707
Ethelbert RM	Parkland	514	28.6	3.4	21.3	26,089
Ethelbert VL	Parkland	315	51.8	16	47	25,846
Flin Flon (part) C	Nor-man	6,572	9.6	7.8	13	56,233
Franklin RM	South Eastman	1,724	25.3	4.3	23.8	34,576
Gilbert Plains RM	Parkland	976	20.8	20.7	17.4	36,001
Gilbert Plains VL	Parkland	748	34.7	3.9	33.4	29,763
Gillam LGD	Burntwood	1,534	8.5	11.2	5.1	69,534
Gimli RM	Interlake	3,124	10.6	14.9	8.8	47,498
Gimli T	Interlake	1,574	15	11.5	23.4	49,792
Grandview RM	Parkland	904	19.6	1.7	18.8	40,901
Grandview T	Parkland	856	29.4	0	33.7	36,880
Granville Lake S-E	Burntwood	77	22.2	0	0	0
Grand Rapids LGD	Nor-Man	404	15.1	13.5	15.8	44,947
Hannover RM	South Eastman	9,833	21.7	5.3	13	43,487
Hillsburg RM	Parkland	559	20.5	2.9	20.2	34,846
Ilford S-E	Burntwood	155	28.57	23.1	0	0
La Broquerie RM	South Eastman	2,493	14.3	5.3	13.5	43,858
Lawrence RM	Parkland	608	34.0	3.3	37.6	28,419
Leaf Rapids T	Burntwood	1,504	7.7	3.3	3.5	78,692
Lynn Lake LGD	Burntwood	1,038	17.2	12.1	12.5	53,597
Minnetonas RM	Parkland	1,193	17.3	3.5	14	44,879

Town, RM, LGD VL or First Nation	RHA	Pop	% of pop over 15 with < grade 9	Un-employment Rate %	% of income from transfer payments	Average Family Income \$
Minnetonas VL	Parkland	598	24	4	21.2	39,742
Minnedosa T	Assiniboine	2,443	18.3	6.5	22.8	47,259
Mossey River RM	Parkland	752	21.3	7.5	24.3	37,468
Mountain Nth LGD	Parkland	1,142	32.2	16	40.4	35,247
Mountain Sth LGD	Parkland	766	31.2	9.2	34.1	33,305
Neepawa T	Assiniboine	3,301	19.9	4.1	25.2	44,076
Nelson House 170R	Burntwood	1,760	33.6	45.2	38.1	27,295
Niverville T	South Eastman	1,613	21.6	5.8	17.9	42,216
Ochre River RM	Parkland	980	14.6	4.5	18.8	37,990
Opaskwayak 21AR	Nor-Man	219	21.9	19	0	0
Opaskwayak 21ER	Nor-Man	1,776	23.9	31.6	24.9	30,776
Opaskwayak 21IR	Nor-Man	140	9.5	13.3	0	0
Park North LGD	Parkland	401	46.9	25	31	31,284
Park South LGD	Parkland	961	17.9	5.4	16.7	41,245
Piney LGD	South Eastman	1,604	34.2	15.3	34.4	31,549
Pinawa LGD	NEHA	1,672	1.9	3.9	5.9	67,170
Plumcoolee VL	Central	729	51.1	5.8	29.6	30,241
Roblin T	Parkland	1,885	30.2	7.7	35.1	38,524
Roblin RM	Parkland	968	20.1	1.8	16	38,216
Ritchot RM	South Eastman	5,364	9.5	5	10.2	53,498
Shell River RM	Parkland	1,050	15.1	2.4	19.3	37,010
Selkirk T	Interlake	9,881	11.8	10.2	18.4	48,429
Souris T	Assiniboine	1,613	15.1	0	21.3	44,972
Ste Anne RM	South Eastman	4,213	14.1	7.2	17.1	42,311
St Pierre-Jolys VL	South Eastman	925	11.4	2.1	14.8	44,876
Ste Rose du Lac R	Parkland	944	16.5	6.7	19.8	39,967
Ste Rose du Lac V	Parkland	1,047	22	4.9	20.6	43,230
Steinbach T	South Eastman	8,478	26.2	4.5	16.3	49,646
Stuartburn LGD	South Eastman	1,563	38.4	4.2	33.1	33,768
Swan River T	Parkland	3,986	21.1	7.3	24.7	43,143
Swan River RM	Parkland	2,907	15.0	4.4	18.3	39,186
Tache RM	South Eastman	8,273	9.1	5.2	9.2	54,184
The Pas T	Nor-Man	5,945	9.0	8.1	11.3	53,693
Thompson C	Burntwood	14,385	8.6	8	6.3	62,918
Thompson RM	Burntwood	1,321	24.4	5.4	20	36,370
Whitehead RM	Brandon	1,535	8.3	2.4	13.7	53,901
Winnipeg	WRHA	618,477	9.0	8.2	13.9	53,174
Winnipegosis	Parkland	730	43.6	12	35.2	34,956