

Health Literacy in health promotion: the case of diet and healthy eating

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Much of the research on health literacy focuses narrowly on how to understand basic health information, such as instructions on prescribed medicines. The thinking being that armed with knowledge, people will act on the information to improve their health. However, in reality this rarely happens – neither among people with chronic conditions who rely on medicines to sustain their quality of life, nor among the general public for whom an unhealthy diet or other lifestyle choices can have serious health consequences.

An estimated 2.7 million deaths around the world are due to poor diet and low fruit and vegetable consumption [1]. An unhealthy diet containing lots of fat and sugar (energy-dense foods) is linked to specific health conditions, such as obesity, diabetes and many other chronic problems.

There are many reasons why people consume an unhealthy diet. It could, for instance, be due to poor health literacy skills, such as misjudging portion size [2], trouble accessing nutritional information [3], or difficulty understanding nutritional labels [4]. Food labels and nutrition or dietary facts are often presented in technical rather than ‘plain English’. This makes it difficult for people to understand dietary information.

Poor health literacy skills can be related to poor literacy. Twenty per cent of the population can read at a level no better than an average 10 year old. This could partly explain why many health promotion campaigns are not even understood, let alone change behaviour. For example, the ‘five-a-day campaign’ in the UK, which encourages consumption of at least five portions of fruit and vegetables each day, has had little effect on changing dietary behaviour; average fruit and vegetable consumption remains at three portions daily, as in much of the Western world [5].

As with adherence to medication, consuming a healthy diet relies on many individual and environmental factors. Individual factors include taste, motivation and preferences to eat these foods, rather than energy-dense convenience foods. Additionally, self-efficacy skills such as being able to buy, prepare and cook fresh foods, are consistent predictors of fruit and vegetable consumption [6]. Other factors include the perceived cost and availability of different foods and social support in the form of encouragement from other family members to eat fruit and vegetables [7]. People feel they do not have time and/or cannot be bothered to buy and prepare fruit and vegetables to make meals from scratch, so resort to using convenience foods. This issue of time and effort is often linked to poor cooking skills. The responsibility for cooking a meal usually rests with the female partner in a family who often works and whose ability to cook greatly influences family nutrition. However, the preferences of the husband/partner and children are also influential.

A conceptual framework based on the theory of planned behaviour [8] and risk theory [9] was used for research on young men in Britain urban London and rural Norfolk aged 18-24 to explore fruit and vegetable consumption. This age group is renowned for having a low level of fruit and vegetable consumption. Of the 34 young men interviewed, only one had heard of the five-a-day campaign and all were confused by what they should count as a portion. None knew about the link between fruit and vegetable consumption and specific health benefits. Indeed, this group was generally unaware of public health efforts to promote healthy eating. When they were shown dietary messages from health organisations they found them to be ambiguous and irrelevant to their lives. When the young men were divided into relatively high (4+ portions daily) and low (<3 portions daily) consumers, other factors also impacted on fruit and vegetable consumption: high consumers had high self-efficacy, wanted to be healthy in the future, and their families positively influenced their diet. On the other hand, low consumers had low self-efficacy, relied on convenience foods, and were also influenced by their social lives and friends who “lived for today” [10].

Health promotion has only recently considered health literacy as an important factor in research on behaviour. The notion that simply imparting ‘knowledge’ enables people to improve health is, however, clearly wrong. Not only is this knowledge *not* imparted to many, but there is convincing evidence showing that changing dietary behaviour requires more than just having information or knowledge: it requires understanding the circumstances and viewpoints and skills of the people concerned. Theoretical models, such as the theory of planned behaviour, are considered necessary to explain behaviour and develop successful interventions because they provide a framework that can be tried and tested [11]. However theories must be regularly reviewed to ensure factors – such as those identified above – continue to influence decisions made and behaviour followed in everyday life. Likewise, health literacy research should consider the many factors that influence medication adherence and use theoretical models, based on the experiences of patients, to develop successful interventions.

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