


# How Health Education Practices by Paediatric Registered Nurses Promote Health Literacy: A Critical Analysis

*Ola Kutah*
*RN, BN, MN*

*A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy*
*School of Nursing and Midwifery*
*Division of Health Sciences*
*University of South Australia*

*May, 2014*

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# Glossary of Terms

| | |
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| **Emancipation** | '…members' autonomy and responsibility had been realised…the power of self-reflection, knowledge and interest are one' (Habermas 1972, p. 314). |
| **Empowerment** | '…is a social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives' (Gibson 1991, p. 360). |
| **Enlightenment** | 'The concept of enlightenment functions as a bridge between the idea of scientific progress and the conviction that the sciences also serves the moral perfection of human beings. In the battle against the traditional powers of church and state, enlightenment requires the courage to make use of one's own reason, that is, autonomy or maturity' (Habermas 1984, p. 147). |
| **Functional Health Literacy** | '...the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions' (Ratzan & Parker 2000, p. vi).<br>' ...constellation of skills, including the ability to perform basic reading and numerical tasks required to function in the health care environment' (The Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs of the American Medical Association 1999, p. 553). |
| **Health Education** | '…any combination of learning opportunities designed to facilitate voluntary adaption of behaviour which will improve or maintain health' (Green 1987, p. 4).<br>Is 'the process of providing learning opportunities for patients and their families to increase knowledge of the disease, improve skills in assisting with treatment-related tasks and aid in the development of coping mechanisms' (Wingard 2005, p. 212). |
| **Health Literacy** | 'The ability to access, understand, and communicate information to engage with demands of different health contexts to promote good health across the life-course' (Kwan, Frankish & Rootman 2006, p. 80).<br>'...represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use the information in ways which promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment' (WHO 1998, p. 10).<br>**'**Health literacy is the ability to make sound health |

| | |
|---|---|
| | decisions in the context of everyday life – at home, in the community, at school, at the workplace, in the health care system, the market place and the political arena. It is a critical empowerment strategy to increase people's control over their health, their ability to seek out information and to take responsibility' (Kickbusch & Maag 2008, p. 206). |
| **Health promotion** | '…is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It is a core function of public health and contributes to the work of tackling communicable and noncommunicable diseases and other threats to health' (WHO 2007, p. 10). |
| **Ideal speech situation** | '…a form of communication that is improbable in that it sufficiently approximates ideal conditions' (Habermas 1984, p. 25). |
| **Ideologically False Consciousness** | '…the subjective inconspicuousness of systematic constraints that *instrumentalize* a communicatively structured lifeworld takes on the character of deception' (Habermas 1987a, p. 187). |
| **Language** | 'Language is a medium of communication that serves understanding, whereas actors, in coming to an understanding with one another so as to coordinate their actions, pursue their particular aims' (Habermas 1984, p. 101). |
| **Lifeworld** | '…this concept proves itself in a theory of social evolution that separates the rationalisation of the lifeworld from the growing complexity of societal systems so as to make the connection...between firms of social integration and stages of system differentiation tangible, that is, susceptible to empirical analysis. …the horizon within which communicative actions are "always already" moving--is in turn limited and changed by the structural transformation of society as a whole' (Habermas 1987a, pp. 118-119). |
| **Non-Social Action Situation** | A 'circumstance [that] is given only in the mode of something taked for granted in the lifeworld, something with which those involved are intuitively familiar without anticipating the possibility of its becoming problematic' (Habermas 1987a, p. 124). |
| **Social Action Situation** | '…is segment of *lifeworld contexts of relevance*…that is thrown into relief by theme and articulated through goals and plans of action; these contexts of relevance are concentrically ordered and become increasingly anonymous and diffused as the spatiotemporal and social distance grows' (Habermas 1987a, pp. 122-123). |

# Abbreviations

| | |
|---|---|
| **AHPRA** | Australian Health Practitioner Regulation Agency |
| **AIHW** | Australian Institute of Health and Welfare |
| **ARC** | Australian Research Council |
| **AVCC** | Australian Vice-Chancellors' Committee |
| **Children's NSF** | Children's National Service Framework |
| **DARE** | Database of Abstracts of Research Evidence |
| **DEEWR** | Department of Education, Employment and Workplace Relations |
| **DOH** | Department of Health |
| **FHL** | Functional Health Literacy |
| **HMSO** | Her Majesty's Government |
| **HREC** | Human Research Ethics Committee |
| **MCaFHNA** | Maternal, Child & Family Health Nurses Australia |
| **MeSH** | Medical Subject Headings |
| **NHMRC** | National Health and Medical Research Council |
| **NSW** | New South Wales |
| **PhD** | Doctor of Philosophy |
| **RCN** | Royal College of Nursing |
| **RN** | Registered Nurse |
| **SA** | South Australia |
| **SPPS** | Statistical Package for the Social Sciences |
| **STOFHLA** | Short Test of Functional Health Literacy in Adults |
| **TRIP** | Transferring Research Into Practice |
| **UCSF** | University of California San Francisco |
| **UNCRC** | United Nations meeting on the Rights of the Child |
| **UniSA** | University of South Australia |
| **WCHN** | Women's and Children's Health Network |
| **WHO** | World Health Organisation |
| **WRAP** | Web Resource Appraisal Process |

# Abstract

In this study I engage paediatric and child and youth health registered nurses (paediatric RNs) in a process of reflection about health education and health literacy. The intent has been to explore those conditions that shape, limit or determine their actions and what health education practices are made possible to promote health literacy in children and young people.

My doctoral study was premised on the view that health literacy is as vital to children and young people as to adults. For people to accept greater responsibility for their health and health status, a key activity is the education of people of all ages. If children understand more about their health and practice healthy lifestyles from a young age, the hope is that children and young people will be better placed to maintain a healthy life and minimise the occurrence of chronic conditions later in their life.

Jurgen Habermas's critical social theory, specifically two significant theoretical constructs, knowledge-constitutive interests and communicative competence, informed the research. These constructs provided the lens to guide and shape the research design and methods of data collection and analyses implemented. A sequential transformative mixed methods research design was conducted in three stages:

Stage 1 - Describe the context;

Stage 2 - Identify recurring themes; and

Stage 3 - Apply a critical lens.

The sequential nature of the design involved the use of both quantitative and qualitative data collection methods with one type of data collection (document analysis and literature review) followed by another (Delphi survey) subsequently followed by another type of data collection (focus group) and then applying the critical lens to all findings.

# Declaration

This thesis presents work carried out by myself and does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university.

To the best of my knowledge it does not contain any materials previously published or written by another person except where due reference is made in the text; and all substantive contributions by others to the work presented, including jointly authored publications, is clearly acknowledged.

Name: Ola Kutah

Signature: *Ola Kutah*

9th May 2014

# Acknowledgements

I am grateful to Almighty Allah, for his mercifulness and blessing.

I would like to acknowledge the following people and give them my genuine appreciation:

- My supervisors - Associate Professor Kay Price and Professor Helen McCutcheon - for sharing their skills; a job absolutely well done.
- All the participants in the study.
- To Wendy Bastalich, Monica Behrend and all the Learning and Teaching Unit staff at the University of South Australia for on-going educational support and encouragement to complete this PhD thesis.
- My dearest friends Kate, Shona and Desrae for their massive emotional support through my PhD journey.
- My parents and family who have always believed in me and in my abilities to complete this PhD and for their continued support over the years.
- My lovely sons Deya and Hashim; during their short lives I have completed this degree. Deya and Hashim have given me love and kept me focussed on finishing and without whom I could not have completed this task. Thank you my darlings.

Finally, I dedicate this thesis to my late Grandmother, Rabihat, who very sadly passed away in 2009. It was her love and belief in me that helped me to finish this project, and she will never leave my heart.

# 1 Introduction

## Why this study?

The World Health Organisation (WHO) estimates that non-communicable diseases such as cancer, heart and lung diseases, and diabetes kill more than 36 million people each year (WHO 2011; WHO 2013a). Four key risk factors to these diseases are tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets (WHO 2013a). Being able to influence and assist children and young people under the age of 18[1] to maintain a healthy lifestyle is clearly crucial to mitigate against these risk factors; the goal of health education is as vital to children and young people as it is to adults. The involvement of paediatric, child and youth health RNs (hereafter referred to as paediatric RNs) to assist children and young people to learn how (and why) to improve their health behaviours, through a focus on health education practices by nurses, is a critical contribution. Paediatric RNs have the potential to inform children and young people how to advocate for themselves and to take a more influential role in their health care outcomes. The study described in this thesis supports the view of Speros (2011) that nurses, including paediatric RNs, have a critical role in the promotion of health education and increasing an individual's health literacy.

This thesis explores how paediatric RNs understand the concepts of health education and health literacy, and the implications of these understandings for their clinical practice and in turn the health of children and young people. My overarching research question was: How is health education and health literacy constructed by paediatric RNs and what role, for nurses, is promoted?

[1] The *UN Convention on the Rights of the Child* defines a child as 'every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier' (Article 1, Convention on the Rights of the Child 1989). In Australia the age of majority is eighteen, which means that a child is a person less than 18 years of age (The Library of Congress 2014).

Advancing health literacy in a populace encompasses more than spreading health information; it entails assisting individuals to develop self-reliance to act on that knowledge and the capacity to work with and educate others. Poor health literacy results in lack of awareness of health conditions and treatment options, and increased risk of hospitalisation (Baker, Parker, Williams, Clark & Nurss 1997; Andrus & Roth 2002). The implications of poor health literacy are significant and serious and have been explored in published literature for the last thirty years. According to Rudd, Mneykens and Colton (1999) those with low health literacy are less involved in disease prevention practices, fail to seek preventive care, and are less able to detect illness at an early phase (Davis, Crouch, Wills & Miller 1991; Lindau, Tomori, Lyons, Langseth, Bennett & Garcia 2002). They struggle to access information about community-based resources (Dreger & Tremback 2002). Those with a chronic illness and low health literacy lack vital information about the illnesses that affect them and their management regimen, negatively affecting their management of their long-term chronic illnesses (Williams, Baker, Honig, Lee & Nowlan 1998; Silverstein, Iverson & Lozano 2002).

## Project Overview

Through the research methods employed my intent was to engage paediatric RNs in a process of reflection on how their professional practices, specifically health education practices, may or may not contribute to creating viable conditions for children and young people to become health literate. I utilised the theoretical work of Habermas (1972, 1984, 1987a) to explain the conditions that shape, limit or determine actions, as well as possible actions by which paediatric RNs may influence the health literacy of children and young people. The findings described in this thesis regarding health education experiences and attitudes of nurses, extends the existing literature and knowledge on the topic. Nurses perceptions of lacking time and resources need to be re-thought or re-contextualised as structural problems whereby they permit their actions to be driven by other priorities (the health system's priorities), controlling how they then structure the environment and communication interactions with children, young people and their parents/guardians. How a focus on these 'other priorities' contributes to low levels of health literacy in vulnerable groups will continue to require further exploration.

I did not undertake this study with the view that I could change the social practices of paediatric RNs or that I would directly influence care provided to children and young people. My data becomes the focal point through which I discuss what is already known

about health literacy and how health education is considered, to make recommendations for change. I hold the view that a critically informed paediatric RN is one who is aware of constraints on their efforts in their role to work with children and young people to become health literate. In turn, critically informed paediatric RNs understand these constraints and look for alternative ways to work with children, young people and their parents/guardians to assist them to give meaning and direction to making healthy choices. An RN can never be certain that they achieve the goal of enabling a child or young person to be health literate, but the goal of raising awareness of health literacy in this group I argue remains an important part of the role of paediatric RNs.

In *Chapter 2*, I present a thorough but not complete literature review on health education and health literacy. The purpose of this review is to acknowledge that which has already been published related to structural and/or organisational issues that impact on the quality of practices implemented by nurses and show how this study extends beyond this body of work. *Chapter 3* describes in detail how I understand Habermas's Theory of Knowledge and Human Interest (1972) and Theory of Communicative Action (1984, 1987a) and the way these understandings relate to this study.

The methods of data collection and data analysis I used, informed by my understandings of Habermas, are outlined in *Chapter 4*. This chapter provides a detailed account of the sequential transformative mixed methods research design that I conducted in three stages:

Stage 1 - Describe the context;

Stage 2 - Identify recurring themes; and

Stage 3 - Apply a critical lens.

I also detail how I recruited participants and acknowledge the ethical considerations in undertaking the study.

*Chapter 5* discusses the research study's findings from Stages 1 and 2. Findings generated from the document analysis, Delphi surveys and focus group interview are presented. *Chapters 6 and 7* present a detailed discussion employing theoretical insights drawn from Habermas (1929- ) to illuminate the main themes identified in this research study. I show how applying the lens of Habermas's theories to the participants' responses and research study findings in relation to health education and health literacy provides a perspective of

what constitutes nursing interests, ideologies and actions with regard to caring for children and young people in the health care system.

I draw together all my work in my final chapter and discuss the contribution of this study to nursing, implications for further research and limitations of the study. What follows in this introductory chapter is why health education and health literacy are important concepts to explore in nursing.

## The importance of health education

Health education, as Irvine (2010) explains, is a complex process and a difficult concept to separate from health promotion. Irvine, a Professor of Nursing, considers that the outcome of health education influences the knowledge and attitudes of individuals, indeed even empowering them, though Irvine (2010) does not relate the significance of health education to health literacy. Whilst the importance of literacy in influencing health has been demonstrated worldwide (Nutbeam 2008; Kearsey 2002), there has not been widespread research on how best to inform nurses, public health workers, physicians, pharmacists and other health-care professionals of the many aspects related to health education that increase health literacy (Kearsey 2002).

Several studies have issued calls for increased awareness or capacity for nurses promoting health education in a range of nursing contexts (see for example Boswell, Cannon, Aung & Eldridge 2004; Rowe & Barnes 2006; Baur 2011; Macabasco-O'Connell & Fry-Bowers 2011; McKinlay, Mackie, Arcus & Nelson 2012). One study urges nurses to engage in continuing education to improve delivery of health promotion (Cannon & Boswell 2009), and Stiles (2011) recommended strategies by which health education may be undertaken. What was more difficult to locate were studies that explored health education in the paediatric nursing context; specifically, the understandings that inform nurse-led health education interventions in paediatric nursing, and how paediatric nurses address organisational or systemic influences on their delivery of health education to children and young people.

While there are studies of health promotion in the context of educating parents/guardians and teenaged youth (Kowalski, Leef, Mackley, Spear & Paul 2006; Rowe & Barnes 2006; Betz, Ruccione, Meeske, Smith & Chang 2008; DeWalt & Hink 2009; Wood & Bolyard 2011; Chappuy, Taupin, Dimet, Claessens, Treluyer & Cheron 2012), only one study was located describing an intervention to deliver health education specifically to children and

young people (Robinson, Calmes & Bazargan 2008). Of the latter, barriers to health education were discussed amongst pharmacists (Devraj & Gupchup 2012), and in the context of medical care for clients with epilepsy (Keikelame & Swartz 2013), but the only studies to address barriers for nurses focused on nursing students, exploring both health education strategies (Scheckel, Emery & Nosek 2010) and barriers to the integration of health education (Zanchetta, Taher, Fredericks, Waddell, Fine & Sales 2012).

Whilst the barriers raised by nursing students, such as a lack of support in clinical settings for the delivery of health education, may also impact on health education delivery of experienced nurses, nurses with more experience may identify other organisational, structural or systemic barriers to the effective delivery of health care. Different barriers may also arise in the paediatric nursing setting, where additional factors such as parents/guardians and limited capacity of children and young people come into play. Consequently, for effective paediatric health education to occur in the pursuit of increased health literacy amongst children and young people, gaining an understanding of the experiences of nurses attempting to undertake this task is necessary. This thesis attempts to address this gap in knowledge to make a critical argument about the value of health education by paediatric RNs to inform health literacy of children and young people.

## Defining 'health literacy' and understanding its relevance

The broadest definition of health literacy was released in the late 1990s by the WHO, and emphasises the importance of education to enable people to become health literate, thus assisting them to choose the healthiest health choices (Kickbusch 2008). The WHO definition reads:

> Health literacy implies the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions. Thus, health literacy means more than being able to read pamphlets and make appointments. By improving people's access to health information, and their capacity to use it effectively, health literacy is critical to empowerment. Health literacy is itself dependent upon more general levels of literacy. (WHO 1998, p.10)

Poor literacy can affect people's health directly by limiting their personal, social and cultural development, as well as hindering the development of health literacy.

The concept of health literacy is not new, and encompasses more than being able to read and write; it is also about empowering people with knowledge and skills to make informed choices about their health and interests, in order for them, in their environment, to have greater control over their actions (Nutbeam 1999a; Speros 2005; Brey, Clark & Wantz

2007). Conceptualising health literacy in this way requires the ability of people to choose what knowledge and abilities are vital to everyday health practices that may promote changes for healthier lifestyle (Nutbeam 1999a). In discussing health education strategies, it is important to understand the fundamental outcome that health education aims to reach – health literacy.

In the late 1990s, Nutbeam came up with a framework that pulled together the following themes from the fields of literacy practice outlined by Freebody and Luke (1990): code-breakers, text-participants, text-users and text-analysts. His framework categorised three levels of autonomy and empowerment in health literacy: functional health literacy, interactive health literacy and critical health literacy (Nutbeam 1999b).

The standard definition of functional health literacy, accepted by the U.S. Institute of Medicine and Healthy People, 2010 is: 'The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions' (Ratzan & Parker 2000, p. 713). Weiss defines functional health literacy as 'following the physician's recommendations faithfully and accurately in treatment and lifestyle' (in Giorgianni 1998, p. 6).

Interactive health literacy, according to Nutbeam (1999b), is the ability to read and then act autonomously on health information. Nutbeam (2008) suggests that in this way health literacy can be viewed as a personal asset. Important to health literacy being a personal asset is the process of health communication in both clinical and community settings (Nutbeam 2008).

Critical health literacy, according to Nutbeam, necessitates an acknowledgement and better understanding of the socio-political aspects of education, and empowers people with self-efficacy to utilise the health knowledge to engage in healthier behaviours for their own benefit. As well as assisting people to develop the self-confidence to act on that information, critical health literacy involves increased capacity to assist others to work towards major autonomy and empowerment. It is this understanding of health literacy that aligns to the role of nurses who work in a primary health care perspective.

This research is grounded in a primary health care perspective (Chamberlain & Beckingham 1987; Talbot & Verrinder 2010). Primary health care is conceptualised as 'a philosophy permeating the entire health system, a strategy for organizing health care, a level of care and a set of activities' (Chamberlain & Beckingham 1987, p. 158). The role of

primary health care as identified by the World Health Organization (WHO) is 'a people-centred approach to health that makes prevention as important as cure ... It can prevent much of the disease burden' (Chan 2008). In this research, primary health care as a philosophy shapes the conceptualisation of health literacy, and education is a key activity performed by nurses within the primary health care philosophy. To assist my exploration of paediatric RNs' understanding of the concepts of health education and health literacy, and the implications of these understandings for their clinical practice and in turn the health of children and young people, I utilised Habermas's critical social theory as my framework.

## Theoretical Framework

I approached my study informed by Habermas's critical social theory to offer another interpretation of paediatric RNs' understandings of the role that they enact in promoting health and health literacy to children and young people.

Although the critical social theory of Habermas incorporates the fundamentals of positivism and hermeneutics, it also incorporates a third aspect of emancipation (Habermas 1972). In C*hapter 3*, I elaborate on my understanding of the theoretical constructs of Habermas that has guided my research. Critical social theory refers mainly to a series of ideas that emerged by a group of scholars from the Frankfurt School in Germany in the 1920s. Jürgen Habermas, a German philosopher, has further developed and put together a specific view of critical social theory. His work was informed by the works of Marx and Freud in the nineteenth and twentieth century (Kendall 1989).

According to Habermas (1972), emancipation is dynamic meaning any exploration of the practices of paediatric RNs cannot be detached from the social and historical contexts of their workplace. As previously stated, the aim of my research was not to emancipate paediatric RNs or children and young people. I did, however, aim to assist paediatric RNs to understand the role that they play in the way that children and young people think about health. Through participation in my research, and guided by critical social theory, I hoped that paediatric RNs may engage in a process of enlightenment.

Kant's answer to the question 'what is enlightenment?' is as follows:

> Enlightenment is man's [sic] release from his self-incurred tutelage. Tutelage is man's inability to make use of his understanding without direction from another. Self-incurred is this tutelage when its cause lies not in lack of reason but in lack of resolution and courage to use your own reason. (cited in McCarthy 1978, p. 77)

Enlightenment is a philosophical movement that began in the eighteenth century and was characterised by a vigorous inquiring of authority. The view of the movement is that where social structures of power and organisation control people's lives, the populace negate their own autonomy. When people unite together in their oppression, against the power structures of society they previously had unconsciously obeyed, they will be enlightened. It is through Enlightenment, Fay (1987) argues, that critical social theory desires people to beat their powerlessness, transform their collective arrangements to meet their interests and be collectively autonomous.

Habermas (1974, p. 40) says 'in a process of enlightenment there can be only participants'. This means that I cannot do the enlightening or empowering for participants; they can only enlighten or empower themselves and as much as they can enlighten themselves they are capable of regulating themselves. Paediatric RNs also cannot emancipate a child and young person, but my study was premised on the view that paediatric RNs could engage children and young people in a process of enlightenment through health education to learn how to make healthy choices and become health literate.

The goal of critical social research is to 'identify and overcome oppressive structures by exposing power imbalances and assisting the oppressed to take action' (Young 2008, p. 96). Freire (1996) states that for the oppressed to overcome the condition of their oppression they mainly have to critically distinguish its causes. When the causes are shown, via the best suitable practice of inquiry, a new circumstance can be formed. This research seeks to recognise those causes and in doing so has the potential to inform social change by critiquing current understanding and knowledge of health literacy to illustrate how support can be improved for paediatric RNs caring for children and young people.

The involvement of paediatric RNs in this study has been a deliberate exercise to understand conditions that shape, limit or determine their actions so that they may intervene in a positive way in the lives of children and young people. How paediatric RNs are introduced to the concept of health education, and how they in turn deliver health education to children and young people in their practice role, is important to explore. This includes how, in their role as a nurse, they promote health literacy and assist children and young people to become health literate. It is important because education and information are vital to attaining a high level of health literacy, to ensure efficient participation and the empowerment of individuals and communities. Underpinning my research is the

acknowledgement that health education and life skills preparation, when appropriately designed and employed, have the potential to promote positive behavioural changes.

By applying theoretical constructs described in the critical social science of Habermas, detailed in *Chapter 3*, my research also explores whether or not paediatric RNs may be influenced by ideologies about their role and in turn health education and health literacy. I explore what attitudes they hold as true and valid that in turn shapes their understanding of reality and behaviour and are utilised to explain and validate their actions (Mezirow 1981). Indeed my research explored whether the practice of nursing contributes to a child and young person's level of health literacy as well being as a source of the solution to improving a child and young person's health literacy.

The application of Habermas's work to inform my research reflects my understanding that paediatric RNs would have certain rules imposed on them by their employer, their profession, colleagues and administration. How they dwell on or reflect upon these imposed rules will affect their communicative action role with children, young people and their parents/guardians. The types of actions that they consider as suitable in their role will be predisposed by historical, social and institutional influences.

Paediatric RNs need to think that their practices can influence children and young people to become more critically aware of the consequences of their behaviours and lifestyle decisions related to their health and welfare. Critical social theory provides the framework to this research study so that the focus is on challenging paediatric RNs to reflect on vulnerabilities in their practices with children and young people and their capacities to act meaningfully together to nourish children, young people with their parents/guardians to learn how to make healthy lifestyle choices.

## In summary

This chapter has provided an outline of the purpose, context and significance of my research, identifying how primary health care shapes my view that health education is a key activity of nurses. To assist my exploration of how paediatric RNs understand the concepts of health education and health literacy I introduced Habermas's critical social theory as my theoretical framework. To demonstrate how my study extends beyond the body of already-published work, *Chapter 2* acknowledges and interrogates what is known about structural and/or organisational issues that impact on the quality of practices related to health education as implemented by nurses.

# 2 The health education role of nurses to promote health literacy

## Introduction

In *Chapter 1* I argued that poor health habits present a serious childhood threat. Several non-communicable diseases diagnosed in adulthood have their foundation in behaviours established in childhood; therefore, to prevent chronic illnesses from developing, it has been argued that there is a need for healthy behaviours to be established during childhood (Mustard 2007; WHO 2013b). Florence Nightingale acknowledged health education as a key element of the nursing role as early as the middle of the 19th century (Nightingale 1859). Eminent nurse and scholar Virginia Henderson (1966, p. 15) also agreed that 'It is part of the nurses' role to improve the patients' level of understanding and thus promote their health'. To this end, as health education has been described as a means 'to promote the presence of conditions that assist people in creating health-enhancing conditions for personal and community health' (Talbot & Verrinder 2010, p. 179), requirements of nurses worldwide include a responsibility for them to provide health education to people in their care (Lindeman 1973; Rankin & Duffy 1983; Close 1988; Wilson-Barnett & Macleod-Clark 1993; Latter 1993; Morgan 1994; Stömberg 2002; Phillips, Pearce, Hall, Kljakovic, Sibbald, Dwan, Porritt & Yates 2009; Barton, Bevan & Gail Mooney 2012; Howell 2012). Effective health education requires that nurses create opportunities or 'communicative spaces' (Habermas 1984, p. 335) appropriate to the capacity of the person in their care, understand the characteristics and life context of the person, and recognise their limitations, to promote successful outcomes as a consequence of the health education they deliver. In this chapter, I demonstrate how my study extends beyond the body of already published work to explore what is written in relation to nurse-delivered health education and how this influences the health literacy level of a child and young person.

To begin this review I explore literature that defines health education, its relationship to health literacy, and the issues relevant to its implementation in the role of nurses. I will then describe the value of nurses providing health education with a specific linking to

health literacy in children and young people so that there is a greater potential for nurses to influence the health outcomes of this vulnerable group.

## Health education – what is this?

As there are numerous definitions of health, there are also numerous definitions of health education. The 2000 Joint Committee on Health Education and Promotion Terminology defined Health Education as 'any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions' (Gold & Miner 2002, p. 6). The World Health Organization [WHO] defined Health Education as 'compris[ing] [of] consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health' (WHO 1998, p. 4). Health education has also been defined as the profession of educating people about health (McKenzie, Neiger & Thackeray 2009) and encompasses environmental health, physical health, social health, emotional health, intellectual health and spiritual health (Donatelle 2009).

Health education has also been expressed as 'any combination of learning opportunities designed to facilitate voluntary adaption of behaviour which will improve or maintain health' (Green 1987, p. 4). This definition infers that people operate in an intentional way, and choose their own health-related behaviour. It may not result in people modifying their behaviour; they may continue to take health risks and perpetuate poor health as a consequence of their choices. To this end, Tones and Tilford (1994) viewed health education as a process of 'critical consciousness raising', perceiving the nurse's role as a client educator to promote enlightened client education. For a long time this task has been expressed as a professional expectation of nurses; to address '... the need, on the one hand, to prevent disease and safeguard the public health while, on the other hand, respecting individual freedom of choice – including the freedom to adopt an unhealthy lifestyle' (Tones 1997, p. 33).

In 2005 Rebecca Wingard stated that '... patient education is the process of providing learning opportunities for patients and their families to increase knowledge of the disease, improve skills in assisting with treatment-related tasks, and aid in the development of coping mechanisms' (2005, p. 212); a view shared by several authors (Visser, Deccache & Bensing 2001; Rankin, Stallings & London 2005). Coping with disease may be an ongoing

focus of adults and health professionals as they often enter the health care system when it is too late to prevent the development of disease and they lack fundamental information to assist them in understanding their condition (O'Connell, Baker & Prosser 2003; WHO 2013c). But, for children and young people opportunities exist to prevent the incidence of non-communicable diseases and reduce even mitigate against risk factors associated with these diseases.

Prevention of non-communicable diseases in a health care system of developed countries where there is an increase in specialisation and fragmentation (Dell'Api, Rennick & Rosmus 2007; Lee 2008) is not without difficulties. This fragmentation and specialisation, particularly in the biomedical-focused acute care sector, is attributable to the increase in medical and pharmacological knowledge and shortened length of stay for adults and children and young people alike during hospitalisation (Lee 2008). It is understandable, therefore, that the role of nurses may also become increasingly fragmented, particularly where nurses become specialised to deal with for example cardiovascular problems (Kutzleb & Reiner 2006) and diabetes mellitus (Assal & Golay 2001; Chyun 2004). Nurses must be knowledgeable about the diseases, medicines, treatments, devices and all of the nursing practices regarding specialised care. In addition, paediatric RNs have the challenge of ensuring they communicate with children and young people and their parents/guardians to ensure they also know about prevention and not just coping with diseases.

For adults and children and young people alike to make decisions about their behaviour, it is essential that they have access to accurate information (WHO 2013c). They should be conscious of the hazards associated with particular activities to make an informed decision about whether to participate, even where the enjoyment derived from a risky behaviour may offset the potential hazards to their future health (WHO 2013c). Should an adult then choose to engage in behaviour that may harm his or her health, in full knowledge and acceptance of the risks, influencing this choice may be difficult for nurses and other health care professionals. For children and young people who will rely on their parents/guardians, paediatric RNs need to include in their health education focus not only children and young people but their parents/guardians as well, to assist them to understand the consequences of their decisions on their children and the impact of chronic condition on their lives.

Chronic conditions can disrupt the normal growth and development processes of children and young people, either directly or indirectly, as a result of ongoing treatment (AIHW 2012). Chronic conditions can also affect the social and emotional development of children

and young people, through fear of stigmatisation, school absences or inability to participate in age-appropriate activities, and through physical pain and suffering that can negatively affect future functioning (Dell'Api, Rennick & Rosmus 2007). Although the mortality rate of Australian children and young people has halved over the last twenty years, the pattern of morbidity has profoundly shifted, with obesity in children and young people rapidly becoming one of the most serious health matters in Australia (AIHW 2012).

Paediatric RNs have a critical role to play in educating children, young people and their families about health, because they come in contact with children, young people and their families in many different settings. If health is viewed as a marathon that begins during pregnancy of the mother, at birth and continues throughout childhood and adolescence, it is clear that children and young people need to establish lifelong healthy behaviours that persist into adulthood. Even preschool children and young people make important health decisions every day; decisions about safety, hygiene, smoking and drugs, sun safety, nutrition and physical activity. Nurses have the opportunity to work to enable children and young people to develop healthy lifestyle habits that persist over the course of their lives, teaching them about how to keep healthy, to believe that healthy living is really important to them, and to practice and reinforce good health behaviours.

## The link between health education and health literacy

As health literacy is the anticipated outcome of health education, health education is a vital element for promoting people's health, and accurate health information should be delivered in an accessible and appropriate format that suits the client's learning needs. Health knowledge is critical to enable people to make decisions concerning their lifestyle, and make changes to activities that create health risks (Talbot & Verrinder 2010).

The primary health care philosophy aims to achieve 'Health Care for All', and calls for social justice, equity, community control, social changes that improve on health and well-being, and focuses on working with people to enable them to make decisions about their needs and how best to address them (WHO cited in Talbot & Verrinder 2005). The WHO states that:

> Primary Health Care should be a philosophy permeating the entire health system, a strategy for organizing health care, a level of care and a set of activities. (WHO cited in Talbot & Verrinder 2005, p. 4)

Focusing on the process of empowerment and the increase of control over every influence that impacts upon health (Talbot & Verrinder 2010), primary health care encourages and encompasses the integral relationship between health education and health literacy.

Many studies (see for example DeWalt, Berkman, Sheridan, Lohr & Pignone 2004; Davidson 2004; Scudder 2006) have shown that poor literacy is associated with poor health in a wide variety of settings, affecting people of all social classes but more frequently among people who are elderly, of young age, from minority groups, of low income, unemployed, and who have lower levels of educational attainment, chronic disease, or do not speak the health care provider's language. Whilst literacy is an essential determinant of health, it has furthermore been argued that health literacy is a crucial element of social, economic and health development (Kickbusch 2001). Health literacy is recognised as a skill that develops throughout life, and lifelong learning is essential (Kickbusch 2001). It is regarded as vital to efficient engagement in good health and wellbeing (Hohn 1998; Kickbusch 2001).

In 2008 a report for the South Australian government prepared by Professor Ilona Kickbusch (2008) made several recommendations to progress health literacy in South Australia. Amongst these recommendations was a commitment to support research, training and education about health literacy. Kickbusch (2008) highlighted a need for incorporating a health literacy element into the medical and health sciences curricula in South Australian universities as one way of achieving this particular recommendation. Describing a social environment in which the health consumer is overwhelmed by information about health from the media and marketing campaigns, in addition to the increasing complexity of the rapidly changing health system, Kickbusch highlighted the importance of education to inform health consumers and arm them with the appropriate knowledge to choose the healthiest as well as the easiest health choice (Kickbusch 2008).

The current study was developed on the premise that health literacy education needs to become a universal element of healthcare, particularly for children, young people and their families. A report by Mustard (2007) about investing in the early years, in which he draws awareness to early brain development and its effect on lifelong behaviour, learning and health, suggested all people whose work influences very young children, including parents/guardians and community caregivers, understand the fundamentals for a healthy and flourishing life. The current study argues that setting the foundation for health literacy

early in life will help children and young people to establish healthy behaviour patterns that will hopefully lead to good health across the lifespan.

Implications of children and young people not establishing healthy behavioural patterns extend beyond the individual. Investment in early child and young person development programmes is about social justice and is significant to economic growth and wealth (van der Gaag 2002). Early childhood experiences have an influential effect on the cognitive, social and emotional capability and the health and wellbeing of adults that are rudimentary to economic efficiency in the adult population (Mustard 2007; WHO 2013b). Successful societies depend in part on a well-educated and adaptable labour force that is proficient in learning new skills to stay competitive in a frequently shifting global market (Heckman 2000). This emphasises the long-term value of the role of paediatric RNs in delivering health education in their practice role.

The primary statement of the WHO definition of health literacy (WHO 1998, p. 10) indicates that an individual ought to be able to obtain health information, understand this information, and utilise this information to enhance their health and the health of their families or communities. It also indicates that this does not always require being able to read or write (Kickbusch 2008), and highlights that the threat of miscommunication or misunderstanding is not exclusive to those who cannot read. Some groups of people have an increased risk of disease because of social, cultural, socioeconomic or other factors such as their place of residence, economic status, employment status, skills, education level, language and cultural barriers, and lifestyles (Kickbusch 2008). For example, health-related knowledge is intimately linked with literacy (DeWalt & Hink 2009), and misunderstandings about the association between lifestyle choices and health outcomes have been attributed to poor understanding of the nature and causes of disease (Kickbusch 2008). These contextual aspects can make it hard to make changes to diet, smoking, drinking and other lifestyle behaviours. For example, some people find it hard to adopt a healthy diet, because it is more expensive than one based on foods that are high in fat, salt and sugar.

The growing complexity of health care necessitates the increased participation of the healthcare consumer, because low health literacy leads to poorer outcomes (Williams 2002). People lacking health literacy skills are less able to navigate health care systems, and may fail to receive the health care that they need. Kickbusch (2008, p. 46) described these disadvantaged community groups with low health literacy as experiencing ‘double

inequity'. Addressing this inequity depends upon taking action through advocating, communicating and developing the capacity of people in the healthcare workforce (Kickbusch 2008); people like paediatric RNs.

Improving health literacy is not the sole responsibility of those providing healthcare services; policymakers, regulatory bodies and consumers themselves must accept some responsibility. The *Joint Commission 'What Did the Doctor Say?:' Improving Health Literacy to Protect Patient Safety* (2007) aims to promote organisational action to promote health education, education for staff to better educate clients, and widespread commitment to using clear communication in all client encounters. It also prioritises clients' communication requirements across the continuum of care, from the time a client enters a healthcare organisation up until they have been discharged to independently manage their condition. This necessitates policy modifications that endorse enhanced provider-client communication (The Joint Commission 2007). How paediatric RNs focus on enhancing nurse-client communication is important to explore.

Health literacy interventions by health professionals reviewed in publications collated for this review focus predominantly on older adults, clients with limited formal education, and individuals who speak English as a second language. Yet, the need is for all people (adults and children) to receive information in a way that meets individual requirements (Murphy-Knoll 2007). One of the challenges inherent in improving health literacy for children and young people is the distribution of accountability between the parent/guardian and the child and young person for the child's and young person's health outcome, as maturational cognitive capabilities influence a child's and young person's capacity to recognise and engage in self-care (Pignone & DeWalt 2006). Furthermore, children and young people differ in their capacity to engage in self-care within the same age groups, and parents/guardians employ different strategies to encourage their child and young person to engage in self-care activities (Saucier 1984; Moore 1993; Moore & Mosher 1997). Consequently, a child's and young person's maturity, engagement in self-care activities, self-concept, family structure and support, health care providers, maternal self-efficacy, length of disease, knowledge of disease, academic accomplishment and engagement in outside activities all influence communication. The potential value of improving child and young person health literacy has become increasingly evident over the last four decades, with clear links established between recognised risk factors and adverse health behaviours, and accelerated atherosclerotic and hypertensive processes in childhood and adolescence, with the latter leading to increased risk for cardiovascular disease throughout adulthood

(Hayman 2010). These factors add to the complexity but stress a necessity of the paediatric RNs' focussing on enhancing nurse-client communication.

## The health education role of nurses to improve health literacy

The role of a nurse can create opportunities for delivering health education, and the competency requirements for Australian registered nurses include health education as a primary nursing responsibility (Nursing and Midwifery Board of Australia 2013). This includes educating people to make informed decisions about their health care and treatment, health promotion, disease prevention, and achieving peaceful death (Nursing and Midwifery Board of Australia 2013). Health teaching and health counselling are included in the policy statement of the competency requirements for Australian registered nurses (Nursing and Midwifery Board of Australia 2013). This responsibility of nurses to teach clients is both an ethical and a professional responsibility.

The nurse's role is to support the rights of the individuals to know their health status, and to assess and assist a person's physical, psychological and spiritual response to that knowledge. The nurse also provides health teaching and health counselling based on the interest of the client (Bandman & Bandman 2002), and using health education principles the nurse can assist people in achieving their health goals in a way consistent with their lifestyles, values and beliefs (Bandman & Bandman 2002). Educating people is an integral part of the nurse's role in every practice setting, including in schools, the community, and at work sites, health care delivery sites and homes. Many publications (McAllister, Presler & Cooley 2007; Bodenheimer 2008; Howell 2012; Looman, Presler, Erickson, Garwick & Cady 2013) identify the role of nurses as health care coordinators for individuals in their care. Depending on the interest and needs of a person, nurses establish a partnership to guide the individual in the selection and use of relevant health services. Hence, health education encourages self-care, self-empowerment and, ultimately, less dependence on the healthcare system (The Health Foundation 2011).

A variety of studies published in the 1990's argued that nurses can be efficient health educators (Macleod-Clark, Haverty & Kendall 1990; Roe 1990; Wyness 1990; Allen, Knight, Falk & Strang 1992). There are many humanistic and economic profits of nurses' adoption of a health education approach, such as enhanced quality of care, client satisfaction, participation in care and self empowerment (Latter, Macleod-Clark, Wilson-Barnett & Maben 1992). Economic advantages may also emerge as the incidence of preventable disease and morbidity decreases, in turn decreasing reliance on hospital care

and medication costs (Miller 1992). Indeed the 1990's heralded an extensive focus on health education by nurses.

Lack of knowledge and skills such as assessment and communication had previously been recognised as obstructions to client education (Macleod-Clark 1988; Gott & O'Brien 1990), in addition to the intensity of the client's distress (Tones, Tilford & Robinson 1990), the lack of sufficient and suitable materials and resources (Gott & O'Brien 1990) and confrontation from other medical staff (Murdaugh 1980). As early as 1976, Winslow (1976) observed that the organisation of care at ward level was a significant factor influencing nurses' participation in health education activities in hospitals. Research from the early 1990's revealed that whilst all nurses reported a high level of health education activities in their respective wards, this did not correspond to the observational data collected by the researchers in the case study wards (Macleod-Clark, Wilson-Barnett, Latter & Maben 1992). The study exposed contrasting levels of incorporation of health education activities, ranging from wards with no or negligible incorporation to wards in which health education practice could be regarded as advanced. The study concluded that the inconsistencies reflected the nurse's level of understanding of health education. Macleod-Clark *et al.* (1992) suggest that barriers to delivering health education are inextricably related to nurses' perceptions about the concept of health education. If health education activities are considered to be 'isolated activities to be added on to care' (Macleod-Clark *et al.* 1992 p. 253), rather than essential to all care, health education cannot be integrated into the nursing approach.

Research from the 1990's continued to explore the impact of communication between nurses and clients on the attainment of efficient health education practice. Jones (1993) analysed the raw data of the case studies undertaken by Macleod-Clark *et al.* (1992) to investigate nurse-client communication. She concluded that skilled communication 'remains for the majority a theoretical concept' (p. 81) and that even where health education was incorporated into practice, it centered around 'illness oriented' activities, with 'information-giving' as the main type of health education practice. This analysis also identified overlooked occasions for health education, that clients' requirements were often disregarded, and that opportunities such as hospital admissions were not utilised for health education. Throughout field observation and interviewing nurses from community, school, hospital and occupational health nursing settings, Gott and O'Brien (1990) established that the concepts of partnership and participation – the philosophy upon which health education practice is based – had not yet been established in nurses' agendas, with nurses in hospital

settings particularly bound by routinised systems and practices. Twinn and Lee (1997) identified lack of time, heavy workload and the related complexities of insufficient staffing as the key factors restraining health education practice in acute settings, in addition to lack of knowledge and skills in performing health education.

Additionally, Robinson and Hill (1999) argue that the hospital environment focuses on functional efficiency, with an emphasis on the biomedical approach to human disease. This approach conceptualises the human body as a machine, and therefore the practices within diagnosis, treatment and cure aim to fight the disease and repair the body to a completely functional state (Pelling, Berridge, Harrison & Weindling 1993; Baggot 1994; Jones 1994). Robinson and Hill (1999) also claim that doctors and managers have applied this mechanistic view to the running of hospitals. Restructuring activities designed to improve efficiency and economy has reduced the number of non-acute hospital beds; consequently, hospitals have become more acute in their focus (McBride 1994; Coakley 1998).

While research literature from the 1990's suggests that an increase in acuity levels of clients, increasing medical and technical knowledge and shorter length-of-stay in hospitals has resulted in nurses having a narrowly focussed role in delivering health education, literature published from 2000 to today suggests that the situation has not changed. Whilst the importance of health education to client care has been acknowledged for nurses in their professional competencies required to practice as an RN, there is a dearth of research exploring the reality of health education practice by nurses in acute care health facilities.

More recent publications suggest that nursing roles are influenced by health system reform, legislation relevant to the regulation of nursing, and factors relating to workforce and health care delivery processes (Henderson & Winch 2008). Other influences include professional practice matters, knowledge development, consumers, and workforce supply and demand (Henderson & Winch 2008). Jackson and Daly (2008), though, consider that nurses who are aware of the social, economic and political aspects that affect the health system can be influential in developing nursing care and practice. Nurses require such awareness to assume leadership roles, joining forces with academia to develop inventive models for clinical skill development, such as offering targeted clinical placements for undergraduate students.

The changes in acute care health facilities in Australia through the 1990's (decreasing lengths of stay, fewer acute care beds, increased acuity levels of clients particularly given associated co-morbidities) prompted a national review of care delivery and outcomes

(Australian Government National Health and Hospitals Reform Commission 2009). As the demand for health services changed (Aitken, Faulkner, Buchnall & Parker 2001), transformations in care provision, nursing and interdisciplinary models of care also needed to occur (Senate Community Affairs Committee 2007). Nurses were informed that they needed to understand these changing models of care, given the shifting contexts of their work and the differing skill mix of healthcare professionals within multidisciplinary teams (NSW Department of Health 2006). Therefore the effect nurses have on healthcare delivery and client outcomes became reliant upon how nurses' interpret the health policy that drove models of care.

Many argue that health policy has focussed the educational approaches of universities so that knowledge and skill transfer is underpinned by competency development and professional values (Heath 2002; National Nursing and Nursing Education Taskforce 2006; Henderson & Winch 2008; Daly, Macleod-Clark, Lancaster, Bednash & Et Orchard 2008). Educators of nurses need to create opportunities for persons who will become nurses to understand and integrate the personal characteristics necessary for effective nursing, such as interpersonal understanding, compassion, critical thinking, self control and responsiveness (Zhang, Luk, Arthur & Wong 2001). Findings from the 1990's indicate they also need the skills for delivering health education within the economic and administrative limitations of the system in which they will work. Interestingly Sayers and DiGiacomo (2010) argue that the healthcare system, precisely because of promoting specialist nursing roles, risks restricting opportunities for health education to specialist nurses, and not every nurse is required by competency expectations. If nurses' perceptions about health education are restricted to the clients' medical conditions and treatments as found in the 1990's (Gott & O'Brien 1990, Macleod-Clark *et al.* 1992, Twinn & Lee 1997), this questions how nurses understand the concept of health literacy.

Although nursing professionals form the largest group of healthcare providers (Sanders, Thompson & Wilkinson 2007), no studies were found that explored the knowledge of nursing professionals about educational preparation, role or practice specialty in relation to health promotion and client outcomes, or the use of resources to assist communication with individuals with low health literacy. Changes in healthcare systems, healthcare technologies and rising and varying epidemiological matters, direct nurses' instructional practices in client education (Bastable 2006, Redman 2007). Whilst nursing's views on health literacy remain largely unexplored, health promotion activities and client education nevertheless form inherent components of nursing care (Mason 2001). Enhanced

understanding of what nursing professionals presently know about health literacy would inform education practices and could identify opportunities to enhance care at the point of nurse-client contact.

## Nurse-led delivery of health education to children and young people: issues of power, age and vulnerability

The need for an increased understanding of the significance of the early years of a child's and young person's life (see for example Center on the Developing Child 2007; Shonkoff, Boyce & Mcewen 2009) has led to the establishment of child and young person development policies in Australia and overseas (such as the United Kingdom Department of Health 2013). Australia has an extensive and established 'well-child' health service that has been servicing families for over 100 years (Kruske & Grant 2012) and provides maternal, child and family health nurses (MCaFHNA) to work with families with children and young people under five years of age to support child and young person development and offer services for both primary and secondary prevention of physical and psycho-social health matters (Kruske & Grant 2012). In recent years Australia produced a National Agenda for Early Childhood to drive major transformations in early childhood care and education (DEEWR 2011). An essential element of this agenda is a National Early Childhood Development Strategy that acknowledges that 'the early childhood workforce is central to delivering early childhood development services and bringing about fundamental cultural change required for responsive service delivery' (DEEWR 2011, p. 20). Hence the role of the MCaFHNA, and particularly their purpose of maximizing growth and development in children and young people between zero to five years, is significant.

The physiology of children and young people changes over the course of their development, creating a range of illnesses throughout early infancy to adolescence that differ substantially to those of adults (Ratcliffe 1998), and children and young people differ in weight, size, shape, intellectual capability and emotional reaction (Advanced Life Support Group 2005). Furthermore, children and young people and their families present with diverse psycho-social needs (Hewitt-Taylor 1999). Therefore, it is essential for nurses to sustain their knowledge and skills and to work within the boundaries of their competence to address the diversity of needs of children, young people and their families (Nursing and Midwifery Board of Australia 2013). Coyne (2006) suggests that nurses under workforce pressures may experience conflicting priorities and expectations in relation to helping children and young people to participate in decisions about their care.

The past decade has seen increasing acknowledgment at both a national and international level of the significance of children and young people's rights, and the need to listen to and discuss with children and young people (Her Majesty's Government 1989; United Nations Convention on the Rights of the Child 1989; Children's National Service Framework DOH 2004). Calls to increase efforts to engage children and young people in decision-making have occurred for years (see for example Oldfield & Fowler 2004), with consultation with children and young people identified as a policy matter by non-government and voluntary organisations such as Action for Sick Children, Barnardo's, Carnegie Young People Initiative, National Youth Agency, National Children's Bureau and Save the Children. The United Nations meeting on the Rights of the Child (UNCRC 1989) stipulated the right of every child and young person to free will, dignity, respect, non-interference and the right to make informed decisions. Following on from this, the European Convention on the Exercise of Children's Rights (Council of Europe 1996) affirmed that in all actions regarding children and young people, the best interests of the child and young person should be the main concern.

Since 1989, when the Children Act (1989) in England was enacted to support healthcare personnel to consider children and young people's views and engage children and young people in negotiations concerning them, a substantial body of evidence has grown that highlights the child's and young person's right to information and contribution with regard to medical care, in reference to age and maturity (Alderson 1990, 1993; DOH 1993, 1997; Lowes 1996; Hart & Chesson 1998; Alderson 2000). Twenty years ago, the Welfare of Children and Young People in Hospital Report (1993) suggested that:

> Children and young people ought to be entirely informed as possible about their situation and treatment to permit them to use their rights. Even where younger children do not have the necessary understanding they ought to be provided with as much information as possible and their needs determined and considered. (DOH 1993, p. 6)

This reflects growing acknowledgement that children and young people have the right to be consulted over decisions influencing them and to have their views taken into consideration by adults caring for them (Mayall 1994, 1995, 1996; Roche 1999).

To facilitate implementation of these policies and positions, the Children's National Service Framework (DOH 2003) is a 10-year approach designed to enhance the health and social care services for children, young people and families by setting up national principles. The Children's NSF states that hospital services should be child-centred and

that each child and young person should be consulted and involved in all aspects of their care. The report asserts that:

> Children and young people should receive care that is integrated and co-ordinated around their particular needs, and the needs of their family. They, and their parents, should be treated with respect, and should be given support and information to enable them to understand and cope with illness or injury, and the treatment needed. They should be encouraged to be active partners in decisions about their health and care, and, where possible, be able to exercise choice. (DOH 2003, p. 9)

This reflects that children and young people should be engaged as dynamic associates in decisions about their care.

However, while there may be an increasing appreciation within and outside of paediatric nursing of the need to consult with children and young people, this is not mirrored in the healthcare system overall, with children and young people labelled the 'silent consumers of care' (Carter 1998, p. 57). Likewise, in spite of the increase in consultation by children's and young people's organisations, research has found that children's and young people's views are seldom sought during the development of policies in healthcare settings (Alderson & Montgomery 1996; Dixon-Woods, Young & Heney 1999; Bricher 2000). They were less likely to take part in service deliverance or policy setting (Hill, Davis, Prout & Tisdall 2004; Oldfield & Fowler 2004). This is despite research conducted more than 30 years ago that found that when children and young people obtain knowledge about their situation and are involved in their care, they are more compliant with treatment, tolerate painful treatments better, appear less distressed and recuperate better (Skipper & Leonard 1968; Visintainer & Wolfer 1975; Reissland 1983).

Research performed with children and young people in hospital reports anecdotal incidents of children and young people being consulted and involved in their care (Alderson 1990, 1993; Bricher 2000; Noyes 2000; Runeson, Enskar, Elander & Hermeren 2001; Carter 2002; Coyne 2003; Hallstrom & Elander 2004) and that children and young people experience sub-optimal communication (Alderson 1990, 1993; Epstein & Wayman 1998; Bricher 2000; Beresford & Sloper 2003). Studies of children and young people's medical encounters in clinics found that all children and young people, even older children and young people, were habitually excluded from deliberations and experienced restricted autonomy (Strong 1979; Silverman 1987; Shiminski-Maher 1993; Van Dulmen 1998; Carter 2002). These and other studies demonstrate that incorporating children's and young people's views in the enhancement and assessment of services can have a noteworthy effect on health outcomes (Lansdown 1996; Alderson & Montgomery 1996; Amstrong,

Hill & Secker 1998). Whilst the importance of including children and young people in healthcare decisions has been established, the provision of information and opportunity for decision-making presents a challenge to healthcare providers because of the vulnerability and cognitive confines as a child and young person develops.

Children's and young people's perceptions of their value are important, because research suggests that there is an association between self-esteem, and self-worth and medical outcomes (Herzlich 1973; Norbeck & Tilden 1983; Moss-Morris & Paterson 1995; Prilleltensky, Nelson & Peirson 2001). There is research endorsing the empowerment of children and young people in their own healthcare (Skipper & Leonard 1968; Visintainer & Wolfer 1975; Lewis & Lewis 1982; Reissland 1983; Igoe 1989; Alderson 1990). Adolescents have been found to want to be involved in care decisions, to feel that they have some control over what is happening to them in hospital (Belmont 1970; Alderson 1993; Lansdown 1996; Gusella, Ward & Butler 1998; Kools, Gilliss & Tong 1999). Furthermore, concern about loss of control and feelings of reliance have been reported by hospitalised children and young people as stressful and of consequence to hospitalised adolescents (May & Sparks 1983; Reissland 1983; Bossert 1994; Thompson 1994; Gusella, Ward & Butler 1998; Coyne 2003).

Children as young as four have been found to be competent in analysing and discussing matters that are of significance to them (Weithorn & Campbell 1982; Alderson 1990, 1993; Mayall 1994, 1996; Coles 1997; Borland, Laybourn, Hill & Brown 1998). Receiving information and being educated about the risks also provided comfort for some children and young people (Visintainer & Wolfer 1975; Reissland 1983; Peterson 1989; Alderson 1990), with the exception that involving children and young people in major decisions about surgery may present a substantial psychological load for some children and young people due to their vulnerability and limited cognitive abilities.

Recognising the right of children and young people to be listened to and informed and educated about health is not the same as giving them exclusive accountability for making decisions (Flatman 2002). Every child and young person has to be treated as an individual and, via efficient communication, choose the extent to which they desire to exercise the right to autonomy. Promotion of children's and young people's autonomy promotes improvement of wellness and coping in children and young people, and affects health outcomes; consequently nurses should be dedicated to educating children and young people about their health and incorporating their views in service delivery, which should

lead to more focused and relevant services for children and young people (Lane & Kohlenberg 2012).

## The role of nurses in increasing the health literacy of children and young people

In addition to the rights of the child and young person to be educated and included in matters relating to their own health, children and young people have a right to be health literate. Health literacy is vital for children and young people to ensure that reasonable measures are taken to maintain a healthy life at the same time acknowledging a child and young person is dependent on their parents/guardians to act on health education even where provided. Inadequate health literacy of children, young people and their families therefore reduces awareness of health conditions and treatment options, and creates greater risk of hospitalisation (see for example Baker, Parker, Williams, Clark & Nurss 1997; Andrus & Roth 2002). The manner in which paediatric RNs are introduced to the concept of health literacy and the child-parent relationship informs how they in turn provide health education to children and young people; consequently the decision to explore the role of paediatric RNs in assisting children and young people to become health literate became the focus of this thesis.

To improve the health literacy of children and young people, paediatric RNs need to be introduced to the concept of health literacy during their education and staff development activities. The Royal College of Nursing in the United Kingdom (2003a) promotes the right of children and young people to be looked after by competent nurses skilled to meet their needs; it could be argued that this includes the provision of health education. The RCN (2003a) also stresses the need for qualified nurses operating in the care environment to be familiar with paediatric RNs' physical and emotional health.

In both clinical and community health care settings, all nurses have many opportunities to educate, advocate and model healthy lifestyle behaviours with children, young people and families – for paediatric RNs to improve a child's and young person's health literacy. In light of the lifelong importance of developing health literacy, therefore, this places significant emphasis on the role of paediatric RNs in promoting health literacy in their practice role. Furthermore, nurses can be influential in sustaining and advocating for governmental and policy efforts to optimise health in schools and communities and in media messages targeted towards children and young people. Collaboration of nurses with other organisations and multidisciplinary groups increases impact beyond healthcare

policies to address community and social approaches to promoting healthy behaviours and healthy environments for children, young people and families (Hayman 2007; Estabrooks, Fisher & Hayman 2008).

Rothman, Yin, Mulvaney, Co, Homer and Lannon (2009) consider that nurses can improve their communication skills to optimise client understanding, promote shared decision-making, and enhance self-care behaviours that can translate into enhanced quality and safety. It is time to consider new models for preparing professional nurses, and develop an empowering nursing curriculum that promotes the concept of client health literacy. Reconceptualising nursing education will bring a considerable burden for change, however, requiring new practice models and new education and practice partnerships. All this in turn will provide us with a generation of nurses that is able to tackle the multifaceted healthcare requirements of their society.

By integrating the concept of health literacy into the nursing curriculum to support the nurses' competence as health educators, it is implicit that the focus on developing the skills and confidence of graduate nurses is to enlighten and empower people to make choices that improve their health outcomes, rather than being limited to the transmission of information. The concept of empowerment entails an individual's capacity for attaining good health for oneself, as well as the effect of the social environment on individual health (Clay 1992). Clay (1992, p. 15) stated that 'Education is a fundamental prerequisite for empowering nurses' and by empowering nurses we will empower the people they serve and improve the quality of care provided.

## In Summary

The organisational, social and political systems in which nurses are educated and employed influence both the role of a nurse in delivering health education, and the way in which a nurse understands and enacts the role of 'nurse' in performing 'health education'. For the role of nurses to move beyond existing as 'an idealism that sounds good in theory' (Cullen 2002, p. 42), it is in the best interests of nurses to be self-determining in relation to their own health practices and agendas. This thesis explores the understanding of paediatric RNs of the concept of health literacy, the importance of this concept in their clinical practice of health education of children and young people, and how health literacy is addressed in nursing curricula and staff development programs. As stated by Lady Lovell-Davis, chairwoman of the Joint British Advisory Committee on Children's Nursing, the role of the paediatric RN is '... to understand the needs of young children and to support

the family in looking after a child, instead of interfering and doing all the care' (cited in Laurent 1990, p. 72). Paediatric RNs are in a unique position to foster health literacy development in children and young people through their health education practices, but it is unclear how health education activities are supported by paediatric nurses. The burdens placed on a nurse are daunting, but educating clients is within the scope of nursing practice and can be incorporated into any client-centred plan of care.

In the next chapter I will discuss in depth the theory that underpins this research study.

# 3 Critical social theory

## Introduction

Having outlined in *Chapter 1* the relevance of critical social theory to my research, in this chapter I describe specifically my interpretation of Jürgen Habermas's (1929 -) critical social science. I introduce how I use the work Habermas presented in *Knowledge and Human Interests* (1972) and his text *Theory of Communicative Action* (fully expounded in the two-volume *Theory of Communicative Action*, Habermas 1984, 1987a). I detail two significant theoretical constructs: knowledge-constitutive interests and communicative action. These constructs provided the theoretical lens to focus my thinking and guide how I collected and analysed data and discussed my findings. However, using Habermas does not mean I have utilised all of his work or agree with all that Habermas writes — indeed his theories are only one way of thinking. Habermas has many critics; in fact he has critiqued his own work (Dallmayr 1972). Before summarising my chapter, I provide an overview of some criticisms as well as limitations to my theoretical framework.

The chapter starts with a discussion on the text *Knowledge and Human Interests* (Habermas 1972). This text provided me with the theoretical lens to explore whether specific knowledge-constitutive interests connect nurses' knowledge about health literacy to their health education practices. I utilised his text *Theory of Communicative Action* (1984, 1987a) to explore what implications are inherent in the role of nurses and nursing in relation to health education to influence health literacy of children and young people.

## Theoretical construct 1: knowledge-constitutive interests

*Knowledge and Human Interests* (1972) is a historically based text in which Habermas seeks to clarify the relationship between knowledge and interest. For Habermas, the connection between knowledge and interest is only attained through self-reflection: '*It is in accomplishing self-reflection that reason grasps itself as interested'* (Habermas 1972, p. 212; italics in the original). Knowledge-constitutive interests, he argues, maintains, or

using Habermas's word 'preserves' existing, though not necessarily developed, links between action and theoretical knowledge (p. 370). In proposing the hypothetical construct of knowledge-constitutive or knowledge-guiding interests, Habermas sought to offer a systematic critique of science.

Habermas (1972) argues that there is not one 'legitimate knowledge', only different types of knowledge shaped by different interests that in turn shape how human beings may think and act. Critical to this understanding is how Habermas explains the influence of the *a priori* of experience as being different to the *a priori* of reasoning and the implications of this distinction on action. *A priori* is defined in the Free Dictionary (2011) as that which is known to be true independently of, or in advance of, experience of the subject matter. Habermas (1972) explains how knowledge can never be designated as unbiased, objective or neutral and that different kinds of knowledge are shaped by the particular human interest they serve and is evident in his critique of positivism.

Positivism, or positivist science as Allen (1985) and Hendricks-Thomas and Patterson (1995) describe, positions human actions as passive and compliant to universal laws that are outwardly forced. For Habermas (1972), positivist science resulted in the disempowerment of individuals and decreased their potential for full interaction in their world.

For Habermas (1974), his dispute with positivist science relates not to positivist science itself, but with the way Habermas considered positivist science achieves epistemological exceptionality and universality. Habermas (1974), in short, aimed at questioning the circumstances that have positivist science seek to control western thought, both with its language and method. His concern was that positivist science had exceeded its boundaries as an ideology (as explained below) through which social action may be legitimated and universalised.

Agger (1998) argues that all types of knowledge were viewed with cynicism by Habermas, because he argued all understandings might be contaminated with ideology. Ideologies from Habermas's view are 'belief systems which can maintain their legitimacy despite the fact that they could not be validated if subjected to rational discourse' (Held 1980, p. 256). Ideology is socially constructed (Therborn 1999), so it can be disputed for its interests and fundamental values. It is merely founded on the interest individuals have in something. When an ideology is uncritically accepted the embedded principles may be masked and

those principles may support some understandings over others. Habermas maintained his critique of ideology, since ideology is intimately defined by cultures and customs.

Nursing as ideology has been discussed for many years (please see Rafferty 1991; Barker, Reynolds & Ward 1995; Gavin 1997; Taylor 1997). Although being a complex concept, Habermas (1972) writes that belief systems sustain an ideology: a belief system being a set of conjointly supportive beliefs. The beliefs could be religious, philosophical, ideological or a mixture of these. Ideology as such imposes onto the understanding and in relation to my study on the everyday practices of nurses and in turn the scope of nursing that is made possible. According to Thompson (1984, p. 41), to 'study ideology…is to study the ways in which meaning serves to sustain relations of domination'. Indeed Habermas argues that human knowledge is victim to ideology.

Whether the knowledge of nurses makes nurses victims to nursing as an ideology can be construed as a requirement of a disciplinary way of thinking for a professional group, where certain types of knowledge serve the interests of certain groups. This is important because if certain groups, for example hospital administration, seek to structure environments in which nurses work by placing greater emphasis on certain types of knowledge to assist in the organisation of the environment, then the interests of these groups dominate and condition, shape and determine what nursing is possible. As such it may be possible to identify if there are any ideological assumptions about environments in which nurses' work that may influence actions of nurses in relation to health education and health literacy practices. This perspective is illustrated in the following example from one of the study focus group:

> I think that you have got an expert group here. We are all very experienced clinicians who have been around for a long time, but I think it is representative of all paediatric nurses that are out there particularly the nurses at the bedside, first contact. But I think hospitals are seen as businesses and that our CEO and health department have very strict directives about money and I don't want to sound cynical but there is so much pressure to perform through efficiencies that nurses are measured for what they do, the tasks that they do, the systems Exelcare or the new systems that are coming in. It is not how you do it, it is not how it is evaluated, it is measured by length of stay, measured by patients in beds… the cost of the drugs and the number of nurses on the shift and if you have a patient that you can't quantify because the parents are falling apart or are devastated we have a system that doesn't understand the velocity and intricacies of nursing and what it is all about. It is so frustrating. We find it very difficult to articulate it and I think every clinical nurse and every nurse who tries to manage a shift, they guiltily stay on and do extra hours, it is horrible at the coal face. (FG, PP16-17, L490-L503)

A principle that underpins critical social theory, as well as this thesis, is the view that no feature of social phenomena can be assumed as autonomous or separate from the historical, social and political structure in which it is found or located. Therefore, this thesis opens up the opportunity of examining the knowledge claims of nurses related to health education and health literacy from a critical position. That is, from a standpoint where nurses are regarded not as disinterested or objective individuals, but rather as sources of the production and reproduction of specific interests and practices in health care. The quest then is to distinguish these specific interests in nursing and nurses, recognise the restrictions and capacities of different types of knowledge, and more significantly to make judgments about nursing's prospect from a critical point of view.

Habermas (1972) proposed three human interests, to which he speculated the following three categories of knowledge (rationalities) correspond:

1. Rational/Empirical Knowledge or the specific viewpoint to understand social reality as an orientation to technical control: As Crotty (1998) explains, for Habermas empirical sciences are led by a technical interest in predicting and controlling objectified processes that is the realm of instrumental action.

2. Historical/Hermeneutical Knowledge or the specific viewpoint to understand social reality as an orientation to mutual understanding: Crotty (1998) elaborates the cultural or human sciences are guided by a practical interest to reach intersubjective understanding. It is practical for Habermas, given the need for human beings to secure and develop 'mutual understandings in the everyday conduct of life' (Crotty 1998, p. 143).

3. Critical/Emancipatory Knowledge or the specific viewpoint to understand social reality as an orientation to emancipation: critical sciences, and Habermas, including psychoanalysis and the critique of ideology, are governed by the intent to bring about emancipation—an interest in liberating persons from unacknowledged circumstances of domination.

I now discuss the three interests articulated by Habermas and relate them to my focus of study.

### *Technical cognitive interest: Habermas's first knowledge-constitutive interest*

Technical cognitive interest, according to Habermas, concerns the application of empirical-analytic science in order to foresee and control purposeful, rational social action (1972, p.

308). Empirical-analytic science is also referred to as biomedicine and in turn bio-medical knowledge (Patel, Arocha & Zhang 2005). Nutbeam's health literacy framework (1999b) reflects an increasing degree of autonomy and personal empowerment, whereby functional or basic health literacy is 'sufficient basic skills in reading and writing to be able to function effectively in everyday situations' (Nutbeam 2000, p. 236). This functional or basic health literacy has been argued by Ratzan and Parker (2000) as a belief in knowing that the health information people need to make suitable health decisions is known and only needs to be obtained and processed. That is, technical cognitive interest.

Technical cognitive interests (the application of biomedical knowledge) have been called into question by Rolfe (2006), who argues that where there is a dominance of technical rational knowledge interests in a hospital setting, for example, the potential exists in this setting to reduce nursing interests to a focus on the physical aspects of health problems. Rolfe believes that the increasing impact of evidence-based practice over the past decade has led technical rationality to be the overriding discourse in nursing in the hospital context (2006, p. 39). Where nurses seemingly follow only specific law-like evidence they are complicit in being objects of technical rationality.

The usefulness of being functionally health literate has also been brought into question by authors like Cuban (2006). Cuban writes that functional health literacy focuses on promoting compliance with bio-medical information and the transmission of medical facts, of health risks, knowledge of health services and adherence to prescribed actions: it is a tool to craft an expert patient capable of searching for, reading and understanding bio-medical information (Cuban 2006, p. 4). This argument by Cuban links to Habermas in relation to issues Habermas discussed about technical cognitive interests.

Technical matters not only advantage a particular interest but influence the very structure of interests as well, for example the structure of nursing interests and nurses' interests. The predictive possibility of technical interest, in relation to health and social care, can only function to control social action when nurses/children/young people are made into objects or technical problems. This technical interest possibility is aligned to the biomedical model as 'the personal troubles of the patient are reduced to a set of technical problems for the expert physician to resolve, without significant communicative recourse to the person who is suffering the troubles' (Porter 1994, p. 271).

In undertaking this study I explored if technical cognitive interests connected nurses' knowledge about health literacy to their actions in relation to health literacy. In doing this I

have been able to comment on whether health literacy was understood as functional health literacy as described within a biomedical perspective. In hospitals, as Rolfe (2006) has argued, nurses may become a conduit for promoting compliance by children, young people and their parents/guardians to actions that do not take account of their specific subjective or contextual circumstances given they are framed as objects of technical problems. For example, children, young people and families coming from different cultures and religions may refuse to be complicit with the health care plan that a nurse suggests, simply because it contradicts their culture or their religious beliefs.

Manderson and Allotey (2003) reported on stories of conflict with hospital services, medical mismanagement and the negative effects of processes and treatment flow with immigrant communities. However, they argue that although the understandings of health care procedures are frequently grounded on misunderstandings, the stories have their significance in that they clarify an unfamiliar system to new immigrants and provide starting points for advocacy for improved services (Manderson & Allotey 2003). However, a nurse who may not understand these differences and could argue for why children, young people and parents'/guardians' compliance with what she/he is urging them to do is better for their health. It may be that technical interests could give nurses a sense of autonomy in their actions, although being a conduit to relay this knowledge is a 'false autonomy [because it] entails regarding fellow humans … as objects' (Grundy 1987, p. 17). The focus will also significantly influence how they implement health education practices.

Regarding people as objects or technical problems seems in opposition to how nursing and the role of nurses are described by nurses (Mallik 1997; Norton 1998; Walsh & Kowanko 2002; Hanssen 2004). These authors describe nursing and the role of nurses in health education as advocating for clients (Mallik 1997; Norton 1998), maintaining of client dignity (Walsh & Kowanko 2002) and preserving autonomy and respecting clients' health choices. In Walsh and Kowanko's (2002) research many of their nurse participants stated that the client should not be perceived as an object or body only; all clients are human beings. According to Walsh and Kowanko (2002), from the nurses' perspective clients are required to be perceived as having a distinctive right to be treated with dignity and respect in all circumstances and at all times whether the client was conscious or unconscious, alive or dead. Therefore, paediatric RNs should not demand compliance for the sake of compliance, but be prepared to accept the choices of children and young people with regard to the health care provided.

Applying a Habermasian view, nurses also exist in an institutional space; most likely as employees, but always as a nurse bound by legislation of the healthcare system they work in (Andrews & Shaw 2008). The title 'nurse' is a legislated title (see for example Nursing and Midwifery Board of Australia 2013; Royal College of Nursing 2003b). The title of 'nurse' means that only nurses deliver that which is termed nursing (Royal College of Nursing 2003b) and there is not one definition of nursing (Royal College of Nursing 2003b). Nurses can be registered or enrolled and to be an RN, according to the Nursing and Midwifery Board of Australia (2013), this person has:

- Minimum of three years study/training at a university to achieve a Bachelor Degree in Health Science (Nursing) or Bachelor Degree in Nursing.
- High level of accountability and more responsibility than an EN or AIN regulated by the Nurses' and Midwives' Board.

Roles may include administration, team leader or unit manager duties, medication administration, assessment and management of the client including complex nursing care, specialised nursing care or undertaking research.

Therefore, an RN is a person with appropriate educational preparation and competence for practice, who is registered and licensed under the appropriate Nursing Act to practice nursing in Australia (Nursing and Midwifery Board of Australia 2013). The national competency standards give certain responsibilities exclusively to RNs and midwives, giving them more autonomy in their practice decisions than other nurses (Nursing and Midwifery Board of Australia 2013). RNs and midwives are then responsible for ensuring the quality of the work through their involvement in teaching, competence assessment, supervision and the evaluation of clients' outcomes (Nursing and Midwifery Board of Australia 2013).

According to Norrish and Rundall (2001), how nurses understand their role in an institutional space (for example, hospitals) and in turn enact their actions (like health education practices) will be guided by how an institutional space is understood by nurses. In other words, they may be complicit in this institutional space (hospital) to specific actions because of a view that they have no opportunities to act differently. Applying Habermas, nurses can be knowingly or unknowingly complicit; however, the knowledge made possible and hence dominating what social action is possible or required by nurses, is shaped by their understanding of what may be practical in an institutional space.

### *Practical cognitive interest: Habermas's second knowledge-constitutive interest*

Habermas (1976) argues that many practical matters may be characterised mistakenly as technical matters. Nurses', children's, young people's and their parents'/guardians' ability to make choices about the type of health care needed by a child and young person may be characterised as a technical matter (because they do not have the necessary knowledge), but it may be a practical matter. This is because many conditions have a variety of treatment possibilities, and new knowledge is constantly being updated and implemented; at times doctors and nurses can be in doubt as to the best way to treat a condition. When this occurs, the health care provider simply decides on the process that he or she considers will attain the most appropriate outcome as determined by the interests influencing their actions.

Allen (1985) argues that the practical cognitive interest is a sphere of human action relating to an orientation to what is true and just in certain historic circumstances. This necessarily entails attaining the consensus of everybody involved. However, as Allen argues, for people from a different culture or religion, in order for all of them to reach a consensus about what constitutes good health care, consensus must be based on a joint understanding of meanings and responsibilities instead of being based on standards of effectiveness or success (Allen 1985). He also contends that central to the practical interest is 'understanding, rather than controlling' where 'value choices' are attached to 'practical activity' (Allen 1987, p. 67).

In relation to my focus on health education practices of nurses influencing health literacy of children and young people this would mean that practical interests would align with Nutbeam's interactive health literacy because it opens a possibility for dialogue between stakeholders, whoever they are. It is 'practical' for Habermas because of the need for human beings to secure and develop 'mutual understandings in the everyday conduct of life' (Crotty 1998, p. 143). Like Allen (1987), and based on my reading of Habermas, nurses who apply practical interests compared to those who apply solely technical interests aim at understanding events, not controlling events; the intent is interpretation and then to move beyond interpretation to negotiation (Allen 1987).

Nurses' actions, shaped by both technical and practical interests, could be 'grounded in structures of action and experience—i.e. the constituent elements of social systems' (Habermas & Lenhardt 1973, p. 176). Therefore, nurses could be aware of knowledge and institutional forces that influence and control their actions; for example some nurses, as

Rolfe (2006) explains, may actually feel entrapped by the practices of the organisation. Norrish and Rundall (2001) have also argued that hospital restructuring affects the work of registered nurses in many ways. Though as previously explained an RN is a person with appropriate educational preparation and competence for practice to practise nursing (Nursing and Midwifery Board of Australia 2013). RNs are responsible for ensuring the quality of their work; the quality of their health education practices and quality of its outcomes.

Using Habermas's critical social theory as my theoretical lens, my aim has been to engage paediatric RNs in a process in which I explore with them the role they believe they have with regard to paediatric and child and youth health literacy. An aim of this research has been to provide an opportunity for paediatric RNs to self-reflect on the role that they play in the promotion of specific ways of thinking or distorted understandings that children and young people (and/or their parents/guardians) may have in relation to health and health literacy. Health education practices of paediatric RNs are a potential conduit for social action—a means by which children and young people might become critically health literate.

### *Emancipatory cognitive interest: Habermas's third knowledge-constitutive interest*

Emancipatory cognitive interest according to Habermas concerns self-reflection and self-determination with a focus on power relationships to remove barriers to self-conscious improvement (Habermas 1972). Habermas developed these ideas more in his theory of communicative action (Habermas 1984, 1987a) and I will discuss this later in this chapter given Grundy's view (1987) that the emancipatory interest described by Habermas remains his unique contribution to contemporary philosophy. For Habermas the emancipatory interest in knowledge is different to technical and/or practical interest because of the act of self-reflection. Technical and practical interests result from distorted communication and 'thinly legitimised repression' (Habermas 1974, p. 176).

In *Chapter 4* I detail the methods I used to engage paediatric RNs in a disciplined form of self-reflection in relation to health literacy. The focus placed on them thinking about their assumptions and if necessary how and why these assumptions constrain the way they see themselves and their relationships with children, young people and their parents/guardians was to set up the possibility for improvement in paediatric and child and youth health literacy practices should this be needed.

Enforced specific meanings in relation to health education and health literacy are socially and historically constructed meanings and are formed in part by social institutions, for example the media and the educational system, that make certain meanings more obvious than others, according to their agendas (Allen 1987). These meanings produce both internal and external constraints on individuals (Allen 1987). For example, paediatric RNs would have certain professional/legal/management/political rules imposed on them by their employer, their profession, colleagues and administration as well as personal limitations and viewpoints. How they think about or reflect upon these imposed strategies and their personal limitations/viewpoints will influence their communicative action role—what they actually do in relation to health education services/activities with children, young people and their parents/guardians. The forms of action that they believe are appropriate or viable in their role will be influenced by historical, social and institutional factors.

When paediatric RNs interact with children, young people and their parents/guardians without openly discussing their assumptions, they jeopardise infringing the autonomy of the child, young person and their parents/guardians and limiting conditions of responsibility. The emancipatory cognitive interest diverges from the practical interest in asserting that even when individuals elucidate their understanding of a condition, the meanings entrenched in those understandings can also have foundations in other constraints (Allen 1987). For example, paediatric RNs driven by this emancipatory cognitive interest are more likely to communicate with the child, young person and their parents/guardians, as well as listening to them, in order to understand their meaning and experience concerning a particular health problem. Ultimately a paediatric RN will encourage the child, young person and parents/guardians to make their own decisions and to act upon them.

Habermas considers emancipation and self-reflection are consistent with freedom, autonomy and responsibility (1972, pp. 197-8). I have argued in *Chapter 1* that within a critical health literacy view, nurses' health education actions would be focussed on working with children, young people and their parents/guardians to contribute to them having the capacity to act rationally, to reason self-consciously and to make decisions in light of available knowledge, rules and needs. That is, nurses' interest would be to engage with children, young people and their parents/guardians to understand through reflection what actions they may be implementing, or circumstances they have not acknowledged, that act as barriers to what Nutbeam (2000) described as being critically health literate. Critical health literacy for Nutbeam are 'more advanced cognitive skills which, together

with social skills, can be applied to critically analyse information and to use this information to exert greater control over life events and situations' (2000, p. 236).

### *Moving on*

Since his publication *Knowledge and Human Interests* (1972), Habermas has developed a denser and more abstract theory of communicative action that is aimed at actively achieving emancipation (Bernstein 1985). Habermas (1984) did not deny the significant contribution of positivism to knowledge generation; however, he resisted the use of a positivist approach alone. He is critical of the statement of positivist science to be the foundation of all knowledge, and considers his work partially as an effort to amplify a theory of society with an actual intention towards the expansion of a more inclusive notion of reason. This more inclusive notion is not diminished to a technical interest in the control of the natural world, but a relatively comprehensive notion to reaffirm the substitute rationalities intrinsic in practical and emancipatory human apprehensions.

Habermas argues that technical cognitive interests have increasingly gained power over social life since a 'developmental tendency characteristic of advanced capitalism …: the scientisation of technology,' while 'technology and science become a leading productive force' institutionalised in the social order (1971, p. 104). This institutionalised power, Habermas maintains, has currently occupied its own life, consequently 'the development of the social system seems to be determined by the logic of scientific-technical progress' (1971, p. 105). Accordingly, Habermas argues that 'the culturally defined self-understanding of a social lifeworld is replaced by the self-reification of men [sic] under the categories of purposive-rational action and adaptive behaviour' (1971, pp. 105-106). This has led technical cognitive interest to control the practical (Habermas 1971, p. 113).

This force of 'technology and science as "ideology"' on society, Habermas argues, has been catastrophic. Technological progress is seen as vital to social life, but since this development does not relay the 'intersubjectivity of mutual understanding', society is no longer focussed *'toward the realization of practical goals.'* (1971, p. 103; italics in the original). As a substitute '*Practical substance is eliminated'* (1971, p. 103; italics in the original). Therefore, the supremacy of scientific knowledge is maintained through systems of classification that elevate scientific research methods over other types of knowledge. Articulating health education practices that are evident in nursing is important. It is important because as Habermas argues 'the process of democratic decision-making about practical problems loses its function' (1971, p. 105). In it, people have no say in

resolutions that bear on their social lives since all problems are viewed always as technical, examined under the guidance of the technical cognitive interest, and 'the solution of technical problems is not dependent on public decisions' (Habermas 1971, pp. 103-104) and this is, in Habermas's view, a meagre substitute for communicative action in the public realm.

Human beings, like nurses, acquire knowledge and as Habermas (1987a) explains, knowledge evolves from a process where competing social, political and historical interests influence the resultant actions of an individual. Habermas (1987a) was not ready to abandon technical rationality in accord of the more philosophical and/or inter-subjective extents of reasoning. Instead, Habermas (1987a) contended that technical knowledge was a significant kind of knowledge, as it served a human interest in the control of the natural world, and also contended for another means of knowing where the ethical, critical and inter-subjective extents of humanity could be addressed.

Habermas (1984, 1987a) recognised that all philosophies, theories and methodologies are somehow based on interests and ideologies and accepted that critical social science was also based on its own ideology. Hence he changed his focus from critiquing science and ideology to critiquing intersubjective communications and interpretations. He concedes that he had to fine-tune his thinking on communicative actions (Habermas 1984, 1987a). As a result he wrote a two-volume book *Theory and Communicative Actions* (1984, 1987a), in which he concentrated on individual communication, identifying how principles and assumptions can distort communications (Habermas 1984, 1987a), which will be discussed next.

## Theoretical construct 2: communicative action

Habermas's theory of communicative action (1984, 1987a) has as its goal emancipation of each individual: individuals who can make decisions free from the restrictions of domination (Gander 1989). Communicative action is the process by which participants assess for themselves the clarity, reality, reliability and moral appropriateness of the substantive content of these processes as personally requisite upon them; that is, action oriented towards mutual understanding and unforced consensus (Habermas 1984). Habermas is interested in what aspects of language make communication possible, and he argues that communicative action takes place within a social context, a context he describes as 'the lifeworld'.

Lifeworld is the sphere that 'secures a continuity of traditions and coherence of knowledge sufficient for daily practice' (Habermas 1987a, p. 140). Habermas says: 'What raises us out of nature is the only thing whose nature we can know: language. Through its structure, autonomy and responsibility are posited to us' (1972, p. 314).

Habermas's theory of communicative action (1984, 1987a), contributes to social theory by encouraging reflection and discussion needed to interrupt everyday technical or practical action to explore its nature, motives and value. In the social institutions that paediatric RNs work, and in which children and young people become patients or clients, my interest has been to explore what may influence the communicative action of these nurses. Specifically this interest is to understand how nurses may uncover children's and young people's health literacy (and/or their parents' or guardians') and with what implications.

Habermas recognised a growing sense of aim, achievement and outcome-orientated culture to the disadvantage of equality orientated interactive dialogue in late capitalist societies. Hence, in the *Theory of Communicative Action* (1984, 1987a), he discussed the advantages and disadvantages of the systems theory and theories of social action and disapproves of them both. Through reformulating earlier social theories, Habermas investigates the apprehensions and interconnections between lifeworld and system as two faces of the social world of modernity.

The lifeworld symbolises the space where meaning, cohesion and personal characteristics are linguistically communicated (Habermas 1984). It is created and reproduced through verbal language, and encompasses culture, the social world and personality (Habermas 1987a). It also encompasses the environment of understandings and supposes mutuality within a society that infuses daily interactions (Habermas 1987a). It symbolises an implied, pre-reflexive knowledge form of taken-for-granted everyday suppositions (Habermas 1987a). The system, however, symbolises the technical scientific rationality of society, and is controlled by power and economic affairs; it necessitates competence and strategic rationality in its functions (Habermas 1984).

In addition, Habermas (1984) differentiates between non-social and social action situations in both lifeworld and system. Non-social action situations are orientated to success, and are mediated by instrumental purposive-rational action. However, social action situations are of two types, depending on their orientation; those orientated to success are mediated by strategic action, while those orientated to reaching understanding are mediated by communicative action (Habermas 1984, pp. 285–286). For Habermas the main distinction

between these two types of social action is in the way individual social actions are synchronised into models of interaction (Habermas 1984, p. 101).

Social action situations orientated to success are comparable to non-social action situations that are mediated by instrumental purposive-rational action and strategic action. They both are correlated to the system and are related to competence and effect (Habermas 1984). They function through designation of goals, the designation of principles against which development towards achieving the goals can be considered, the setting of aims for what will be understood as achievement, and the monitoring of progress towards goals to assess and develop system competence described in terms of the relation of inputs to outcomes attained. Concerns are with system functioning; thus it typically utilises a type of reason that can be expressed as functional rationality (Habermas 1984). Communicative action, however, is correlated to the lifeworld and symbolises a sort of act entrenched in the ethics of a performance, at which the objectives of the acts are clear and knowingly resolute (Habermas 1984).

In an institutional space, for example hospitals, health clinics and health centres, certain opportunities are created for communicative action like interactions between nurses and children and young people. However, actors (read as paediatric RNs) in communicative action, as Habermas explains, 'are not primarily oriented to their own individual success'; rather and under the influence of the practical interest they are more oriented toward 'the process of reaching understanding among members of a life world' (Habermas 1984, p. 286). Therefore paediatric RNs look to 'pursue their individual goals under the condition that they can harmonise their plans of action' (Habermas 1984, p. 286). Agreement will be 'one that already exists or one to be negotiated—about definitions of the situation and prospective outcomes' (Habermas 1990, p. 134); an agreement that 'is grounded only in the intersubjectivity of the mutual understanding of intentions' (Habermas 1971, p. 92). In relation to my study what is not known is the extent to which paediatric RNs allow an institutional effect to influence the communicative space and practical outcomes, in which they relate to children and young people as paediatric RNs in such a way that they undertake health education to promote health literacy.

Habermas contends that 'individuals act within a matrix of intersubjective meanings' (1974, p. 307). For Habermas, intersubjectivity is a mutual understanding, or a 'background knowledge' (1984, p. 13). However, it is also the mutual affiliation essential to shape these understandings. Communicative actors, for example paediatric RNs, 'relate

simultaneously to something in the one objective world, something in their common social world, and something in each other's own subjective world [as well]' (Habermas 1984, p. 392). Habermas differentiates between the relation that is founded on taking positions and reacting to another, and a higher-level intersubjectivity where participants internalise the uttered thoughts and knowledge of the other (1972, p. 10).

According to Habermas (1970a), intersubjectivity basically pledges the ego-identity of participating subjects (read paediatric RNs and children, young people and their parents/guardians); 'in normal communication an intersubjectivity of mutual understanding, guaranteeing ego-identity, develops and is maintained in the relation between individuals who acknowledge one another' (p. 210). Intersubjective relations are established and sustained among persons who distinguish each other as subjects. Mutual acknowledgment is the main aspect here, in which one subject distinguishes the other as an individual ego, distinct but like oneself (Habermas 1970a, p. 211). Habermas maintains that this affiliation must be balanced and exclusive of dispensation on one part or the other (1970b, p. 371). Habermas (1970a) argues that speaking 'to' or 'with' another instead of 'at' or 'for' them is contrary to instrumental relations. This distinctive shape of communication engages gratitude of the other as a like being with like feelings and intentions but as a separate subject who merits fair consideration. Intersubjectivity engages people together emphasising oneself and identifying the other. It is a practice pursued not for instrumental, controlling affiliation, rather for communication founded on the sustained tension of mutual acknowledgment.

Weaving intersubjectivity into health education practices by paediatric RNs would be a condition free from control and strategic motivations. Contribution would be open to all those able and engrossed; each could question others' suggestions or make their own; and anyone could unreservedly offer their views, positions or requests. Habermas recognises that 'a speech situation determined by pure intersubjectivity is an idealisation' (1970b, p. 372). However, with a mastery of the skills of communicative capability, one can hope to attempt to redeem its potential. This means that in turn these actions can be analysed and recognised through self-reflection. This reflection brings recognition to forces that control an individual and that in the act of 'knowing' or being enlightened creates the possibility for emancipation to be attained. Nurses working this way with children, young people and their parents/guardians, for example, would therefore seek to understand what influences are impacting on a child, young person and their parents/guardians through reflection rather than telling children, young people and their parents/guardians what to do.

Therefore, in relation to my study, information-giving and communicating health care through health education practices by paediatric RNs might constrain rather than facilitate the choices of children and young people and in turn impact on their health literacy.

Nurses' characteristics are defined in part by the functions they play, and these functions are enclosed by the lifeworld of the healthcare location in which they work in. Hence, nurses function in a distinctive social world to which they carry their lifelong understandings, principles and viewpoints, and prospects of the other. Feelings and motivation are inextricably tangled for both, and both of these features control how each cooperates with the other. Habermas (1987a, p. 138) suggests three 'structural nuclei' of the social matrix of lifeworld on which social action depends: culture (stock knowledge), society (legitimate orders through which membership is organised), and person (competencies to enable individuals to assert their identity), which are 'made possible' by three enduring and interacting sets of processes—cultural reproduction, social integration and socialisation. Communicative actions are necessary for life; however, they are challenging and not without difficulties. This is to some extent conquered in modern societies by the development of markets and bureaucracies (Fredriksen 2003) and these two subsystems comprise a second level in Habermas's theory of society. Within these subsystems, actions do not correspond by communication but by two steering media: money and power. Habermas says 'Steering media uncouple the coordination of action from building consensus in language' (Habermas 1987a, p. 390).

Habermas's thesis of 'uncoupling' of system and lifeworld is about the process of developing a 'relative autonomy' in systems synchronised by the characteristic steering media of money and administrative power. Habermas argues that steering media features of the economic and political-legal systems – money and administrative power, respectively – now do their work of co-ordination so smoothly that the systems have begun to operate 'relatively autonomously'; that is, 'on their own terms'. This rather independent performance of systems in societies exemplified by complex delineation involves an 'uncoupling' of system and lifeworld. The systems in this uncoupling appear to be 'objects' to the persons who restrain them, as if they functioned according to their own rules and procedures, in an unbiased way uninterested in the unique personalities and interests of the individuals restraining them. As such, indifference is shown to the dynamics of cultural reproduction, social integration and socialisation necessary for the development and reproduction of lifeworlds (Habermas 1987a, p. 154).

In civilisations known by differentiation and the virtual autonomy of economic and political-legal systems, Habermas argues, individuals and groups increasingly describe themselves and their ambitions in system conditions. Consequently, their 'privatised hopes for self-actualisation and self-determination are primarily located … in the roles of consumer and client' (1987a, p. 356) with regard to the economic and political-legal systems correspondingly. This is 'colonisation' where the economic and political-legal systems replace communicative action that underlines the structure and reproduction of lifeworlds, and offer instead a structure of language, perceptive, principles and customs for systems and their functions. Consequently, the symbolic reproduction processes of the lifeworld (cultural reproduction, social integration and socialisation) become drenched with a dialogue of roles, functions and functionality, restructuring individual and communal self-understandings, relations and practices (Habermas 1987a).

In relation to this study, the consequence of the colonisation of the lifeworld by the systems is that individuals and groups like paediatric RNs increasingly recognise themselves and their ambitions in system terms, and the theory of communicative action proposes a 'stereoscopic vision' that allows the results of uncoupling and colonisation to come into view (Habermas 1987b, p. 363). When applied to my research field, paediatric RNs can be engaged in three kinds of lifeworld processes through their practices. Firstly, the practice of individualisation-socialisation where paediatric RNs' own characteristics and capabilities are shaped and developed; secondly, the practice of social integration where legitimately-ordered social relations amid individuals as children, young people and their families are shaped and developed; and thirdly, the practice of cultural reproduction and transformation where mutual cultures and discourses are shaped and developed. I aimed to examine how nurses described practices in the settings or systems in which they work. As Habermas (1984, 1987a) is concerned with confusions, distortions and misplaced importance, I aimed to expose confusions, distortions and misplaced importance held by paediatric RNs in relation to health education and health literacy for children and young people.

I engaged paediatric RNs in a process that informed them about their role and practices – that is, those conditions that shape, limit or determine their actions and those actions that they may need to take to intervene in a positive way in the lives of children and young people. I also aimed, through this research, to explore whether they considered they have a role to intervene or change the processes to impact on the health of a child or young person, or more specifically their health literacy, when they interact with these children

and young people in the everyday course of their work. My argument is that paediatric RNs will have a view about their role in health education and health literacy and therefore I explored this view.

I also hold the view that a critically informed and functioning paediatric RN is one who is aware of constraints on their efforts in their role to work with children, young people and their parents/guardians to become health literate. They would understand why these constraints exist and they would have access to alternative perspectives for understanding their situation. They could also give meaning and direction to their role and look for alternative ways to work with children, young people and their parents/guardians to assist them to give meaning and direction to make healthy choices.

I have considered Australian paediatric and child and youth health nursing leaders as persons capable of producing and reproducing particular values, interests and practices in relation to health education and health literacy. The role of paediatric RNs is positioned as a form of social action to enable critical health literacy; this means there is a need to identify forms of action that are appropriate or viable given the specifics of social, historical and institutional circumstances of paediatric RNs as well as children and young people.

I engaged paediatric RNs in a disciplined form of self-reflection (Delphi Survey, see *Chapter 4*) aimed at enlightenment. While paediatric RNs are my sample, it is their communicative actions (meaning created between people) that I wanted to influence through their involvement in my study. I sought to collaborate with them to enable them to become critically aware if necessary about how and why assumptions constrain, and if assumptions influenced the way they see themselves and their relationships with children, young people and their parents/guardians with respect to critical health literacy. The research aimed at enabling nurses to reflect and to work towards new understandings of their role in critical health literacy. Finally I wish to acknowledge that I was also in a process of enlightening myself as a researcher as I was not separate from the research process.

### *Social action in practice*

If the role of paediatric RNs can be viewed as a form of social action to enable critical health literacy, then there is a need to identify forms of action that are appropriate or viable given the specifics of social, historical and institutional circumstances of paediatric RNs as

well as children and young people. The work of Habermas can help to identify whether or not paediatric RNs have a specific ideology or belief system about their role in health education and health literacy. If so, what attitudes they hold as true and valid in turn shape their interpretation of reality and behaviour and are used to justify and legitimate their actions (Mezirow 1981). I positioned paediatric RNs as occupying an important role in providing opportunities for children, young people and their families to confront obstacles to emancipatory awareness in health literacy. The process of negotiation in the course of a consensual discussion will not come to an end, but will evolve towards building new relationships. In relation to my study, confusions and distortions that might be held by paediatric RNs in relation to health education and health literacy for children and young people can be explored to explain how paediatric RNs work to enable children and young people be health literate.

A critically informed paediatric RN, following Habermas, would be conscious of restraints on their efforts in their work with children and young people, as well as their parents/guardians, to become health literate. They would also likely have access to different viewpoints for considering their role and to look for substitute methods to work with children and young people to help them make healthy choices. The emphasis in critical and social theory is on collective decisions made through the contributions of paediatric RNs.

While I acknowledge different and contested understandings of health education and health literacy, my interest is to explore if any one understanding is more prevalent among paediatric RNs. Included in this exploration is a focus on understanding if health education and health literacy were considered important by paediatric RNs and if so, what activities they have implemented and why. My interest is to explore if practices by paediatric RNs in relation to health education and health literacy were shaped by ‘taken-for-granted’ assumptions and to consider whose interests were being served through their practices and with what implications for children and young people and nursing. As Rolfe (2006) argues, nurses need different forms of knowledge to guide their actions.

## Theoretical Limitations

Habermas’s theory has been a framework to enable me to talk about human nature and interests and how humans choose to communicate. His work assists me to explain if and why nurses may tell people what knowledge they need to know rather than opening up

choices for them. However, following Gander (1989), my use of Habermas's theory has not been without difficulties and I now reflect on these.

The limitations of this study methodology pertain both to the various theoretical and methodological difficulties encountered within the framework of Habermasian critical social theory and to the limitations imposed by the intentions of this particular research project. The following discussion is confined to an exposition of the various methodological limitations and difficulties that are associated with Habermasian critical social theory and specific limitations that are associated with the methods employed within this particular study are addressed in detail in *Chapter 4*.

Roderick (1986), I believe, provides one of the best summaries with regard to the critical social theory of Habermas up to the point of the publication of *Knowledge and Human Interests*. Some of the main criticisms he identified are that Habermas had two distinct types of reflection, which seem confusing. The first reflection was actually with regard to restoration of the universal characteristics of individual nature and the opportunity of knowledge. The second, however, 'refers to the Marxian idea of a critique of ideology which involves reflection capable of freeing the subject from hidden constraints' (Roderick 1986, p. 63).

Habermas argues that the ideologies were not to be found in the structure of the constitutions of labour, to the degree they were for Marx, but in the constitutions of meaningful social action and speech. These are two different types of schemes necessitating different types of dispute and verification.

It is problematic to try simply to link reflection to political action, as Habermas seemed to want to do in *Knowledge and Human Interests.* While the second form of reflection is quite close to action, since it can directly free at least those who carry it out from the influence of ideology on their own actions, the first form of reflection is somewhat more distant. What is truth about our transcendental capacities is not known and cannot be assumed to necessarily connect with action, even in the restricted sense just mentioned.

The second criticism is with regard to the sufficiency of the argument Habermas made for the transcendental (basis of reflection) for the opportunity of reflection that transcends cultural or sectional bias. Roderick (1986) argues that it rests on the conflation of the two types of reflection. According to Roderick, the transcendental argument is a philosophical one that is based on the heritage of German idealism; however, Marx developed his

critique of ideology through a clear refutation of the philosophy and its means. Habermas's restoration of philosophy guides to an internal opposition among the establishment of a theory free from history and culture (transcendental) and the claim of the partially ideological historical structure of humanity (1986, p. 65)

Scott (1978) argues that critical social theory seeks to develop a society where rationality is completely comprehended; a society in which people create their own history in a full awareness of their potential and limitations. In other words, critical social theory aims at human freedom or emancipation.

Emancipation takes different meanings depending on which thread of critical social theory is being engaged with. Habermasian critical social theory is principally a theoretical approach that is aiming to emancipate people from the domination of distorted ideologies (Brocklesby & Cummings 1996). However, Jackson (1991) argues that: 'This is to be achieved by raising the quality of work and life in the organisations and society in which they participate' (1991, p. 298). Therefore, through a critical social theory, nurses can use the concept of emancipation to influence the health care of children and young people in relation to decision-making. Health care practices must be examined by nurses, for their effect on their clients' ability to arrive at free choices.

Habermas's theory of knowledge and human interests aims, as Brocklesby and Cummings (1996) argue, at creating a link between epistemology and human emancipation. To attain human emancipation all three of Habermas's interests should be addressed. To attain for all persons the utmost improvement in their potential, to reach human emancipation, systems practice have to be concerned with the complementary progress of the three main methodological spheres in maintenance of the three basic interests (Brocklesby & Cummings 1996). Gottlieb (1981) critiqued Habermas's work in relation to knowledge and human emancipation and his effort to rationally ground social customs and ethical values. He argues that, although 'We might agree that each individual has an interest in being freed from false constraints via critical reflection … this does not imply that each individual has an interest in all other people becoming free' (p. 286).

I need to acknowledge here that I am utilising the critical social theory of Jürgen Habermas as a way to involve paediatric RNs to engage in a process of enlightenment in which I explore with them the health education role they believe they have with regard to paediatric and child and youth health literacy. I want their 'enlightenment' to come to bear directly on paediatric and child and youth health literacy. I cannot enlighten these nurses: it

is only they who can enlighten themselves and that means they are capable of regulating themselves. Neither am I suggesting that children and young people will become emancipated; however, I hope that paediatric RNs will understand the health education role that they can play in the promotion of specific ways of thinking or distorted understandings that children and young people (and/or their parents or guardians) have in relation to health and health literacy.

Given the widespread use of Habermas's critical social theory within research a number of criticisms of the theory have been made; two of these are Agger (1998) and Heslop (1997) and the emphasis on Habermas's foreseen ideal of free speech. Given that the liberal ideal of free speech or 'discursive will formation' (constraint-free discussion) has continuously been some distance from an achievable reality, it is certainly paradoxical, as Held (1980) contends, that it (discursive will formation) is in Habermasian terms, entirely anticipated in discourse, and thus symbolises an uncomprehended event.

My analysis has been restricted to a critical journey of investigation, to uncover and reveal possible dominant ideologies that are entrenched, both metaphorically, within the understandings and action of paediatric RNs in relation to health education and health literacy. In the context of this critique presented as a doctoral thesis, the principles of communicative action are regarded not as an achievable ideal but somewhat as a critical standard; a guide contrary to which predominant conceptions of reason can be uncovered and resisted.

## In summary

If the ideals and beliefs about people held by nurses are informed by nurses' understandings about what is nursing, then these understandings could be considered as nursing interests that make possible the actions of nurses. Applying Habermas, nursing interests may produce technical, practical or emancipatory knowledge or any combinations of these. Hence, how nurses act or practice could be assumed to be shaped by the nursing interests they engage in and which, in turn, will influence their role as a nurse and how they communicate with others. In their everyday work, nurses may feel they are confronted by the need to address bio-medical interest in cure and recovery of disease/illness, as well as health education and literacy interests. It is possible that one interest may dominate over another. Nurses' practices may be shaped knowingly or unknowingly by interests that have become institutionalised in the social system in which they work and these would then

shape the way knowledge is constituted in social actions undertaken by nurses, for example those practices related to health education and health literacy.

In this chapter I have explained Habermas's knowledge guiding interests and communicative action and how they apply to my research. Insights I gained from the work of Habermas guided my choice of data collection methods as much as the analytical process. Involvement in the research process was structured as a tool that may provoke new insights and the acquisition of new knowledge for paediatric RNs. I now detail my research process.

# 4 Research Design

## Introduction

*Chapter 3* detailed the theoretical framework of this study and in this chapter I provide information on the process of the research design, ethical considerations and methods of data collection, their limitations, and data analyses implemented. I used a mixed method research design, which is a methodology and a method involving gathering, analysing, and combining qualitative and quantitative methods in a distinct study or a stream of studies (Creswell & Plano Clark 2007). I concur with Carr that given the complexity of nursing, this complexity supports the use of mixed method approaches (Carr 2009). As O'Cathain and Thomas (2006) have argued, mixed methods research can generate different ways of viewing data given the wider lens approach: an approach that cannot be produced by singular methods.

I now start by discussing my specific mixed method research design.

## A sequential transformative mixed methods design

Creswell, Plano Clark, Gutmann and Hanson (2003) advanced six diverse designs of mixed methods: sequential explanatory design, sequential exploratory design, sequential transformative design, concurrent triangulation design, concurrent embedded design, and concurrent transformative design. A sequential transformative design guided my research (Creswell *et al*. 2003; Andrew & Halcomb 2009; Creswell 2009; Creswell & Plano Clark 2011). It is transformative because of my use of critical social theory to inform the three stages of this research and to guide data collection and analysis. These three stages were:

**Stage 1: Describe the context**

**Stage 2: Identify recurring themes**

**Stage 3: Apply a critical lens**

The sequential nature of my design involves the use of both quantitative and qualitative data collection methods with one type of data collection (document analysis and literature review) followed by another (Delphi Survey) subsequently followed by another type of data collection (focus group) and then applying my critical lens to all findings (Andrew & Halcomb 2009; Creswell 2009; Creswell & Plano Clark 2011). Before detailing these stages and the different methods of data collection and analysis, I discuss ethical considerations in this research.

## Ethical considerations

The purpose of the *Australian code for the responsible conduct of research* (NHMRC 2007a) is to direct organisations and researchers in what constitutes accountability in research practices. In labelling good practice, this Code endorses reliability in research for researchers and articulates what is expected of researchers by the community. In providing advice on how to achieve best practice, this Code helps researchers, administrators and the community to meet ethical guidelines.

Before commencing the research, my project was approved by the relevant ethics committees (*Appendix 1*). I addressed ethical issues associated with informed consent, ensuring confidentiality, how collected data was to be stored, and how published and grey literature were portrayed and reported.

### *Informed consent*

According to the National Statement on Ethical Conduct in Human Research (NHMRC, ARC & AVCC 2007b) respect for human beings includes giving potential participants the option to make their own choices. In the research context, this usually requires that participation be the outcome of choice, made by contributors, generally known as 'the requirement for consent'. This prerequisite has the subsequent conditions: consent must be a voluntary choice and must be grounded on adequate data and sufficient understanding of both the anticipated research and the repercussions of participation in it.

Prior to the involvement of any potential participant, I sent to them an invitation letter (*Appendix 2*), information sheet (*Appendix 3*) and consent form (*Appendix 4*) either electronically or via hard copy. To enable potential participants to understand their role, I detailed the project aims and objectives and provided them time to carefully consider their involvement. All were given the opportunity to ask any questions prior to involvement and were asked to read and sign a consent form and return it to myself either as a hard copy or

electronically. The consent form made clear to them that their participation was entirely voluntary and that they were free to withdraw at any time with no consequence to their employment or working relationships.

### *Non-disclosure of information*

I stressed to all potential participants and within the information sheets (*Appendix 3*) that their personal information and/or the university/hospital/organisation would not be identified in any way in this document and in the reports and publications arising from it. All identifying information has been removed during data analysis. For example, individual participants' names have been replaced with Participant 1, 2, 3 etc., and identifying documents and/or university/ hospital/organisation names by university/hospital/organisation A, B, C.

Personal information collected as part of the socio-demographic data was aggregated and analysed using descriptive statistics; in this way no individual participating in this research can be recognised. However, I was still able to comment on and include the descriptive information of all participants either as the total population of participants or as groups where a number of participants have similar information.

All potential participants were assured that their anonymity and confidentiality would be preserved at all times.

### *Storage of data*

All identifying details and information provided by participants, including audio-tapes and transcription of meetings and survey forms, are kept in a locked filing cabinet in a secure office at the School of Nursing and Midwifery, University of South Australia (City East Campus). All data has been retained in accordance with ethics regulations of the University of South Australia and Function 6 of the Records Disposal for South Australian public Hospitals and will be stored for a period of 15 years following the completion of the research project. Only I, as the researcher, and research supervisors are able to access and review data collected.

### *Reporting the work of others and grey literature*

I ensured that I did not misrepresent what other researchers (and authors of articles) had said or had written. Hence I kept hard copies of articles I found relevant to my research and properly referenced whatever material I had used. In order for me to develop the first

Delphi Survey Questions I extracted direct quotes from articles I located and screened against inclusion/exclusion criteria. I kept track of these direct quotes referenced as illustrated in *Figure 5*. I will discuss this in depth later in the focussed review of the literature section.

During the process of undertaking the literature review I retrieved a research paper titled: 'Clinical, classroom, or personal education: attitudes about health literacy' (Logan 2007). Logan (2007) has utilised the Delphi Survey technique in his research. I considered some of Logan's statements to be appropriate in my Delphi Survey. Based on my assessment, I sent an introductory email (*Appendix 5*) and formal letter (*Appendix 5*) to the author requesting his permission to apply some of his statements to my Delphi Survey. I also mentioned to the author that I would reference his work in my thesis or any research papers that may be produced in the future. Once I received his approval in a reply email (*Appendix 5*) I used some of his statements modified for my research.

I now detail the three stages of my research.

## Stage 1: Describe the context

As I discussed in *Chapter 3*, Habermas (1972) argues that there is not one 'legitimate knowledge', only different types of knowledge shaped by different interests that in turn shape how human beings may think and act. In addition to the literature review presented as *Chapter 2*, I completed a document analysis of publicly available undergraduate and postgraduate nursing curricula documents in Australia to understand how nursing and nurses are provided opportunities to translate this concept of health literacy to their health education role while working with children and young people. Findings from this document analysis revealed a potential gap in nursing curricula with regard to health literacy and possible effects on undergraduate nursing students' understanding and comprehension of health literacy and its implications on health care.

I then focussed my literature review more specially on published literature related to health literacy available from national and international publications and websites. I did this to describe the 'place' for health literacy in nursing and in the practices of nurses. I positioned published materials by nurses as reflective of a view promoted by nursing about health education and health literacy.

Although health education and health literacy are important concepts that could be applied into various nursing fields and aspects, I purposefully delimited the scope of my literature

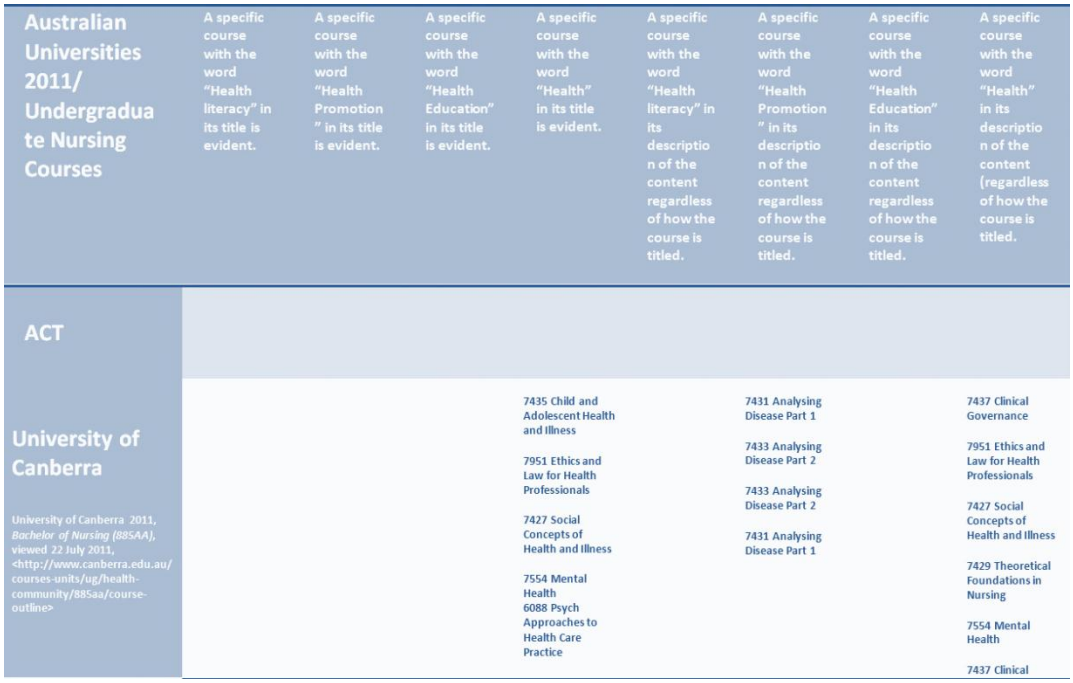
review, which was in addition to *Chapter 2*, to obtain in-depth understanding of how health literacy is promoted in paediatric nursing and child and youth health related published literature. Findings from my focussed review of the literature informed the development of my Delphi Survey from which findings that emerged informed the focus group discussion. What follows is how I collated and reviewed related documents and published grey literature related to health literacy.

### *University nursing curricula (postgraduate and undergraduate) for RNs*

Publicly available undergraduate and postgraduate nursing curricula documents were obtained from the internet sites of University Schools of Nursing across Australia to describe the context in which nursing students and RNs potentially learn about health education and health literacy. Findings from this search of documents enabled me to describe the extent to which nursing academics in Australia give visible acknowledgement to these concepts in courses within the different programs on offer. The findings from this search are detailed in *Appendix 6*. I sought to identify within the documents:

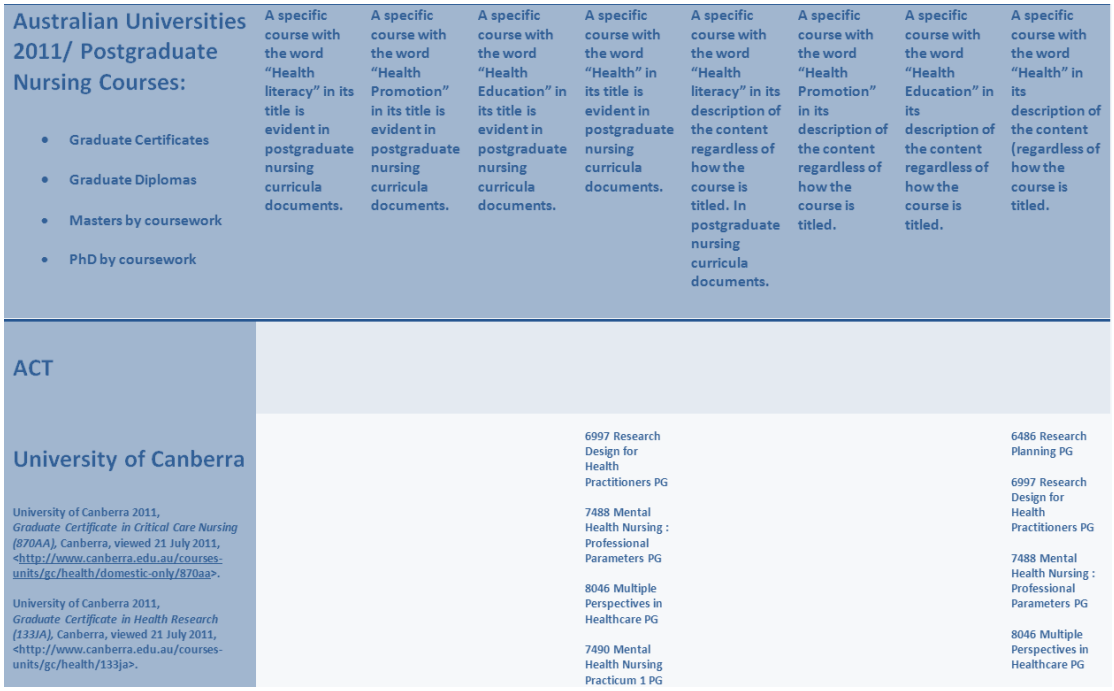
- A specific course with the word 'Health literacy' in its title in postgraduate nursing curricula document;
- A specific course with the word 'Health Promotion' in its title in postgraduate nursing curricula documents;
- A specific course with the word 'Health Education' in its title in postgraduate nursing curricula documents;
- A specific course with the word 'Health' in its title in postgraduate nursing curricula documents;
- A specific course with the word 'Health literacy' in its description of the content (regardless of how the course is titled) in postgraduate nursing curricula documents;
- A specific course with the word 'Health Promotion' in its description of the content regardless of how the course is titled;
- A specific course with the word 'Health Education' in its description of the content regardless of how the course is titled; and
- A specific course with the word 'Health' in its description of the content regardless of how the course is titled.

*Figures 1* and *2* portray examples of search results of Australian universities' 2011/ undergraduate and postgraduate nursing courses.



| Australian Universities 2011/ Undergraduate Nursing Courses | A specific course with the word "Health literacy" in its title is evident. | A specific course with the word "Health Promotion" in its title is evident. | A specific course with the word "Health Education" in its title is evident. | A specific course with the word "Health" in its title is evident. | A specific course with the word "Health literacy" in its description of the content regardless of how the course is titled. | A specific course with the word "Health Promotion" in its description of the content regardless of how the course is titled. | A specific course with the word "Health Education" in its description of the content regardless of how the course is titled. | A specific course with the word "Health" in its description of the content (regardless of how the course is titled. |
|---|---|---|---|---|---|---|---|---|
| ACT | | | | | | | | |
| University of Canberra<br>University of Canberra 2011, *Bachelor of Nursing (885AA)*, viewed 22 July 2011, <http://www.canberra.edu.au/courses-units/ug/health-community/885aa/course-outline> | | | | 7435 Child and Adolescent Health and Illness<br>7951 Ethics and Law for Health Professionals<br>7427 Social Concepts of Health and Illness<br>7554 Mental Health<br>6088 Psych Approaches to Health Care Practice | 7431 Analysing Disease Part 1<br>7433 Analysing Disease Part 2<br>7433 Analysing Disease Part 2<br>7431 Analysing Disease Part 1 | | | 7437 Clinical Governance<br>7951 Ethics and Law for Health Professionals<br>7427 Social Concepts of Health and Illness<br>7429 Theoretical Foundations in Nursing<br>7554 Mental Health<br>7437 Clinical |

**Figure 1** Example of search results of Australian universities' 2011/ undergraduate nursing courses



| Australian Universities 2011/ Postgraduate Nursing Courses:<br>• Graduate Certificates<br>• Graduate Diplomas<br>• Masters by coursework<br>• PhD by coursework | A specific course with the word "Health literacy" in its title is evident in postgraduate nursing curricula documents. | A specific course with the word "Health Promotion" in its title is evident in postgraduate nursing curricula documents. | A specific course with the word "Health Education" in its title is evident in postgraduate nursing curricula documents. | A specific course with the word "Health" in its title is evident in postgraduate nursing curricula documents. | A specific course with the word "Health literacy" in its description of the content regardless of how the course is titled. In postgraduate nursing curricula documents. | A specific course with the word "Health Promotion" in its description of the content regardless of how the course is titled. | A specific course with the word "Health Education" in its description of the content regardless of how the course is titled. | A specific course with the word "Health" in its description of the content (regardless of how the course is titled. |
|---|---|---|---|---|---|---|---|---|
| ACT | | | | | | | | |
| University of Canberra<br>University of Canberra 2011, *Graduate Certificate in Critical Care Nursing (870AA)*, Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/gc/health/domestic-only/870aa>.<br>University of Canberra 2011, *Graduate Certificate in Health Research (133JA)*, Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/gc/health/133ja>. | | | | 6997 Research Design for Health Practitioners PG<br>7488 Mental Health Nursing : Professional Parameters PG<br>8046 Multiple Perspectives in Healthcare PG<br>7490 Mental Health Nursing Practicum 1 PG | | | | 6486 Research Planning PG<br>6997 Research Design for Health Practitioners PG<br>7488 Mental Health Nursing : Professional Parameters PG<br>8046 Multiple Perspectives in Healthcare PG |

**Figure 2** Example of search results of Australian universities' 2011/ postgraduate nursing courses

The final search results of Australian universities' 2011 undergraduate and postgraduate nursing courses are presented in *Chapter 5* and provided me with information about a

potential gap in nursing curricula with regard to health literacy, possible effects on undergraduate nursing students' understanding and comprehension of health literacy and its implications on their health education role.

### *Focussed review of literature*

Gillham (2002) developed the Web Resource Appraisal Process (WRAP) pedagogy and software. WRAP is a tool that provides structure for reviews based on accessible online resources. This approach can permit a diverse variety of research sources to be included. Given that databases linked to the WRAP tool provide broad coverage to primary, secondary and tertiary web databases such as Cochrane, Database of Abstracts of Research Evidence (DARE) and Transferring Research into Practice (TRIP), MEDLINE, CINAHL and PubMed the use of this tool was considered appropriate as it allowed me to locate and source reviews of research already carried out by expert reviewers (Gillham 2002).

According to Gillham (2002, p. 257) the WRAP tool is a website with three chief utilities:

- It is a teaching and learning source endorsing collaborative learning via online resources;
- It endorses the use of research evidence to practice by providing a standardised outline for the critical review of data resources; and
- It offers a mechanism for the cooperative credentials of nursing knowledge.

The WRAP tool not only provides the users with a set structure for the collation of knowledge in a particular practice field, but it also provides a method of capturing the knowledge of clinicians by assimilating this knowledge with the most recent research and Internet based data resources (Gillham 2002).

The WRAP tool guided how this review was conducted requiring the following:

- Objectives of the review to be identified;
- Literature identified according to an explicit search strategy;
- Studies to be selected according to defined inclusion and exclusion criteria; and
- Literature to be evaluated/assessed against defined criteria.

Conducting the focussed review of literature served the following objectives:

- Investigate the level of existing knowledge about health literacy and how different professional groups understand the concept and how they address the education of students about this concept;
- Locate a range of studies and opinion papers addressing health literacy and the importance given to this concept and to the clinical practice of paediatric RNs, and to the health of children and young people; and
- Identify gaps or tensions in existing knowledge as elaborated by the profession of nursing and paediatric RNs related to health literacy.

### *Search Strategy*

I considered a broad range of published academic and grey literature relating to health literacy. In addition to the WRAP databases, further searching was conducted of the following databases/resources: AMED, Academic search elite, Health source, nursing/academic edition, HighWire Press, Informit e-library, Web of science, Current Contents Connect, ScienceDirect and Health Sciences a SAGE full-text collection (1998—October 2007) to ensure a comprehensive coverage. A strategy consisting of Medical Subject Headings (MeSH) and text words was developed for each of the key terms: health literacy, nurse or nursing, child or children and paediatric or paediatrics. These were combined with each other. Please see *Figure 3* below

| **Medline (Ovid)** | **Amed (Ovid)** |
|---|---|
| Health literacy .mp. | Health literacy .mp. |
| Health literacy and Nurs$ .mp. or Nursing/ | Health literacy and Nurs$ .mp. or Nursing/ |
| Health literacy and Child$ .mp. | Health literacy and Child$ .mp. or Child/or Adolescent |
| Health literacy and P$ediatr$ .mp. | Health literacy and P$ediatr$ .mp. or Child/ |
| 2 and 3 | 2 and 3 |
| 2 and 4 | 2 and 4 |

**Figure 3** Example of search terms

While these searches yielded large numbers of studies, many contained little or no information about health literacy in paediatric nursing and child and youth health. For

example, papers focused on health literacy and its relation to medical conditions, particularly in chronic illness. The search results are displayed in *Table 1*.

**Table 1 Search results**

| Databases Searched | No. Hits |
|---|---|
| Medline (Ovid) | 544 |
| Amed (Ovid) | 6 |
| Academic Search Elite (EBCO host) | 329 |
| CINAHL (EBCO host) | 287 |
| Health Source Nursing/ Academic Edition (EBCO host) | 302 |
| PubMed | 490 |
| Highwire Press | 267 |
| Informit e-Library | 236 |
| ISI web of Knowledge | 1041 |
| Current Content | 1309 |
| Science Direct | 231 |
| Health Sciences | 486 |
| Blackwell Synergy | 483 |
| ERIC | 49 |

### Search difficulties encountered

I managed any search difficulties I encountered while conducting the review of literature following specific steps. In the case that too few relevant articles were found, then the following steps were considered:

- Which key words found the best references?
- Which keywords might be inappropriate?
- Alternative keywords.
- Whether the search statement was entered correctly and whether the correct commands were used.
- If the databases searched were the most appropriate.

If there were too many references found then the search was narrowed and made more specific by:

- Adding another concept or key word.

- Adding limits to the search.
- Restricting the search to specific field.

If more references were needed the search was broadened by:

- Using alternative key words and synonyms, including alternative spelling.
- Using truncations or wildcards to capture all forms of needed keywords.

### Inclusion criteria

I included published articles, in English only, that focussed on 'health literacy' not literacy. I included English-only articles as preliminary searches uncovered non-English papers. I am not conversant in different languages to critique a research paper, and based on initial searching it was reasonable to examine English-only papers.

I included articles that were research-based including all types of research. I also considered the relevance of a broad range of literature that included conference abstracts, text books, published articles, commentaries, editorials, doctoral dissertations, master's theses, systematic reviews, speeches, pamphlets and letters. The above process was done to certify an inclusive coverage and it yielded relevant material to health literacy that I considered for review and inclusion in the research.

My focus was paediatric RNs but I also considered a wide range of health professionals, for example: GPs, pharmacists, occupational therapists, social workers, school teachers, children, young people and/or their families.

I only considered literature dating between 1998 up to October 2007. The justification for this choice was because the concept of health literacy had been first defined by the World Health Organization (WHO) in 1998 and the commencement of the planning for the Delphi Survey commenced October 2007.

### Screening and data extraction

My search strategy generated over 6060 research titles and abstracts of articles. Screening articles across different databases and excluding the duplicates resulted in over 1322 articles. I assessed the titles and abstracts of these articles, applying my inclusion criteria and the focussed review of literature objectives and this process resulted in 182 articles meeting the inclusion criteria and the review objectives. Results of this process are illustrated in *Figure 4*. All 182 articles were successfully retrieved. The retrieved articles

were read and re-read to extract their characteristics (*Appendix 7*) and also to extract quotes that later formed the Delphi Survey round one statements.

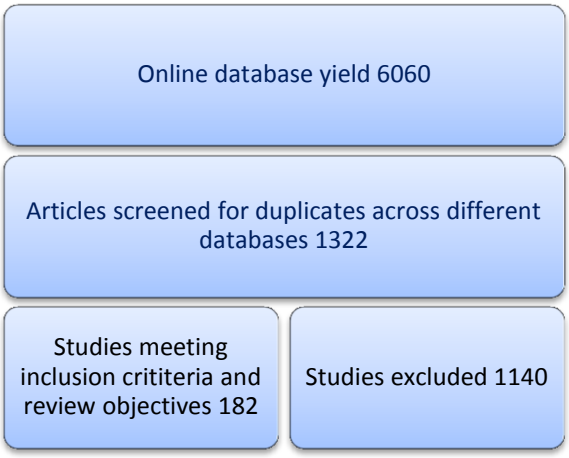



**Figure 4** Search and retrieval process

Although 182 articles met the inclusion criteria and review objectives, only 16 articles were used. This is because the actual statements used in the first round Delphi Survey had been extracted from these 16 articles. The final set of included studies is included in *Table 2.*

**Table 2** Characteristics of included studies

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Nutbeam D 2000, 'Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century', *Health Promotion International*, vol. 15, no. 3, pp. 259-267. | *Health Promotion International* | Opinion | | Health Literacy | English | Health promoters, consumers, government, healthcare professionals, patient advocacy groups, healthcare organisations, media, industry, policymakers and community-based organisations | Improving health literacy in a population involves more than the transmission of health information, although that remains a fundamental task. Helping people to develop confidence to act on that knowledge and the ability to work with and support others will best be achieved through more personal forms of communication, and through community-based educational outreach. If we are to achieve the ultimate goal that is reflected in that definition of health literacy—trying to promote greater independence and empowerment among the individuals and communities we work with—we will need to acknowledge and understand the political aspects to education, focused on overcoming structural barriers to health. | The journal of *Health Promotion International* is published by Oxford Journals, Oxford University Press (a department of Oxford University, UK). This journal is published in association with the WHO and includes original refereed articles and reviews from the sectors of education, health services, employment, government, the media, industry, environmental agencies and community networks. Articles in this publication not only cover areas of research, policy and theory, but also organisational change and social and environmental development. The Editor-in-Chief (Professor John Catford) trained in medicine at Cambridge University, UK and currently holds these positions: Pro Vice-Chancellor of the Faculty of Health, Professor of Health Development at Deakin University, Melbourne, the Chair of the Postgraduate Medical Council of Victoria, Editor-in-Chief of the journal *Health Promotion International* published by Oxford University Press and Adjunct Professor in the Faculty of Medicine, Nursing and Health Sciences at Monash University. The Chair of the Editorial Board (Ilona Kickbusch) is known worldwide for contributing to the body of knowledge in innovation in public health, health promotion and global health. Professor Kickbusch gained her PhD in political science from the University of Konstanz, Germany, and is currently the Director of the Global Health Programme, Graduate Institute of International and Development Studies, Geneva. Peer reviewers volunteer and are assessed by the editorial staff.<br>Sources: http://heapro.oxfordjournals.org/<br>http://www.deakin.edu.au/hmnbs/staff/bio/jcatford.pdf<br>http://www.ilonakickbusch.com/home/index.shtml | According to The Web of Knowledge Journal Citation Reports the current impact factor for this journal is 1.737 and the five year impact factor is 2.137. |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 2 | Logan RA 2007, 'Clinical, classroom, or personal education: attitudes about health literacy', *Journal of the Medical Library Association*, vol. 95, iss. 2, pp. 127-137. | *Journal of the Medical Library Association* | Non-experimental descriptive study (Delphi Survey) | Medical Librarians | Health Literacy | English | Medical Librarians | This study explores how diverse attitudes about health literacy are assessed by medical librarians and other health care professionals.<br><br>An online survey of thirty-six items was conducted using Q methodology in two phases in spring 2005 and winter 2006. Respondents (n = 51) were non randomly self-selected from a convenience sample of members of the Medical Library Association and a group of environmental health consultants to the National Library of Medicine.<br><br>Three factors were identified. Factor 1 is optimistic and supportive of health literacy's transformative sociocultural and professional potential, if clinical settings become a launching point for health literacy activities. Factor 2 is less optimistic about health literacy's potential to improve clinical or patient outcomes and prefers to focus health literacy initiatives on classroom education settings. Factor 3 supports improving the nation's health literacy but tends to support health literacy initiatives when people privately interact with health information materials.<br><br>Each factor's attitudes about the appropriate educational venue to initiate health literacy activities are different and somewhat mutually exclusive. This suggests that health literacy is seen through different perceptual frameworks that represent a possible source of professional disagreement. | The aim of the *Journal of the Medical Library Association* is 'to advance the practice and research knowledge base of health sciences librarianship' (MLA 2012). It is published by the Medical Library Association, California (the MLA has existed for over a century) which has a significant number of individual and organisational members. The MLA publishes, and is committed to supporting, health information research and promoting access to credible health information. The Editor in Chief (Susan S Star) gained her PhD from Boston University USA in the field of Psychology.<br><br>The JMLA has a peer review Editorial Board, selected from members of the Medical Library Association who apply to be on the Board. Selection of Board members is based on a combination of experience in medical librarianship and experience in scholarly publication. Manuscripts are sent for review to two members of this Board and an outside reviewer. The latter is selected based on their experience with the topic of the article.<br><br>Sources: http://www.mlanet.org/publications/jmla/<br><br>hhttp://www.mlanet.org/about/index.html<br><br>http://www.mlanet.org/publications/jmla/jmlaed.html | According to the journal the current impact factor is .844 and the five year impact factor is 1.23 |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 3 | Ratzan SC 2001, 'Health literacy: communication for the public good', *Health Promotion International*, vol. 16, no. 2, pp. 207-214. | *Health Promotion International* | Opinion | | Health Literacy | English | Health promoters, consumers, government, healthcare professionals, patient advocacy groups, healthcare organisations, media, industry, policymakers and community-based organisations | This article builds upon a presentation at the Fifth Global Health Conference on Health Promotion (Mexico City, 9 June 2000), seeking to advance the development of health literacy through effective communication. First, it offers a timely reflection for health promotion epistemology in particular, and the potential approach to framing health promotion activities in general, with health literacy as a bridging concept. The concept of health literacy is briefly explained and defined, followed by identification of some promising communication interventions to diffuse health literacy. Four predominant areas within the communication field are described and shed light on approaches for developing health literacy: integrated marketing communication, education, negotiation and social capital. Each component can contribute to strategic science-based communication. Finally, the article clearly states that communication and developing health literacy are not simple solutions. Communication is not simply message repetition, but includes the development of an environment for community involvement to espouse common values of humankind. With effective communication, worldwide health literacy can become a reality in the 21st century, embodying health as a central tenet of human life. | The journal of *Health Promotion International* is published by Oxford Journals, Oxford University Press, and (a department of Oxford University, UK). This journal is published in association with the WHO and includes original refereed articles and reviews from the sectors of education, health services, employment, government, the media, industry, environmental agencies and community networks. Articles in this publication not only cover areas of research, policy and theory, but also organisational change and social and environmental development. The Editor-in-Chief (Professor John Catford) trained in medicine at Cambridge University, UK and currently holds these positions: Pro Vice-Chancellor of the Faculty of Health, and Professor of Health Development at Deakin University, Melbourne, the Chair of the Postgraduate Medical Council of Victoria, Editor-in-Chief of the journal *Health Promotion International* published by Oxford University Press and Adjunct Professor in the Faculty of Medicine, Nursing and Health Sciences at Monash University. The Chair of the Editorial Board (Ilona Kickbusch) is known worldwide for contributing to the body of knowledge in innovation in public health, health promotion and global health. Professor Kickbusch gained her PhD in political science from the University of Konstanz, Germany, and is currently the Director of the Global Health Programme, Graduate Institute of International and Development Studies, Geneva. Peer reviewers volunteer and are assessed by the editorial staff.<br>Sources:<br>http://www.oxfordjournals.org/about_us.html<br>http://heapro.oxfordjournals.org/<br>http://www.deakin.edu.au/hmnbs/staff/bio/jcatford.pdf<br>hhttp://www.ilonakickbusch.com/home/index.shtml | According to The Web of Knowledge Journal Citation Reports the current impact factor for this journal is 1.737 and the five year impact factor is 2.137 |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 4 | Stockton PL 2004, 'Improving health literacy', *The American Medical Writers Association Journal*, pp. vol. 19, no. 3, 101-104. | *AMWA Journal* | Opinion | | Health Literacy | English | Health educators | This article introduces the problem of low health literacy and provides a few examples of what the Center for Disease Control and Prevention (CDC) is doing about it. | Situated in Maryland USA the AMWA was established in 1979 with the aim to 'promote excellence in medical communication' (AMWA 2012). *The American Medical Writers Association Journal* 'aims to be an authoritative, comprehensive source of information about the knowledge, skills, and opportunities in the field of medical communication worldwide' (AMWA 2012) The Editor (Lori Alexander) holds a master's degree in technical and professional writing from Northeaster University, Boston USA. Now talk about editorial board.<br><br>Peer reviewers volunteer for the position, but must have experience in peer reviewing and are required to undertake further peer review training (offered by the editor). The Editorial Board is made up of the Editor; five members appointed by the editor, each of whom serves a 3-year term; the current AMWA President; and the current AMWA Publications Administrator.<br><br>Sources:<br><br>http://www.amwa.org/default.asp?Mode=DirectoryDisplay&id=1&DirectoryUseAbsoluteOnSearch=True<br><br>http://www.amwa.org/default.asp?Mode=DirectoryDisplay&id=372<br><br>http://www.editorialrx.com/officer-bios.php | No impact factor recorded |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 5 | Brey RA , Clark SE & Wantz MS 2007, 'Enhancing health literacy through accessing health information, products and services: an exercise for children and adolescents', *Journal of School Health*, vol. 77 no. 9, pp. 640-644. | *Journal of School Health* | Report on a project | | Health Literacy | English | Physiologists, health scientists and school teachers working with children and adolescents | After completing the lesson/project, the student will be able to:<br>1. Identify and describe the 4 health education settings where health information, services, or products can be found.<br>2. Explain how to use at least 2 examples of health information, services, or products from each of the 4 health education settings.<br>3. Acquire contact information for at least 3 agencies, organisations, or institutions under 1 of the 4 health education settings and determine if they are sources of valid health information.<br>4. Identify at least 3 reasons a health agency, organisation, or institution would be considered a credible source of health information, services, or products.<br>5. Call, e-mail, or write to at least 3 agencies under 1 of the 4 health education settings to determine the provided health information, products, and services.<br>6. Prepare and present an oral report of health information, products, and services provided by the assigned agencies, organisations, or institutions.<br>7. Compose a summary of health information, products, and services provided by the assigned agencies, organisations, or institutions for inclusion in a class computer data file.<br>8. Explain at least 3 examples of personal, family, or community health advocacy activities in a reflective paper. | The *Journal of School Health* is published by Wiley-Blackwell on behalf of the American School Health Association. Its content is health research, practical and theoretical, majoring on school aged young people. The Editor in Chief, (Robert McDermott), gained his PhD at the University of Wisconsin. Currently Professor McDermott is the co director of the Department of Community and Family Health, University of South Florida.<br>The Editorial Board is appointed by the President of the organisation.<br>Manuscripts receive a blind peer review by at least three reviewers. Reviewers volunteer and their expertise in a particular area are evaluated by the Editorial Board. The journal Editor-In-Chief makes the final decision concerning acceptance of manuscripts.<br>Sources: http://www.wiley.com/bw/journal.asp?ref=0022-4391&site=1h | According to The Web of Knowledge Journal Citation Reports the current impact factor for this journal is 1.422 and the five year impact factor is 1.911 |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 6 | Stephenson L 2006, 'Health literacy: are you doing enough to communicate with your patients?' *Iowa Medicine*, vol. 96, iss. 4, pp. 16-17. | *Iowa Medicine* | Opinion | | Health Literacy | English | Physicians | The author argues that there are strategies that [physicians] can do and should be doing better in [their] practice to help [their] patients understand their medical conditions. What may surprise [physician], though, is that working to improve health literacy isn't as time consuming and costly as [they] might think. Excellent resources are available to guide [them] and [their] staff toward simple strategies [they] can implement to improve how [they] communicate with [their] patients. | The *Iowa Medicine* journal is a socioeconomic magazine (rather than clinical) and as such does not have a peer review process or an editorial board. The journal is the official journal of the Iowa Medical Society. The Editor (Lucinda Stephenson) has a Master's degree in Journalism from the Iowa State University. | No impact factor recorded |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 7 | Andrus MR & Roth MT 2002, 'Health literacy: a review', *Pharmacotherapy*, vol. 22, iss. 3, pp. 282-302. | *Pharmacotherapy* | Literature review | Literature | Health Literacy | English | Pharmacists and other healthcare professionals | It is important for all health care professionals to be educated about the prevalence and consequences of inadequate health literacy so that individuals who struggle with this problem can be compassionately identified. Once identified, we can work to assist these patients in overcoming the barriers that may be limiting their ability to function adequately in the health care environment. Additional studies are needed to advance our understanding of inadequate health literacy, and continued research is necessary to determine effective strategies for improving the functional health literacy status of our patients and measuring the impact of such interventions on health care. | The journal is the official journal of the American College of Clinical Pharmacy. '*Pharmacotherapy* publishes peer-reviewed, innovative scientific and professional information and knowledge that catalyze change to improve patient outcomes through optimal pharmacotherapy' (2011). This journal is based in Boston, USA and invites authors to submit original research articles 'on all aspects of human pharmacology and review articles on drugs and drug therapy. The Editors and Editorial Board invite original research reports on pharmacokinetic, bioavailability, and drug interaction studies, clinical trials, investigations of specific pharmacological properties of drugs, and related topics' (n.d.). The Editor-in –Chief (Dr Richard Scheife) holds a Doctorate in Pharmacy from the University of Michigan. This journal, which is published by Wiley, has an impressive list of Scientific Editors and members of the Editorial Board. Peer reviewers volunteer for the task and the editor assesses their work. Procedures for article submission review are rigorous involving peer reviewers, scientific editors and other editorial staff. The Editorial Board is selected by invitation. Each year the Scientific Editor Council (SEC) submits names of clinicians and researchers they feel would add to the abilities and scientific depth of the Editorial Board. Candidates are selected based on a history of excellent performance as reviewers and/or as authors, support for the journal. Members of the EB are appointed for 3 years and are evaluated based on performance as reviewers, expert screeners, and authors.<br>Sources:<br>http://pharmacotherapyjournal.org/loi/phco<br>http://pharmacotherapyjournal.org/page/Staff<br>http://pharmacy.wisc.edu/discoverx/winter-2010/citation-awards-and-alumnus-year<br>http://pharmacotherapyjournal.org/userimages/ContentEditor/1294762568925/Instructions_to_Authors.pdf | According to The Web of Knowledge Journal Citation Reports the current impact factor for this journal is 2.631; the five year impact factor is 2.260 |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 8 | Jackson R 2005-2006, 'Health literacy: an introduction of the literature', *Journal of Indiana Dental Association*, vol. 84, iss. 4, pp. 10-13 | *Journal of Indiana Dental Association* | Opinion | | Health Literacy | English | Dentists | Dentists should be aware that a significant proportion of their patients may have poor literacy skills. As a result, these patients may not be able to understand fully and follow written instructions for the treatment of their dental disease. While certain groups have been identified as being more likely that others to have poor health literacy skills, the dentist and his or her staff should be aware that poor health literacy skills are found in persons from all walks of life. To improve the health outcomes of their patients, dentist should be willing to evaluate the literacy skills of patients they suspects of having difficulty. Practitioners should then modify their educational programs to meet the needs of individual patients based on their literacy skills. Written materials, including informed consent statements and pamphlets, should be evaluated to ensure that these materials can be understood readily.<br>Assessing health literacy and providing appropriate materials geared to the literacy level of the patient will lead to improvement in health education and health communication. Improving health literacy will result in the patient being able to take an active part in his or her own health care as an informed member of the health care team. | JIDA is the official journal of the Indiana Dental Association; the American Dental Association is constantly monitoring and working on the national issues that matter to dentists and their patients.<br>The mission of the Indiana Dental Association is to support dentists, to promote professionalism in the dental profession, and to improve oral health in the state of Indiana.<br>Articles are primarily drawn from dental professionals from within the state of Indiana. Articles range from case studies, scientific articles, as well as human interest pieces featuring our members. An Editorial Board selects the articles.<br>Sources:<br>http://www.indental.org/Professional-Resources/Publications/Journal-IDA | No impact factor recorded |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 9 | Erlen 2004, 'Functional health illiteracy: ethical concerns', *Orthopaedic Nursing*, vol 23, iss. 2, pp. 150-3. | *Orthopaedic Nursing* | Opinion | | Functional Health Illiteracy | English | Healthcare professionals | The purposes of this article are to provide an overview of the problem of inadequate functional health literacy and consider ethical concerns that may arise when nurses care for patients who are unable to understand healthcare information. Selected, relevant nursing implications are discussed. Nurses are in a unique position to identify gaps in their patients' understanding of their health needs and also to serve as advocates, mediators, and translators for patients. | *Orthopaedic Nursing* (published by Wolters, Kluwer Health/Lippincott, Williams and Wilkins) is the official Journal of the National Association of Orthopaedic Nurses (NAON). This international journal provides continuing education with research articles for orthopaedic nurses who practice in a variety of health care settings. The editor (Mary Faut Rodts) holds a Doctorate (DNP) from Rush University, Chicago and is currently Associate Professor with Rush College of Nursing. Peer reviewers volunteer and their qualifications and expertise are evaluated by the editor. An electronic system matches potential reviewers to the submitted manuscript based on classification descriptions that the peer reviewer has identified; the peer reviewer is then matched to the manuscript. The Editorial Board is selected by the Editor from those who either volunteer or are nominated for these positions. | According to The Web of Knowledge Journal Citation Reports the current impact factor for this journal is .304 and the five year impact factor is 0.763. |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 10 | Kickbusch I, Wait S, Maag D 2005, *Navigating health. The role of health literacy*, The International Longevity Centre-UK, Alliance for Health and the Future, London. | *The International Longevity Centre-UK* | Opinion | | Health Literacy | English | Health care professional, academics, researchers, policymakers and the general public. | • Health literacy is a right of citizenship<br>• Create a voice for health literacy in the political process<br>• Politicians, professionals and the public all must take responsibility for health literacy<br>• Governments must commit to long-term investment in health<br>• Build partnerships to promote heath literacy<br>• Adopt a multilevel approach in health literacy building<br>• Invest in new types of professionals<br>• Health literacy should be put on the school curriculum<br>• Enabling health literacy in health settings<br>• Building health literacy to reduce health inequalities<br>• Develop more simple and practical information<br>• Create a European Centre of Excellence on Health Literacy<br>• Develop a research a network agenda on health literacy in the European Union | This report, commissioned by the Alliance for health and the future and the International Longevity Centre – UK, addresses and defines the need for health literacy in the community. The conclusions and recommendations provide for the reader a comprehensive plan to implement changes within community health settings.<br>The authors:<br>Ilona Kickbusch is known worldwide for contributing to the body of knowledge in innovation in public health, health promotion and global health. Professor Kickbusch gained her PhD in political science from the University of Konstanz, Germany, and is currently the Director of the Global Health Programme, Graduate Institute of International and Development Studies, Geneva.<br>Dr Suzanne Wait was the Director of Research at the Alliance for Health and the Future until 2007. The Alliance is a think-and-do-tank exploring the impact of the ageing population in society. Currently she is a Research Fellow at the School of Public Policy, University College London. Dr Wait has published extensively in the areas of public health and the impact of the ageing population in society.<br>Dr Daniela Maag is a faculty member of the University of Lugano, Health Care Communication Laboratory. Dr Maag has published in the area of public health and is associated with the Alliance for health and the future and the International Longevity Centre – UK,<br>Sources:<br>http://www.ilcuk.org.uk/<br>http://healthandfuture.org/<br>http://www.ilonakickbusch.com/home/index.shtml<br>http://www.deepdyve.com/lp/pier-professional/from-age-discrimination-to-age-equality-in-health-care-a-european-r11jerYv5Z/1<br>http://eurpub.oxfordjournals.org/content/16/suppl_1/64.full.pdf | No impact factor recorded |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 11 | Norton L, 1998, 'Health promotion and health education: what role should the nurse adopt in practice?' *Journal of Advanced Nursing*, vol. 28, iss. 6, pp. 1269-1275. | *Journal of Advanced Nursing* | Opinion | | Health promotion and health education | English | Nurses | Health promotion and health education: what role should the nurse adopt in practice? Health promotion is widely accepted as part of the role of the nurse, midwife and health visitor. Theoretical definitions of health promotion and health education are presented. The author suggests that a variety of different approaches to health promotion can be adopted by nurses in practice, including education, persuasion, manipulation and attempts to promote an environment where healthy decisions about lifestyle can be made. Each strategy is examined and the advantages and the ethical limitations are explored. It is suggested that nurses may theoretically accept the notion of being a health promoter, but that in the reality of practice, their role may be primarily that of the health educator. The importance of recognising that there are a variety of determinants of health, including social and environmental factors, as well as individual lifestyle, is emphasised throughout the paper. | The *Journal of Advanced Nursing* is a world-leading peer reviewed journal based in Malden, Massachusetts, USA. The Editor (Roger Watson) gained his PhD at the University of Edinburgh and currently holds the position of Professor of Nursing at the University of Sheffield, UK. 'The *Journal of Advanced Nursing* (*JAN)* contributes to the advancement of evidence-based nursing, midwifery and healthcare by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy' (2012). The editorial board is selected by a combination of self-selection (experts volunteer) and invitation. All reviewers are evaluated for expertise. Manuscript submissions that pass a stringent assessment process against the guidelines of the journal are then reviewed by two external peer reviewers chosen according to subject matter and expertise. An editor from JAN works closely with the author at this point.<br>Sources:<br>http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2648/homepage/ProductInformation.html<br>http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2648/homepage/EditorialBoard.html | According to The Web of Knowledge Journal Citation Reports the current impact factor for this journal is 1.540; the five year impact factor is 2.347 |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 12 | Cutilli CC 2005, 'Do your patients understand? Determining your patients' health literacy skills', *Orthopaedic Nursing*, vol. 24, iss. 5, pp. 378-379. | *Orthopaedic Nursing* | Case Study | Nurse<br><br>Client | Health Literacy | English | Nurses | In the ideal healthcare setting, M. G. would have had health literacy testing and the nurse would have been able to give him information at his literacy level. Striving for this ideal situation is a goal for all healthcare providers. To ensure that patients understand their healthcare information, it must be provided in a manner that matches their health literacy skills. In addition, nurses need to evaluate the patients' comprehension, which is easily accomplished by asking the patient to describe and/or demonstrate aspects of their healthcare.<br><br>The type of test that is used to assess the literacy levels of patients depends on the specificity of literacy information that is needed and time available for testing. The tests described in this article have various literacy level delineations and required testing times. Each healthcare professional must decide what type of literacy assessment is suitable for his or her patients.<br><br>Patients and nurses alike value effective and pertinent healthcare information. Nurses have an obligation as patient advocates to identify patient literacy issues and seek information that corresponds to the patients skills. In the future, nurses should not have to ponder the question, "Do your patients understand?" Nurses will know the answer to that question through the use of health literacy assessment, appropriate teaching methods, and the evaluation of healthcare knowledge.<br><br>The patient benefits of effective teaching are numerous; however, the benefits to society cannot be ignored. Patients who understand and effectively manage their health issues use healthcare resources wisely. One could conclude that providing effective healthcare education leads to restrained healthcare costs and a healthier society. | *Orthopaedic Nursing* (published by Wolters, Kluwer Health/Lippincott, Williams and Wilkins) is the official Journal of the National Association of Orthopaedic Nurses (NAON). This international journal provides continuing education with research articles for orthopaedic nurses who practice in a variety of health care settings. The editor (Mary Faut Rodts) holds a Doctorate (DNP) from Rush University, Chicago and is currently Associate Professor with Rush College of Nursing. Peer reviewers volunteer and their qualifications and expertise are evaluated by the editor. An electronic system matches potential reviewers to the submitted manuscript based on classification descriptions that the peer reviewer has identified; the peer reviewer is then matched to the manuscript. The Editorial Board is selected by the Editor from those who either volunteer or are nominated for these positions. | According to The Web of Knowledge Journal Citation Reports the current impact factor for this journal is .304 and the five year impact factor is 0.763. |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 13 | Speros C 2005, 'Health literacy: concept analysis', *Journal of Advanced Nursing*, vol. 50, iss. 6, pp. 633-640. | *Journal of Advanced Nursing* | Nursing, medical, public health and social science literature | Concept analysis | Health Literacy | English | Nurses | An analysis of the concept of health literacy enhances nurses' ability to assess more accurately their clients' levels of health literacy, thus identifying those at risk for misunderstanding health care instructions, shame associated with inadequate reading skills and inability to adhere to health care recommendations. | The *Journal of Advanced Nursing* is a world-leading peer reviewed journal based in Malden, Massachusetts, USA. The Editor (Roger Watson) gained his PhD at the University of Edinburgh and currently holds the position of Professor of Nursing at the University of Sheffield, UK. 'The *Journal of Advanced Nursing* (*JAN)* contributes to the advancement of evidence-based nursing, midwifery and healthcare by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy' (2012). The editorial board is selected by a combination of self-selection (experts volunteer) invitation. All reviewers are evaluated for expertise. Manuscript submissions that pass a stringent assessment process against the guidelines of the journal are then reviewed by two external peer reviewers chosen according to subject matter and expertise. An editor from JAN works closely with the author at this point.<br>Sources:<br>http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2648/homepage/ProductInformation.html<br>http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1365-2648/homepage/EditorialBoard.html | According to The Web of Knowledge Journal Citation Reports the current impact factor for this journal is 1.540; the five year impact factor is 2.347 |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 14 | Barrett SE & Puryear JS 2006, Health literacy: improving quality of care in primary care settings, *Journal of Health Care for the Poor and Underserved*, vol. 17, no. 4, pp. 690-7. | *Journal of Health Care for the Poor and Underserved* | Opinion | | Health Literacy | English | Clinicians | Raising awareness about the implications of low health literacy among clinicians and providing tools and resources to address these issues is important. Health facilities can conduct Lunch and Learn sessions where clinicians can get lunch time training on health literacy, culture, and strategies they can use to communicate with patients. More intensive trainings can include cross-training, role playing, and case study discussion. E-mail reminders, bulletin board reminders, and bathroom reminders are all ways health facilities can keep health literacy a priority of their clinicians.<br><br>Improving patient-communication involves systemic changes that involve health systems giving clinicians time during medical encounters to interact with the patient in a shame-free environment. It also involves patients being aware of their rights and being equipped with the knowledge that they are allowed to be, and are encouraged to be involved in their health care and it involves clinicians having the skills to communicate and interact with patients.<br><br>There is still much work that must be done to ensure patients and clinicians are able to communicate effectively given varying health literacy levels, cultures, and linguistic backgrounds. However, it is encouraging to learn that many primary care health facilities, especially those serving underserved communities are aware of the problem and are using what resources they have to help patients understand and care for their health condition. | JHCPU is published by the Johns Hopkins University Press and is the official journal of the Association of Clinicians for the Underserved Association of Clinicians of the Underserved. This peer-reviewed journal 'addresses such diverse areas as health care access, quality, costs, legislation, regulations, health promotion, and disease prevention from a North American, Central American, Caribbean, and sub-Saharan African perspective' (2012).<br><br>The Editor (Virginia M. Brennan) gained her PhD at the University of Massachusetts and is currently a member of the faculty of Meharry Medical College. Manuscripts are peer-reviewed by at least two external reviewers and go through a 'double blind' process. Peer reviewers volunteer and are assessed by the Editor and/or editorial board. Applications for the office of the editorial board are either self volunteering or nominated. These are assessed for academic impact and then appointed.<br><br>Source: http://www.press.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/ | The 2010 impact factor for this journal is 1.033. |

**Table 2** Characteristics of included studies (cont'd)

| No | Article citation | Journal | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes | Journal Information | Impact Factor |
|---|---|---|---|---|---|---|---|---|---|---|
| 15 | Cole MR 2000, 'The high risk of low health literacy', *Nursing Spectrum*, vol. 13, no. 10, pp. 7-16. | *Nursing Spectrum* | Opinion | | Health Literacy | English | Nurses | Effective communication is the cornerstone of nursing interventions. The goal of patient education has become the empowerment of consumers in a market-driven healthcare system. In today's savvy environment, it has become clear that the best prescription we can offer our patients is culturally and linguistically appropriate health education. | Although this journal is an industry related publication aimed at RNs working in the US, part of the mandate for this publication is to provide continuing education for RNs.<br>Source: http://www.nurse.com/ | None recorded |
| 16 | Schlichting JA, Quinn MT, Heuer LJ, Schaefer CT, Drum ML & Chin MH 2007, 'Provider perceptions of limited health literacy in community health centers', *Patient Education and Counseling*, vol. 69, iss. 1-3, pp. 114–120. | *Patient Education and Counseling* | Non-experim-ental descript-tive study (Surveys) | Health care providers in a community health centre | Health Literacy | English | Healthcare professionals | This study is the first to our knowledge that examines health care providers' perceptions of limited health literacy's effect on their patients, and to gather their opinions and experiences regarding methods they use or would like to use to help their patients overcome limited health literacy. The study also identified several barriers providers foresaw that could be addressed if their centre tried to implement a health literacy program. This study serves as a first step in determining future health literacy interventions in health centres, which will ultimately lead to better care and improved health outcomes for medically vulnerable patients.<br>Providers estimate limited health literacy to be highly prevalent in their health centres, and use various techniques to assist patients. | *Patient Education and Counseling* is published by Elsevier and is the official journal of the European Association for Communication in Healthcare and the American Academy on Communication in Healthcare. This journal 'is an interdisciplinary, international journal for patient education and health promotion researchers, managers, physicians, nurses and other health care providers' providing a forum for fundamental and applied research' (2012).<br>The Editor-in-Chief (Arnstein Finset) is the Professor of the Department of Behavioural Sciences in Medicine, University of Oslo Norway. Submitted manuscripts are peer reviewed and the editor works with authors during the revision process. An Advisory Board and an Editorial Board are elected and provide academic support for reviewers, editors and authors.<br>Sources:<br>http://www.elsevier.com/wps/find/journaldescription.cws_home/505955/description<br>http://www.elsevier.com/wps/find/journaleditorialboard.cws_home/505955/editorialboard<br>http://alexithymia.med.up.pt/public/dir/rightframe_files/a_finset.htm | According to The Web of Knowledge Journal Citation Reports the current impact factor for this journal is 2.237; the five year impact factor is 2.733. |

Articles collated were assessed against the following questions:

- How is health literacy defined?
- How do different professional groups understand the concept?
- Is importance given to health literacy by different professional groups? If it is, how and why?
- Is importance given to addressing health literacy in undergraduate programs for different professionals (health and education)? If it is, where and how?
- How important is it for undergraduate nursing students and RNs to understand what health literacy is?
- Do RNs have a role to play in influencing the health literacy of children and young people?

Each text collected was read noting words, phrases, sentences or paragraphs for key ideas. Consistency of opinions, frequency, intensity and specificity of ideas were also noted. Codes were developed; these original codes were very close to the data as there was no attempt to infer what was meant. For example, when an article reported the effect of inadequate health literacy on health outcomes, the designated code given was 'low health literacy'. Codes were added this way as needed. The texts assembled of the literature were re-examined when a new code was identified. An immersion in the data enabled recurrent patterns to be identified. They were conceptually larger than the codes as they seemed to incorporate related groupings of codes. Recurrent patterns were identified on the basis of similarity and/or regularity and grouped together for further analysis. A word processor was used to cut and paste the preliminary themes into groupings. Based on this process, recurrent patterns were refined. Some were put aside and others confirmed.

Recurrent patterns developed from the literature collated were grouped under the first Habermasian theoretical construct - critique of instrumental or technical rationality. These included:

- What is health literacy?
- Consequences of low health literacy.
- Health literacy role of paediatric RNs.

- The ‘place’ for health literacy.

Under each recurrent pattern, a group of direct quotes were pulled out directly from the literature and listed. These direct quotes were reworded to form the final statements that would be included in the first round of the Delphi Survey. In order to keep track of the statements through the process, I developed a table of three main columns showing the statements that have been included in the Delphi Survey (*Appendix 8*); to see the direct quotes where these statements have been reformed from and their references see *Figure 5*.

| # | Statements | Original Statements | References |
|---|---|---|---|
| 1 | **Being health literate means more than being able to read pamphlets and successfully make appointments.** | ‘Health literacy means more than being able to read pamphlets and successfully make appointments.’ | Nutbeam D 2000, ‘Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century’, *Health Promotion International*, vol. 15, no. 3, pp. 259-267. |
| 2 | **Improving health literacy amongst children and young people is important for their health and wellbeing.** | ‘Improving health literacy will first result in patients who are more discerning about the medical advice they receive.’ | Logan RA 2007, ‘Clinical, classroom, or personal education: attitudes about health literacy’, *Journal of the Medical Library Association*, vol. 95, iss. 2, pp. 127-137. |
| 3 | **Health literacy is part of lifelong learning.** | ‘Health literacy is not simply health knowledge. The goal is a change in social norm of developing health literacy at a level commensurate with age, mental capacity, gender and environment.’ | Ratzan SC 2001, ‘Health literacy: communication for the public good’, *Health Promotion International*, vol. 16, no. 2, pp. 207-214. |

**Figure 5** Example of direct quotes extracted from the literature to form the Delphi Survey round 1 descriptive statements

Descriptive statements for each recurrent pattern for the first round of the Delphi Survey are grouped below.

Recurrent pattern 1: What is health literacy?:

- Being health literate means more than being able to read pamphlets and successfully make appointments.
- Improving health literacy amongst children and young people is important for their health and wellbeing.
- Health literacy is part of lifelong learning.
- Being health literate may enable people to better manage their own health.

- A child or young person who is health literate may access, understand and interpret basic health information.
- A parent/guardian of a child or young person who is health literate has the skills to use health services to promote their child's health and well-being.
- Being health literate should help more children and young people understand their needs.
- Being health literate will enable children and young people to make informed health care decisions.
- Being health literate will enable parents/guardians of children and young people to make informed health care decisions.

Recurrent pattern 2: Consequences of low health literacy:

- A low level of functional health literacy can affect anyone.
- Low health literacy increases health care costs at an individual level.
- Children and young people with low health literacy are unlikely to seek preventive health care.
- Parents/guardians of children and young people with low health literacy skills are unlikely to facilitate preventive care for their children.
- Improving an individual's health literacy will help overcome health inequalities.
- Healthcare professionals generally assume health consumers to be functionally health literate.
- Child and youth health nurses may have deficits about the concept of health literacy.

Recurrent pattern 3: Health literacy role of paediatric RNs:

- Promoting health literacy should be an essential element of child and youth nurse practice.
- It is important for child and youth health nurses to recognise health literacy problems experienced by children and young people.

- It is important for child and youth health nurses to recognise health literacy problems experienced by parents/guardians of children and young people.
- Educating children and young people about their health should be an essential part of nursing.
- Clarifying the concept of health literacy to child and youth health nurses is essential.

Recurrent pattern 4: The 'place' for health:

- Health literacy is a priority focus in health policy.
- Health literacy development should be an integral component of health promotion for children and young people.
- Health education which includes health literacy should be provided by child and youth health nurses.
- Providing health education to children and young people will not always result in adopting good health habits/behaviours.
- Health education alone will not be useful to people who do not feel that they have the capacity to change their personal circumstances.
- Nursing and midwifery curricula and/or staff development should address health literacy.
- There is little or no time for health education in current health settings.

Recurrent patterns developed from the literature collated and findings of the first Delphi Survey were grouped under the second Habermasian theoretical construct - communicative action. These included:

- Responsibilities of paediatric RNs.
- Possibilities in relation to health literacy.

Each recurrent pattern confirmed a group of statements that were included in the second round of the Delphi Survey. The following section shows the recurrent patterns confirmed and the descriptive statements from the second round of the Delphi Survey, which have been modified by myself and grouped together.

Recurrent pattern 1: Responsibilities of paediatric RNs:

- Child, youth and paediatric nurses have a professional responsibility to improve children's and young people's access to evidenced based information.
- Child, youth and paediatric nurses have a professional responsibility to improve how children and young people learn to navigate the health care system.
- Child, youth and paediatric nurses have a professional responsibility to improve how children and young people learn to know what is good advice related to their health.
- Child, youth and paediatric nurses have a professional responsibility to take a long-term view to educating children and young people about their health during any professional encounter.
- Child, youth and paediatric nurses have a professional responsibility to explore ideas on how to improve a child's or young person's health literacy.
- Children and young people learn about how to be healthy from their parents not child, youth and paediatric nurses.
- Child, youth and paediatric nurses have a professional responsibility to evaluate children and young people's health literacy skills.
- Child, youth and paediatric nurses have a professional responsibility to advocate for a focus on health literacy for children and young people.
- Child, youth and paediatric nurses have a professional responsibility to be aware of how health policy related to children and young people is informed, developed and in turn enacted.
- Child, youth and paediatric nurses have a professional responsibility to communicate the importance of health literacy to children, young people and their parents/guardians.
- Child, youth and paediatric nurses have a professional responsibility to undertake research on health literacy.
- Child, youth and paediatric nurses have a professional responsibility to recognise that low health literacy can be a problem affecting children and young people's health outcomes.

- Child, youth and paediatric nurses have a professional responsibility to focus on assisting children and young people to realise that prevention of non-communicable diseases is a possibility.
- Child, youth and paediatric nurses have a professional responsibility to evaluate whether parents/guardians of children or young people with whom they interact are health literate.
- Child, youth and paediatric nurses have a professional responsibility to influence the health literacy levels of children and young people.

Recurrent pattern 2: Possibilities in relation to health literacy:

- A child, youth and paediatric nurse can create the appropriate opportunities for children and young people to learn about being health literate.
- A child, youth and paediatric nurse can create the appropriate opportunities for children and young people and their parents/ guardians to learn about being health literate.
- A child, youth and paediatric nurse can create the appropriate opportunities for children, young people and their parents/guardians to understand how to make healthy choices in their everyday lives.
- It is possible for children and young people to learn how to say no to unhealthy activities.
- Child, youth and paediatric nurses' ability to provide effective health advice to children and young people is influenced by their own health literacy.
- The provision of health education is an instrument of change.
- Child, youth and paediatric nurses are important role models for children and young people.
- There is a lack of opportunities for child, youth and paediatric nurses to promote health literacy for children and young people.

## Stage 2: Identify recurring themes

The purpose of this stage was to explore with expert paediatric RNs how they understand the concept of health literacy and the importance of this concept to their clinical practice and to the health of children and young people.

I sought participants who could be regarded as experts in the field of paediatric and child and youth health nursing. Following Mead and Moseley (2001) experts invited to participate were identified as Australian paediatric and child and youth health nursing leaders: Directors of Nursing of paediatric hospitals, educators, academic staff specifically those teaching paediatric nursing and child and youth health within Australia, clinical nurse consultants, practitioner nurse specialists and nursing leaders of child health organisations.

By involving expert paediatric RNs in my research, I was aiming to help these practitioners inform themselves about their practices and any conditions that shape, limit or determine their actions and those actions that they may need to take to intervene in a positive way in the lives of children and young people. I wanted to learn if they consider if they have a role to intervene or change the processes that may be impacting on the health of a child or young person or more specifically their health literacy when they interact with these children and young people in the everyday course of their work.

I specifically engaged with paediatric RNs to have them collaborate in the organisation toward their own enlightenment with a view to learn how they may transform their practices. I did this by engaging them in a Delphi Survey and focus group interview. I have positioned paediatric RNs in my research as persons capable of producing and reproducing particular values, interests and practices in relation to health education and health literacy.

I conducted a Delphi Survey and focus group discussion with them. In engaging paediatric RN participants in a Delphi Survey I sought to identify what influences them as individuals and as a professional group in relation to shaping the decisions that affect their roles in relation to health literacy and in turn that of children and young people. From emerging findings of the Delphi Survey I identified issues that informed the questions put to a focus group discussion. In both the Delphi Survey and the focus group discussion, I wanted to understand if the views of participants echoed or were similar to the views I had identified in documents and published literature sourced in Stage 1.

Before I applied a critical lens (Stage 3), I analysed quantitative data collated using the software application, the Statistical Package for the Social Sciences (SPPS). I thematically analysed all Delphi qualitative data and focus group data in accordance with Leininger (2006, pp. 61-62). This involved the following four phases:

- The entire material collected was studied to give a sense of the whole;
- Themes and categories were identified;
- Recurrent patterns were identified; and
- Summative themes and research findings were developed.

In *Chapter 5*, I present findings from Stage 2. I now detail the different data collections methods used.

### *Delphi Survey method*

A Delphi Survey is a structured, indirect interaction method that employs a sequence of rounds to collect data that are sustained until consensus amongst a panel of experts is reached (Hasson, Keeney & McKenna 2000; Powell 2003). The Delphi Survey technique entails using experts to give opinions on areas of interest. Experts' views are initially charted and then organised to get an explicit comprehension of what participants regard as significant, of main importance, most valuable or of chief concern (Keeney, Hasson & McKenna 2001; French, Yin-Yu & Lan-Suen 2002).

The process of undertaking a Delphi Survey was very much in keeping with the fundamental basis of critical social theory. Involving paediatric RNs in this research aimed at helping these practitioners inform themselves about their practices – those conditions that shape, limit or determine their actions and those actions that they may need to take to intervene in a positive way in the lives of children and young people. I specifically focussed on paediatric RNs to have them collaborate within their organisation and with their own enlightenment with a view to learn how they may transform their practices by engaging them in a Delphi Survey.

Utilising a Delphi Survey enabled me to distribute a large number of invitations to paediatric RNs to participate in the research and at the same time facilitate the paediatric RNs in the process of articulating their understanding of the concept of health literacy and

the importance of this concept to their clinical practice and to the health of children and young people.

Even though the Delphi Survey provides many advantages, it still has its restrictions. In *Table 3* below a number of the advantages and the limitations of this method are presented.

**Table 3** Advantages and limitations of using a Delphi Survey

| Advantages of using a Delphi Survey | Limitations of using a Delphi Survey |
|---|---|
| Delphi Surveys have various advantages that facilitate the gathering of a wide range of details from a great number of individuals (Hasson, Keeney & McKenna 2000). Nevertheless, a high drop-out rate amongst respondents and surveys might cause researcher bias (Keeney, Hasson & McKenna 2001). | Time consuming (Jairath & Weinstein 1994; Williams & Webb 1994) |
| It is practical in circumstances where there is a lack in consensus (Graham, Regehr & Wright 2003). | There is a high drop-out rate as the panel might become exhausted with what could appear to them to be the same sort of questions in the questionnaire rounds (Duplantie, Gagnon, Fortin & Landry 2007).<br>Delphi questionnaires are open to manoeuvring and manipulation (Duplantie *et al.* 2007). |
| It is realistic when ambiguity surrounds the subject of research (Hardy, O'brien, Gaskin, O'brien, Morrison-Ngatai, Skews, Ryan & Mcnulty 2004). | Choosing the panel members based on their knowledge around specific area does not guarantee that they are experts (Keeney, Hasson & McKenna 2001). |
| It has the capacity to conquer the bias that might occur due to the group dynamics, such as dominant characters, interactive dynamics and dominance by key opinion personnel (De Vos, Spivak, Hatmaker-Flanigan & Sege 2006). It is mainly useful in assisting communications among experts and for overcoming the difficulties found often in a customary group debates (Wissema 1982). The method permits negotiations devoid of the pressure of social status, allows participants to change their decisions without feeling embarrassed and offers a professional and economical way to join a lot of opinions into one array of standards in a realistic period of time. | The absence of an explicit definition of consensus (Sackman 1975). |
| It is also a convenient method for getting views from experts who may be living and working in diverse geographic regions and settings (Duplantie *et al.* 2007). In terms of this research flexibility was significant since the participants were located throughout Australia and the use of Delphi Survey facilitated all of those who were interested to participate. The process of data collection would have been expensive and extremely time consuming with other data collection methods. | |
| It facilitates recruiting a large sample of people (Duplantie *et al.* 2007). | |
| It provides authenticity, by permitting the experts to recognise what is important (Duplantie *et al.* 2007). | |
| The series of questionnaires used permits the researcher to recognise what is most significant, extremely valued or of maximum priority (Duplantie *et al*. 2007). | |
| It is a fairly cost-effective process as it decreases the need for travel time in the field, gathering data (Duplantie *et al*. 2007). | |
| When little or no information has existed before, it can be researched by using Delphi Surveys (Duplantie *et al*. 2007). | |

A Delphi Survey may comprise a number of iterations each one informing the development of the next. A consensus-building two rounds, electronic-mail survey was conducted.

The first Delphi Survey generally aims to collect demographic data (to ensure that these criteria were met) and to invite participants to state their views around and on the subject of research. The first round is employed to produce ideas, which are considered in following rounds (Hicks 1999). The focus of the study is introduced with a sequence of statements regarding what has been perceived from reviewing the literature. The statements are presented in a structure that participants can mark, signifying their degree of concurrence with or their recognition of, the significance of statements presented (Hasson, Keeney & McKenna 2000). A Likert scale is generally used to get participants to answer the survey by marking the box that corresponds to their viewpoint. Once responses to the first survey have been collected the responses are analysed and the second survey established in light of the analysis and outcomes of the round one survey. Every participant obtains feedback about the grouped findings, jointly with a record of their response. In this way they are offered a chance to review their previous responses and compare them with other participants' responses without having to meet.

### Sample

The Delphi Survey technique entails participants to be 'experts' in their field. Soanes and Stevenson state an expert is 'a person who is very knowledgeable about or skillful in a particular area' (2005, p. 610). However, there is no consensus in the literature as to who is an expert (Baker, Lovell & Harris 2006). This absence of clarity as to a definition has resulted in an extensive number of varied definitions (Keeney, Hasson & McKenna 2001).

The Delphi Survey technique does not simply utilise an arbitrary sample that is considered demonstrative of the target population. Rather, it utilises experts who have proficiency on the topic of enquiry (Moseley & Mead 2001; Powell 2003). It is considered unsuitable to use a random sample for the target population and it is more proficient to recruit individuals who are considered experts in the area of interest or who at least are acquainted individuals (Goodman 1987).

Goodman (1987) implies that it may be favourable to have a panel consisting of individuals with specific knowledge of the subject under study when the subject is very broad. The panel would be comprised of individuals who are able to enter into some in-depth discussion without necessarily being labelled as expert. Mead and Moseley (2001)

argue that there are many ways to define a Delphi expert. For example, an expert may be denoted by their place in a hierarchy or industrial recognition within an organisation. Crisp, Pelletier, Duffield, Adams and Nagy (1999), however, argued that the use of the term 'expert' might be unsuitable and proposed using the phrase 'informed advocates' as an alternative.

Keeney, Hasson and McKenna (2001, p. 196) conducted a critical review of the Delphi method that delivered a variety of definitions of expert such as: 'informed individual', 'specialist in the field', or 'someone who has knowledge about a specific subject'. They caution that 'simply because individuals have knowledge of a particular topic does not necessarily mean that they are experts' (2001, p. 196). A narrowly defined criterion to determine an expert decreases the size of the sample of those that can be selected to be involved (Duncan, Nicol & Ager 2004).

Although there is no specific rule that clearly states the optimum size of a panel of experts, Linstone and Turoff (1975), who were innovators of the method, claimed that the Delphi method can be employed with 'anywhere from 10 to 50 people' without providing any additional explanation. It has been recommended though that a trustworthy panel should contain 20 or less individuals so it maintains all of their members (Jeffery, Ley, Bennun & Mclaren 2000; Mullen 2003). Reid (1988), however, notes that panel sizes might range from 10 to 1685. Murphy, Black, Lamping, McKee, Sanderson, Askham and Marteau (1998) consider that the more respondents there are the better, signifying that as the number of the panel increases, the trustworthiness of a combined opinion increases. Goodman (1987) maintains that the Delphi technique is convenient in attaining validity when the sample population is a representative group instead of a random sample. As participants are nominated due to their expertise in a given field, this increases the possibility of content validity. Consequently, a non-probability purposive sample was preferred as a substitute to systematic sampling methods such as randomisation. I initially planned to target and recruit up to 100 participant experts expecting a 50% non-response rate.

### Recruitment of 'expert' participants

Following research approval, potential members for the expert panel from Australia were invited to participate in my research. The identification of experts for participation in the Delphi survey was as follows: All Directors of Nursing of all paediatric hospitals in Australia (nine hospitals were identified), Heads of Nursing Schools and leaders of child

health organisations were identified by internet-based searching. Leaders were considered those actively involved or interested in the development, planning, and selection of paediatric and child and youth health course resources. Academics were those teaching paediatric and child and youth health nursing within Australian universities in the postgraduate and undergraduate areas. Being in these positions was deemed as confirming these people as recognised experts in the paediatric and child and youth health field.

An introductory email/letter introducing the research was forwarded to these people. The purpose of the email/letter was to introduce the aims and objectives of the research and to seek their permission and assistance to approach and recruit relevant staff by passing to them the introductory flyer making available work email/postal address contact details.

The self-selection criteria were as follows:

- Employment within clinical paediatric and child and youth health settings as a registered nurse, nurse practitioner, clinical nurse consultant, nurse educator or nursing manager.

- A nursing academic in the field of paediatric and child and youth health nursing or Director of Nursing of a paediatric and/or child and youth health organisation.

Those who met these criteria and wished to participate in the Delphi Survey contacted the researcher. Once the potential participants had been identified, they each were sent a copy of the consent form and survey.

### Validation of the instrument and development of the survey

Using categories developed from the theory of Habermas and the focussed review of the literature the first round survey was developed. A total of 34 statements were included in the Delphi Survey.

In order to recognise obscurities and enhance the viability of distribution (Jairath & Weinstein 1994) the survey was pilot tested with 10 experts from the University of South Australia (excluded from the Delphi Survey) to assess the clarity of the questions, the clarity of instructions and adequacy of the format. Following the pilot test, three items were added to the survey, clarifications were made to 15 items and two items were deleted because of redundancy.

I will now discuss issues of consensus, reliability and validity as related to Delphi Surveys.

### Consensus

Consensus is an essential aspect of Delphi studies, however, few researchers have actually described consensus in distinct statistical standings (e.g. closeness to a mean value). Consensus provides the potential to steer complex areas of health care where evidence, based on large randomised study data, is not obtainable or not possible given the nature of the research question (Cramer, Klasser, Epstein & Sheps 2008). However, the definition is habitually random or post hoc (Williams & Webb 1994). While consensus may be significant, it can never be the chief aim of a Delphi Survey.

As the researcher, I had to be aware of the time frame of the data collection and to an appropriate level of consensus with regard to the study's results (Williams & Webb 1994). Fink, Kosecoff, Chassin and Brook (1984) stressed that consensus level should be described in advance of a study.

Keeney, Hasson and McKenna (2006) argue that the literature is limited as to clear guidelines on what a suitable level of consensus should be for the Delphi Survey technique. However, Fink *et al*. (1984, p. 982) anticipated that there are diverse criteria to make the decision for when consensuses is achieved such as:

- Any topic or issue with X percent of participants support will be accepted (however, what X percent should be has not been defined);
- After rounds of voting, the issues or topics receiving the most votes of participants are approved;
- When using a scale, for example a Likert scale with a rating of 1 to 5, the issues or topics receiving a mean rating of 3 are accepted. (Again, the authors give no rationale for selecting a mean rate of 3, or even why the mean was chosen as the appropriate statistic. Fink *et al*. (1984, p. 982) suggested that consensus is reached when 'only those topics receiving a mean range of 3.0 or greater are accepted.' However, in the case of a 5 point Likert scale Fink *et al*. (1984) were not specific in pointing out whether the '3' is equal to 'not sure' or 'agree' on a five point scale: if the scale starts at '0' then '3' would equal 'agree' but if the scale starts at '1' then '3' equals 'unsure');
- All issues or topics are rated on a scale of 1 to 3. All issues or topics receiving a rating of '1' from at least 51% are accepted; and

- Any topic or issue is dropped if it is strongly countered by at least X percent of participants (again, what X percent should be has not been defined).

In a range of Delphi studies reviewed, consensus was defined in different ways. Keeney, Hasson and McKenna (2006) argue that the significance of deciding a consensus level may exist in the significance of the subject of research. If it was a life and death issue, for example, whether or not to turn off a ventilator in a critical care unit, the consensus of 100% might be required in that case. However, if it was a matter of deciding on a new nurses' uniform, a 51% a consensus may be satisfactory. Delphi studies are also used to articulate policy for backing new research or service advance. Subject to the significance of the policy, a 51% consensus cut-off point might result in low morale or conflict amongst those who supported those opinions that merely gained 50% agreement. Achieving just a 1% advantage, however, if there is consensus on a matter or not appears hard to explain (Keeney, Hasson & McKenna 2006).

Loughlin & Moore (1979) recommended that consensus should be associated with 51% agreement among participants. Green (1982), however, proposes that not less than 70% of Delphi Survey participants are required to rate three or higher on a four point Likert-type scale. Keeney, Hasson and McKenna (2006) seem to settle that 75% is a consensus cut-off point. However, they did declare that there is no clear scientific reason for this. Consensus levels in the literature range between 51% and 80%, in many cases using a benchmark of 70%, depending on sample size and the features of the study and iteration (Hasson, Keeney & McKenna 2000). McKenna (1994) suggested 51% as a consensus cut-off point to reflect agreement amongst participants; Sumsion (1998) on the other hand advises 70%, while Green, Jones, Hughes, David and Williams (1999) recommended 80% as a consensus cut-off point.

In their Delphi Survey on curriculum content, Williams and Webb (1994) required 100% agreement for items to be established. Nevertheless, they argued for other researchers' choices of a consensus level. For example Orton (1981) used a modified Likert scale in a Delphi Survey examining ward learning in nursing students and set the level of agreement as low as 55%. However, it appears that Orton felt this to be somewhat of an arbitrary decision and concluded that consensus was more informed by the researcher's observations during the study than by a predetermined level.

Duplantie *et al*. (2007) decided that to reach consensus, a given proposition of factors related to tele-health that might possibly affect recruitment and retention of doctors had to

be agreed upon by at best 60%; however, they categorised the question as having a substantial effect when a consensus of 75% was attained from the experts. Unfortunately, no explanation was provided for the consensus levels chosen.

Kilroy and Driscoll (2006) used the Delphi Survey technique to classify the content of the postgraduate anatomy curriculum for trainees in emergency medicine in the UK. The survey was used to define consensus concerning requisite knowledge of anatomy for postgraduate trainees in Emergency Medicine, aiding the development of a national curriculum document. Kilroy and Discoll (2006) deliberately decided to apply a four point Likert scale to avoid questions attaining a neutral score at the midpoint of an odd numbered scale. They decided on a consensus cut-off of <75% agreement for questions scoring $\geq 2$ in order to limit the requisite knowledge to those questions regarded essential to safe clinical practice. The choice of <75% as a cut-off level has not been explained by the authors.

Boyce, Gowland, Russell, Goldsmith, Rosenbaum, Plews and Lane (1993) set up 66% as the consensus level in the Delphi Survey they applied to establish what physiotherapists felt about the issue of quality of movement and as a gross motor performance measurement tool for children with cerebral palsy. Choosing 66% as the consensus level has been justified by the authors only as being 'reasonable for the development of consensus on a continuous topic such as quality of movement' (Boyce *et al*. 1993, p. 97).

Duffield (1988) conducted a Delphi Survey aimed at establishing if the nursing literature supported nursing unit managers in their role development. The survey was mainly concerned with determining the competencies required by nursing managers. Duffield (1988) admitted that consensus had not been defined beforehand by other researchers and that she made a decision to set the consensus level in her study at 'the point at which ten percent or less of the competencies moved from above to below the mean of 3.000 or reverse, from below to above the mean of 3.000 on a round' (p. 249). She has not provided an explanation of how her choice of a mean score of three was chosen. However, it can be concluded that because a 5 point Likert scale was used where 'three=agree', the mean score of three was chosen as a consensus level.

Scheibe, Skutch and Schofer (1975) argued that in establishing a cut-off consensus level the researcher may fall short to take full advantage of the variety of information provided by participants, hence important divergences or views held by a minority are abandoned. From Scheibe, Skutch and Schofer (1975) stability of responses to a question that re-

emerges in following survey(s) was worthier of consideration as stability of responses from participants would not conceal extremes in responses while consensus measures such as the mean would. They tested this and indicated that applying this proposal of stability resulted in areas of both agreement and disagreement being recognised. Scheibe, Skutch and Schofer (1975) stated that being able to recognise agreement and disagreement has more validity than statistical tests. Goodman (1987) reflected on the view expressed by Scheibe, Skutch and Schofer (1975) and concluded that the use of mean or median values to establish consensus might be misinforming.

To summarise, I thought that it was essential to decide on a consensus level before commencing; however, the criteria for determining what that level should be were not available. The literature did not provide one definite way that had been tested that described suitably what the level of consensus in a Delphi Survey should be. However, reviewing the literature raised some issues that should be addressed when deciding what the predetermined level of consensus should be. All of the issues mentioned in the previous section were considered before deciding that the consensus level for the Delphi Survey in this research would be 80%. This percentage was chosen as it reflects the most frequently chosen percentage response to be acknowledged and accepted in the literature. For example, 100% is a very high percentage to be achieved considering that the topic of this research is not a life and death issue.

### Reliability and validity

In this section reliability and validity will be discussed with regard to the Delphi Survey used in this research. Reliability is the degree to which a process generates parallel findings under unvarying circumstances on all times (Hasson, Keeney & McKenna 2000). However, there is a lack of evidence of the reliability of the Delphi method. There is no way to guarantee that if similar material were provided to two or more Delphi panels similar findings will be acquired (Williams & Webb 1994; Walker & Selfe 1996). However, the principles for qualitative studies might be useful to assist that trustworthy analysis is produced (Lincoln & Guba 1985). Based on four main aspects the principles are: credibility, applicability, consistency and construability.

The results of a Delphi Survey characterise expert judgment instead of unarguable fact. Agreed standards depend on the rationalisation of comprehensive decision-making and firmness in the implementation of the study. Additional investigation to certify the results may be significant. These procedures will add to the reliability of the research. A review of

related nursing literature where the Delphi method has been utilised signified that a small number of researchers have tackled matters of reliability and validity (Lindeman 1975; Oberst 1978; Rauch 1979; Bond & Bond 1982; Henney, Chrissafis, Mcfarlane & Crooks 1982; Anderson 1986; Goodman 1987; Reid 1988; Grant, Kinney & Guzzetta 1990; Beech 1991; Fitzpatrick, Sullivan, Smith, Mucowski, Hoffman, Dunn, Trice & Gross 1991; Bartu, Nelson, Ng, McGowan & Robertson 1993; McKenna 1994).

Sackman (1975), in his critical review of the method, suggested that studies using the Delphi Survey method have not satisfactorily addressed the issues of reliability and validity in their findings. As the Delphi Survey method is anticipated to substitute for a lack of decisive data by employing, and allocating, the experts' knowledge and experience (Fink *et al*. 1984), it must not be measured against the same substantiation standards as pure science. Murphy *et al*. (1998) suggest that the Delphi method should not be reviewed as a scientific method for generating original acquaintance, but as procedures for creating the finest use of accessible knowledge, be that scientific information or the shared understanding of participants. As Pill (1971, p. 62) proposed: 'It is the questions of intuitive judgements, the marshalling of subconscious processes, dredging of half-formed ideas from the group memory that Delphi is most useful and as such, one cannot judge it on the same basis as a concrete measurement'.

Rowe, Wright and Bolger (1991), on the other hand, suggest that with multiple iterations in the Delphi Survey technique more valid judgments will be provided; that participants also tend to generate more effective decisions over rounds even with a lack of further information from others. They suggested that the process of iteration itself might be playing a part in allowing panellists to reconsider their original thoughts and move their own opinions closer to a reconsidered, final consensus. Jairath and Weinstein (1994) stress the significance of pilot testing, not just in recognising phrasing mistakes, but also enhancing the practicability of circulation. Even though a small number of Delphi researchers state taking on pilot tests before carrying out the actual research, it is uncertain how many pilot tests should be carried out when utilising this method. For example should there be one for each round or just one for the first round.

In the research reported in this thesis, the issue of reliability was addressed by the fact that the first survey was developed from information obtained from a focussed review of the literature process and it was also piloted on a group of paediatric RNs and feedback was incorporated into the survey. The second survey was developed from the responses and

comments to the first survey. In this way I endeavoured, when framing the survey, to ensure consistency, stability and dependability, which are essential criteria for achieving reliability.

The Delphi Survey technique has also been criticised with regards to its validity. In Delphi there is a strong assumption that several individuals are less likely to reach an incorrect conclusion than a single person. Judgments are then reinforced by rational dispute in which suppositions are tested. Therefore, rationality can be enhanced. Demand for a consensus of predictions undermines the validity (Hill & Fowles 1975) of elements that challenge the Delphi's predicting facility. Nevertheless, the use of people who have expertise and an involvement in the matter of interest can assist to raise the content validity of the Delphi Survey (Goodman 1987) and the use of consecutive rounds of the survey assists to increase the simultaneous validity. Goodman (1987) also states that if the panel recruited for the study is representative of the study group or the study area of concern, then content validity might be presumed, bearing in mind that the latter criticisms can be taken against any qualitative research method.

There are two aspects of validity in this research: internal and external. Internal and external validity of Delphi Surveys may be restricted by biases related to expert invitation and approval, their recall and mental availability, wishes to please or avoid embarrassment and information sharing before or during the study (Woodward, Chambers & Smith 1991; Redelmeier 1991). Internal validity pertains to the content of the surveys, and especially with ‘how representative are the questions on this test of the universe of all questions that might be asked of this topic?’ (Polit-O’Hara & Hungler 1989, p. 247). Raising the number of choices offered for verdicts in a survey or clinical problem can also raise the chance of participants ‘maintaining the status quo, selecting a default option, or delaying the decision’ (Redelmeier & Shafir 1995, p. 303). There is no ideal way of determining this type of validity; rather it is based on judgment. Hill and Fowles (1975) propose that the Delphi panel should contribute in phrasing the statements if the researcher is going to avoid possible phrasing bias in the survey and final findings. The accepted practice has been to use experts to examine the tool or survey prior to its use to determine the adequacy of the questions (Polit, Beck & Hungler 2001, p. 41). This was the case in this research. The first survey was piloted and those who participated in the piloting of the survey were asked to indicate if they considered if any important questions had been omitted.

The Delphi Survey is grounded on the supposition of safety in numbers. Decisions are then reinforced by a rational quarrel in which suppositions are confronted, therefore helping to improve external validity. The external validity communicates to the participants whether they are representative and if the results of the research are generalisable. In this research the paediatric RNs who volunteered to participate were from a broad spectrum of institutions, places of employment, levels of expertise, years of experience and ages. Although the sample was not random, the participants as experts appeared to be representative of paediatric RN populations in Australia and this would suggest that the research has external validity.

There are a number of potential limitations in using a Delphi Survey. Consequently, at the beginning a decision was made to reduce, as far as possible, these limitations and to become accustomed to the techniques of this form of survey to meet the special needs of this research by adopting the following actions.

One limitation of the Delphi Survey technique is the amount of time it takes to complete. Data collection for this research was set to take place over one year rather than extending the time period. Another limitation of using the Delphi Survey technique is that the number of paediatric RNs who volunteered to participate was small to begin with. To increase that number a strategy was developed for recruiting more participants. It was decided that one week after sending the initial invitation email, which included an information sheet and a consent form, a reminder email was sent to each participant re-inviting them to participate in the research or to send an apology.

Another issue with the Delphi Survey technique is that a number of participants do not respond on successive rounds of the survey. To reduce that number a strategy was developed for following up participants. It was decided that one week prior to the survey return date a reminder email (*Appendix 8*) would be sent to each participant reminding them of the survey and when it was due to be returned, as well as offering to send a replacement survey if the first one had been misplaced. One week following the due date for return a reminder email was sent to those individuals who had not yet returned their survey, and this was followed up one week later with a phone call. This strategy appeared to work well with a 99% response rate.

### Development of the survey

As explained, recurring themes emerging from a focused review of literature served to inform the beginning statement and questions to distribute in the first round of a Delphi

Survey. In this way the number of rounds required in the Delphi Survey was reduced by one. The first survey comprised of three sections. The first section offered a definition of health literacy, functional health literacy and health education. The second section included guidelines asking the participants to complete questions relating to socio-demographic information. The third section contained statements pertaining to health literacy, knowledge, experience and expertise. The socio-demographic data provided an overview of the paediatric RNs who participated in this research. It is essential to recognise that the participants volunteered for the research and therefore they are considered a random sample. Participants were required to make a choice regarding how they felt about each statement by using a 5 point Likert scale.

Before distributing the first Delphi Survey it was subsequently piloted with members of the School of Nursing and Midwifery staff and doctoral colleagues who were interested in the research and volunteered to participate (*Appendices 2* and *8*). It is important to pilot the Delphi survey in order to:

- Test how long it takes to complete the survey;
- Check that the instructions are clear;
- Check that the questions are clear and realistic; and
- Allow the researcher to eliminate questions that are biased or too complex.

Based on the pilot group responses to the survey and feedback on the instructions, design and layout of the survey as well as the clarity of the statements, necessary changes were made to the tool and the process of administering the Delphi Survey.

### Recruitment

An introductory email/letter introducing the research had been forwarded to those holding the position of Head of School (Nursing) within all Australian universities offering undergraduate or postgraduate nursing courses, Directors of Nursing within Australian children's hospitals and child health organisations and their state branches within Australia (*Appendix 2*). The purpose of the email/letter was to introduce the research's aims and objectives and to seek their permission and assistance to approach and recruit relevant staff by passing them the introductory flyer (*Appendix 2*) making available work email/postal address contact details.

Following receipt of approval to undertake the research from each participating School of Nursing Head of School, Australian children's hospitals Directors of Nursing and child health organisations, a copy of the Delphi Survey was forwarded to them according to their preference of electronic or hard copy. Where a return email was not received within a week of forwarding the initial invitation, a reminder email was sent. In this email I made it clear that no further emails will be forwarded, but a hard copy of the invitation letter and Information Sheet will be sent by post. A Project Flyer (*Appendix 2*) had been distributed to potential staff either via email from the Director of Nursing or Head of School or Leader of the organisation to those with whom initial contact had been made. Hard copies of the flyer had been forwarded for distribution upon request.

All participants received an information sheet prior to receiving the survey (*Appendix 3*) either electronically or via hard copy detailing the project's aims and objectives, the participants' role and my responsibilities, as the researcher. This enabled participants the time to carefully consider their involvement. Participants received a consent form (*Appendix 4*) as well, which informed them that their participation is entirely voluntary and that they are free to withdraw at any time without consequence. In the letter of invitation, participants were encouraged to respond by return email with their consent to participate or to sign the consent form and return to me either in hard copy or electronically. A total of 34 paediatric RNs responded to the request for volunteers.

## Procedure

### *The first Delphi Survey*

The survey (*Appendix 8*), the information sheet and the consent form had been sent either electronically or as hard copy with a stamped self-addressed envelope to each participant (*Appendices 3* and *4*). Thirty-four (n = 34) volunteers deemed experts were given two weeks to complete the survey. As previously described, a strategy had been developed to encourage participants to return the completed survey (*Appendix 8*). A four-week period was allocated from the time the survey was sent out until the actual cut-off date of return for surveys to be included in the data analysis. At this point the data from the first Delphi Survey was entered into the SPSS program to start the analysis process.

### *The second Delphi Survey*

The second Delphi Survey (*Appendix 8*) was formulated from the responses to the first. Specifically, items where consensus had been reached were removed from the survey; items where consensus had not been reached remained in the survey but in some instances

the statement was reworded to expand or delimit the statement and, finally, a number of new items were added. These items reflected new information obtained from comments made by participants who had completed the first survey. The second survey was distributed to only those participants who had returned a completed survey in round one. The second Delphi Survey had only one section. The statements were formatted in the same way as the first survey and the same 5 point Likert scale was used.

A summary page of results from the first survey was included with the second as well as a letter outlining the process, expected completion date, date of return of the second Delphi Survey and information that gave a general overview of the responses to the third section of the previous survey. The second Delphi Survey was smaller than the first and this was a result of consensus that had been reached on most of the statements that had been included in the first Delphi Survey.

Participants were again given two weeks to complete the second Delphi Survey and this was sent either electronically or as a hard copy with a stamped self-addressed envelope for the return of the completed survey to each participant. One week prior to the survey return date a phone call was made to each participant reminding them of the survey and when it was due to be returned, as well as offering to send a replacement survey if the first one had been misplaced. One week following the due date for return a reminder note was sent to those individuals who had not yet returned their survey. This was followed up one week later with another phone call. From the time the second Delphi Survey was sent out until the actual cut-off point for it to be completed and returned to be included in the data analysis, a four-week period had elapsed. Data from the second Delphi Survey was added to the SPSS program to continue the analysis process.

An overview of the process is provided in *Figure 6*.

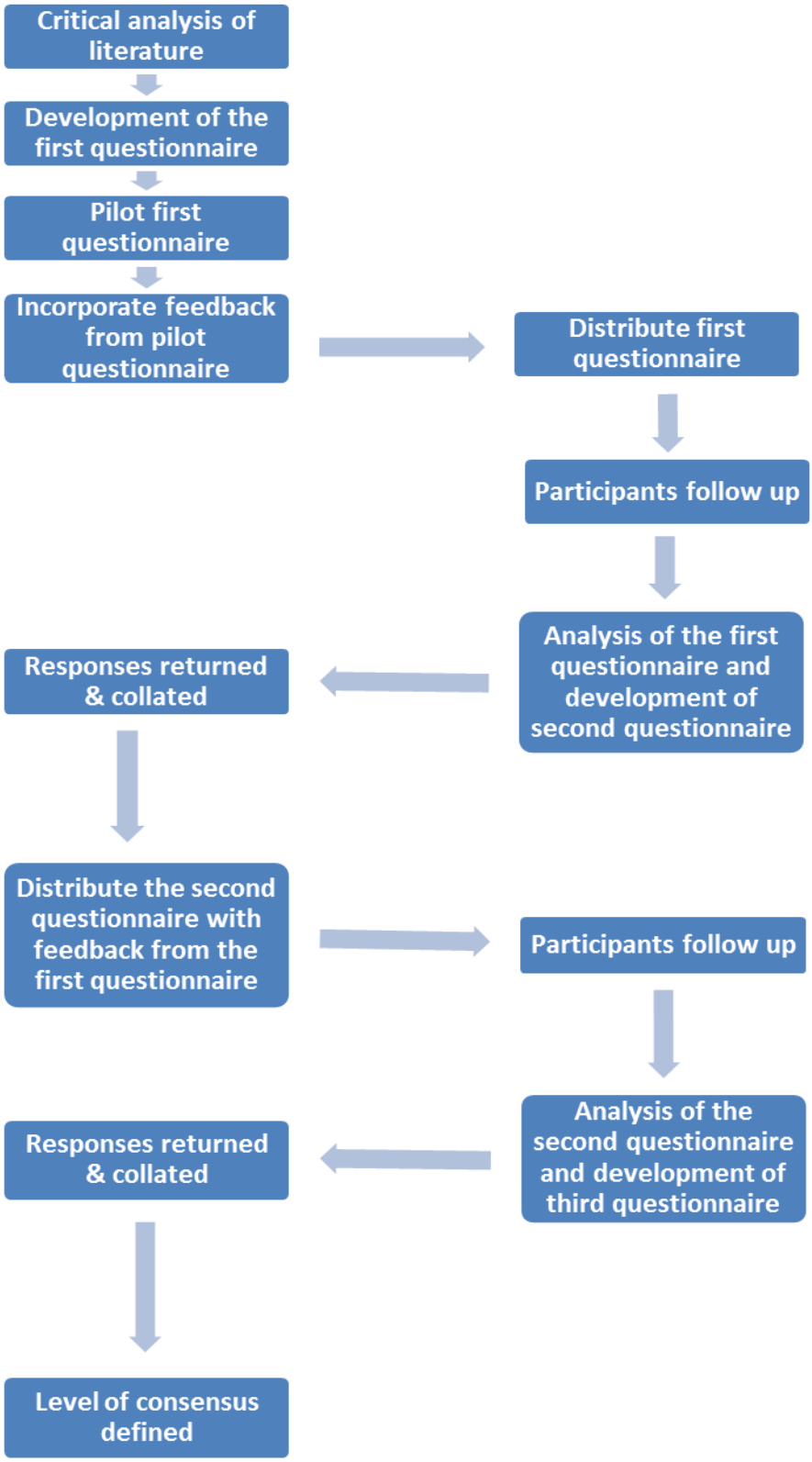



**Figure 6** Using the Delphi Survey technique to gather, analysis and interpret

### Analysis of Delphi Surveys data

As data from the first and second Delphi Surveys was both quantitative and qualitative the appropriate analysis for each type of data was undertaken.

#### *Qualitative analysis*

Comments made for each statement were collated and typed into a separate document for each question in the first Delphi Survey. These comments were then thematically analysed in accordance with Leininger's criteria (2006) that I listed earlier. In this way themes and categories that had emerged from data were compared with each other and recurrent patterns and summative themes had been identified.

The second Delphi Survey data, that is the comments made against each statement, were treated in the same way as the information obtained from the first survey. In this way I was able to ascertain if the additional information was providing any new data or whether the data was confirming the themes and categories that had already emerged from the earlier data. This assisted me in deciding if a third survey or focus group interviews was appropriate.

Thematic analysis involves the identification, analysis, and reporting themes within data (Braun & Clarke 2006, p. 79). Thematic analysis enables the identification of themes through 'careful reading and re-reading of the data' (Rice & Ezzy 1999, p. 258). Therefore it diverges from other analytical techniques that seek to illustrate patterns across qualitative data (Braun & Clarke 2006, p. 79). It is a type of pattern identification within the data, where arising themes turn into the categories for analysis. Thematic analysis requires a search for themes that surface and prove to be significant to the explanation of the phenomenon (Daly, Kellehear & Gliksman 1997).

#### *Quantitative analysis*

Descriptive statistics were used to calculate the statistical mode for each statement because it had been decided that this mode was the most suitable statistical method for determining consensus in this research. This was followed by inferential statistics of the data, which was made possible since data from a Likert scale was considered to be interval data (Wilson 1989; McLaughlin & Marascuilo 1990, p.101; Judd, Smith & Kidder 1991, p.164). For the inferential statistical analysis of the data the dependent variables were considered to be the participants' Delphi Survey responses and the independent variables were the various responses to the questions in the first section of the first Delphi Survey pertaining to socio-demographic data. The independent variables were as follows:

Current professional position:

- Director of Nursing
- Clinical Nurse Consultant
- Nurse Specialist
- Head of School
- Course Coordinator
- Senior Lecturer/Lecturer

Age range:

- 20-29 years
- 30-39 years
- 40-49 years
- 50-59 years
- 60-69 years

Gender:

- Male
- Female

Highest educational qualification:

- PhD
- Master’s degree
- Bachelor degree
- Diploma
- Certificate
- Other

Years of nursing experience as paediatric RN.

The first Delphi Survey contained five questions that were concerned with obtaining socio-demographic data about the participants. The survey also contained twenty-eight statements that were concerned with issues that related to health literacy and for analysis became the dependent variables. The results of each question from Questions 1 to 28 in the first Delphi Survey are discussed revealing where they are significant in terms of the recurrent patterns developed from the focussed review of the literature on health literacy or where the data generated new themes. Descriptive statistics for each question are displayed in tables in *Chapter 5*. The statistical analysis was undertaken using the computer software Statistical Package for the Social Sciences (SPSS).

### *Focus group interviews*

Among the most extensively employed research methods in the social sciences are focus group interviews (Stewart, Shamdasani & Rook 2007, p.1). Focus group interviews have many uses according to Stewart, Shamdasani and Rook (2007, pp. 41-42) among them are: gaining overall contextual information about the subject of interest; producing research propositions that can yield more research utilising more quantitative methods; inspiring innovative notions and original thoughts; identifying the possibilities for difficulties with an original program, facility, or artefact, creating influences on programs, facilities, organisations or other matters of interest; and understanding how defendants comment on the phenomenon of interest. This, consequently, can enable the making of surveys, survey tools, or other research tools that could be utilised in further quantitative studies. Finally it helps in interpreting previously obtained quantitative results as in the case of this research.

Even though focus groups are considered as an important research method and provide numerous advantages, they cannot provide an answer for all research prerequisites, as they have restrictions. In *Table 4* below, a number of the advantages and the limitations of this method are presented.

**Table 4** Advantages and limitations of using Focus Group interviews

| Advantages of using Focus group interviews | Limitations of using Focus group interviews |
|---|---|
| Focus groups can be cost and time efficient more than would be the case with individual interviews (Stewart, Shamdasani & Rook 2007). | The issue of generalisation to a larger population might be affected by the small number of participants focus groups usually employ (Stewart, Shamdasani & Rook 2007). |
| The organisation of focus group interviews can be done with much shorter notice than it would be in the case of a larger survey (Stewart, Shamdasani & Rook 2007). | The results gained in a focus group may be influenced by a dominant or prejudiced participant. More reserved participants may be tentative to participate (Stewart, Shamdasani & Rook 2007). |
| With focus groups the researcher can relate directly with participants. This makes it easier for the researcher to follow up with questions to clarify the participant's point of view. (Stewart, Shamdasani & Rook 2007). | The open-ended nature of responses attained in focus groups habitually makes summarisation and elucidation of results complex (Stewart, Shamdasani & Rook 2007). |
| With focus groups the researcher might find it easier to pick up on the participant's gestures, emotions and body language. These signs can help the researcher to gain more understanding and even an opportunity to compare them against the participant's verbal responses (Stewart, Shamdasani & Rook 2007). | The researcher might affect or contaminate results by intentionally or unintentionally offering prompts concerning what kinds of responses are wanted or looking to attain group consensus on specific subjects (Stewart, Shamdasani & Rook 2007). |
| Focus groups can be used to enhance the group dynamic as it gives participants the chance to effectively communicate their opinions and built on these with each other (Stewart, Shamdasani & Rook 2007). | If participants fail to turn up at the decided time and there are not adequate participants to make the group feasible, the occasion may need to be rearranged (Stewart, Shamdasani & Rook 2007). |
| Focus groups prove to be an adaptable approach for investigating a variety of subjects i.e. people and backgrounds. The interface among the participants may facilitate the collection of rich data without the researcher needing to prompt the group or guide it in answering the specific questions prepared prior to the focus group interview (Stewart, Shamdasani & Rook 2007). | The findings from focus group interviews may not apply to the wider population (Stewart, Shamdasani & Rook 2007). Yet, in qualitative research the prominence is more on the individual's reflections and feelings than aggregating the findings (Nyamanthi & Shuler 1990; Gray-Vickery 1993). |

### Why a focus group?

Among the findings from my Delphi Survey was that paediatric RNs recognise the concept of health education as a significant issue in understanding how they view health literacy. Focus group interviews were chosen to explore with paediatric RNs the how and why of their understanding of health education and its relationship to health literacy and how and why these understandings then influenced their roles. Focus group discussions were undertaken with volunteer paediatric RNs. I originally aimed at conducting a minimum of two focus group discussions, each including between 6-8 paediatric RNs who agreed to participate. Potential participants had to be paediatric RNs. Registered midwives, enrolled nurses and nursing students were excluded. The sample was purposefully selected.

Following ethics approval, an introductory email (*Appendix 2*) introducing the research was forwarded to the Director of Nursing of a specific child and youth hospital. The purpose of the email was to:

- Introduce the study's aims and objectives;
- Seek permission and assistance to approach and recruit relevant staff; and

- Seek permission and assistance to determine a venue and suitable time.

Approval to approach potential participants was given by the Director of Nursing of the target hospital. I sent all potential participants an invitation electronically (*Appendix 2*). An information sheet (*Appendix 3*) had been attached detailing the project aims and objectives, the participants' role, and my responsibilities prior to commencing the focus group interview. Specific dates and times to conduct the focus groups were arranged with the Director of Nursing and scheduled to coincide with handover times. Unfortunately no participants turned up at the arranged time of the first focus group. The second focus group consisted of five paediatric RNs.

At the start of the focus group the participants were again given an information sheet about the research and asked to read it. If they agreed to proceed then they were asked to sign a consent form to enable the recording of the conversations (*Appendix 4*). I outlined how the interview was to proceed and discussed confidentiality issues and the need to have only one person speaking at a time. I also assured participants that although they felt that they might have a professional and/or personal obligation or responsibility to take part in this research, their involvement was entirely voluntary and that they were free to withdraw from the research at any time without consequence.

### Focus group questions

The focus group interview was semi-structured in that I had prepared a list of questions to put to the focus group, and intended the participants to be free in their conversation. Beside asking the questions and directing the conversation, my role as the facilitator was also to ensure that everyone had an opportunity to speak.

The questions I had prepared prior to the focus group interview were compiled in light of the preliminary findings of the Delphi Survey and are presented below:

- What is the role of RNs in health education?
- What do health education activities for children and young people involve?
- Who should implement these activities?
- Why implement them?
- What may enable or constrain the implementation of health education sessions?

Prior to the focus group interview the digital recorders were checked to ensure they were working properly. The focus group interview was transcribed from the digital recording to a Word document by a transcriber who signed a confidentiality agreement (*Appendix 9*) prior to the transcribing of the digitally recorded interviews. The transcribed records do not include the names of the focus group participants.

### Analysis of Focus group data

Once the transcription process had been completed, the transcribed interview was read carefully and then thematically analysed in accordance with Leininger's criteria (2006). Again, in so doing, themes and categories that had emerged from the data were compared with each other and recurrent patterns and summative themes were identified.

## Stage 3: Apply a critical lens

Using the information gained from Stages 1 & 2, and analysing this information in the context of critical social theory and primary health care, I propose a response in *Chapters 6, 7 & 8* to my research question: *How is health education and health literacy constructed by paediatric RNs and what role, for nurses, is promoted?*

A principle that underpins critical social theory, as well as this thesis, is the view that no feature of social phenomena can be assumed as autonomous or separate from the historical, social and political structure in which it is found or located. Therefore, this thesis opens up the opportunity of examining the knowledge claims and communicative competence of nurses related to health education and health literacy from a critical position. That is, from a standpoint where nurses are regarded not as disinterested or objective individuals, but rather as sources of the production and reproduction of particular values, interests and practices in health care.

## Advantages of using Mixed Methods as a research design

Mixed methods research can generate knowledge that cannot be produced by other approaches through the creation of a wider lens picture (O'Cathain & Thomas 2006). The distinctive contribution of a mixed methods approach is precisely the use of different methods within a single study (Creswell, Fetters & Ivankova 2004). Collins, Onwuegbuzie and Sutton (2006) reviewed a wide variety of mixed methods research and recognised four major justifications for conducting mixed research. I discuss each of these in relation to my study.

### *Participant enrichment*

Participant enrichment refers to the benefits associated with using multiple approaches in order to increase the number of participants and optimise the sample. In this research, to ensure participant enrichment, volunteer participants were approached from a variety of different settings and comprised experienced paediatric RNs, Directors of Nursing, educators, academic nursing staff, and nursing leaders within Australian universities, children's hospitals and child health organisations.

### *Instrument fidelity*

Usually the aim of any research study is to attain data in order to have one or more of the following characteristics: trustworthiness, credibility, dependability, legitimation, validity, plausibility, applicability, consistency, neutrality, reliability, objectivity, confirmability, and/or transferability (Onwuegbuzie & Johnson 2006). To maximise the appropriateness and/or utility of the Delphi Survey instrument, statements were based on a focussed review of related literature and I undertook a pilot to assess both the process and the instrument with a view to making amendments, where required, or creating and improving a new instrument. Only members of the School of Nursing and Midwifery staff and doctoral colleagues at the University of South Australia were invited to participate to review the Delphi Survey and these participants were excluded from the main survey.

### *Treatment integrity*

Rather than treatment integrity, the implementation fidelity of the Delphi survey was ensured by the researcher being the only point of contact for potential and actual participants.

### *Significance enhancement*

Facilitating thickness and richness of data and augmenting interpretation and usefulness of findings has been assured by the use of a sequential transformative design consisting of three stages with different data collection and analysis methods. A focussed literature review and document analysis informed the development of statements for the Delphi Survey. Through the Delphi Survey both quantitative and qualitative data was collected through the same instrument and findings were used to guide the questions of the focus group interview.

## Limitations and addressing critics of mixed methods

Even though the advantages of mixed methods research are considerable, there are critics to applying mixed method designs. Criticisms include the time consuming nature of conducting mixed methods research, an increase in the costs of conducting research and the controversy about how the decisions are made when using resources across different methods (Flemming 2007; Creswell 2009). A further challenge is that in using different and additional methods this does not necessarily enhance the value of the research if the researcher(s) do not have the necessary expertise (Flemming 2007).

As I have discussed, a sequential transformative design guided my doctoral research (Creswell *et al*. 2003; Andrew & Halcomb 2009; Creswell 2009). For this study to be transformative relies on how readers consider my understanding and application of critical social theory. I have provided detailed background to why I used critical social theory and how in *Chapter 3.* The detail I provide in all my chapters provides the reader with evidence to address the challenge in mixed methods studies which is more so than in single method studies, as it relates to the complexity of gaining results and/or providing conclusions that are reliable, dependable, trustworthy, transferable and/or certifiable (Onwuegbuzie & Johnson 2006). As a doctoral student I sought to learn and utilise varied data collection and data analysis methods to increase my knowledge and skills. Having my supervisor attend the focus group discussion was in recognition of my limited experience in qualitative research and in ensuring that I was able to capture and interrogate the experiences of participants (Denzin & Lincoln 2005). How I have interrogated the mixed methods I used has been explained and the value of having both qualitative and quantitative components within the study discussed.

As this research made up my program of research for my PhD, with the support of my university I was able to complete this research without external funding constraints and time was only limited by my PhD candidature requirements, in turn influenced by personal and family circumstances. My doctoral supervisors bring the necessary expertise in the different methods used in my research and the theory, and in so doing have assisted my learning.

## In summary

This research meets Collins, Onwuegbuzie and Sutton's (2006) four major justifications for conducting mixed methods research. These justifications are: participant enrichment, instrument fidelity evaluating the suitability and/or usefulness of prevailing instruments,

treatment integrity assessing fidelity of the intervention, and significance enhancement enabling depth and productivity of data, amplifying analysis and effectiveness of results.

I invited experienced paediatric RNs, Directors of Nursing, educators, academic nursing staff and nursing leaders within Australian universities, children's hospitals and child health organisations to participate in a Delphi Survey. Inviting paediatric RN participants was a means to engage them in a disciplined form of self-reflection (Delphi Survey) with the hope that through this they would be enlightened and as a consequence challenge how they ensured their own health literacy and that of children and young people through their respective roles.

Having detailed how I conducted the three stages of my sequential transformative mixed methods research, I now, in the next chapter, present findings from Stages 1 and 2 that include document analysis, Delphi Surveys round 1 and 2 as well as the focus group interview findings.

# 5 Stage 1 & 2 Findings

## Introduction

In *Chapter 4* I described how this study was conducted in three stages:

- Stage 1: Describe the context;
- Stage 2: Identify recurring themes; and
- Stage 3: Apply a critical lens.

In this chapter I present findings from my document analysis, Delphi Survey and focus group discussion, which constitute Stages 1 and 2 of my research.

## Document analysis

I undertook a review of university undergraduate and postgraduate nursing curricula to identify if there were any gaps and/or to raise any potential concerns in relation to the preparation of nursing students to be competent in health education and influence the health literacy of children and young people. Once the curricula documents were collated for RNs, these were read and re-read. Titles then content (regardless of how the course was titled) were searched to identify what was included and not included.

Only one course in only one university, out of 34 universities searched, included the word 'Health literacy' in its specific title to the course name in undergraduate/postgraduate nursing curricula documents. In 33 courses in 14 universities, out of 34 universities searched, was 'Health Promotion' included in the titles and only 19 courses in 12 universities was the word 'Health Education' included in the titles in undergraduate/ postgraduate nursing curricula documents. The positioning of these words in a title does not mean that these concepts were not content topic in a course. In regards to content, in undergraduate/postgraduate nursing curricula documents searched only six courses in six universities, out of 34 universities searched, included 'Health literacy' in the description of

the content, regardless of how the course is titled. In 88 courses in 30 universities, out of 34 universities searched, 'Health Education' was included in the description of the content and 189 courses in 32 universities, out of 34 universities searched, included 'Health Promotion' in the description of the content. While these findings may reflect structural limitations for titling courses in a particular university there is the potential that this lack of prominence of health literacy in titles and content is a reflection of a wider view related to the relative significance of this concept to the health education role of nurses.

The following tables present in numbers the findings of the document analysis of university nursing curricula (postgraduate and undergraduate) for RNs.

**Table 5** Summary of the University undergraduate nursing curricula for RNs findings

| Australian Universities 2011/ Undergraduate Nursing Courses | Number of specific courses with the word 'Health literacy' in the title. | Number of specific courses with the word 'Health Promotion ' in the title. | Number of specific courses with the word 'Health Education' in the title. | Number of specific courses with the word 'Health' in the title. | Number of specific courses with the word 'Health literacy' in the description of the content. | Number of specific courses with the word 'Health Promotion ' in the description of the content. | Number of specific courses with the word 'Health Education' in the description of the content. | Number of specific courses with the word 'Health' in the description of the content. |
|---|---|---|---|---|---|---|---|---|
| **ACT** | | | | | | | | |
| University of Canberra | | | | 6 | | 4 | | 8 |
| **NSW** | | | | | | | | |
| Avondale College | | | | 13 | | | | 11 |
| Charles Sturt University | | 3 | 1 | 31 | | 5 | 3 | 42 |
| Southern Cross University | | 1 | | 7 | | 2 | | 8 |
| The University of Newcastle | 1 | | | 20 | 1 | 8 | 4 | 51 |
| University of New England | | 1 | 1 | 15 | | 8 | 3 | 30 |
| The University of Sydney | | | | 13 | | | | |
| University of Technology – Sydney | | | | 25 | 2 | 9 | | 41 |
| University of Western Sydney | | | | 16 | | 8 | | 20 |
| University of Wollongong | | | | 11 | | 2 | 2 | 19 |
| **NT** | | | | | | | | |
| Charles Darwin University | | | | 13 | | | | |
| **QLD** | | | | | | | | |

**Table 5** Summary of the University undergraduate nursing curricula for RNs findings (cont'd)

| Australian Universities 2011/ Undergraduate Nursing Courses | Number of specific courses with the word 'Health literacy' in the title. | Number of specific courses with the word 'Health Promotion ' in the title. | Number of specific courses with the word 'Health Education' in the title. | Number of specific courses with the word 'Health' in the title. | Number of specific courses with the word 'Health literacy' in the description of the content. | Number of specific courses with the word 'Health Promotion ' in the description of the content. | Number of specific courses with the word 'Health Education' in the description of the content. | Number of specific courses with the word 'Health' in the description of the content. |
|---|---|---|---|---|---|---|---|---|
| ACU National | | | | 21 | | 10 | | 57 |
| Central Queensland University | Could not gain access to courses offered and their description | | | | | | | |
| Griffith University | | | | 11 | | | | 19 |
| James Cook University | | | | 6 | | 1 | | 15 |
| Queensland University of Technology | | 2 | 1 | 10 | | 2 | 1 | 22 |
| The University of Queensland | | | | 11 | | 4 | 3 | 18 |
| University of Southern Queensland | | | | 7 | 1 | 1 | 1 | 18 |
| University of the Sunshine Coast | | | | 9 | | 4 | 2 | 19 |
| **SA** | | | | | | | | |
| Flinders University | | 1 | | 9 | | 2 | | 29 |
| The University of Adelaide | | | | 8 | | | | |
| University of South Australia | | | | 6 | 1 | 1 | 1 | 9 |
| **TAS** | | | | | | | | |
| University of Tasmania | | | | 6 | | 3 | | 8 |
| **VIC** | | | | | | | | |
| Deakin University | | 1 | | 5 | | 6 | 1 | 15 |
| La Trobe University | | | | 4 | | 1 | 1 | 18 |
| Monash University | | | | 7 | | | 1 | 15 |
| RMIT University | | | | 6 | | 4 | | 18 |
| University of Ballarat | They offer undergraduate courses but they do not provide access to the degree structure | | | | | | | |
| The University of Melbourne | They do not offer undergraduate nursing degrees | | | | | | | |
| Victoria University | | | | 10 | | 2 | | 17 |
| **WA** | | | | | | | | |
| Curtin University of Technology | | | | 12 | | 1 | | 21 |
| Edith Cowan University | | | | 9 | | 1 | 1 | 12 |
| Murdoch University | | | | 17 | | 1 | | 10 |
| The University of Notre Dame | | | | 14 | | | | |
| **Total** | **1** | **9** | **3** | **397** | **5** | **90** | **24** | **566** |

**Table 6** Summary of the University postgraduate nursing curricula for RNs findings

| Universities 2011/ Postgraduate Nursing Courses: Graduate Certificates Graduate Diplomas Masters by coursework PhD by coursework | Number of specific courses with the word 'Health literacy' in the title. | Number of specific courses with the word 'Health Promotion ' in the title. | Number of specific courses with the word 'Health Education' in the title. | Number of specific courses with the word 'Health' in the title. | Number of specific courses with the word 'Health literacy' in the description of the content. | Number of specific courses with the word 'Health Promotion ' in the description of the content. | Number of specific courses with the word 'Health Education' in the description of the content. | Number of specific courses with the word 'Health' in the description of the content. |
|---|---|---|---|---|---|---|---|---|
| **ACT** | | | | | | | | |
| University of Canberra | | | | 13 | | | | 17 |
| NSW | | | | | | | | |
| Avondale College | | 1 | | 2 | | 1 | | 9 |
| Charles Sturt University | | 1 | 1 | 41 | | 2 | 5 | 24 |
| Southern Cross University | They do not offer postgraduate nursing degrees by coursework | | | | | | | |
| The University of Newcastle | | | | 13 | | 1 | | 6 |
| University of New England | | 3 | 2 | 21 | | 8 | 3 | 32 |
| The University of Sydney | | | 1 | 20 | | 5 | 2 | 37 |
| University of Technology – Sydney | | 1 | 2 | 34 | | 5 | 4 | 42 |
| University of Western Sydney | | | | 4 | | | 1 | 5 |
| University of Wollongong | | 1 | | 18 | | 8 | 3 | 26 |
| **NT** | | | | | | | | |
| Charles Darwin University | | | | 5 | | | | 3 |
| **QLD** | | | | | | | | |
| ACU National | | | 1 | 7 | | 1 | 2 | 7 |
| Central Queensland University | They offer postgraduate nursing degrees by coursework but they do not provide access to the degree structures and their unit descriptions | | | | | | | |
| Griffith University | | 1 | 2 | 14 | | 5 | 6 | 40 |
| James Cook University | | 4 | | 27 | | 12 | 3 | 47 |

**Table 6** Summary of the University postgraduate nursing curricula for RNs findings (cont'd)

| Universities 2011/ Postgraduate Nursing Courses: Graduate Certificates Graduate Diplomas Masters by coursework PhD by coursework | Number of specific courses with the word 'Health literacy' in the title. | Number of specific courses with the word 'Health Promotion ' in the title. | Number of specific courses with the word 'Health Education' in the title. | Number of specific courses with the word 'Health' in the title. | Number of specific courses with the word 'Health literacy' in the description of the content. | Number of specific courses with the word 'Health Promotion ' in the description of the content. | Number of specific courses with the word 'Health Education' in the description of the content. | Number of specific courses with the word 'Health' in the description of the content. |
|---|---|---|---|---|---|---|---|---|
| Queensland University of Technology | | 2 | 1 | 34 | 1 | 2 | 2 | 44 |
| The University of Queensland | | | 1 | 30 | | 7 | 8 | 41 |
| University of Southern Queensland | | | | 13 | | 1 | | 19 |
| University of the Sunshine Coast | | 5 | 1 | 10 | | 7 | 2 | 17 |
| SA | | | | | | | | |
| Flinders University | | 1 | 1 | 10 | | 3 | 3 | 24 |
| The University of Adelaide | They offer postgraduate nursing degrees by coursework but they do not provide access to the degree structures | | | | | | | |
| University of South Australia | | | | 18 | | 5 | 5 | 22 |
| **TAS** | | | | | | | | |
| University of Tasmania | | | | 19 | | 3 | 1 | 32 |
| **VIC** | | | | | | | | |
| Deakin University | | | | 6 | | 3 | 2 | 10 |
| La Trobe University | | 1 | | 14 | | 7 | 3 | 22 |
| Monash University | | 1 | 1 | 6 | | 1 | 1 | 9 |
| RMIT University | | | | 7 | | 4 | 3 | 20 |
| University of Ballarat | They offer postgraduate nursing degrees by coursework but they do not provide access to the degree structures | | | | | | | |
| The University of Melbourne | | | 1 | 15 | | 4 | 3 | 27 |
| Victoria University | They do not offer postgraduate nursing degrees by coursework | | | | | | | |

**Table 6** Summary of the University postgraduate nursing curricula for RNs findings (cont'd)

| Universities 2011/ Postgraduate Nursing Courses: Graduate Certificates Graduate Diplomas Masters by coursework PhD by coursework | Number of specific courses with the word 'Health literacy' in the title. | Number of specific courses with the word 'Health Promotion ' in the title. | Number of specific courses with the word 'Health Education' in the title. | Number of specific courses with the word 'Health' in the title. | Number of specific courses with the word 'Health literacy' in the description of the content. | Number of specific courses with the word 'Health Promotion ' in the description of the content. | Number of specific courses with the word 'Health Education' in the description of the content. | Number of specific courses with the word 'Health' in the description of the content. |
|---|---|---|---|---|---|---|---|---|
| **WA** | | | | | | | | |
| Curtin University of Technology | | 1 | | 17 | | 2 | 1 | 27 |
| Edith Cowan University | | 1 | 1 | 19 | | 2 | 1 | 21 |
| Murdoch University | They do not offer postgraduate nursing degrees by coursework | | | | | | | |
| The University of Notre Dame | | | | 3 | | | | |
| **Total** | **0** | **24** | **16** | **439** | **1** | **99** | **64** | **632** |

While 'health literacy' is hardly evident in the names of undergraduate and postgraduate courses and related content listed in publicly available documents of nursing curricula, this does not mean health literacy is not covered. But not naming a course as such, or not naming a course 'health education', reflects that these concepts are not given a preeminent position in nursing curricula. There may of course be reasons for this but an investigation of this was outside the scope of this study. Health literacy, as discussed in *Chapter 1*, is a broad yet significant concept but there is ambiguity and misconceptions in the literature that surrounds the concept, reinforcing the need to identify views of nurses.

Chinn (2011) reviewed and critically analysed the concept of critical health literacy in the context of the expanding body of research into health literacy. Chinn (2011) argues that although there has been a significant development of interest in the health literacy concept universally, there has similarly been criticism that this concept has been poorly defined and that it adds little to the better recognised discipline of health promotion.

Scheckel, Emery and Nosek (2010) have described undergraduate nursing students' experiences of addressing health literacy and state that there is a need to design instructional strategies that expand students' existing knowledge and skills in health literacy prior to graduation from nursing programs. Olson, Blank, Cardinal, Hopf and Chalmers (1996) encourage a focus on health literacy; Youmans and Schillinger (2003) however, provided a practical approach to increasing pharmacy students' understanding of

medication-related requirements of clients with low-literacy skills using a three-step oral interview technique. A review of the University of California San Francisco (UCSF) clinical pharmacy curriculum raised awareness about health literacy among pharmacy faculty and students, and the need for curricular change; this has led to curriculum developments (Soller 2006).

Likewise in the field of medicine, Harper, Cook and Makoul (2007) report that two medical schools in Chicago provide examples of different approaches to curriculum design and implementation, both of which embed and integrate the issue of health literacy into required courses. More specifically Harper, Cook and Makoul (2007), at the Pritzker School of Medicine, University of Chicago, have developed a curriculum on health literacy that spans the first three years of medical school. The Feinberg School of Medicine, North Western University, devotes curricular attention to health literacy during the first year of medical school (Harper, Cook & Makoul 2007). Both universities aimed to raise medical student awareness of how low literacy influences health, healthcare and medical encounters, as well as to develop their skills in communicating with people with low health literacy (Harper, Cook & Makoul 2007). Consequently, it is evident in the literature that health literacy is a critical factor in the approach to care for people and therefore needs the attention of the nursing, pharmacy and medical fields. It is therefore important to prepare RNs competent in health education to promote health literacy through integrating these concepts into nursing curricula. The next section presents the findings of both Delphi Survey rounds.

## Delphi Survey findings: Round 1

In the first round of the Delphi Survey 34 surveys were distributed with a first round response rate of one hundred percent (100%). In section one of the first survey, the questions were concerned with collecting socio demographic data from participants in order to determine whether the participants were a homogenous or heterogeneous group of paediatric RNs in terms of a number of factors. These factors were current professional position, age, gender, highest educational qualification and years of experience in paediatric and child and youth health nursing.

The socio demographic data provides an overview of the paediatric RNs who agreed to participate because they had particular interest in the study area or who considered they were able to significantly contribute to the topic in this study. Those who volunteered came from a diversity of nursing backgrounds, locations, ages, academic qualifications and years

of experience. While paediatric RNs working as clinicians were invited to participate, participants were in the main senior nurses from the clinical and academic settings. Despite the lack of direct clinical paediatric RN involvement, those who did have significant leadership roles in nursing are in positions of influence and can direct what nursing practices and nursing education is to occur.

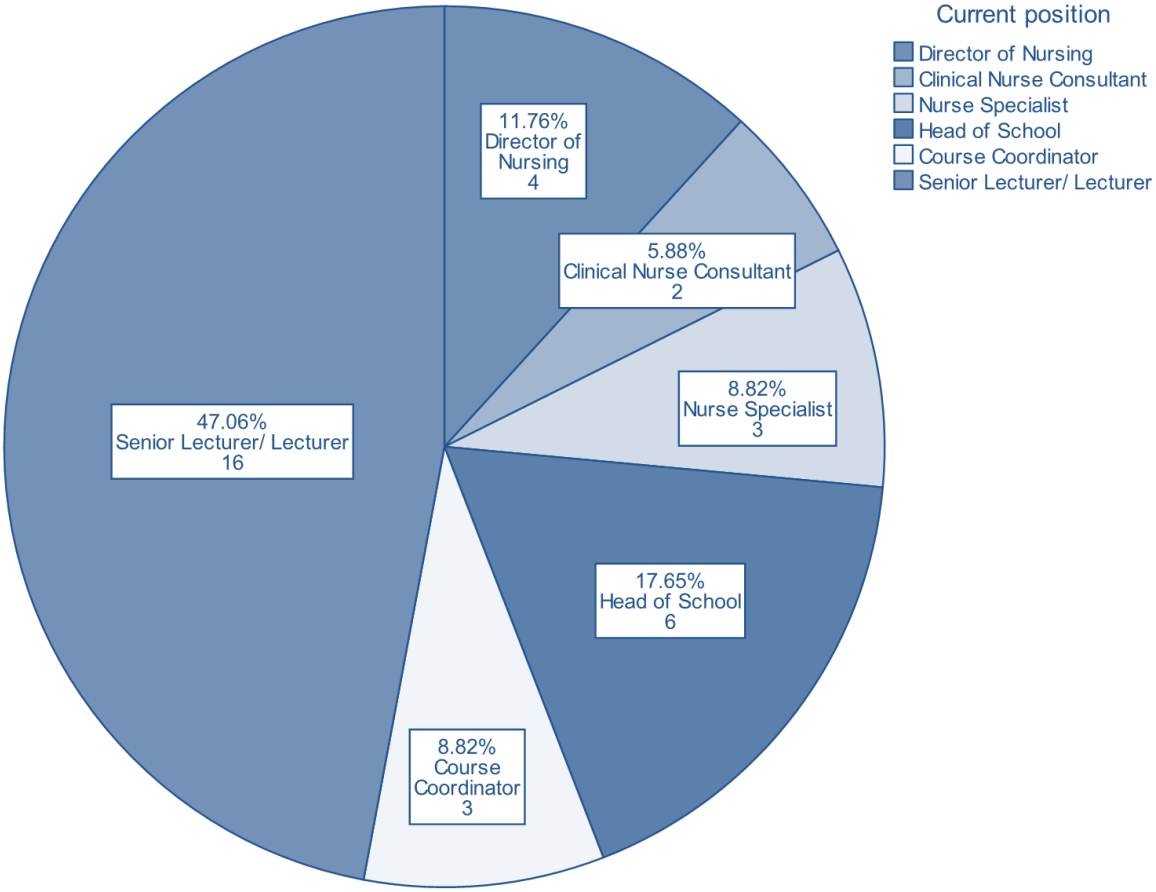



**Figure 7** Current professional position

The range of ages of all participants was thirty to fifty nine years.

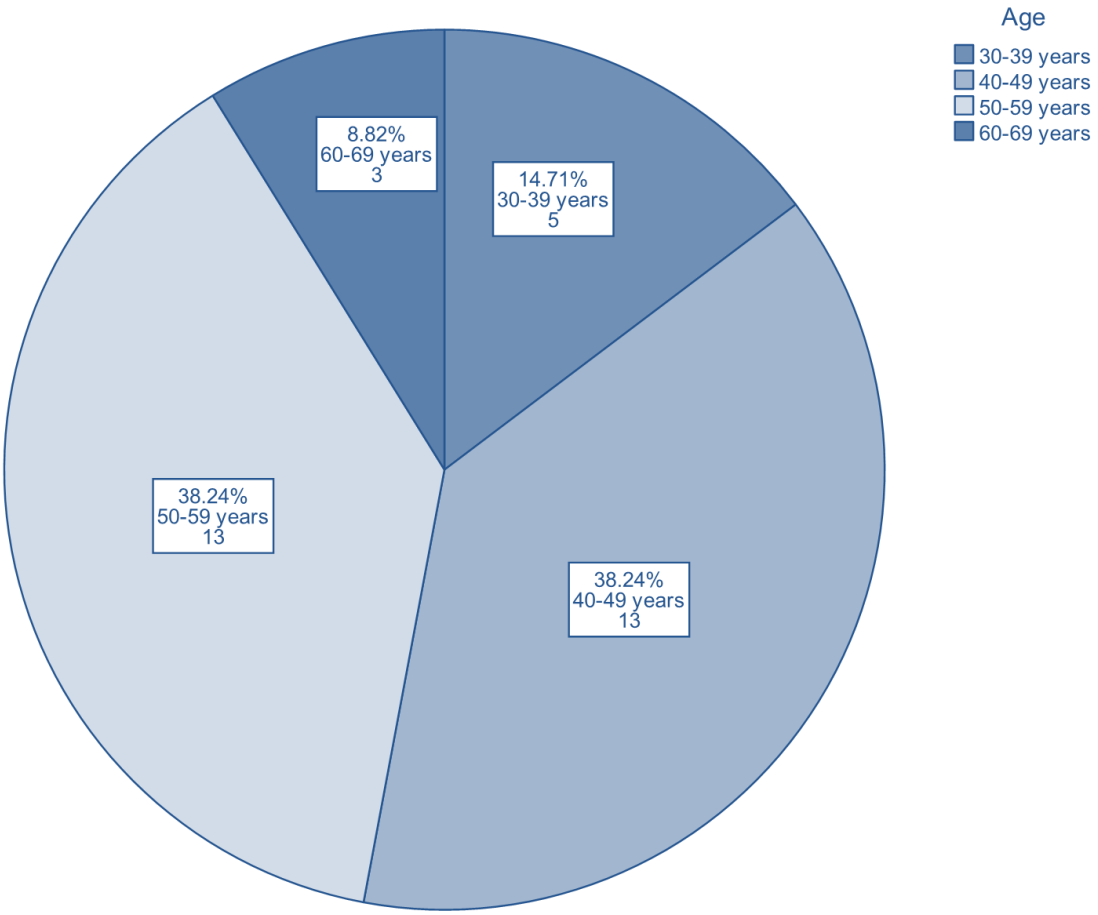



**Figure 8** Paediatric RNs age range

Responses to the question regarding gender indicated that 18% of respondents were male and 82% were female. Figures available via the Australian Institute of Health and Welfare (2011), which is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act* (1987) to provide reliable, regular and relevant information and statistics on Australia's health and welfare, indicate that although nursing is a predominantly female occupation, the proportion of males has increased slightly; in 2009 males comprised 9.6% of employed nurses, which is up from 7.9% in 2005. The sample population in this study had male nurses represented in approximately the same ratio as they are in the general population of RNs in Australia.

The highest educational qualification of participants revealed that 45% had gained a PhD degree and 39% a Master's degree. Participants in the main held a higher qualification than that expected of all RNs in Australia.

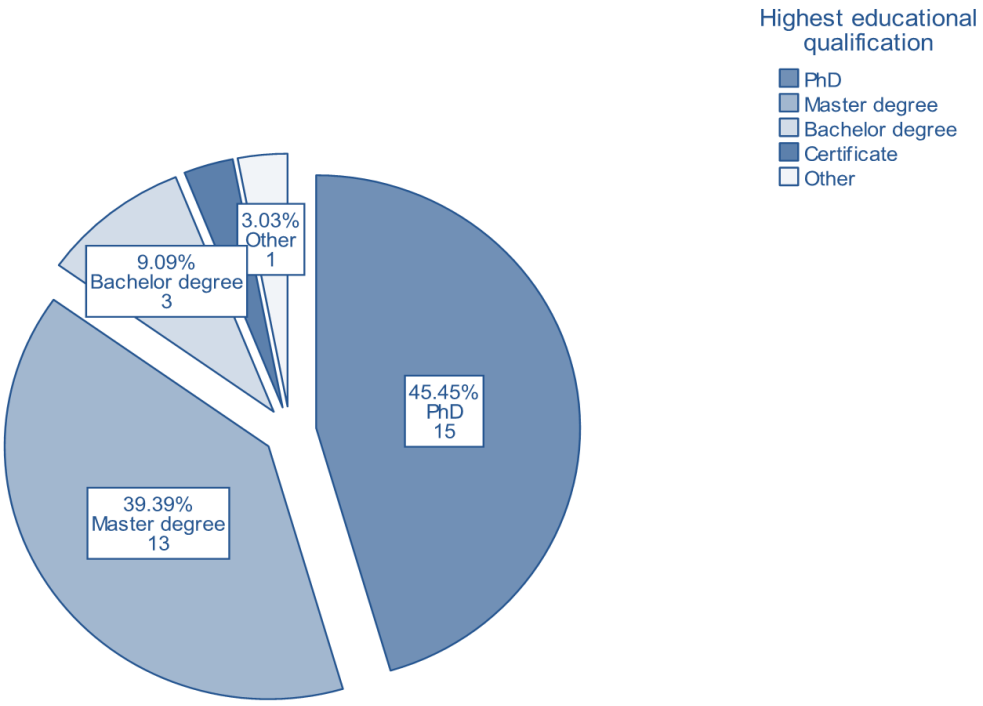



**Figure 9** Highest educational qualification

The number of years of experience of participants as a paediatric RN was as follows: 44% had ten or less years' experience as a paediatric RN; 35% had 11-20 years of experience; 12% percent had 21-30 years of experience; and 9% had between 31-40 years of experience (*Table 7*).

**Table 7** Years of nursing experience as a paediatric RN

| Years of experience | Frequency | Percent |
|---|---|---|
| **0 - 10 Years** | 15 | 44.1% |
| **11-20 Years** | 12 | 35.3% |
| **21-30 Years** | 4 | 11.8% |
| **31-40 years** | 3 | 8.8% |
| **Total** | **34** | **100%** |

The analysis of the responses to the statements in the first Delphi Survey began by undertaking statistical analysis of the quantitative data and then using the results to consider whether the findings added new information or confirmed the information already

contained under the recurrent patterns identified through the focused review of related literature. This was followed by analysis of participants' comments. All comments made by participants on each statement were transcribed into a separate document. In this way I could read all the comments pertinent to one question with ease. At the same time I was able to compare the statistical results for each question with the comments and the theme under which these questions had been grouped.

## Descriptive statistics Delphi Survey: Round 1

Descriptive statistical analysis was carried out, specifically the measure of central tendency. A Likert scale was used in statements 1 to 28, with strongly disagree being coded as a 1, disagree as a 2, unsure as a 3, agree as a 4 and strongly agree as a 5 for the purposes of statistical analysis. As discussed in *Chapter 4*, the consensus level for each statement in the Delphi Survey rounds of this study was 80%.

**What is health literacy?** Nine statements related to this question were included in the survey. These statements were:

**Table 8** What is health literacy?

| Statement # | First Delphi Survey Statements | agree or strongly agree *% (n)* | disagree or strongly disagree *% (n)* | unsure *% (n)* | Missing *(n)* |
|---|---|---|---|---|---|
| **1** | Being health literate means more than being able to read pamphlets and successfully make appointments. | 97.0% *n=33* | 3.0% *n=1* | 0.0% | |
| **2** | Improving health literacy amongst children and young people is important for their health and wellbeing. | 97.0% *n=33* | 3.0% *n=1* | 0.0% | |
| **3** | Health literacy is part of lifelong learning. | 94.0% *n=32* | 6.0% *n=2* | 0.0% | |
| **6** | Being health literate may enable people to better manage their own health. | 97.0% *n=33* | 0.0% | 3.0% *n=1* | |
| **7** | A child or young person who is health literate may access, understand, and interpret basic health information. | 97.0% *n=33* | 0.0% | 3.0% *n=1* | |
| **8** | A parent/guardian of a child or young person who is health literate has the skills to use health services to promote their child's health and well-being. | 87.9% *n=29* | 3.0% *n=1* | 9.0% *n=3* | One missing |
| **9** | Being health literate should help more children and young people understand their needs. | 94.0% *n=32* | 0.0% | 6.0% *n=2* | |
| **12** | Being health literate will enable children and young people to make informed health care decisions. | 88.0% *n=30* | 3.0% *n=1* | 9.0% *n=3* | |
| **13** | Being health literate will enable parents/guardians of children and young people to make informed health care decisions. | 93.9% *n=31* | 3.0% *n=1* | 3.0% *n=1* | One missing |

Statistical findings for statements 1, 2, 3, 6, 7, 8, 9, 12 and 13 indicate consensus among the selected participants that being health literate means more than the ability to perform

basic reading, writing and numerical tasks required to function in the healthcare environment. In other words the view held by participants regarding the concept 'health literacy' is that it is more than being functionally health literate. There was also consensus amongst the participants that enhancing health literacy among children and young people is important for their health and wellbeing and that health literacy is part of lifelong learning; health literacy enables children and young people to access, understand and interpret health information, manage their health and make informed health care decisions.

**Consequences of low health literacy** had eight statements in the survey to explore this view. These statements were:

**Table 9** Consequences of low health literacy

| Statement # | First Delphi Survey Statements | agree or strongly agree *% (n)* | disagree or strongly disagree *% (n)* | unsure *% (n)* | Missing *(n)* |
|---|---|---|---|---|---|
| **10** | A low level of functional health literacy can affect anyone. | 76.0% *n=26* | 9.0% *n=3* | 15.0% *n=5* | |
| **11** | Low health literacy increases health care costs at an individual level. | 73.6% n=25 | 5.8% n=2 | 20.6% n=7 | |
| **14** | Children and young people with low health literacy are unlikely to seek preventive health care | 76.5% *n=26* | 11.8% *n=4* | 11.8% *n=4* | |
| **15** | Parents/guardians of children and young people with low health literacy skills are unlikely to facilitate preventive care for their children. | 76.4% *n=26* | 14.7% *n=5* | 8.8% *n=3* | |
| **18** | Improving an individual's health literacy will help overcome health inequalities. | 73.5% *n=25* | 11.8% *n=4* | 14.7% *n=5* | |
| **26** | Healthcare professionals generally assume health consumers to be functionally health literate. | 55.9% *n=19* | 32.4% *n=11* | 11.8% *n=4* | |
| **28** | Child and youth health nurses may have deficits about the concept of health literacy. | 76.5% *n=26* | 2.9% *n=1* | 20.6% *n=7* | |

Statistical findings for statements 10, 11, 14, 15, 18, 26 and 28 indicate that there was not a consensus among the selected participants with regard to the influence of low health literacy and its effect on children and young people's health.

**Health literacy role of paediatric RNs:** To understand the views of participants, five statements were included in the survey. These statements were:

**Table 10** Health literacy role of paediatric RN

| Statement # | First Delphi Survey Statements | agree or strongly agree *% (n)* | disagree or strongly disagree *% (n)* | unsure *% (n)* | Missing *(n)* |
|---|---|---|---|---|---|
| **5** | Promoting health literacy should be an essential element of child and youth nurse practice. | 100% *n=34* | 0.0% | 0.0% | |
| **16** | It is important for child and youth health nurses to recognise health literacy problems experienced by children and young people. | 100% *n=34* | 0.0% | 0.0% | |
| **17** | It is important for child and youth health nurses to recognise health literacy problems experienced by parents/guardians of children and young people. | 100% *n=34* | 0.0% | 0.0% | |
| **23** | Educating children and young people about their health should be an essential part of nursing. | 100% *n=34* | 0.0% | 0.0% | |
| **24** | Clarifying the concept of health literacy to child and youth health nurses is essential. | 94.0% *n=32* | 3.0% *n=1* | 3.0% *n=1* | |

Statistical findings for statements 5, 16, 17, 23 and 24 indicate consensus among the selected participants that a paediatric RN is actually responsible for recognising low health literacy, promoting health literacy and taking on the role of education of health literacy.

**The 'place' for health literacy**: Seven statements were included in the survey to explore this view. These statements were:

**Table 11** The 'place' for health literacy

| Statement # | First Delphi Survey Statements | agree or strongly agree *% (n)* | disagree or strongly disagree *% (n)* | unsure *% (n)* | Missing *(n)* |
|---|---|---|---|---|---|
| **4** | Health literacy is a priority focus in health policy. | 55.9% *n=19* | 29.4% *n=10* | 14.7% *n=5* | |
| **19** | Health literacy development should be an integral component of health promotion for children and young people. | 100% *n=34* | 0.0% | 0.0% | |
| **20** | Health education which includes health literacy should be provided by child and youth health nurses. | 85.0% *n=29* | 6.0% *n=2* | 9.0% *n=3* | |
| **21** | Providing health education to children and young people will not always result in adopting good health habits/behaviours. | 94.0% *n=32* | 6.0% *n=2* | 0.0% | |
| **22** | Health education alone will not be useful to people who do not feel that they have the capacity to change their personal circumstances. | 85.0% *n=29* | 12.0% *n=4* | 3.0% *n=1* | |
| **25** | Nursing and midwifery curricula and/or staff development should address health literacy. | 97.0% *n=33* | 0.0% | 3.0% *n=1* | |
| **27** | There is little or no time for health education in current health settings. | 47.0% *n=16* | 32.4% *n=11* | 20.6% *n=7* | |

While the statistical findings for statements 19, 20, 21, 22 and 25 indicate consensus among the selected participants, the statistical findings of statements 4 (Health literacy is a priority focus in health policy) and 27 (there is little or no time for health education in current health settings) demonstrate no consensus.

## Analysis of participants' comments on Delphi Survey statements: Round 1

### *What is health literacy?*

The descriptive statistics would suggest that there is consensus among the participants of what health literacy is; however, the written comments indicate that for some participants literacy and health literacy are different capabilities and how people understand health messages varies. For example:

> Reading pamphlets is a GOOD START – considering many Australians have literacy difficulties (i.e. 30% of Australian population has only 'functional literacy levels or less') – the pamphlets provide a good pictorially based introduction to healthy issues and starts to 'get the message out there'.
>
> *(D1, Participant 12, Q1 comment)*

> I think perhaps you need to include the word 'may BETTER access, understand, and interpret basic health information, in comparison to those who are not health literate', just because they know a little more does not mean that they WILL access, understand or interpret basic health information.
>
> *(D1, Participant 12, Q7 comment.*

> One would think that being health literate SHOULD help more children and young adults understand their health needs, but it will not always be so. I think here of the example of teenage pregnancies. Even though there has been a concerted campaign over the years (in schools) to raise awareness of sex health issues, teenage pregnancy is still a major occurrence in some communities. Just being health 'literate' does not mean that you will follow advice ... there are many other factors/forces operating in a child and young person's world that will affect decision making. i.e. family values and beliefs, culture, social norms, peer group pressure etc.
>
> *(D1, Participant 12, Q9 comment)*

Other participant comments reflected the fact that health literacy competence is always changing and is affected by many factors such as: the individual cognitive and financial abilities to follow healthy advice; the appropriateness of the health information provided; when, where, how and by whom health literacy has been provided. For example:

> It also depends on the sensitivity of the service to listen to the carer. Maybe we should teach 'assertiveness training'. This is assuming the parent has enough or all the information required to make an informed decision and has a measure of understanding. There are factors that can influence the parent/guardian in decision making.
>
> *(D1, Participant 17, Q8 comment)*

> Ideally yes, but this assumes that individuals have the capacity and means to act on the basis of being informed; again context is important.
>
> *(D1, Participant 22, Q12 comment)*

### *Consequences of low health literacy*

The descriptive statistics would suggest that there is consensus between participants reading the consequences of low health literacy. The written comments accompanying statements 10, 11, 14, 15, 18, 26 and 28 though reflect different points of views. For example:

> Initially, we are told that health prevention is cheaper for the state than treatment, but it is not necessarily so, as they may not know what to ask for or for what they are eligible.
>
> *(D1, Participant 11, Q17 comment)*

### *Health literacy role of paediatric RNs*

There was consensus to the view that a paediatric RN is actually responsible for recognising low health literacy, promoting health literacy and taking on the role of education of health literacy. The written comments accompanying statements 5, 16, 17, 23 and 24 reflect consensus as well. For example:

> It is a fundamental part of practice to elicit the child/parents understanding in order to treat ethically, in terms of consent and simply to make a thorough assessment. One must consider though, e.g. is the individual literate? How do they understand their body? Do they have an internal or an external locus of control?
>
> *(D1, Participant 17, Q16 comment)*

> I believe all nurses should be schooled in the laws of health- specialised education should be provided to nurses who wish to specialise further.
>
> *(D1, Participant 28, Q24 comment)*

### *The 'place' for health literacy*

While participants were in consensus regarding statements 19, 20, 21, 22 and 25 as mentioned earlier, responses to statement 4 indicate that almost half of the participants disagreed or strongly disagreed or were unsure that health literacy is a priority focus in health policy. The participants stated that even though health literacy is essential to reducing disparities and it aims to treat all people equally by health services, it is important to remember that not everyone has the same health literacy abilities. There must be policy-oriented strategies for improving health literacy. For example:

> While health literacy is a focus, I would disagree that it is a strong focus. While public health campaigns aim to raise awareness of one or two major health issues i.e. smoking and Sunsafe, there is a lack of a wide ranging awareness campaigns that would raise literacy in many highly relevant health areas.
>
> *(D1, Participant 12, Q4 comment)*

> Health policy is more about health care and health service than literacy issues
>
> *(D1, Participant 31, Q4 comment)*

Also more than half of the participants disagreed or strongly disagreed or were unsure that there is little or no time for health education in current health settings. These participants argue that there is actually a time for health education, but paediatric RNs usually either miss the opportunity to educate or they simply do not prioritise the task of education. The following is a comment that accompanied a participant response to statement 27:

> I think that education could take place during care and that it can be done without it appearing to be specifically education.
>
> *(D1, Participant 15, Q27 comment)*

Summary of the findings of the Delphi Survey – Round 1 is presented in *Table 12*.

**Table 12** Summary of the findings of the first Delphi Survey

| From critical review of literature statements of Delphi Survey 1 focussed on: | What is health literacy? | Consequences of low health literacy | Health literacy role of paediatric RNs | The 'place' for health literacy |
|---|---|---|---|---|
| **Descriptive Data** | Statement numbers: 1, 2, 3, 6, 7, 8, 9, 12 and 13 | Statement numbers: 10, 11, 14, 15, 18, 26 and 28 | Statement numbers: 5, 16, 17 and 23 | Statement numbers: 4, 19, 20, 21, 22, 25 and 27 |
| **Findings** | There is a consensus between paediatric RNs in health literacy being more than reading and writing – it is interactive<br>There is a consensus between paediatric RNs that health literacy enables children and young people to access, understand and interpret health information, manage their health and make informed health care decisions. | There is not a consensus as to the influence of low health literacy. | There is a consensus between paediatric RNs of being responsible for recognising low health literacy, promoting health literacy and enacting this responsibility | There is not a consensus with health literacy being a priority focus in health policy<br>There is not a consensus on the role of health education |

While in Round 1 consensus has been achieved about 'what is health literacy?' and 'the role of health literacy with paediatric RNs', participants did not achieve consensus for 'consequences of low health literacy' and 'the "place" of health literacy'. This required further investigation in Round 2. Considering that both these recurrent patterns where related to the complexity of health literacy and the role of paediatric RNs' role in relation to health literacy, two main themes emerged from the findings of the first Delphi Survey:

- Responsibilities of paediatric RNs; and
- Possibilities in relation to health literacy.

The second round of the Delphi Survey was constructed to gain additional information specifically pertaining to the themes that had emerged.

## Delphi Survey: Round 2

The 23 statements in the second Delphi Survey were constructed to elicit information about the themes that had emerged from Delphi Survey: Round 1. This followed analysis of the participants' written comments after they were transcribed. In this way I could read all the comments pertinent to one question with ease. At the same time I was able to compare the statistical results for each question with the comments and the theme under which these questions had been grouped.

As in Round 1, descriptive statistical analysis was carried out using measures of central tendency. A Likert scale was used in statements 1 to 23, with strongly disagree being coded as a 1, disagree as a 2, unsure as a 3, agree as a 4 and strongly agree as a 5 for the purposes of statistical analysis.

The results of each statement from statements 1 to 23 in the second Delphi Survey are discussed where they are significant in terms of the themes and summative themes developed from the focussed review of literature on health literacy and Delphi Survey: Round 1, or where the data generated new themes. Descriptive statistics for each statement are displayed in *Tables 5.9* and *5.1*.

## Descriptive statistics Delphi Survey: Round 2

Under the theme of **Responsibilities of paediatric RNs** fifteen statements were included in the survey. Findings for these statements are displayed in *Table 13*.

**Table 13** Responsibilities of paediatric RNs

| Statement # | Second Delphi Survey Statements | agree or strongly agree % (n) | disagree or strongly disagree% (n) | unsure% (n) | Missing (n) |
|---|---|---|---|---|---|
| **1** | Child, youth and paediatric nurses have a professional responsibility to improve children and young people's access to evidenced based information. | 97.0% *n=32* | 0.0% | 3.0% *n=1* | |
| **2** | Child, youth and paediatric nurses have a professional responsibility to improve how children and young people learn to navigate the health care system. | 94.0% *n=31* | 3.0% *n=1* | 3.0% *n=1* | |
| **3** | Child, youth and paediatric nurses have a professional responsibility to improve how children and young people learn to know what is good advice related to their health. | 94.0% *n=31* | 0.0% | 6.0% *n=2* | |
| **6** | Child, youth and paediatric nurses have a professional responsibility to take a long term view to educating children and young people about their health during any professional encounter. | 88.0% *n=29* | 0.0% | 12.0% *n=4* | |
| **7** | Child, youth and paediatric nurses have a professional responsibility to explore ideas on how to improve a child's or young person's health literacy. | 94.0% *n=31* | 3.0% *n=1* | 3.0% *n=1* | |
| **10** | Children and young people learn about how to be healthy from their parents not child, youth and paediatric nurses. | 39.4% *n=13* | 36.4% *n=12* | 24.2% *n=8* | |
| **12** | Child, youth and paediatric nurses have a professional responsibility to evaluate children and young people's health literacy skills. | 84.4% *n=27* | 0.0% | 15.6% *n=5* | One missing |
| **14** | Child, youth and paediatric nurses have a professional responsibility to advocate for a focus on health literacy for children and young people. | 90.9% *n=30* | 0.0% | 9.1% *n=3* | |
| **15** | Child, youth and paediatric nurses have a professional responsibility to be aware of how health policy related to children and young people is informed, developed and in turn enacted. | 97.0% *n=32* | 0.0% | 3.0% *n=1* | |
| **16** | Child, youth and paediatric nurses have a professional responsibility to communicate the importance of health literacy to children, young people and their parents/guardians. | 96.9% *n=32* | 0.0% | 3.1% *n=1* | One missing |
| **18** | Child, youth and paediatric nurses have a professional responsibility to undertake research on health literacy. | 72.7% *n=24* | 12.1% *n=4* | 15.2% n=5 | |
| **20** | Child, youth and paediatric nurses have a professional responsibility to recognise that low health literacy can be a problem affecting children and young people's health outcomes. | 97.0% *n=32* | 0.0% | 3.0% *n=1* | |
| **21** | Child, youth and paediatric nurses have a professional responsibility to focus on assisting children and young people to realise that prevention of non-communicable diseases is a possibility. | 93.8% *n=30* | 3.1% *n=1* | 3.1% *n=1* | One missing |
| **22** | Child, youth and paediatric nurses have a professional responsibility to evaluate whether parents/guardians of children or young people with whom they interact are health literate. | 91.0% *n=30* | 0.0% | 9.0% *n=3* | |
| **23** | Child, youth and paediatric nurses have a professional responsibility to influence the health literacy levels of children and young people. | 94.0% n=31 | 0.0% | 6.0% *n=2* | |

Statistical findings for statements 1, 2, 3, 6, 7, 12, 14, 15, 16, 20, 21, 22 and 23 indicate consensus amongst participants that paediatric RNs have a professional responsibility for

health promotion and health literacy. However, statistical findings for statements 10 and 18 indicate that there was no consensus among participants for these statements.

Under the theme of **Possibilities in relation to health literacy** eight statements were included in the survey. Findings for these statements are displayed in *Table 14*.

**Table 14** Possibilities in relation to health literacy

| Statement # | Second Delphi Survey Statements | agree or strongly agree *% (n)* | disagree or strongly disagree *% (n)* | unsure% *(n)* | Missing *(n)* |
|---|---|---|---|---|---|
| **4** | A child, youth and paediatric nurse can create the appropriate opportunities for children and young people to learn about being health literate. | 88.0% *n=29* | 3.0% *n=1* | 9.0% *n=3* | |
| **5** | A child, youth and paediatric nurse can create the appropriate opportunities for children, young people and their parents/guardians to learn about being health literate. | 85.0% *n=28* | 3.0% *n=1* | 12.0% *n=4* | |
| **8** | A child, youth and paediatric nurse can create the appropriate opportunities for children, young people and their parents/guardians to understand how to make healthy choices in their everyday lives. | 97.0% *n=32* | 0.0% | 3.0% *n=1* | |
| **9** | It is possible for children and young people to learn how to say no to unhealthy activities. | 87.8% *n=29* | 0.0% | 12.1% *n=4* | |
| **11** | Child, youth and paediatric nurses' ability to provide effective health advice to children and young people is influenced by their own health literacy. | 81.8% *n=27* | 12.1% *n=4* | 6.1% *n=2* | |
| **13** | The provision of health education is an instrument of change. | 94.0% *n=31* | 3.0% *n=1* | 3.0% *n=1* | |
| **17** | Child, youth and paediatric nurses are important role-models for children and young people. | 81.2% *n=26* | 3.1% *n=1* | 15.6% *n=5* | One missing |
| **19** | There is a lack of opportunities for child, youth and paediatric nurses to promote health literacy for children and young people. | 54.6% *n=18* | 24.2% *n=8* | 21.2% *n=7* | |

Statistical findings for statements 4, 5, 8, 9, 11, 13 and 17 indicate consensus among the selected participants indicating that for them a paediatric RN can create opportunities for children, young people and their parents/guardians to learn more about being health literate and understand how to make healthy choices in their everyday lives. There was also a consensus that paediatric RNs' ability to provide effective health advice to children and young people is influenced by their own health literacy and that they are important role models for children and young people. However, statistical findings for statement 19 indicate that there was not a consensus among participants.

## Analysis of participants' written comments on Delphi Survey statements: Round 2

### *Responsibilities of paediatric and child and youth health registered nurses*

Statistical findings for statements 10 and 18 showed that there was no consensus among the selected participants. For example, their responses to statement 10 indicates that more than half of the participants disagreed or strongly disagreed or were unsure that children and young people actually learn how to be healthy from their parents/guardians not paediatric RNs. They argued that children and young people learn from different sources of which they are one. Here is an example from the participants' written comments:

> Children and young people learn from everyone; their parents, nurses, school teachers, peers and the media. Therefore it is important to clarify what is truth.
>
> *(D2, Participant 16, Q10 comment)*

Also there was no consensus among participants as nearly 30% disagreed or strongly disagreed or were unsure that paediatric RNs have a professional responsibility to undertake research on health literacy. They argue that there is little time for them to conduct research.

> They don't all need to understand research, but they do need to access, critique and apply research evidence.
>
> *(D2, Participant 13, Q18 comment)*

### *Possibilities in relation to health literacy*

More than half of participants agreed or strongly agreed that there is a lack of opportunities for paediatric RNs to promote health literacy for children and young people. Therefore, they may understand it is their role but they also consider they do not have the possibility to implement this role. The participants stated that there is a lack of resources available for paediatric RNs to create opportunities for helping children, young people and their families to improve their health and health literacy. The accessibility to resources and sufficient time is not always available for paediatric RNs. Comments that accompanied participants' responses to statement 19 were:

> Busy schedules. Too many clients. Not enough time. Limited opportunities.
>
> *(D2, Participant 12, Q19 comment)*

> Lack of peer support, time and financial resources place constraints on nurses through all aspects of health care. These negative impacts would affect the opportunities to promote health literacy.

*(D2, Participant 26, Q19 comment)*

Summary of the findings of the Delphi Survey: Round 2 are presented in *Table 15* below.

**Table 15** Summary of the findings of the second Delphi Survey

| Based on Delphi Survey 1 and critical review of literature statements for Delphi Survey 2 focussed on: | Responsibilities of paediatric RNs | Possibilities in relation to health literacy |
|---|---|---|
| **Descriptive Data** | Statement numbers: 1, 2, 3, 6, 7, 10, 12, 14, 15, 16, 18, 20, 21, 22 and 23 | Statement numbers: 4, 5, 8, 9, 11, 13, 17 and 19 |
| **Findings** | There is a consensus between paediatric RNs that they have a professional responsibility for health promotion and health education.<br>There is no consensus that paediatric RNs are the only source to enable a child and young person to be health literate.<br>There is no consensus that paediatric RNs have a professional responsibility to undertake research on health literacy. | There is no consensus between paediatric RNs in relation to creating opportunities for promoting health literacy. |

The findings from the second Delphi Survey reflected a consensus amongst paediatric RNs that health education was considered one of their professional responsibilities. They did not achieve consensus that undertaking research was one of their professional responsibilities. With regard to creating suitable opportunities for promoting health literacy for children, young people and their families, the participants also did not achieve consensus. To summarise, the main summative themes identified in light of the findings of the focused review of literature, the first and second Delphi Survey are:

- Paediatric RNs do identify with the complexities inherent in enabling a child or young person to be health literate;
- Influencing this complexity, paediatric RNs include the communication opportunities and resources available to them; and
- Paediatric RNs recognise the concept that health education may be a significant issue in understanding how they view health literacy.

In order to explore how paediatric RNs understand the concept of health education and its relationship to health literacy and their views about how these concepts influence their roles, I undertook a focus group discussion with volunteer paediatric RNs from a child and youth hospital.

## Focus group findings

Following detailed reading of the transcript I re-examined the content and categorised the data line-by-line, sentence-by-sentence and paragraph-by-paragraph. Recurrent statements were categorised whether they were simply a word, a phrase, a sentence or a whole paragraph. These statements were written in the margin next to the data. When the transcript had been fully analysed I identified recurrent statements that were then transferred onto a separate sheet paper.

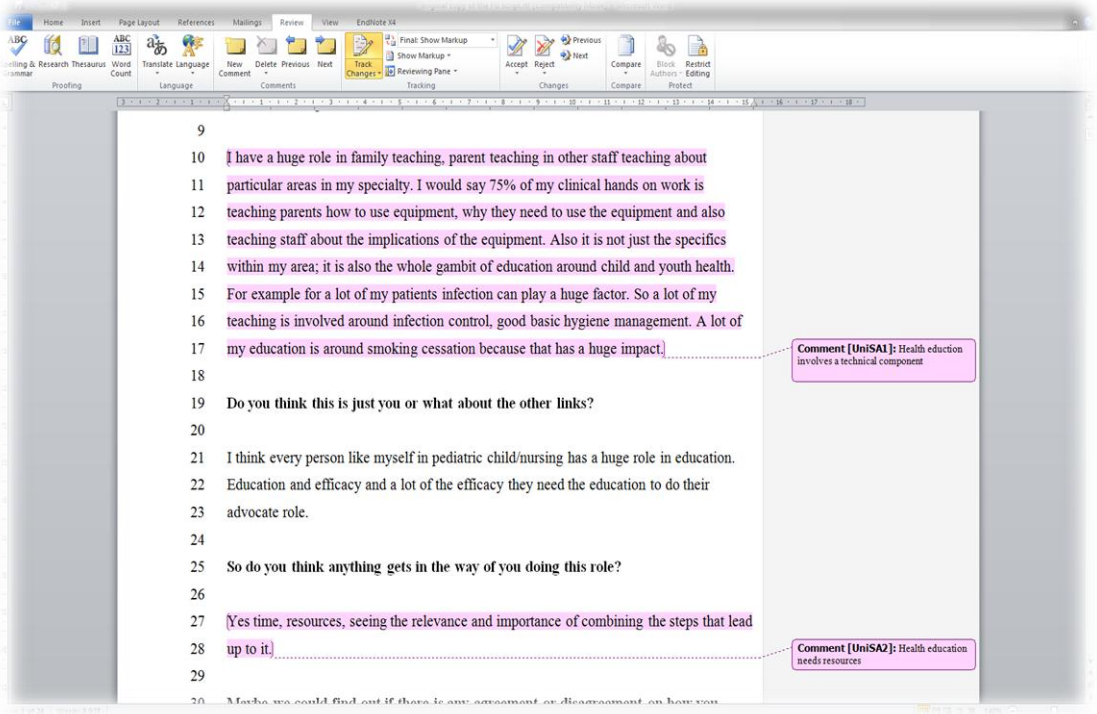



**Figure 10** Example of the Focus Group transcript preliminary analysis

I then examined all recurring statements and clustered together those that were similar. Recurrent themes then emerged. The themes that emerged from the focus group interview were:

- Health literacy is more than health education;
- Health education involves a technical component;
- Health education – messages/information must be consistent not different whoever delivers health education;
- Health education needs resources;

- Experience is needed to provide health education;
- Health education is about creating and ensuring appropriate communication opportunities with different audiences – knowing how to and why;
- Health education as fundamental in every paediatric RN's role especially in paediatrics;
- Spaces for nursing (and health education) are needed by paediatric RNs in the system;
- Recognising is different to doing;
- Paediatric RNs are responsible for promoting appropriately resourced health education;
- Individual responsibility of paediatric RNs to empower themselves; and
- Health education involves paediatric RNs as role models.

Finally, summative themes and research findings were developed and elaborated in *Table 16* below

**Table 16** Summary of the focus group findings

| Summative themes | Health education as part of health literacy | Putting boundaries around what is health literacy | The imperative of paediatric RNs being effective in health education |
|---|---|---|---|
| Themes | Health literacy is more than health education and health promotion | Health education needs resources | Recognising is different to doing |
| | Health education involves a technical component | Needing experience to do health education | Paediatric RNs as responsible for promoting appropriately resourced health education |
| | Health education – messages/information must be consistent not different whoever delivers health education | Health education is about creating and ensuring appropriate communication opportunities with different audiences – knowing how to and why | Individual responsibility of paediatric RNs to empower themselves |
| | | Health education as fundamental in every paediatric RN's role especially in paediatrics | Health education involves paediatric RNs as role models |
| | | Spaces for nursing (and health education) needed by paediatric RNs in the system | |

## In summary

This chapter contributes to describing the context in which health education and health literacy is portrayed to and by paediatric RNs in Australia and in identifying the recurring themes related to the health education role of nurses and nursing working with children and young people in relation to health literacy. Findings from the document analysis, Delphi

Surveys: Round 1 & 2 and focus group discussion add density and richness of data collected. Paediatric RNs do identify with the complexities inherent in enabling a child or young person to be health literate and influencing this complexity, paediatric RNs include the communication opportunities and resources available to them. 'Health education as part of health literacy', 'Putting boundaries around what is health literacy', and 'The imperative of paediatric RNs being effective in health education' emerge as significant themes and inform what I discuss in *Chapters 6* and *7* applying a critical lens.

As I explained in *Chapter 3*, I detail my critical findings within Habermas's two significant theoretical constructs: knowledge-constitutive interests and communicative action. These provided the theoretical lens to discuss my findings – Stage 3 of my research 'applying a critical lens'. In *Chapter 6*, I provide a perspective on what constitutes nursing interests and how these interests influence actions of nurses in relation to health education and in turn the implications for children and young people being health literate. In *Chapter 7*, I focus on a critical discussion related to paediatric RNs opening up communicative spaces.

# 6 The influence of nursing interests

## Introduction

In this chapter I provide an analysis of what constitutes nursing interests and how these interests influence actions of nurses, specifically health education practices, and in turn the potential influence of nursing interests on the health literacy of children and young people. This chapter is informed by Delphi Survey findings, literature reviewed, document analysis findings and the focus group themes: 'health education as part of health literacy' and 'the imperative of paediatric RNs being effective in health education'.

## Putting in place specific actions based on 'the right knowledge' at the 'right time' in 'the right way'

Nurses have written about the knowledge used by nurses. For example Hall (2005) maintains that nursing knowledge has developed to become more multifaceted and focused and therefore is continuously developing.

Participants did achieve consensus that paediatric RNs have a professional responsibility toward improving children's and young people's access to evidenced based information, improving how these children and young people learn to navigate the health care system, as well as evaluating whether parents/guardians of children or young people with whom they interact are health literate. Nurses' actions may be influenced by their perceptions of what is or what is not a priority. Whether it is or is not a priority in health policy it is important to explore if nursing, through a focus on nurses' actions/views, is to place health education practices to promote health literacy as a priority. Participants did not believe health literacy was a priority in health policy as evidenced by one of only two areas where nurses had not achieved consensus in the Delphi Survey.

In Delphi Survey round 1, Question 4, 44.1% of the participants disagreed or strongly disagreed that health literacy is a priority focus in health policy:

> I am not sure that it is a priority, but if it isn't, it should be.
>
> *(D1, Participant 19, Q4 comment)*

> Am not convinced it is included in health policy as highly prioritised as it could be.
>
> *(D1, Participant 22, Q4 comment)*

Nearly half of the participants were unsure if health literacy is a priority focus in health policy. While nurses may not view health literacy as a priority focus in health policy, this does not mean that nurses do not view health literacy as a nursing priority.

As reflected in my findings, determining what information is 'right' and when may be 'the right time' and 'the right way' to provide this information to children and young people is an interest of participants. The definition of a technical interest is recalled from *Chapter 3.* A technical cognitive interest, according to Habermas, is an interest in knowledge seeking as a causative understanding of events. Indicators of a technical cognitive interest are:

- The importance placed on finding the 'right solutions'.
- A need for control.
- A reliance on evidence, facts or other 'scientific' data.

As findings displayed in *Chapter 5* highlight, there was a consensus among participants of the perceived importance of health literacy and what they considered health literacy is and could achieve. The following examples are brought forward here as exemplars of this consensus:

> 97.0% of the Delphi Survey round 1 participants agreed or strongly agreed that being health literate means more than being able to read pamphlets and successfully make appointments.
>
> *(Table 8 in Chapter 5)*

> 97.0% of the Delphi Survey round 1 participants agreed or strongly agreed that being health literate may enable people to better manage their own health.
>
> *(Table 8 in Chapter 5)*

> 88.0% of the Delphi Survey round 1 participants agreed or strongly agreed that being health literate will enable children and young people to make informed health care decisions.
>
> *(Table 8 in Chapter 5)*

> 100% of the Delphi Survey round 1 participants agreed or strongly agreed that promoting health literacy should be an essential element of paediatric and child and youth nurse practice.
>
> *(Table 10 in Chapter 5)*

> 100% of the Delphi Survey round 1 participants agreed or strongly agreed that it is important for paediatric RNs to recognise health literacy problems experienced by children and young people.
>
> *(Table 10 in Chapter 5)*

> 100% of the Delphi Survey round 1 participants agreed or strongly agreed that educating children and young people about their health should be an essential part of nursing.
>
> *(Table 10 in Chapter 5)*

When reviewing written comments provided by Delphi Survey participants, their understanding of health literacy aligned to functional health literacy as identified by Nutbeam and highlighted in C*hapter 1*. Technical interests connect this understanding to functional health literacy. For example, in relation to seeking a causative understanding of events, one participant refers to 'families' needing specific knowledge:

> Families need to know about what is normal health so that they know when something is not right. They need to be educated about illness and how to maintain optimum health.
>
> *(D1, Participant 15, Q1 comment)*

With regard to the need for control, a participant refers to the matter of compliance required of children and young people as they age:

> Compliance becomes an issue as children grow older as they oppose 'expert' ideas of healthcare. It's important for them to understand their health needs and the services to avoid adverse health outcomes – to optimise their full potential in health and wellbeing as well as social and psychological aspects of life in the future.
>
> *(D1, Participant 26, Q2 comment)*

With regard to the reliance on evidence, facts or other 'scientific' data, another participant focuses on teaching moments in the use of equipment as a major part of their role:

> I would say 75% of my clinical hands on work is teaching parents how to use equipment, why they need to use the equipment and also teaching staff about the implications of the equipment. Also it is not just the specifics within my area; it is also the whole gambit of education around child and youth health. For example for a lot of my patients infection can play a huge factor. So a lot of my teaching is involved around infection control, good basic hygiene management. A lot of my education is around smoking cessation because that has a huge impact.
>
> *(FG, P1, L11-L17)*

Participants seem to hold the view that correct and necessary information exists or what is said to be best practice is available to them to inform their actions, i.e. a form of technical control. A focus group participant was asked if they would give different advice/ information to their clients than known dominant views:

> That is a hard one ethically.
>
> *(FG, P13, L378)*

And when I asked what this ethical issue was another focus group participant commented that:

> We use our standards whether they are best practice all the time I am not sure.
>
> *(FG, P13, L380)*

Participants also suggested that health literacy is more than reading and writing – it has an interactive component. As such, my findings suggest that participants are informed by different knowledge interests – both technical cognitive interest as well as a practical cognitive interest informing their actions. Recalling the definition from *Chapter 3* of practical cognitive interest, it is an interest in knowledge that is directed at interpretation and understanding. Indicators of a practical cognitive interest are:

- A lack of concern at losing control.
- A need for understanding and the importance of interpretation.
- Shared, collaborative and focused actions on mutual understanding and values.

Whether or not parents/guardians of children and young people in hospital have the capacity to 'process information' was an important consideration by participants. For example, participant #26, a nurse specialist, commented about the need for information but finding the right time for an interaction to provide this information was important.

> I work in a tertiary children's hospital where there are many time constraints to health education and advice. Parents are often anxious and stressed during their child's admission and are not able to process information given, especially if it doesn't relate directly to their child's immediate health needs.
>
> *(D1, Participant 26, Q27 comment)*

From participant #24 ensuring nurses provided resources for use beyond her/his contact was important:

> It is important for child, youth and paediatric nurses to provide accurate information and alert their clients to appropriate well informed resources to improve their health.
>
> *(D2, Participant 24, Q3 comment)*

Focus group participants also portrayed a need for understanding and creating a shared, collaborative context at the right time in the right place by the right people; that is actions influenced by technical and practical interests at the same time:

> In Oncology a lot of nurses were afraid like I was to come and work in the area and we thought what can we do because I was a strict boss. What can we do to give confidence to nurses? So one of the girls had just had a baby and we said look the mums come in and we teach them how to bathe baby, hold baby; it is all through demonstration. So what can we do with regard to education of patients and families to give confidence to nurses? So what we decided was we had a sign in all the parent's rooms on the ward; what topic would they like to discuss in the coffee morning. We had a very experienced nurse on the ward and then a rotation of junior nurses and we would take a topic like mouth care, managing fevers at home and give the nurses a roster and say next month we would like you to talk about fevers with children and mums and dads. They could look up as we had educational resources about fevers and they could go through with their mentor or senior nurse and then go in and talk. But again they were lacking confidence in thinking will they say it right so the other person was there not to say it, but if there were any questions like the parents asking something that was a bit curly, the senior nurse was there to provide back up. We did not want there to be a senior/junior feeling and we wanted the inexperienced nurse to be prepared to provide the education and gain confidence in doing that. What we were trying to do was stop that variation in practice which confuses patients and families, to make sure we were giving consistent information.
>
> *(FG, P5, L133-L151)*

> The other thing is we got a grant that most university people would be envious of, we got this brilliant grant and that was to educate rural people about caring for kids with cancer when they go home. That was all about increasing health literacy; not only of the parents, but health professionals themselves because a place like this has so many specialities and that is where you can challenge it. We should be giving out the information so they can be looked after in rural centres.
>
> *(FG, P18, L526-L533)*

Offering health education in the context of the workplace, different participants did offer different perspectives. Health education was the other area (only two) where nurses had not achieved consensus in the Delphi Survey round 1, Question 27: 47.0% of the participants agreed or strongly agreed that there is little or no time for health education in current health settings.

Participant #27, a nurse specialist, said:

> Limited time. Use the time to the best of your ability.
>
> *(D1, Participant 27, Q27 comment)*

Whereas participant #31 who is a senior lecturer said:

> Health 'education' can be a five minute chat at the bedside at the 'teachable moment'.
>
> *(D1, Participant 31, Q27 comment)*

A focus group participant highlighted that creating opportunities for health education should be at all levels not only limited to tertiary or bedside level:

> I think picking up on your point though, it is very important that the bedside nurses aren't disempowered, that they do feel comfortable educating even though we have those specialist people around. Because at 10 pm when the mum has a question, it is always after-hours when they have the most questions, so the level one nurse at the bedside must be able to provide that information.
>
> *(FG, P21, L622-L626)*

Another participant pointed out that it is not always possible to educate a child and depends on the severity of the child's condition, his/hers' and the family's mode and ability to receive health messages at the time. As a focus group participant stated:

> Talking about the time I think there is a flip side to that coin. An example is with regard to asthma where it is not the most appropriate time to teach somebody when they are feeling lousy. The family is disrupted because they are in hospital and they have to collect the other kids from school. Who is going to do the dinner, shopping and so on? If you think about concentration and focus and what is an ideal learning environment. I think that it is an opportunity to make some messages, but I think it is really important to tailor those messages.
>
> *(FG, P13, L393-L399)*

Participants also reflected that it was not the sole responsibility of nurses to promote health literacy suggesting a keenness to ensure health literacy is achieved but at the right time by the right person. For example:

> While paediatric and child and youth health RNs are more than capable of promoting health literacy – to isolate health education to this group alone limits many possibilities ... extent of reach (are there paediatric and child and youth health RNs in ALL communities? – no) ... types of promotion - most children and young people health workers have limitations on how they operate - other community workers may not be so limited... It is VERY possible to employ other educated people to assist in promoting health literacy - for example, teenagers with melanoma, or those who have survived cancer, car accidents, drug overdoses etc. have been enormously successful in encouraging others to consider the health risks they are taking – this is an EXCELLENT peer education technique - and reaches an age group that would not normally take a minute to listen to a nurse.
>
> *(D1, Participant 12, Q20 comment)*

Brown and Piper (1995) suggested, many years ago, that nurses in their health education role tend to 'paternally' preselect the definite behavioural outcomes that they consider are suitable for the client and try to persuade the client towards an anticipated reaction. Relating this to health literacy suggests that Brown and Piper may be of the view that nurses do not approach their health education role from a critical health literacy perspective. Behavioural outcomes referred to by Brown and Piper would be influenced by the specific knowledge constitutive interests held by nurses that produce what actions are implemented by nurses.

Influencing the health literacy of children and young people will depend on how paediatric RNs, as individuals, practice within an institutional space and how they self-reflect. Reflection is defined as '... a process of consciously examining what has occurred in terms of thoughts, feelings and actions against underlying beliefs, assumptions and knowledge as well as against a backdrop (i.e. the context or stage) in which specific practice has occurred' (Kim 1999, p. 1207). Reflection comprises of both emancipation of oneself from self-deception, and emancipation of participants (in the case of nurses and their children and young clients) from misapprehension and hiding towards mutual understanding about aims and intents. In other words, and in accordance with Habermas, reflection begins with worlds and ends with the self.

In terms of this research study 85% of the Delphi Survey round 1 participants agreed or strongly agreed that health education, which includes health literacy, should be provided by paediatric RNs (*Table 11* in *Chapter 5*). All nurses are responsible for health education as reflected in Australia within the National Competency Standards for the Registered Nurse (Nursing and Midwifery Board of Australia 2013):

> 7.7 Educates individuals/groups to promote independence and control over their health

- identifies and documents specific educational requirements and requests of individuals/groups.
- undertakes formal and informal education sessions with individuals/groups as necessary.
- identifies appropriate educational resources, including other health professionals.

(Australian Nursing and Midwifery Council 2006)

The expectation of nurses who are registered in Australia is that they are competent. Paediatric RNs and they take responsibility for their actions (Nursing and Midwifery Board of Australia 2013). Although participants have different views with regard to health education, they did agree that health literacy development should be an integral component of health promotion for children and young people (*Table 11* in *Chapter 5*). This agreement is also reflected in their written comments:

> Health promotion concepts cannot be understood without a level of health literacy.
>
> *(D1, Participant 11, Q19 comment)*

> Health in western medicine is a complex, massive issue. It requires the development of a conceptual understanding – there is more to it (if it is meaningful) than learning to wash your hands. What do glycaemic index levels mean?
>
> *(D1, Participant 17, Q19 comment)*

> Refer to question 4. This topic should be a mandatory part of the school curricula and School Nurses/Public Health Nurses should support School Teachers, who have had health literacy training in the delivering of the topic.
>
> *(D1, Participant 28, Q19 comment)*

Participants also achieved consensus (97%) in relation to whether nursing and midwifery curricula and/or staff development should address health literacy. Their written comments though focus attention on issues within current nursing curricula. For example:

> The trouble is that our curricula are overcrowded and everything is important and everything vies for attention. And there is little to be gained from surface learning. We have some - not enough on client and family education.
>
> *(D1, Participant 34, Q25 comment)*

Results from my document analysis of university undergraduate and postgraduate nursing curricula documents for RNs has revealed there is no specific or obvious profiling of health literacy as a specific topic/course in nursing curricula. This is the same for health education. Participants were of the view that these foci were important:

> Opportunities to influence health outcomes and behaviours is fundamental to the role of nurses.
>
> *(D1, Participant 22, Q23 comment)*

> Childhood/adolescence is a window of opportunity for healthy behaviours to be established. Even at an older age adapting behaviours to promote one's health and wellbeing is vital for health in later years.
>
> *(D1, Participant 26, Q3 comment)*

> Health education can be provided by all nurses and midwives.
>
> *(D1, Participant 21, Q19 comment)*

> The health and wellbeing of children should be the priority of all communities and nations. To do that, there should be policies in place at international, national and local level based on health literacy being an integral part of health care.
>
> *(D1, Participant 26, Q19 comment)*

> Health education/promotion should be a priority for health professionals. It is also the domain of education and sporting groups to engage and challenge young people in changing/improving their behaviours – to optimise health and wellbeing
>
> *(D1, Participant 26, Q20 comment).*

Since my research, Macabasco-O'Connell and Fry-Bowers (2011) have argued that nursing professionals' knowledge of health literacy and their understanding of the role health education on health literacy and client health outcomes is limited. Macabasco-O'Connell and Fry-Bowers (2011) argued that nursing plays a significant role in direct client care and in the delivery of health services. Educating nurses about health education to promote health literacy and enhancing client communication and understanding can improve health outcomes.

My review of undergraduate and postgraduate nursing programs provides a perspective about health education and health literacy as privileged knowledge. As Habermas states, knowledge can never be designated as unbiased, objective or neutral and that different kinds of knowledge are shaped by the particular human interest they serve (Habermas 1972). This review of publicly available nursing programs describes the context in which nurses have an opportunity to privilege health education practices to promote health literacy. Referring to the document analysis, health education did not have high visibility in undergraduate curricula when compared to postgraduate curricula. However, health literacy has hardly any visibility in both undergraduate and postgraduate nursing curricula.

Understandings that nurses form through nursing education are usually affected by ideologies that in turn affect their everyday practice, which are guided by certain interests. Many years ago Grundy (1987) argued that an obsession with knowledge derived from the practical interest is the very value that distinguishes a professional from a craftsperson. While a craftsperson acts upon objects, and is henceforth involved in technical interests, the professional interacts and communicates with subjects and is henceforth involved in knowledge of a practical nature (Grundy 1987). Interaction and communication is not only between the nurse and people receiving nursing, but similarly between nurses themselves, with a shared interpretation of what establishes nursing as a profession. Nurses as professionals need an ability to learn about health education practices and how to recognise, interpret and comprehend situations to implement appropriate services to/for a client.

Whitehead (2008) conducted an international Delphi Study examining health promotion and health education in nursing practice, education and policy. Whitehead's research aimed to arrive at an expert consensus in relation to health promotion and health education constructs as they apply to nursing practice, education and policy. Whitehead (2008) reported that an expert consensus emerged around the matters of defining health promotion and health education and the emergence of a wider health promotion and health education role for nursing. However, no consensus was reached on only one of the 13 identified topic categories - that of 'nurses working with other disciplines and agencies in a health education and health promotion role'.

Nurses with a practical cognitive interest recognise the limitations of their own knowledge or that of others regarding health education and health literacy, and the value of others in facilitating dialogue in these unfamiliar arenas. The following extract demonstrates this aspect of a practical interest in a participant response:

> While parents and peer groups will influence a child's health choices; child, youth nurses can provide alternative viewpoints and information. Children who recognise that there are other choices may just follow the road of others, but may also choose otherwise.
>
> *(D2, Participant 12, Q10 comment)*

For nurses, technical cognitive interest is allied with task-related skills, such as clinical procedures. Consequently, technical reflection engages empirical knowledge, rationality, the scientific method, critical thinking and problem solving. Practical cognitive interest, however, entails human interaction, or communicative action, connecting to mutual

prospects about behaviour as defined and understood by the people involved. In nursing, communicative action renders into something as recognisable as the communication models that are set up by nurses and the people with whom they interact.

As has been discussed, I argue that paediatric RNs as participants constitute nursing interests as knowledge cognitive interests. In the next section I discuss the influence of this on their practice.

## The influence of nursing interests

Dunne (1993) says that in his later writings Habermas realised that technical reason, practical reason and critique cannot be strictly compartmentalised, rather that they keep 'criss-crossing' each other. When reviewing nursing related literature my view is that nurses for a long time have been aware of technical and practical cognitive interests influencing nursing. Nursing has often been referred to as a science and an art. For example Peplau (1988) stated that the concepts science and art are important for the practice of nursing. These two concepts have an exacting implication and their essential distinctiveness assists with revealing the nature of nursing practice. A consideration of each concept is fundamental to the understanding of similarities and dissimilarities and to a comprehension of the composite relation played out in nursing (Peplau 1988).

Darbyshire (1999) argues that the claim that nursing is an art as well as a science is not new as Florence Nightingale (1967) stated famously:

> Nursing is an art, and if it is to be made an art, it requires an exclusive devotion, as hard a preparation, as any painter's or sculptor's work; for what is the having to do with dead canvas or cold marble, compared with having to do with the living body—the temple of God's spirit? It is one of the fine arts; I had almost said the finest of the Fine arts. (cited in Styles, Moccia & Evans 1993, p. 149)

Darbyshire (1999) also argues that science and technology are not essentially our opponents, either in our world at large or in health care. What is more hazardous, though, is the technological perceptive of being, which perceives everything in our world incorporating health-care staff and clients as being no more than a reserve to be utilised. As Dreyfus (1991) has illustrated: 'We experience everything, including ourselves as resources to be enhanced, transformed and ordered, simply for the sake of greater and greater efficiency' (1991, p. 202).

As Darbyshire (1999) has argued, an uncontrolled technical rationality creates a risk to nursing or any practice discipline since it can rapidly develop into a totalising and

enframing orthodoxy, a pattern to be squeezed down on top of all thought and practice until consistency is attained. This is what Ritzer (2011) has illustrated as 'The MacDonaldization of society'. One of the advantages of incorporating an arts and literature standpoint into nursing, Darbyshire (1999) argues, is that this embraces the likelihood of other types of knowledge and understandings for nursing.

Critical social theory, from Habermas's point of view, has as its chief aim the enhancement of the human condition. One significant supposition of critical social theory is that individuals can adjust their world, and more precisely, those within organisations have the competence to change organisational structures and cultures. Paediatric RNs organise the everyday practice of paediatric nursing. Participants seemingly recognised the need to serve the genuine interests of all, especially children and young people. However participants did not recount an ability to adjust or change their organisational context.

It is significant to recall from Habermas (1972) that the maintenance and reproduction of human knowledge alone is inadequate. Knowledge and action together establish the life structure of humanity. This is a vital point, for it means that neither knowledge nor action is adequate in itself to guarantee maintenance; both must cooperate in performance for the welfare of humanity. Even though Habermas has highlighted the role that those interests play in creating knowledge, they are also 'action-constitutive' interests (Habermas 1972, p. 211). This is significant when we contemplate nursing health education and health literacy practices as a socially constructed function of the life structure of a society. Both knowledge and action as they interact in everyday nursing practice in health education and health literacy are determined by a particular cognitive interest.

Interaction is as Habermas describes:

> By interaction…I understand Communicative action, symbolic interaction. It is governed by binding consensual norms, which define reciprocal expectations of behaviour, and which must be understood and recognised by at least two acting subjects. (Habermas 1971, p. 92)

Interaction is not considered action upon an environment that has been objectified; it is action with the environment (organic or human), which is regarded as a subject in the interaction. Likewise, the knowledge that directs such action is subjective, not objective. This is what Habermas articulates, that access to the truth is provided by understanding of meaning, not observation. While such knowledge is subjective, this does not necessarily mean that it is arbitrary. The practical interest, consequently, is the interest that produces

subjective instead of objective knowledge. In short, this is of vital interest in understanding the environment via an interface based on a consensual interpretation of meaning.

The vital notions related to the practical cognitive interest are understanding and interaction. Contemplating the inferences of a practical interest for nursing practice, these same concepts are central. Nursing in health education and health literacy, informed by practical interest, is not a means to an end practice by which a secure outcome for the child and young person is produced through the action of nurse upon a parent/guardian. Instead, it is regarded as a process whereby worker and parent/guardian interact to impute meaning to the world. It follows from the moral imperative linked with the practical interests that nursing informed by such an interest will be concerned, not simply with promoting child and young person health education, but also with promoting appropriate action to increase health literacy. Habermas claims that the connection between understanding an action is a hermeneutic notion of application (Gadamer 1989). Application is not, though, an elective connection between understanding and action because paediatric RNs do not just act as a result of applying understanding gained from one circumstances to another. Paediatric RNs cannot completely understand any given circumstance without applying it to themselves:

> Hermeneutic knowledge is always mediated through this pre-understanding, which is derived from the interpreter's initial situation. The world of traditional meaning discloses itself to the interpreter only to the extent that his (sic) own world becomes clarified at the same time. The subject of understanding establishes communication between both worlds. He (sic) comprehends the substantive content of tradition by *applying* tradition to himself (sic) and his (sic) situation. (Habermas 1972, pp. 309-310)

It is significant to understand that interests can be stimulated by principles of reason. Hence, interests inspired by reason are more acceptable than interests that are inspired by a desire.

It has been reported by Dewey (1916) that when an action takes place without reflection, when it is impulsive, then there is nothing in the experience to link it to any previous activity of an individual. Dewey (1902) also cautioned regarding the seductive relief and risk of routine action without reflection when he said:

> Familiarity breeds contempt, but it also breeds something like affection. We get used to the chains we wear and miss them when removed…because meaningless activities may get agreeable if long enough persisted in. (Dewey 1902, p. 481)

Likewise, Habermas (1972, p. 310) acknowledges the significance of identifying overriding ideologies that are liable to be uncritically accepted and are entrenched in everyday conditions and practices. Such ideologies turn into a part of language, social

habits and cultural norms and they legitimise certain social structures and practices so that they are recognised as normal (Brookfield 1995, p. 87).

Paediatric RNs, regardless of the setting in which they work, have a multiplicity of roles and responsibilities. As nurses they are legislated to perform nursing (Nursing and Midwifery Board of Australia 2013). As employees they are subject to organisational rules and resources that influence them. Paediatric RNs are both employees and professionals who are responsible for advancing nursing. How nursing is understood by a paediatric RN will be informed by the knowledge constitutive interests that a nurse privileges. A paediatric RN might think that an institution, or the organisational heads of an institution, have control over nursing activities yet this would stand in conflict with the professional responsibilities of a paediatric RN. A nurse may be an employee, but as an RN a nurse is legislated as responsible and accountable for their own actions and the knowledge informing these actions. If an employer-employee contract informs the actions of nurses such that the organisational interests override professional interests, then organisational interests become nursing interests. Therefore a specific ideology informed by institutional factors that shape their interpretation of reality and behaviour can direct what are considered the right actions to be implemented, at what is deemed to be the right time, and can be used to justify and legitimate actions implemented (Mezirow 1981). Participants seemed to be aware of forces/circumstances that act on them in their role. Like Habermas states, the consequence of the colonisation of the lifeworld by the systems is that individuals and groups increasingly recognise themselves and their ambitions in system terms (Habermas 1987a).

I have argued in *Chapter 3* that a critically informed paediatric RN is one who is conscious of restraints on their efforts in their work with children and young people, as well as their parents/guardians, to become health literate. They also have access to different viewpoints for considering their role and look for substitute methods to work with children and young people to help them make healthy choices. The majority of nurses practice nursing within a hospital or institutional setting (Whitehead 2005). RN competencies position health education as an integral part of the RN role (Nursing and Midwifery Board of Australia 2013). Recurrent themes from my findings highlight that paediatric RNs do identify the complexities inherent in enabling children and young people to be health literate and this includes the communication opportunities and resources available to a paediatric RN. A focus on practical interests by paediatric RNs may be favoured by them to enable the

opportunity for opening up communicative spaces with children, young people and their parents/guardians.

## In summary

Participants designated as experts on the one hand seem to appreciate the complexity of health literacy. On the other hand they elaborate the difficulties in creating opportunities to implement health education practices for children and young people to have an influence on health literacy. Technical and practical knowledge constitutive interests of participants connect their knowledge about health education to promote health literacy to their actions. Connecting technical and practical knowledge constitutive interests to nurses' knowledge and their actions is not new (see for example the range of authors acknowledging this: Hartrick 1997a & b; Holmes and Warelow 2000; Cody and Mitchell 2002; Manley and McCormack 2003; and, Taylor 2004). Taking the position that 'nursing' informs the actions of nurses then technical and practical *nursing interests* act as an ideological commitment as to how to address a focus, such as health literacy through health education practices implemented. These technical and practical *nursing interests* are the conditions that shape, limit and determine nurses' actions in relation to health education practices to promote health literacy. In turn, these interests can be explored to look for ways to progress nursing and nursing's contributions to improving the health literacy of children and young people to improve their health outcomes.

I accept that there are different understandings and viewpoints nurses can adopt to influence those health education practices they implement to promote health literacy. Understanding these influences, I argue, is critical in exploring what shapes nurses' actions and I offer one perspective, commenting on possible consequences to nursing's contribution to the development of a health literate child or young person. As Whitehead (2001) has argued, if nurses perform within reductionist and biomedical agendas, they will limit the scope of nursing and nursing's contribution to health care outcomes. Through an exploration of ideological influences on nursing interests my hope is to enable nurses to reconsider those conditions that shape, limit or determine their actions and those actions that they may need to take to intervene in a positive way in the lives of children and young people. Liberating nurses from the false ideologies that may surround them necessitates that nurses understand themselves in a new way. Understanding their own responsibility in how they create opportunities to influence the health of children and young people requires

nurses to learn how to open different communicative spaces. This is the focus of my next chapter.

# 7 Opening up communicative spaces

## Introduction

In this chapter, I provide a perspective on health education as communicative action. Drawing from study findings and using Habermas's theory of communicative action (1984, 1987a) I discuss how paediatric RNs come to understand what communicative practices are possible in their role and what specific possibilities in relation to health education to promote health literacy are created as a consequence. As described in *Chapter 5*, participants agreed that paediatric RNs have a professional responsibility regarding improving access to and delivery of information, viewing health education as a long-term commitment requiring active engagement with evaluation, education and governance activities. Engaging in these activities requires that paediatric RNs to actively create what Habermas (1984) refers to as 'communicative spaces'; in this context, creating opportunities for engaging with and providing health education to children and young people.

## Creating communicative spaces for health education

According to Habermas' theoretical framework, paediatric RNs create communicative spaces through their actions to create the potential for health education and in turn the promotion of health literacy. Whitehead (2004) identified several functions of health education, including imparting health related information that influences values, beliefs, attitudes and motivations, achieving health- or illness-related learning through knowledge acquisition, assimilation and dissemination, and leading to skills development and lifestyle/behaviour modification. Being attentive to opportunities to provide health education is therefore important, and has been emphasised by many nurses for many years (see for example Appleton 1993; Bottorff & Varcoe 1995; Norton 1998; Whitehead 2004).

In the current study, participants achieved consensus that it is within the ability of paediatric RNs to create communicative opportunities for health education:

> 88.0% of the Delphi Survey round 2 participants agreed or strongly agreed that a paediatric RN can create the appropriate opportunities for children and young people to learn about being health literate.
>
> *(Table 14 in Chapter 5)*

> This should be an integral part of the nurses' practice. I believe it is not appropriate to just tell people about healthy living. The outcomes will be better if people are encouraged to be actively involved in making healthy choices.
>
> *(D2, Participant 31, Q4 comment)*

> 97.0% of the Delphi Survey round 2 participants agreed or strongly agreed that a paediatric RN can create the appropriate opportunities for children and young people and their parents/guardians to understand how to make healthy choices in their everyday lives.
>
> *(Table 14 in Chapter 5)*

In the Focus Group some 'how' elements in creating communicative opportunities emerged:

> I think there is a huge array, that is why I think paediatric nursing is just the best because you talk to neonates and prem babies 'I am just going to lift your arm darling' and then you talk to an 18 year old and say 'hey dude do that again and I will murder you'. So I think we adapt, you may have children that can't speak or can't hear. I think most paediatric nurses are children themselves, we come up with very creative ways to play, communicate with a child through art, through music. I think there are lots of different means of communicating with patients.
>
> *(FG, P3, L79-L85)*

In contrast, a number of written comments provided by some participants argued that the ability of paediatric RNs to create communicative opportunities for health education depends on internal factors, such as the settings where they practice, time and resources available for them:

> It depends on the setting in which the paediatric and child and youth health RN operates. They cannot teach literacy skills or be responsible for the education level of their clients, but they can help them to access appropriate information and help them to interpret that information. But some settings do not provide time or access to environments in which the nurse can create these learning opportunities.
>
> *(D2, Participant 24, Q4 comment)*

> If appropriate support (practical), time and resources are directed to their learning as a priority. Health literacy will ease the burden of ill health in adulthood as healthy choices will be more likely followed.
>
> *(D2, Participant 26, Q4 comment)*

In the Delphi Survey round 2, 3.0% of participants disagreed or strongly disagreed and 9.0% of them were unsure that a paediatric RN could create the appropriate opportunities for children and young people to learn about being health literate (*Table 14* in *Chapter 5*). Written comments acknowledged that opportunities existed:

> Opportunity there, not the time.
>
> *(D2, Participant 18, Q19 comment)*

> An opportunity exists in every encounter with a client.
>
> *(D2, Participant 31, Q19 comment)*

Focus Group discussions also highlighted that opportunities existed:

> I think fundamentally it is a real privilege to be a paediatric nurse and I think that education and how to communicate with the child because it is not just our patient, the patient is the core but we have the siblings, parents.
>
> *(FG, P2, L48-L50)*

> I also think that paediatric nurses do a lot of translation work – from physicians to parents or from parents to siblings or in amongst the family, they can see different scenarios and they transition and they assist and help. I think we communicate and educate on many levels and I think the most important thing is that it actually comes; it is not necessarily something that we are taught, but something very fundamental in what we do.
>
> *(FG, P2, L57-L61)*

Focus group participants identified a number of difficulties and barriers they faced in creating and ensuring appropriate communication opportunities, such as the age of the child and young person, the presence of a disability of some sort and the fact that children, young people and their families belong to different cultural backgrounds with different languages and beliefs about health and sickness:

> I think we are always learning and fundamentally some of the difficulties I have had are maybe in culturally understanding, particularly some Aboriginal children that I have learnt so much from. Coming from really outback areas, who don't speak English, or maybe have a history of abuse and may be terrified and the hospital environment as it is so foreign and I don't understand their culture enough and am restricted within the boundaries of the hospital to create something that feels safe for them. So I think there are many challenges, but I don't think necessarily it is related to

> age, because I think fundamentally again that it is something we do if you have good training, you will go from medical to surgical.
>
> *(FG, P3, L85-L93)*

> But there is still a bit of a thing around what can I approach and what can I talk about and what is okay with the parent. I think that makes it really difficult for people.
>
> *(FG, P3, L179-L181)*

> But in saying that as part of the graduate program we do have education around disabilities and how to communicate not only with disabled children, but disabled parents as well, deaf parents, people like that.
>
> *(FG, P4, L108-L111)*

Focus group participant reflected a view about how hospital nurses' actions provide opportunities for information sharing with children, young people and their families, suggesting that the time when children are sick is the time to take any opportunity possible to teach them:

> I think it is learning the opportunities that you can utilise for doing education at the time. For example, giving a puffer and spacer, that is always an educational opportunity as you are doing it, you can be talking to them about cleaning it, talking to them about the medication itself, you can be talking to them about when to use it, not just blindly going up and doing it.
>
> *(FG, P12, L366-L370)*

> It is not utilising, yes people do like a piece of paper to take home but if you are repeatedly giving the same message at an opportunistic time they often don't refer to the piece of paper.
>
> *(FG, P13, L389-L391)*

Participants were asked to reflect on how they seek to overcome barriers to creating communication opportunities. Some participants focussed on their own education program, differentiating between elements missing from their undergraduate education that were included in their postgraduate studies. The focus group participants also considered that there was an advantage in waiting until a child or young person was sick before nurses provided them with health information. Some also mentioned communicating by touch:

> I think communication is something we do and I think the other thing is paediatric nurses are really good at communicating and educating without speech, by demonstration, touch, showing someone that baby is much more comfortable if you snuggle them this way. So I think there is a real nurturing experience that comes through education as well.

*(FG, P4, L94-L98)*

Others argued that children's and young people's choices regarding their health might be somewhat affected by their peers and/or the media:

> Children are of course faced with many pressures from peer groups, media etc - but well educated children are less likely to make choices that are unhealthy – education has been shown to have a powerful influence on decision making.
>
> *(D2, Participant 12, Q9 comment)*

> It is possible for children and young people to say 'no' but they may still be enforced by their peers or by role leaders in society (celebrities, sports people, etc) into making wrong choices.
>
> *(D2, Participant 26, Q9 comment)*

Participants did not achieve consensus regarding how children and young people learn about how to be healthy from their parents. Many (60.6%) of the Delphi Survey round 2 participants disagreed or strongly disagreed that children and young people learn to be healthy from parents (*Table 13* in *Chapter 5*). They argued that parents might not be good role models:

> Parents who are not clear or have no idea about being healthy will not do this.
>
> *(D2, Participant 14, Q10 comment)*

> Some parents do not act as good role models for their children, as seen by the high levels of obesity (poor dietary intake and lack of exercise). Young people often do not listen to their parents or will do the opposite of what their parents say - risk-taking behaviour.
>
> *(D2, Participant 26, Q10 comment)*

In Delphi Survey round 2, some participants suggested that nurses can be important role models for children and young people, creating opportunity for communication in this role, but that their own health literacy affects their capacity to offer effective health advice to children and young people. Participants also agreed that health education was an effective instrument of change in their work with children and young people:

> 81.2% of the Delphi Survey round 2 participants agreed or strongly agreed that paediatric RNs are important role models for children and young people.
>
> (*Table 14 in Chapter 5*)

> 81.8% of the Delphi Survey round 2 participants agreed or strongly agreed that paediatric RNs' ability to provide effective health advice to children and young people is influenced by their own health literacy.
>
> (*Table 14 in Chapter 5*)

> 94.0% of the Delphi Survey round 2 participants agreed or strongly agreed that the provision of health education is an instrument of change.
>
> (*Table 14 in Chapter 5*)

Participants who did not consider paediatric RNs as role models reflected on the age difference between the nurses and young clients:

> CHN nurses tend not to see themselves as role models. I suspect that young people do not see them as role models either. I also suspect that this is related often to the age gap between the nurses and the children they are working with, along with the fact that they are in irregular contact and do not feature prominently in the young person's life. I think we need to ensure that child health nurses working with teenagers need to be young, vibrant and be able to relate to the youth with whom they work - so the young people can relate back. Older CHN may be more appropriately working with parents and younger children.
>
> *(D2, Participant 12, Q17 comment)*

Irrespective of whether or not children and young people see paediatric RNs as role models, participants agreed that children and young people can understand health messages and make good and healthy choices in relation to their own health:

> 87.8% of the Delphi Survey round 2 participants agreed or strongly agreed that it is possible for children and young people to learn how to say no to unhealthy activities.
>
> *(Table 14 in Chapter 5)*

As such, it is important that nurses actively seek and create opportunities to communicate health education messages in ways appropriate to the capacity of the child and young person. Whilst participants agreed that nurses have a professional responsibility to children and young people to assist them in learning to navigate the healthcare system and evaluate the health literacy of parents/guardians, some written comments reflected different viewpoints regarding nurses' professional responsibility to teach children and young people to navigate the health care system:

> The potential problem with this is there are so many other groups which can interfere or contradict guidance given by paediatric nurses so it is difficult to categorically state we have a responsibility.
>
> *(D2, Participant 14, Q2 comment)*

> Again, this is not just their role – it is up to all health professionals and families. Child health nurses are primarily responsible for health, but will advise on this or make referrals during the course of their work.
>
> *(D2, Participant 24, Q2 comment)*

These comments suggest that some paediatric RNs may feel that they do not have a role in health education where specialist RNs are involved with caring for the same client. Yet health education is a shared responsibility between all health professionals and families.

Focus group participants expressed their concerns regarding paediatric RNs abdicating their health education, health promotion and health literacy to RNs who may have developed a specialty in these areas as the following extract shows:

> I worry about the specialist roles that are happening in nursing about disempowering the clinicians at the bedside, so that if you have the Hens? Nurse or AYA nurse or whatever I was really very conscious about disempowering the clinicians who were providing the primary information. Looking at the patients in silos rather than looking at the holistic approach for the family and the number of people coming through. So I think with this chronic disease management and care management of complex patients and somebody having key roles and being clear about that role will ensure that the bedside clinicians are empowered and have a very important role to play.
>
> *(FG, P20, L597-L604)*

> Absolutely and I am really concerned about the role of boundaries of specialists nurses because they provide really great, I have heard on many occasions because some nurses are not always very nice about other nurses, I wish there was more discharge planning or on the ward they did it or in oncology the day clinic could be given out by the ward, there is this competing, blaming thing that somebody else says – I will hand it on that is not my responsibility.
>
> *(FG, P21, L628-L633)*

> You can picture education nurses coming in, nurses will do the care and then you have a health educator, I have been to conferences about play therapists and whatever. There was this play therapist that would come around to each child with puppets and things to explain about the operation. It sounds gorgeous but what if she is sick who will tell them then, why does she get the resources.
>
> *(FG, P21, L639-L643)*

Participants from the focus group were also asked if they thought that the health promotion role of paediatric RNs diminished once there was a health promotion unit. The following extracts show some of their answers:

> I keep harping back to asthma but the commonest reason for children to come to hospital. I think as a paediatric nurse you should be able to do some basic asthma education. We have this great thing every winter when we have an overflowing surgical ward, come and do asthma education because we don't know how to do it. So

> what happens if you have a child who is in traction with asthma who happens to have symptoms, what do you do then – they call us?
>
> *(FG, P22, L658-L663)*

> I think we talk the talk but we don't walk the walk.
>
> *(FG, P22, L672)*

Some participants believed that some nurses abdicate the health promotion and health education role as tasks falling outside of their general nursing role due to the establishment of specialised units within the health system that take on that role. The relationship between paediatric RNs and specialist RNs from specialised units for health education, health promotion and health literacy is not clear. Norton (1998) many years ago raised a similar concern, citing research by Latter (1993) and Bradford and Winn (1997), suggesting that much of the health promotion work carried out by nurses is undertaken at specialist clinics that focus on particular diseases such as diabetes and asthma. This focusses attention on how nursing students are educated and whether changes have taken place since the challenge by Norton (1998) for nurses to consider whether they provide a health-promoting view in health education opportunities, questioning whether nurses were really involved in health promotion at the public policy level to empower people to make healthy choices about their lifestyle.

If paediatric RNs cannot evaluate a client's health literacy, they may assume that their clients have adequate understanding of the complex medical information that they are given (Safeer & Keenan 2005; Wallace, Rogers, Roskos, Holiday & Weiss 2006), and fail to actively create communicative spaces for health education. Whyte, Watson and McIntosh (2006) have argued that while nurses may be aware of occasions when it is appropriate to initiate a conversation about a health topic, many communications may not develop further than an assessment of a child's or young person's unhealthy habits. How nursing students are educated is therefore critically important to how they develop as nurses.

Zanchetta *et al.* (2012) explored nursing students' perceptions of structural, organisational, and political barriers to the promotion of health literacy in social and health care organisations. The authors found that students performed best as health promoters in supportive teaching hospitals, but that their performance was hindered by clinical settings unsupportive of health education, an absence of role models, and insufficient theoretical preparation for health teaching. This highlighted the barriers created by organisations that

may not appreciate the value of integrating health education into their organisational strategies and guidelines (Rootman, Kaszap, Frankish, Dupéré, Pederson & Rootman 2006). Furthermore, student sensitivity to their clients' multicultural diversity reinforced the connection between health literacy and other social determinants of health, calling for the education of future nurses to expand their role as health promoters (Zanchetta *et al*. 2012). While it is important that nursing students receive adequate preparation for creating communicative spaces to provide health education (Lolas 2002) and in their curricula they are provided opportunities to develop their skills and competencies as health literacy promoters (Zanchetta *et al*. 2012), my review of publicly available curricula documents does not portray a high profile being given to health education and health literacy.

Creating opportunities for providing health education and enabling children and young people to be health literate requires that nurses interact with children, young people and their parents/guardians in age-appropriate ways to assist them to learn how to make healthy decisions. For this to occur, all paediatric RNs in all settings would have to participate in age-appropriate negotiation with children, young people and their parents/guardians, and be aware of the ideological forces that would influence their provision of health education. This would require time and resources in addition to providing usual healthcare to clients. But while findings from participants suggest they may need additional time and resources to create effective communicative spaces, Habermas' interpretative framework also assists with how to open communicative spaces.

Habermas argues that the main issue for modern societies is not how order is sustained, but how to generate circumstances for what he calls communicative action -– action oriented towards mutual understanding. For Habermas, the analysis of society and its development begins with the idea that social action emphasises the intersubjective accomplishment of shared understanding. Action focused on obtaining a shared understanding is what Habermas calls 'communicative action'. It is a 'form of social action in which plans of actions of different actors are co-ordinated through an exchange of communicative acts, that is, through a use of language (or corresponding non-verbal expressions) oriented toward reaching understanding' (Habermas 1982, p. 234).

Habermas does not reject that persons contributing in communicative action have individual ends, but argues that to obtain a communicatively-produced agreement they must utilise language in such a way as to reach understanding (Habermas 1982, p. 237). The language is not of itself an action, but it offers the mechanism for the encouragement

of action. This distinguishes it from strategic action, which is concerned with success and is synchronised on the foundation of common interests (as in market circumstances or in bureaucratically structured activities). In strategic action, an individual impacts on the choices of another individual by 'sanctions or gratifications, force or money' (Habermas 1982, p. 269), seeking empirical over mutual understanding.

In relation to my study, this relates to how paediatric RNs in all settings not only sustain a role for themselves, but how they generate communicative actions that work towards ensuring mutual understanding about being healthy with children, young people and their parents/guardians. Habermas (1987a) relates the tasks of communicative action to structural nuclei of the lifeworld and their correlative reproduction processes. Habermas establishes a conceptualisation of the social matrix of lifeworlds, classifying three structural nuclei of the lifeworld – culture, society and person – which are sustained by three continuing and interrelating groups of processes – cultural reproduction, social integration and socialisation (see *Chapter 3*; Habermas 1987a).

Due to the progressive differentiation of modern societies (such as the different professional settings in which nurses are employed), it is possible that entire aspects of social life are directed by purposive-rational action and functional reason in preference to mutual understanding and consensus. As stated previously, there is evidence that a privileged focus is to the purposive-rational action of spreading specific health information in pursuit of functional health literacy. If, as Habermas proposes, individuals labour under the constraints of the systems in force without critically evaluating the negotiation of authentic personal agreement, nurses who perceive a need for more resources or time may only be engaging in purposive-rational actions, and not actively generating actions to ensure mutual understanding with children and young people about how to be healthy and to keep healthy.

It is important to highlight the focus on achieving work valued under the purposive-rational approach, because as Habermas argues, suspending mutual understanding and consensus comes at a cost. This cost may include the failure of paediatric RNs to implement health education practices in pursuit of promoting health literacy. Participants were asked their views in relation to paediatric RNs undertaking research into health literacy. Only 27.3% of the Delphi Survey round 2 participants disagreed or strongly disagreed that paediatric RNs have a professional responsibility to undertake research on health literacy (*Table 13* in *Chapter 5*):

> They don't all need to understand research but they do need to access, critique and apply research evidence.
>
> *(D2, Participant 13, Q18 comment)*

> Responsible for research in some area not always literate?
>
> *(D2, Participant 18, Q18 comment)*

A focus group participant suggested that some paediatric RNs might not identify with the term health literacy itself as an integrated part of their role:

> I don't think they identify with the word at all.
>
> *(FG, P18, L558-L559)*

> The word health literacy doesn't seem to resonate with people at the moment and it is really important. It is something to understand that it is beyond health promotion and health teaching, it is another area and it quite easily could be thought of as the new buzz word and it needs to be promoted more in our journals and whatever, have more articles about it. That transferring is a brilliant example.
>
> *(FG, PP22-23, L676-L681)*

My research highlights Norton's key concern that if the privileged focus by paediatric RNs is the management of illness, rather than ensuring children and young people are health literate, then the concept of health literacy is also not privileged. When applying a Habermasian lens, nurses may retain a focus on illness management because of workplace pressures and complexities surrounding health literacy. Holmes (2002) contended that some nurses are aware that their actions are determined for them – actions that may privilege a focus on illness management.

To facilitate health education practices, the relationship between nurses and clients must be seen as a partnership, rather than as the traditional hierarchical 'health care provider'—'health care receiver' relationship. It is significant that nurses create opportunities to provide information to clients. Creating opportunities is a dynamic and mutual process that permits nurses and clients to introduce topics important to the child or young person and share information that contributes to informed decision-making. It also requires that nurses be attentive to appropriate circumstances in which to discuss topics with children and young people, thereby creating an opportunity to educate (Appleton 1993; Bottorff & Varcoe 1995).

For Habermas, an effective communicative action is one in which a disparity is worked out by negotiation, where the best argument attains consensus without oppression, domination or manipulation (Habermas 1987a). Undistorted communication is communication in which all validity claims – whether what is said is true, justified and genuine – can be defended. Habermas calls this 'ideal speech situation', where there are no external constraints inhibiting participants from evaluating evidence and offering argument, and in which each participant has an equivalent and open chance for discussion. Paediatric RNs that embrace opportunities to implement health education practices to promote health literacy of children and young people would need to understand through research the language appropriate for different communicative opportunities. Though as Habermas indicates, language is frequently the conduit of struggle and power. His focus is to assist in working toward communicative action and self-reflection free from distortions and domination. Therefore, Habermas (1984) demands a constant exposure of unnecessary distortions in communication, for the constant consideration of unequal chances for discussion and argument, for constant criticism of dominant ideological principles and rationalisations.

## The possibility of generating communicative action

In this study, there was no consensus amongst participants in relation to creating opportunities for health education to promote health literacy. The findings showed that participant had put boundaries around their own actions. These boundaries were identified as limitations on promoting health literacy imposed on them by their workplace, with participants stating that health literacy and health education needs resources, experience and space within the nursing role.

Nursing undergraduate education programs, as I have elaborated, also offer a limited focus on health education and health literacy. Providers of undergraduate nursing programs are able to impose a specific type of structure on the dialogue involved, without having the accuracy of the dialogue challenged from within (Habermas 1984, 1987a). Nursing students are not in a position of power to challenge what is missing from their program of study unless they become of aware of this point via an external source. Consequently, by excluding or minimising a focus on health education and health literacy, nursing education programs place boundaries around the communicative actions in which RNs may engage. The current study revealed that the extent to which nursing undergraduate education programs prepare nursing students and future RNs to be able to provide health education to

promote health literacy is limited, but that postgraduate education opportunities better provide those skills. The question then is whether health education practices can be an expectation of all RNs.

Organisations in which nurses work and in which they have an employer-employee relationship also have the power to establish a perspective about the communicative actions possible by RNs in relation to health education to promote health literacy. The matter of legitimacy of an organisation encompasses the capability to institutionalise meaning structures not through a rationally resulting consensus, but via the obligation of claims to truth, rightness and sincerity that cannot be informally exchanged. Health education is about creating and ensuring appropriate communication opportunities with different audiences. Participants in this study accept health education as fundamental in every paediatric RN's role, but often they do not know how to create education opportunities and why. A hospital, for example, as a place of work for RNs has been shown to be an organisation that promotes a specific viewpoint and specific information, thus placing boundaries around what is possible for RNs to generate. Participants have also highlighted a privileging of specialist roles whereby all RNs do not take on a health education or health promotion role. Therefore, dependence for more health information, explanation and/or alternative health care for certain health conditions by a client or their carers will create systematically distorted communication if nurses, for example, choose not to inform or provide this type of information because of the ideological belief that they are limited by the organisation rules or they do not have enough time. Such a normatively constituted relationship can be seen by the dependent side as either problematic and in need of change, or else as simply the way things are as the natural structure of organisational behaviour.

These normative relationships are not simply the product of the interface between the different groups concerned, but are also the consequence of the structural features of organising. That is, the meaning structures that are developed by those participating come to have a value to them by virtue of the way in which they are established in material organisational behaviour. This behaviour, in consequence, is outlined by the meaning structures that offer a sense of organisational reality for those participating in communication. These structures, consequently, will affect the meaning organisational members have of clients. The idea of systematically distorted communication must therefore be considered not as a purely discursive phenomenon but as very much a material feature of the process of organising (Habermas 1984, 1987a).

A critical attitude to organisational culture therefore scrutinises the ways by which particular meaning structures come to be more persistent, extensively acknowledged and more legitimate than others. Also, a critical attitude to organisational culture aims to inspect the means by which conferred interests can possibly limit broad choices and therefore produce a false, instead of a rational consensus (Habermas 1984, 1987a).

Organisations, as sites of conferred interests, distort and restrain communication (as was demonstrated in *Chapter 3*) in such a way that those interests are sustained and reproduced. In such a context, the role of critical social theory as considered by Habermas (1972) is one of social reestablishment; that is, restoring of a rational consensus through the critique of systems of ideology and domination, accompanied by the self-reflection and self-formation that happens as an outcome of such critique. As some paediatric RNs have expressed as participants in this study, recognising the importance of creating and ensuring appropriate communication opportunities with different audiences is different to actually doing it. But, a competency requirement of RNs is that they can create effective communication opportunities.

In undertaking this analysis, my hope is that readers have been given insight to the capacity of nurses and nursing to identify the human, social origin of those aspects that produce and reinforce organisational reality. Hence, while there are imperatives for paediatric RNs in being effective in providing health education to promote health literacy in all health contexts in which they work, there are constraints. Participants' responses reflected on the institutional influences on their everyday health education practices. My document analysis of undergraduate nursing programs revealed a minimal focus on health education and health literacy. The role of the paediatric RN in supporting communication in and practising health education and health literacy is complex. In terms of what Habermas refers to as the system-lifeworld distinction, the paediatric RN is in an equivocal situation. As an advocate the nurse is 'of the lifeworld'. However, as a professional nurse, paid by the healthcare facility, the nurse is 'of the system'. A skill of the paediatric RN is to embody both these positions simultaneously. Failure to play both system and lifeworld roles efficiently lead to distorted communication. In these situations deep tensions between the agendas of the system and the lifeworld are revealed.

Habermas (1987b, pp. 336-7) argues for the 'uncoupling' of system and lifeworld, and the colonisation of the lifeworld by imperatives of systems. As discussed in *Chapter 3*, the thesis of 'uncoupling' of system and lifeworld discusses relative autonomy in systems that

are mainly controlled by money and administrative power. For Habermas (1987a), money and administrative power do the work of harmonisation so effortlessly that the systems have begun to function relatively autonomously from the lifeworld in the society we live in. This relatively autonomous functioning of systems in societies, categorised by progressive differentiation, encompasses an uncoupling of system and lifeworld in a way that systems seem to be objects to the individuals who function in them, as if they are functioning along with their own guidelines and ways, in an objective way that disregards the unique personalities and interests of the individuals functioning in them. Therefore, the function seems to be indifferent to the dynamic forces of cultural reproduction, social integration and socialisation; these are necessary for the development and reproduction of lifeworlds.

The thesis of colonisation of the lifeworld of Habermas is applicable to data collected in this research study as this assists to elaborate the imperatives that paediatric RNs think have been imposed on them by the system they work within. Also it is useful to look at the way paediatric RNs allow their understandings to displace the internal communicative action that reinforces the development and reproduction of lifeworlds, and replace it with an external structure of language, understandings, standards and rules based on the systems they work within (Habermas 1987a).

Colonisation of the lifeworld from Habermas's point of view happens when individuals and groups define themselves and their goals in life simply in system terms (Habermas 1987a). This is colonisation in the sense that the imperatives of the economic and political-legal systems displace the internal communicative action that reinforces the development and reproduction of lifeworlds, and replace it with an external structure of language, understandings, standards and rules based on systems and their imperatives. Consequently, the symbolic reproduction process of the lifeworld (cultural reproduction, social integration and socialisation) come to be drenched with a discourse of roles, purposes and functionality, reforming personal and collective self-understandings, associations and performance (Habermas 1987a).

This study has demonstrated the practicality of Habermas's related distinctions between communicative and strategic action and lifeworld and system for contextualising health education practices to promote health literacy by paediatric RNs in the healthcare system. It is clear from many of the participants' responses that they use a mix of communicative

action, oriented to mutual understanding and decision-making, and strategic action, oriented to securing optimal personal outcomes.

The study findings reflected examples of strategic action in the form of unconscious deception or systematically distorted communication. Habermas uses these terms to refer to encounters when all parties believe they are engaging in communicative action whilst, in fact, it is the interests of one party that takes precedence. Nevertheless there remains the existing domination of the voice of the health system over the voice of the lifeworld. Similarly, an enlightening and empowering health education and/or health literacy practice does not require quieting the voice of technical nursing practice. What is essential for communicative action is that technical nursing practice's validity claims are open to challenge, not that they automatically be challenged. This study discloses that paediatric RNs, in ways dogged by both personal character and context, may either conspire in clinicians' strategic initiatives or, in their role as an advocate for children and young people, they venture on their own at the risk of creating conflict. Time restrictions alone mean that paediatric RNs and children and young people are often trapped in surroundings not of their choosing, one that exists alongside communicative decision-making, enables strategic action and encourage collective refutation in the form of systematically distorted communication.

The theory is further applied using Habermas's (1987a) proposal for communicative space which when opened up, proposes a way to redress the current imbalance between individuals and systems. The findings of the study identify how engagement between paediatric RNs, children and young people, and health organisations could occur through the development of communicative space. It is proposed that the dynamic of recognition held within communicative space would offer a way to reframe the way in which the dynamic between individuals and organisations is developed in order to increase the influence of paediatric RNs upon the processes of healthcare they provide. To achieve this requires that nursing students learn in their undergraduate preparation how to open communicative spaces and why, and are able to generate communicative spaces in their working role.

Developing a communicative space doesn't guarantee the cycles of reflection and action described in Habermas's theory of communicative action; it simply offers the chance for such communication to occur. The communicative space is simply an opportunity that will, through the dynamic process of human interaction, be transformed in multiple ways.

## In summary

While paediatric RNs may have acknowledged their responsibility to health education where they identify themselves and their professional objectives in organisational (for example hospital, clinic and/or health centre) terms, then it is proposed that they view the generation of communicative spaces for health education to be limited by lack of resources and time and to be the role of specialist nurses. Learning how to open communicative actions is important; however, if it is not a significant part of their undergraduate preparation this will place delimiting boundaries around what is possible and expected in nursing as depicted in nursing competency standards. Paediatric RNs need to learn as undergraduates how to recognise how they can work within their institutional practices and promote nursing that includes a focus on health education to promote health literacy. The theory of communicative action provides a view as to how nurses can bring about changes in institutional practices. *Chapter 8,* my last chapter asks – where to from here?

# 8 Where to from here

## Introduction

As articulated in *Chapter 1*, this doctoral study was conducted on the premise that health education to promote health literacy is as vital for children and young people as it is for adults. In response to my research question: *How is health education and health literacy constructed by paediatric, child and youth health RNs and what role, for nurses, is promoted?*, my doctoral research highlights how health education practices by paediatric RNs can create and at the same time limit opportunities to promote health literacy for children, young people and their parents/guardians. I have elaborated on how understanding what constitutes nursing interests, and the context of opening communicative spaces for health education, are imperative for facilitating paediatric RNs to influence the health literacy and in turn health and well-being of children and young people. Within all settings in which paediatric RNs work, the promotion of methods by which paediatric RNs can engage in effective health education is both a key activity and an urgent need.

Throughout my chapters I have demonstrated how my understanding of Habermas's critical social theory has enabled an exploration of nursing actions when caring for children and young people, and health education and health literacy. The recurring arguments that at a structural and/or organisational level available time and resources influence their actions brings into focus the need for paediatric RNs to understand the distinction between their responsibilities as an employee (employer-employee contract) and those of a professional self-regulated RN.

A critical transformative approach to address how arguments of not enough time and inadequate resources delimit the possibility of nurses and nursing improving the health literacy of all people through health education practices is needed. Nurses and nursing must respond to ongoing reports like those by Macabasco-O'Connell and Fry-Bowers (2011), Jukkala, Dupree and Graham (2009) and Schlichting *et al.* (2007) that health care

organisations consider health literacy as a low priority due to the time and costs of implementing a health literacy program due to cultural and ethnic diversity. Nurses and nursing must take up the challenge to make health education to promote health literacy a priority.

## Health education as communicative action

The delivery of health education is not obstructed by time and resource restrictions alone, however; structural barriers driven by other priorities (the systems priorities) colonise the life world and communicative elements of nurse interactions with children, young people and their parents/guardians. This thesis has illuminated the structural and/or organisational issues that Habermas identified as leading to 'the uncoupling of system and life world, and the colonisation of the life world by imperatives of systems'.

This thesis has not defined paediatric RNs' understanding of 'health literacy' and how that might then impact on children, young people and their parents/guardians, but highlights how opportunities to actively provide health education are considered. Despite the rhetoric of the importance of health literacy, structural/organisational issues are argued as that which makes it almost impossible for nurses to deliver effective health education, an important and expected element of the nurses' role. Consequently how nursing students learn about health literacy and learn the skills for the delivery of health education in nursing curricula needs further exploration. The education of nurses requires greater scrutiny.

Nursing students need to learn how to promote health literacy through their health education practices, especially how to manage complex demands of the varied clinical settings and how to recognise clients with specific health literacy needs to ensure their better health outcomes. Future research should explore educational approaches for nurses and the effect of enhanced understanding of health literacy on client health outcomes. In addition, to improve delivery of health promotion in various health care systems, education and health care organisations need to make it a priority and provide the necessary education and ongoing development for their staff.

If as Zanchetta, Perreault, Kaszap and Viens (2007) believe, that nurses are in an advantaged position of being able to follow up clients' learning activities related to health literacy, then my finding in my doctoral research and like reports by Macabasco-O'Connell and Fry-Bowers (2011), that nursing professionals' knowledge of health literacy and their

understanding of the role health literacy has on client health outcomes is limited and a low concern must be a concern for the discipline of nursing.

Appraising and improving the health literacy of any individual is fundamental to providing quality health education. Nurses could influence indirectly, through their health education role, the socio-epidemiological significance of health literacy as a social determinant of health (Raphael, 2009). But this can only be possible if they are given capacity to learn about how to implement health education during their education programs. Adapting an argument by Rootman (2004), it is questionable whether the professional knowledge of nurses, their ability to innovate within their scale of practice and to produce new knowledge in the field of health literacy, is being made possible by nursing education systems. I raise a question for further research – What is the imperative of the education system for nursing students and how is this system colonising the life-world of nurses?

My doctoral research was based on Nutbeam's (1999a, 2008) view that enhancing people's health entails more than the transformation and spreading of health information. While not discounting the need for this there are additional needs to assist people to develop self-confidence in order to act on information. As Nutbeam (1999a, 2008) suggests, if the decisive aim of the definition of health literacy is to be achieved, major autonomy and empowerment among people and groups should be endorsed, necessitating acknowledgement and understanding of the political aspect of education. This understanding is as important for the education of nursing students as it is for nurses in implementing their health education roles.

How nursing as a disciplinary practice and nursing educators promote understandings of health education and health literacy practices cannot be separated from the act of implementation. Health education and health literacy practices are a social action and therefore need to be acknowledged as socially constructed. This means that the construction of the health education and health literacy intervention environment is a social act, not merely reliant on the physical or technical environment central to nursing practice. Nursing education is praxis; it is a dialogical relationship between nursing student and educator and in turn client.

Habermas has provided the lens through which I make the claim that through dialogue, based on communicative action, nursing students and educators become participants in the construction of their knowledge of health education practices to influence the health literacy of children and young people. Engaging in critical reflection upon that knowledge

to constantly evaluate and recreate knowledge emerges through implementing health educations practices in the diversity of clinical settings ensuring the effectiveness of these practices on health literacy levels. Meaning-making and interpretation are vital to all knowledge; consequently, a critical orientation to all knowledge is crucial when we are involved in taking action. This in turn indicates that the health education process is inevitably a political action, for meaning-making also encompasses contradictory meanings. Those who have power to control the process of what meaning-making and interpretation occurs are those who have the power to delimit or enhance the possibilities of communicative action. The process of meaning-making within education programs for nursing students becomes an enlightening and empowering act or a controlling dominant act.

My findings also reveal how the role of paediatric RNs in influencing health literacy is the product of how they as individuals enable health education within a system. The importance of adopting a health education approach within the role of paediatric RN was articulated by participants, and is an expected competency of all nurses. Participants advanced the possibility that in a system in which specialist roles for nurses are promoted, however, the specialist role assumes responsibility for health education and limits the possible role of all paediatric RNs as a consequence.

My findings also suggest that paediatric RNs may confuse what it means to be an employee whilst having a professional responsibility to nursing. My findings suggest that the paediatric RN might think that their employment institution, or the organisational heads of the institution, has control over nursing activities. This is not the case; the only interest organisational heads have over that nurse is as the employer, raising the question of whether the role of paediatric RNs is predominantly shaped by their employer-employee contract or their professional responsibility as a regulated nurse. This presents a professional issue, and questions how nurses practice nursing competencies, progress nursing as a profession and a discipline and contribute to enabling children and young people to be health literate. It also becomes an educational issue to challenge how undergraduate nursing students are being prepared in relation to applying nursing skills, contributing to progressing nursing as a profession and a discipline, and contributing to the health literacy of children and young people.

When analysed through Habermas's critical lens of communicative action, paediatric RNs seem to serve the system at the expense of the lifeworld where health education is

concerned. Habermas's Theory of Communicative Action has far-reaching implications for health education because communicative action:

> …describes an ideal, though conceivably achievable, group learning experience where participants put forward their own views on the problem at hand, listen carefully and respectfully to those of others, and seriously examine all relevantly identified information introduced to the situation. It does not take the form of a debate, or the mere weighing of pros and cons. The process is more rational and democratic—a kind of on-going, thoughtful, conversation … It entails a predisposition towards decision-making processes where all participants are engaged in rational discourse that emerges from a genuinely democratic situation. (Collins 1991, p. 12)

The on-going, thoughtful conversation that characterises communicative action reflects the mutual respect and understanding that can be achieved in many health educational situations. Communicative action is problem-based, participatory, dialogical and action-oriented, and can counter instrumental forms of health education that emphasise one-way, top–down, authoritarian communication.

In applying Habermas's Theory of Communicative Action as a critical framework for understanding the act of paediatric RNs providing health education to children and young people in the health system, the question arises as to whether the acts of paediatric RNs have served the health system in which they work or the lifeworld throughout their encounter with the children and young people.

My findings suggest how paediatric RNs involved in providing health education at the clinical level have consciously or unconsciously served the health system. Being aware of this situation is an important first step. In addition paediatric RNs need to know they can make choices to build the lifeworld by increasing, wherever possible, the opportunities for communicative action in encounters with children and young people. The consequence for paediatric RNs in not making this choice leads to them continuing to serve the health system. Although the choices paediatric RNs face in practice are never so clearly delineated, posing these distinctions in stark opposition will help us better understand the implications of the choices nurses may need to make every day.

Imperative to the role of paediatric RNs are their actions that build the lifeworld of a child's and young person's health learning experience as characterised by communicative action. Communicative action is a two-way process that takes place face to face; communicative action cannot occur with one-way communication. Such a one-way approach leaves little room for communication in the true sense of the term—communication as emancipative, non-dominative discourse designed to promote

understanding (Boyd 1991). The challenge for paediatric RNs, in fact all nurses, is to ensure that their focus is not solely on building alliances with corporations; rather their focus needs to be in establishing interactive educational environments where clients can learn and health outcomes can be improved. Similarly educators of nursing students need to ensure that their focus is not solely on building alliances with educational institutions; rather their focus needs to be on establishing interactive educational environments for nursing students. Education and health systems need to minimise alienation with a focus on the importance of communication and how people relate and interact with each other, with the system focusing on rational discourse, reducing power differences, encouraging personal initiative toward action at all care and educational levels, and emphasising relations between human rationality and emotionality.

As said by Alway (1995), transforming the world should engage not ‘a revolutionary transformation of society, but the creation and protection of spaces within which a radical concept of democracy, as a process of shared learning carried out in and through communicative action, might flourish’ (p. 127). Health education is a communicative space and a transformation process.

The task of providing health education by paediatric RNs to promote health literacy in a two-way process it needs to be free from manipulation, and one of de-colonising the lifeworld and addressing the consequences of uncoupling the system and lifeworld (Habermas, 1987a). The lifeworld concept designates that the person is dialectically related to the cultural-social context. Resistance to colonisation has, according to Habermas, taken on new forms, with class conflicts replaced by conflict at the seams or boundaries between system and lifeworld (1987a, p. 395; 1987b, p. 357). Paediatric RNs can bring about change if in their education program they engage in communicative action that encourages thinking in alternative ways: ways that do not inherently promote a focus on the profit-dependent instrumentalisation of work, the market-dependent mobilisation of labour power and the pressures of competition and performance. As Habermas (1987a) says, this would also take aim at the monetarisation of services, relationships and time, at the consumerist redefinition of private spheres of life and personal life-styles (p. 395).

Freire (1996) stated that education is never neutral; in delivering health education a nurse can act for the system or the lifeworld. Narrowing health education practices and the education of nursing students to issues of technical problem-solving through one way

delivery of knowledge can deny the very conditions for communicatively rational decision-making.

## Inserting an emancipatory self-reflection process in everyday practice

In reading my thesis I seek to inspire readers to become involved in conscious political action to bring about change in their world to the extent that my findings suggest a need for them to do so. In short, the aim of critical research is to enhance the life of the social actor, or in the case of this research, to lead to an improvement in paediatric RNs' practice. I have shown how paediatric RNs may confuse what it means to be an employee, and the influence of an employer-employee contract on their professional role, and by nurses having a professional and regulated responsibility to advance nursing. Therefore, the concept of power to influence may be implemented by individuals who sustain a degree of autonomy in the face of ideological meaning formation.

Habermas links emancipation with autonomy and personal accountability. Through self-reflection, the person can liberate him/herself from authoritarian powers. Even though emancipation must be restricted to an individual experience if it is to have any effect, it is not a simple process. Paediatric RNs who maintain and implement their professional and regulated responsibility to advance nursing may have more direct influence on their actual clinical role compared to those who permit their employer-employee contract to dominate the role they enact in an organisational context. This research suggests that health education and health literacy practices implemented by paediatric RNs can enhance the emancipatory and transformational potential of nurses and their clients.

At the level of practice, emancipation will be demonstrated through how RNs undertake actions to change the workplace structures that constrain freedom in often unrecognised ways. Emancipatory paediatric and child and youth health nursing experiences in health education entails a mutual relationship between self-reflection and action. Through the process of self-reflection, emancipatory interest is the means by which individuals can escape the apparently natural limitations that institutional structures provide for people.

For Habermas (1972), emancipation through self-reflection can review the prevalence of the technical interest, which glorifies scientific method and disguises the self-reflective transfer in the formation of knowledge. By locating the criteria for directing social life in purposive-rational action, technocratic consciousness collapses the discrepancy between the technical and practical interests. The technical interest is therefore ideological as it

distorts the nature of social relations by reducing them to matters of prediction and control (the colonisation of the lifeworld by the system). Paediatric RNs' who feel bound by technical interest have limited potential for self-reflection.

The prioritisation of the technical over the practical interest manifests itself in contemporary society in various ways. This study endorses Habermas's view that in order for change to occur at the organisational level it is essential to start at the personal level via self-reflection. Habermas proposes that self-reflection is the way by which emancipation can be evident, yet he did not propose a specific process of self-reflection. In order for health education practices by nurses to promote health literacy to be immersed in everyday nursing, the process of self-reflection needs to be inherent in all paediatric RNs activities. By examining nursing practices like health education it is possible to recognise features or types of nursing practice to be enhanced and to also realise and produce new nursing knowledge by drawing from practitioners' personal knowledge.

## Advancing Nursing Praxis

Praxis is an essential concept to emancipatory interest (Habermas 1974). To exemplify the relevance of praxis, it is essential to make the connection between praxis and Habermas's emancipatory interest. In Habermas's work, there is indissolubility of speech and freedom, a linking of speech with freedom and justice whereby truth is that 'on which all agents would agree if they were to discuss all of human experience in absolutely free and un-coerced circumstances for an indefinite period of time' (Guess 1981, p. 65). The possibility for critical theorems for enlightenment lies in their characterisation of different understandings for the ways in which groups make take for granted how they are experiencing the world. For example, critical social theorems may allow paediatric RNs to understand differently their actions regarding the provision of health education.

The findings of this study reflect that paediatric RNs believe they are acting in the best interest of the child/young person and their own best interests, but the actions may be distorted by organisational needs. The potential benefits of paediatric RNs acting in a child's and young person's best interest (and in their own best interest) can be distorted by unrecognised organisational interests in preserving the present dissemination of power. This can manifest in the RN blaming their inaction on the system for not providing enough time, or blaming the client who they feel is uncooperative.

Praxis encompasses liberally selecting to act in ways that are cognisant of critical theorems. It is not presumed that since such actions are recognised by such theorems it will automatically be the right action. Such actions must regularly become the subject of reflection, as must the theorems that underpin the action. Theory and practice must both be open to critical inspection; thus, praxis is not action that sustains the condition as it is, it is action that alters both the world and our comprehension of the world. Consequently, praxis is cognisant of an emancipatory interest, which endorses the freedom for all to act within their own social circumstances in ways that facilitate the ability to resist oppression and manipulation.

The aim of this study has been to bring forward the way in which nurses and organisations create, sustain and reproduce the day-to-day practices of nurses. I argue that nurses exercise power to the degree that they are able to structure organisational reality in a way that serves their own interests. I have argued that meaning for nurses working in organisations does not develop suddenly and consensually, but is rather the product of vested interest groups. Power is exercised by such groups not only in the control of organisational recourses (technology, information and so on) but also in the extent to which they are able to structure organisational reality to support their own interests. In this study, ideology, in the form of systematically distorted communication, serves in this capacity by creating and reproducing the subjectivity of nurses and their clients via interpellation. As such, the dominant interests are assumed to be the interests of all participants in the system. Ideology is therefore considered not just as a set of opinions and views, but as a materially-located meaning system that establishes the social actors' organisational consciousness. In this regard, a principal point of this study has been the connection between ideology and practice, as expressed through systematically distorted communication and organisational practices.

This study's findings imply that it is vital that nurses advance nursing and answer the call for constructing a health-literate society by taking a dynamic health education role and engaging in health literacy research, education and promotion. Paediatric RNs are critical players in the health system; a system that puts substantial reading and comprehension loads on children and young people. It is integral that paediatric RNs recognise the prevalence of low health literacy, acknowledge it as a substantial hurdle to safe and efficient care, and embrace the need to interconnect more efficiently with children and young people as part of their health education role.

This doctoral research was conducted in one country with a small number of participants who recognised themselves as experts. Many were academics, some directors of services and clinical managers in a tertiary hospital setting and others leaders of related organisations. These individuals can yield enormous influence in relation to the role of paediatric RNs to ensure they uphold their professional responsibility to create communicative opportunities that address the distinctive information requirements of each child and young person. Knowledge and understanding is empowering, and as such the aim of all nurse-child/young person interactions must be to empower the child and/or young person to understand and act upon information necessary for optimal health. This thesis provides a strategic mechanism to enable the interests and practices of nurses to be part of the solution, through understanding their health education role with regard to promoting health literacy and hopefully adopting a more proactive approach to educating clients to be health literate.

# References

*Article 1: Convention of the rights of the child* 2002, [Homepage of Office of the United Nations High Commissioner for Human Rights], [Online]. Available: http://www2.ohchr.org/english/law/crc.htm#part1 [2011].

Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, American Medical Association 1999, "Health Literacy. Report of the Council on Scientific Affairs", *JAMA: The Journal of the American Medical Association,* vol. 281, no. 6, pp. 552-557.

Advanced Life Support Group (ed) 2005, *Advanced Paediatric Life Support: The Practical Approach*, 4th edn, Blackwell Publishing Ltd, Oxford.

Agger, B. 1998, *Critical social theories: an introduction,* Westview Press, United State of America.

Aitken, R., Faulkner, R., Buchnall, T. & Parker, J. 2001, *National Review of Nursing Education-Aspects of Nursing Education: The Types Of Skills And Knowledge Required To Meet The Changing Needs Of The Labour Force Involved In Nursing - Literature Review*, Commonwealth Department of Education, Science and Training, Melbourne.

Alderson, P. 2000, *The Rise and Fall of Children's Consent to Surgery* Open University Press, Buckingham.

Alderson, P. 1993, *Children's Consent to Surgery,* Open University Press, Buckingham.

Alderson, P. 1990, *Choosing for Children: Parents' Consent to Surgery,* Oxford University Press, Oxford.

Alderson, P. & Montgomery, J. 1996, *Health Care Choices: Making Decisions with Children* Institute for Public Policy Research, London.

Allen, D. 1987, "Critical social theory as a model for analyzing ethical issues in family and community health", *Family & community health,* vol. 10, no. 1, pp. 63-72.

Allen, D. 1985, "Nursing research and social control: alternative models of science that emphasize understanding and emancipation", *Image: the Journal of Nursing Scholarship,* vol. 17, no. 2, pp. 58-64.

Allen, M., Knight, C., Falk, C. & Strang, V. 1992, "Effectiveness of preoperative teaching programme for a cataract patients", *Journal of Advanced Nursing*, vol. 17, no. 3, pp. 303-309.

Alway, J. 1995, *Critical theory and political possibilities: Conceptions of emancipatory politics in the works of Horkheimer, Adorno, Marcuse and Habermas*, Greenwood Press, Westport, CT.

Amstrong, C., Hill, M. & Secker, J. 1998, *Listening to Children*, The Mental Health Foundation, London.

Anderson, P. 1986, "The Delphi technique in practice", *The Australian Journal of Advanced Nursing*, vol. 3, no. 2, pp. 22-32.

Andrew, S. & Halcomb, E. 2009, *Mixed methods research for nursing and the health sciences*, Wiley-Blackwell Pub., Chichester, U.K.

Andrews, G.J. & Shaw, D. 2008, "Clinical geography: nursing practice and the (re)making of institutional space", *Journal of nursing management*, vol. 16, no. 4, pp. 463-473.

Andrus, M.R. & Roth, M.T. 2002, "Health literacy: A review", *Pharmacotherapy*, vol. 22, no. 3, pp. 282-302.

Appleton, C. 1993, "The art of nursing: the experience of patients and nurses", *Journal of advanced nursing*, vol. 18, no. 6, pp. 892-899.

Assal, J.P. & Golay, A. 2001, "Patient education in Switzerland: from diabetes to chronic diseases", *Patient Education and Counselling*, vol. 44, no. 1, pp. 65-69.

Australian Government National Health and Hospitals Reform Commission 2009, , *A Healthier Future for All Australians – Final Report of the National Health and Hospitals Reform Commission: Australian Government* [Homepage of Department of Health and Aging], [Online]. Available: http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/nhhrc-report-toc#.Uscvy6LxvIV [2013, November/26th].

Australian Institute of Health and Welfare 2012, *A picture of Australia's children* [Homepage of AIHW], [Online]. Available: https://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737423340 [2013, December/20th].

Australian Institute of Health and Welfare 2011, *Nursing and midwifery labour force 2009*, AIHW, Canberra.

Australian Nursing and Midwifery Council 2006, *National competency standards for the registered nurse*, Australia.

Baggot, R. 1994, *Health and health care in Britain*, Macmillan, London.

Baker, D.W., Parker, R.M., Williams, M.V., Clark, W.S. & Nurss, J. 1997, "The Relationship of Patient Reading Ability to Self-Reported Health and Use of Health Services", *American Journal of Public Health*, vol. 87, no. 6, pp. 1027-1027.

Baker, J., Lovell, K. & Harris, N. 2006, "How expert are the experts? An exploration of the concept of 'expert' within Delphi panel techniques", *Nurse Researcher*, vol. 14, no. 1, pp. 59-70.

Bandman, E. & Bandman, B. 2002, *Nursing Ethics Through the Life Span*, 4th edn, Prentice Hall, Upper Saddle River, New Jersey.

Barker, P.J., Reynolds, W. & Ward, T. 1995, "The proper focus of nursing: a critique of the “caring” ideology", *International Journal of Nursing Studies*, vol. 32, no. 4, pp. 386-397.

Barrett, S.E. & Puryear, J.S. 2006, "Health Literacy: Improving Quality of Care in Primary Care Settings", *Journal of Health Care for the Poor and Underserved*, vol. 17, no. 4, pp. 690-697.

Bartu, A., Nelson, M., Ng, C., McGowan, S. & Robertson, J. 1993, "A Western Australian Delphi survey of staff development priorities", *Journal of Nursing Staff Development*, vol. 9, no. 3, pp. 141-147.

Bastable, S.B. 2006, *Essentials of patient education*, Jones and Bartlett Publishers, London.

Baur, C. 2011, "Calling the nation to act: implementing the national action plan to improve health literacy ", *Nursing Outlook*, vol. 59, no. 2, pp. 63-69.

Beech, B.F. 1991, "Changes: the Delphi technique adapted for classroom evaluation of clinical placement", *Nurses Education Today*, vol. 11, no. 3, pp. 207-212.

Belmont, H.S. 1970, "Hospitalization and its effects upon the total child", *Clinical Pediatrics,* vol. 9, no. 8, pp. 472-483.

Beresford, B.A. & Sloper, P. 2003, "Chronically ill adolescents' experiences of communicating with doctors: a qualitative study", *Journal of Adolescent Health,* vol. 33, no. 3, pp. 172-179.

Bernstein, R. 1985, *Habermas and modernity,* Polity Press, Cambridge.

Betz, C.L., Ruccione, K., Meeske, K., Smith, K. & Chang, N. 2008, "Health literacy: a pediatric nursing concern", *Pediatric Nursing,* vol. 34, no. 3, pp. 231-239.

Bodenheimer, T. 2008, "Coordinating care—a perilous journey through the health care system", *The New England Journal of Medicine,* vol. 358, no. 10, pp. 1064-1071.

Bond, S. & Bond, J. 1982, "A Delphi survey of clinical nursing research priorities", *Journal of Advanced Nursing,* vol. 7, no. 6, pp. 565-575.

Borland, M., Laybourn, A., Hill, M. & Brown, J. 1998, *Middle Childhood,* Jessica Kingsley, London.

Bossert, E. 1994, "Stress appraisals of hospitalized school-age children", *Children's Health Care,* vol. 23, no. 1, pp. 33-49.

Boswell, C., Cannon, S., Aung, K. & Eldridge, J. 2004, "An application of health literacy research", *Applied Nursing Research,* vol. 17, no. 1, pp. 61-64.

Bottorff, J.L. & Varcoe, C. 1995, "Transitions in Nurse-Patient Interactions: A Qualitative Ethology", *Qualitative Health Research,* vol. 5, no. 3, pp. 315-331.

Boyce, W., Gowland, C., Russell, D., Goldsmith, C., Rosenbaum, P., Plews, N. & Lane, M. 1993, "Consensus methodology in the development and content validation of a gross motor performance measure", *Physiotherapy Canada,* vol. 45, no. 2, pp. 94-100.

Boyd, G. 1991, "Emancipative educational technology" in *Paradigms Regained: The Uses of Illuminative, Semiotic, and Post-Modern Criticism As Modes of Inquiry in Educational Technology: A Book of Readings,* eds. D. Hlynka & J. Belland, Educational Technology Publications, Englewood Cliffs, New Jersey, pp. 83-92.

Bradford, M. & Winn, S. 1997, "Practice nursing and health promotion: a case study" in *Debates and Dilemmas in Promoting Health. A Reader*, eds. M. Sidell, L. Jones, J. Katz & A. Peberdy, Macmillan Press, The Open University, Houndmills, pp. 64-73.

Braun, V. & Clarke, V. 2006, "Using thematic analysis in psychology", *Qualitative Research in Psychology*, vol. 3, no. 2, pp. 77-101.

Brey, R.A., Clark, S.E. & Wantz, M.S. 2007, "Enhancing Health Literacy through Accessing Health Information, Products, and Services: An Exercise for Children and Adolescents", *Journal of School Health*, vol. 77, no. 9, pp. 640-644Nov.

Bricher, G. 2000, "Children in the hospital: issues of power and vulnerability", *Pediatric Nursing*, vol. 26, no. 3, pp. 277-383.

Brocklesby, J. & Cummings, S. 1996, "Foucault plays Habermas: An alternative philosophical underpinning for critical systems thinking", *Journal of the Operational Research Society*, vol. 47, no. 6, pp. 741-754.

Brookfield, S. 1995, *Becoming a Critically Reflective Teacher*, Jossey-Bass, San Francisco.

Brown, P. & Piper, S. 1995, "Empowerment or social control? Differing interpretations of psychology in health education", *Health Education Journal*, vol. 54, no. 1, pp. 115-123.

Cannon, S. & Boswell, C. 2009, "Filling gaps in knowledge: educating nurses to provide appropriate patient materials", *Journal of Continuing Education in Nursing*, vol. 40, no. 4, pp. 148-149.

Carr, E. 2009, "Understanding inadequate pain management in the clinical setting: the value of the sequential explanatory mixed method study", *Journal of Clinical Nursing*, vol. 18, no. 1, pp. 124-131.

Carter, B. 2002, "Chronic pain in childhood and the medical encounter: professional ventriloquism and hidden voices", *Qualitative Health Research*, vol. 12, no. 1, pp. 28-41.

Carter, B. 1998, "Children – silent consumers of healthcare", *Journal of Child Health Care*, vol. 2, no. 2, pp. 57.

Center on the Developing Child 2007, *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children* [Homepage of Harvard University], [Online]. Available:

http://developingchild.harvard.edu/resources/reports_and_working_papers/policy_framework/. [2013, November/26th].

Chamberlain, M.C. & Beckingham, A.C. 1987, "Primary health care in Canada: in praise of the nurse?", *International Nursing Review*, vol. 34, no. 6, pp. 158-160.

Chan, M. 2008, , *Primary health care – now more than ever* [Homepage of Director General Speeches, WHO], [Online]. Available: http://www.who.int/dg/speeches/2008/20081014/en/index.html. [2012, April/3rd].

Chappuy, H., Taupin, P., Dimet, J., Claessens, Y.E., Treluyer, J.M. & Cheron, G. 2012, "Do parents understand the medical information provided in paediatric emergency departments? A prospective multicenter study", *Acta Paediatrica*, vol. 101, no. 10, pp. 1089-1094.

Chinn, D. 2011, "Critical health literacy: A review and critical analysis", *Social Science & Medicine*, vol. 37, no. 1, pp. 60-67.

Chyun, D.A. 2004, "Review: Patient education interventions improve glycaemic control in adults with diabetes mellitus", *Evidence Based Nursing*, vol. 7, no. 3, pp. 79.

Clay, T. 1992, "Education and empowerment: securing nursing's future", *International Nursing Review*, vol. 39, no. 1, pp. 15-18.

Close, A. 1988, "Patient education: a literature review", *Journal of Advanced Nursing*, vol. 13, no. 2, pp. 203-213.

Coakley, A.L. 1998, "Health promotion in a hospital ward; reality or asking the impossible?", *Journal of the Royal Society of Health*, vol. 118, no. 4, pp. 217-220.

Cody, W.K. & Mitchell, G.J. 2002, "Nursing Knowledge and Human Science Revisited: Practical and Political Considerations", *Nursing Science Quarterly*, vol. 15, no. 1, pp. 4-13.

Cole, M.R. 2000, "The high risk of low health literacy", *The Nursing Spectrum*, vol. 13, no. 10, pp. 7-16.

Coles, R. 1997, *The Moral Intelligence of Children*, Random House, New York.

Collins, K., Onwuegbuzie, A.J. & Sutton, I. 2006, "A model incorporating the rational and purpose for conducting mixed methods research in special education and beyond", *Learning Disabilities: A Contemporary Journal*, vol. 4, no. 1, pp. 67-100.

Collins, M. 1991, *Adult Education as Vocation: A Critical Role for the Adult Educator (Routledge Series on Theory & Practice of Adult Education in North America)*, Routledge, New York.

Council of Europe 1996, *European Convention on the Exercise of Children's Rights* [Homepage of Council of Europe], [Online]. Available: http://conventions.coe.int/Treaty/en/Treaties/Html/160.htm. [2013, November/26th].

Coyne, I. 2006, "Consultation with children in hospital: children, parents' and nurses' perspectives", *Journal of Clinical Nursing*, vol. 15, no. 1, pp. 61-71.

Coyne, I.T. 2003, *A Grounded Theory of Disrupted Lives: Children, Parents and Nurses in the Children's Wards*, King's College University of London.

Cramer, C.K., Klasser, G.D., Epstein, J.B. & Sheps, S.B. 2008, "The Delphi Process in Dental Research", *Journal of Evidence Based Dental Practice*, vol. 8, no. 4, pp. 211-220.

Creswell, J.W. 2009, *Research design: qualitative, quantitative, and mixed methods approaches*, 3rd edn, Sage Publications Inc, Thousand Oaks, CA.

Creswell, J.W., Fetters, M.D. & Ivankova, N.V. 2004, "Designing a mixed methods study in primary care", *Annals of Family Medicine*, vol. 2, no. 1, pp. 7-12.

Creswell, J.W. & Plano Clark, V.L. 2011, *Designing and conducting mixed methods research*, 2nd edn, Sage Publications Inc, Thousand Oaks, CA.

Creswell, J.W. & Plano Clark, V.L. 2007, *Designing and conducting mixed methods research*, 1st edn, Sage Publications, Thousand Oaks, CA.

Creswell, J.W., Plano Clark, V.L., Gutmann, M. & Hanson, W. 2003, "Advanced mixed methods research designs" in *Handbook of mixed methods research in social and behavioral research*, eds. A. Tashakkori & C. Teddlie, Sage Publications, Thousand Oaks, CA, pp. 209-240.

Crisp, J., Pelletier, D., Duffield, C., Adams, A. & Nagy, S. 1999, "It's all in a name: when is a 'Delphi study' not a Delphi study", *Australian Journal of Advanced Nursing*, vol. 16, no. 3, pp. 32-37.

Crotty, M. 1998, *The foundations of social research: meaning and perspective in the research process*, Allen & Unwin, Australia.

Cuban, S. 2006, "Following the physician's recommendations faithfully and accurately: functional health literacy, compliance, and the knowledge-based economy", *The Journal for Critical Education Policy Studies*, vol. 4, no. 2, pp. 1-13.

Cullen, A. 2002, "Health promotion in the changing face of the hospital landscape", *Collegian*, vol. 9, no. 1, pp. 41-42.

Cutilli, C.C. 2005, "Do Your Patients Understand? Determining your patients' health literacy skills", *Orthopaedic Nursing*, vol. 24, no. 5, pp. 372-377.

Dallmayr, F.R. 1972, "Review symposium on Habermas: II--Critical theory criticized: Habermas's Knowledge and Human Interests and its aftermath", *Philosophy of the Social Sciences*, vol. 2, no. 1, pp. 211-229.

Daly, J., Kellehear, A. & Gliksman, M. 1997, *The public health researcher: A methodological approach*, Oxford University Press, Melbourne.

Daly, J., Macleod-Clark, J., Lancaster, J., Bednash, G. & Et Orchard, C. 2008, "The global alliance for nursing education and scholarship: Delivering a vision for nursing education', International Journal of Nursing Studies", *International Journal of Nursing Studies*, vol. 45, no. 8, pp. 1115-1117.

Darbyshire, P. 1999, "Nursing, art and science: Revisiting the Two Cultures", *International Journal of Nursing Practice*, vol. 5, no. 3, pp. 123-131.

Davidson, D.A. 2004, "Health literacy: adverse implications for patients and physicians", *Medical Practice Management*, vol. 19, no. 4, pp. 207-210.

Davis, T., Crouch, M., Wills, G. & Miller, S. 1991, "Rapid assessment of literacy levels of adult primary care patients", *Family Medicine*, vol. 23, no. 6, pp. 433-435.

De Vos, E., Spivak, H., Hatmaker-Flanigan, E. & Sege, R.D. 2006, "A Delphi Approach to Reach Consensus on Primary Care Guidelines Regarding Youth Violence Prevention", *Pediatrics*, vol. 118, no. 4, pp. e1109-1115.

DEEWR 2011, *Early Childhood Policy Agenda*, Department Of Education', Employment and Workplace Relations, Canberra.

Dell'Api, M., Rennick, J.E. & Rosmus, C. 2007, "Childhood chronic pain and health care professional interactions: shaping the chronic pain experiences of children", *Journal of Child Health Care*, vol. 11, no. 4, pp. 269-286.

Denzin, N.K. & Lincoln, Y.S. 2005, "Introduction: the discipline and practice of qualitative research" in *The sage handbook of qualitative research*, eds. N.K. Denzin & Y.S. Lincoln, Sage Publications, Thousand Oaks, CA, pp. 1-32.

Department of Health 2004, *National Service Framework for children, young people and maternity services*, DOH, London.

Department of Health 2003, *Getting the Right Start: National Service Framework for Children -- Standards for Hospital Services* [Homepage of DOH], [Online]. Available: http://www.nhs.uk/NHSEngland/AboutNHSservices/Documents/NSF%20children%20in%20hospitlalDH_4067251[1].pdf. [2013, November/26th].

Department of Health 1997, *The Specific Health Needs of Children and Young People*, Stationery Office, London.

Department of Health 1993, *Welfare of Children and Young People in Hospital*, Stationery Office, London.

Devraj, R. & Gupchup, G.V. 2012, "Knowledge of and barriers to health literacy in Illinois ", *Journal of the American Pharmacists Association*, vol. 52, no. 6, pp. e183-e193.

DeWalt, D.A. & Hink, A. 2009, "Health literacy and child health outcomes: a systematic review of the literature", *Pediatrics*, vol. 124, no. supplement 3, pp. S265-S274.

DeWalt, D.A., Berkman, N.D., Sheridan, S., Lohr, K.N. & Pignone, M.P. 2004, "Literacy and Health Outcomes: A Systematic Review of the Literature", *Journal of General Internal Medicine*, vol. 19, no. 12, pp. 1228-1239.

Dewey, J. 1916, *Democracy and Education*, The Free Press, New York.

Dewey, J. 1902, *The Child and the Curriculum*, University of Chicago Press, Chicago.

Dixon-Woods, M., Young, B. & Heney, D. 1999, "Partnerships with children", *British Medical Journal*, vol. 319, no. 7212, pp. 778-780.

Donatelle, R. 2009, *Promoting Healthy Behavior Change. Health: The basics*, 8th edn, Pearson Education, San Francisco.

Dreger, V. & Tremback, T. 2002, "Optimise Patient health by treating literacy and language barriers", *Association of Preoperative Registered Nurses,* vol. 75, no. 2, pp. 278-304.

Dreyfus, H.L. 1991, *Being-in-the-world: a commentary on Heidegger's Being and time, division I,* MIT Press, Cambridge, MA.

Duffield, C. 1988, "The Delphi technique", *Australian Journal of Advanced Nursing,* vol. 6, no. 2, pp. 41-45.

Duncan, E., Nicol, M. & Ager, A. 2004, "Factors that constitute a good cognitive behavioural treatment manual: a Delphi study", *Behavioural and Cognitive Psychotherapy,* vol. 32, no. 2, pp. 199-213.

Dunne, J. 1993, *Back to the rough ground: 'Phronesis' and 'techne' in modern philosophy and in Aristotle,* University of Notre Dame Press, Illinois.

Duplantie, J., Gagnon, M.P., Fortin, J.P. & Landry, R. 2007, "Telehealth and the recruitment and retention of physicians in rural and remote regions: a Delphi study", *Canadian Journal of Rural Medicine,* vol. 12, no. 1, pp. 30-36.

Epstein, L.T.F. & Wayman, K.I. 1998, "Interruptions in development: the communicative context of the young hospitalised child ", *Infants and Young Children,* vol. 10, no. 3, pp. 32-43.

Erlen, J.A. 2004, "Functional Health Illiteracy", *Orthopaedic Nursing,* vol. 23, no. 2, pp. 150-153.

Estabrooks, P.A., Fisher, E.B. & Hayman, L.L. 2008, "What is needed to reverse the trends in childhood obesity: a call to action", *Annals of Behavioral Medicine,* vol. 36, no. 3, pp. 209-216.

Fay, B. 1987, *Critical social science: liberation and its limits,* Cornell University Press, Ithaca, New York.

Fink, A., Kosecoff, J., Chassin, M. & Brook, R.H. 1984, "Consensus methods: characteristics and guidelines for use", *American Journal of Public Health,* vol. 74, no. 9, pp. 979-983.

Fitzpatrick, E., Sullivan, J., Smith, A., Mucowski, D., Hoffman, E., Dunn, P., Trice, M. & Gross, L. 1991, "Clinical nursing research priorities: a Delphi study", *Clinical Research Specialist*, vol. 5, no. 2, pp. 94-99.

Flatman, D. 2002, "Consulting children: Are we listening?", *Paediatric Nursing*, vol. 14, no. 7, pp. 28-31.

Flemming, K. 2007, "The knowledge base for evidence-based nursing: a role for mixed methods research?", *Advances in Nursing Science*, vol. 30, no. 1, pp. 41-51.

Fredriksen, S. 2003, "Instrumental colonisation in modern medicine", *Medicine, Health Care and Philosophy*, vol. 6, no. 3, pp. 287-296.

Freebody, P. & Luke, A. 1990, "Literacies' programs: debates and demands in cultural context", *Prospect*, vol. 5, no. 3, pp. 7-16.

Freire, P. 1996, *Pedagogy of the oppressed*, Penguin Books Ltd, Ringwood, Victoria, Australia.

French, P., Yin-Yu, H. & Lan-Suen, L. 2002, "A Delphi survey of evidence-based nursing priorities in Hong Kong", *Journal of Nursing Management*, vol. 10, no. 5, pp. 265-273.

Gadamer, H.G. 1989, *Truth and Method*, 2nd edn, Sheed and Ward Ltd, London.

Gander, E. 1989, "Habermas on Habermas: the perils of communicative action in our postmodern world" in *Annual Meeting of the Speech Communication Association*San Francisco.

Gavin, J.N. 1997, "Nursing ideology and the 'generic carer'", *Journal of advanced nursing*, vol. 26, no. 4, pp. 692-697.

Gibson, C.H. 1991, "A concept analysis of empowerment", *Journal of advanced nursing*, vol. 16, no. 3, pp. 354-361.

Gillham, D. 2002, "Web resource appraisal process (WRAP): A framework to establish critically appraised nursing knowledge—an active web based learning exercise", *Nurse Education in Practice*, vol. 2, no. 4, pp. 257-266.

Giorgianni, S.J. 1998, "Perspectives on health care and biomedical research: Responding to the challenge of health literacy", *Pfizer Journal*, vol. 2, no. 1.

Gold, R.S. & Miner, K.R. 2002, "Report of the 2000 Joint Committee on Health Education and Promotion Terminology", *The Journal of School Health,* vol. 72, no. 1, pp. 3-7.

Goodman, C.M. 1987, "The Delphi technique: a critique", *Journal of Advanced Nursing,* vol. 12, no. 6, pp. 729-734.

Gott, M. & O'Brien, M. 1990, *The role of the nurse in health promotion: policies, perspectives, and practice,* UK: Her Majesty's Stationery Office (HMSO), London.

Gottlieb, R.S. 1981, "Review: The Contemporary Critical Theory of Jurgen Habermas", *Ethics,* vol. 91, no. 2, pp. 280-295.

Graham, B., Regehr, G. & Wright, J.G. 2003, "Delphi as method to establish consensus for diagnostic criteria", *Journal of Clinical Epidemiology,* vol. 56, no. 12, pp. 1150-1156.

Grant, J., Kinney, M. & Guzzetta, C. 1990, "A methodology for validating nursing diagnoses", *Journal of Advances in Nursing Science,* vol. 12, no. 3, pp. 56-74.

Gray-Vickery, P. 1993, "Focus groups: use and application in gerontological research", *Journal of Gerontological Nursing,* vol. 19, no. 5, pp. 21-27.

Green, B., Jones, M., Hughes, D. & Williams, A. 1999, "Applying the Delphi technique in a study of GPs' information requirements", *Health & Social Care in the Community,* vol. 7, no. 3, pp. 198-205.

Green, L. 1987, "Letter to the editor", *Health Education Quarterly,* vol. 14, no. 1, pp. 4.

Green, P.J. 1982, "The content of a college-level outdoor leadership course" in *The Conference of the Northwest District Association for the American Alliance for Health, Physical Education, Recreation, and Dance,* Spokane, WA.

Grundy, S. 1987, *Curriculum: Product or Praxis,* The Falmer Press, London, England.

Guess, R. 1981, *The idea of a critical theory: Habermas and the Frankfurt School,* Cambridge University Press, Cambridge.

Gusella, J.L., Ward, A. & Butler, G.S. 1998, "The experience of hospitalised children: How well do we meet their developmental needs?", *Children's Health Care,* vol. 27, no. 2, pp. 131-145.

Habermas, J. 1990, *Moral Consciousness and Communicative Action,* The MIT Press, Cambridge.

Habermas, J. 1987b, *The philosophical discourse of modernity: Twelve lectures,* Polity Press, Cambridge.

Habermas, J. 1987a, *The Theory of Communicative Action Volume Two: Lifeworld and system: A Critique of Functionalist Reason,* Beacon Press, Boston.

Habermas, J. 1984, *The Theory of Communicative Action Volume One: Reason and the Rationalisation of Society,* Beacon Press, Boston.

Habermas, J. 1982, "Reply to my Critics" in *Habermas Critical Debates,* eds. J.B. Thompson & D. Held, MIT Press, Cambridge.

Habermas, J. 1976, *Legitimation crisis,* Polity Press, Cambridge, UK.

Habermas, J. 1974, *Theory and Practice,* Heinemann, London.

Habermas, J. 1972, *Knowledge and Human Interests,* Polity Press, Cambridge.

Habermas, J. 1971, *Toward a rational society: student protest, science and politics;* Heinemann Educational, London.

Habermas, J. 1970b, "Toward a theory of communicative competence", *Inquiry,* vol. 13, no. Autumn, pp. 360-375.

Habermas, J. 1970a, " On systematically distorted communication", *Inquiry,* vol. 13, no. Summer, pp. 205-218.

Habermas, J. & Lenhardt, C. 1973, "A Postscript to Knowledge and Human Interests", *Philosophy of the Social Sciences,* vol. 3, no. 1, pp. 157-189.

Hall, A. 2005, "Defining nursing knowledge", *Nursing Times,* vol. 101, no. 48, pp. 34-39.

Hallstrom, I. & Elander, G. 2004, "Decision-making during hospitalisation: parents' and children's involvement", *Journal of Clinical Nursing,* vol. 13, no. 3, pp. 367-375.

Hanssen, I. 2004, "An Intercultural Nursing Perspective on Autonomy", *Nursing Ethics,* vol. 11, no. 1, pp. 28-41.

Hardy, D.J., O'brien, A.P., Gaskin, C.J., O'brien, A.J., Morrison-Ngatai, E., Skews, G., Ryan, T. & Mcnulty, N. 2004, "Practical application of the Delphi technique in a bicultural mental health nursing study in New Zealand", *Journal of Advanced Nursing,* vol. 46, no. 1, pp. 95-109.

Harper, W., Cook, S. & Makoul, G. 2007, "Teaching Medical Students About Health Literacy: 2 Chicago Initiatives", *American Journal of Health Behavior,* vol. 31, no. Supplement 1, pp. S111-S114.

Hart, C. & Chesson, R. 1998, "Children as consumers", *British Medical Journal,* vol. 316, no. 7144, pp. 1600-1603.

Hartrick, G. 1997a, "Beyond a Service Model of Care: Health Promotion and the Enhancement of Family Capacity", *Journal Of Family Nursing,* vol. 3, no. 1, pp. 57-69.

Hartrick, G. 1997b, "Relational capacity: the foundation for interpersonal nursing practice", *Journal of Advanced Nursing,* vol. 26, no. 3, pp. 523-528.

Hasson, F., Keeney, S. & McKenna, H. 2000, "Research guidelines for the Delphi survey technique", *Journal of Advanced Nursing,* vol. 32, no. 4, pp. 1008-1015.

Hayman, L.L. 2010, "Starting young: promoting a healthy lifestyle with children", *Journal of Cardiovascular Nursing,* vol. 25, no. 3, pp. 228-232.

Hayman, L.L. 2007, "Behavioral medicine across the life course: Challenges and opportunities for interdisciplinary science", *Annals of Behavioral Medicine,* vol. 33, no. 3, pp. 236-241.

Heath, P. 2002, *Our duty of care: National review of nursing education,* Departments of Education, Science and Technology, Canberra.

Heckman, J.J. 2000, "Policies to Foster Human Capital", *Research in Economics,* vol. 54, no. 1, pp. 3-56.

Held, D. 1980, *Introduction to Critical Theory: Horkheimer to Habermas,* Hutchinson, Australia.

Henderson, A. & Et Winch, S. 2008, "Staff development in the Australian context: Engaging with clinical contexts for successful knowledge transfer and utilisation", *Nurse Education in Practice,* vol. 8, no. 3, pp. 165-169.

Henderson, V. 1966, *The nature of nursing: a definition and its implications for practice, research and education,* McMillan, New York.

Hendricks-Thomas, J. & Patterson, E. 1995, "A sharing in critical thought by nursing faculty", *Journal of advanced nursing,* vol. 22, no. 3, pp. 594-599.

Henney, C.R., Chrissafis, I., Mcfarlane, J. & Crooks, J. 1982, "A method of estimating nursing workload", *Journal of Advanced Nursing*, vol. 7, no. 3, pp. 319-325.

Her Majesty's Government 1989, *The Children Act*, HMSO, London.

Herzlich, C. 1973, *Health and Illness: A Social Psychological Analysis*, Academic Press, London.

Heslop, L. 1997, "The impossibilities of poststructuralist and critical social nursing inquiry", *Nursing Inquiry*, vol. 4, no. 1, pp. 48-56.

Hewitt-Taylor, J. 1999, "Children in intensive care: physiological considerations", *Nursing in Critical Care*, vol. 4, no. 1, pp. 40-45.

Hicks, C. 1999, *Research methods for clinical therapists: applied project design and analysis*, 3rd edn, Churchill Livingstone, Edinburgh.

Hill, K.O. & Fowles, J. 1975, "The methodological worth of the Delphi forecasting technique", *Technological Forecasting and Social Change*, vol. 7, no. 2, pp. 193-194.

Hill, M., Davis, J., Prout, A. & Tisdall, K. 2004, "Moving the participation agenda", *Children and Society*, vol. 18, no. 2, pp. 77-96.

Hohn, M. 1998, *Empowerment health education in adult literacy: a guide for public health adult literacy practitioners, policy makers and funders* [Homepage of National Institute for Literacy], [Online]. Available: http://files.eric.ed.gov/fulltext/ED425342.pdf. [2013, November/26th].

Holmes, C.A. 2002, "Academics and practitioners: nurses as intellectuals", *Nursing Inquiry*, vol. 9, no. 2, pp. 73-83.

Holmes, C. & Warelow, P. 2000, "Nursing as normative praxis", *Nursing inquiry*, vol. 7, no. 3, pp. 175-181.

Howell, W.L.J. 2012, "The Changing Role of Nurses", *Hospitals and Health Networks Magazine*, vol. 86, no. 3, pp. 36-49.

Igoe, J.B. 1989, "Primary health care - a challenge for nursing practitioners", *11th National Conference*.

Irvine, F. 2010, "Contextualizing health promotion" in *Health promotion and health education in nursing: a framework for practice*, eds. D. Whitehead & F. Irvine, Palgrave Macmillan, United Kingdom, pp. 1-21.

Jackson, D. & Daly, J. 2008, "Nursing and pre-registration nursing education under the spotlight again", *Collegian,* vol. 15, no. 1, pp. 1-2.

Jackson, M.C. 1991, "Modernism, post-modernism and contemporary systems thinking" in *Critical systems thinking: Directed readings*, eds. R.L. Flood & M.C. Jackson, John Wiley & Sons, Chichester, pp. 287-301.

Jackson, R. 2005-2006, "Health literacy: an introduction of the literature", *Journal of the Indiana Dental Association,* vol. 84, no. 4, pp. 10-13.

Jairath, N. & Weinstein, J. 1994, "The Delphi Methodology (Part One): A useful administrative approach", *Canadian Journal of Nursing Administration,* vol. 7, no. 3, pp. 29-40.

Jeffery, D., Ley, A., Bennun, I. & Mclaren, S. 2000, "Delphi survey of opinion on interventions, service principles and service organisation for severe mental illness and substance misuse problems", *Journal of Mental Health,* vol. 9, no. 4, pp. 371-384.

Jones, K. 1993, "Opportunities for health education: an analysis of nurse—client interactions in acute areas" in *Research in Health Promotion and Nursing*, eds. B.J. Wilson & C.J. Macleod, Macmillan, London, pp. 80-85.

Jones, L. 1994, *The social context of health and health work,* Macmillan, London.

Judd, C.M., Smith, E.R. & Kidder, L.H. 1991, *Research methods in social relations,* 6th edn, Holt, Rinehart and Winston, Fort Worth.

Jukkala, A., Dupree, J.P. & Graham, S. 2009, "Knowledge of limited health literacy at an academic health center", *The Journal of Continuing Education in Nursing,* vol. 40, no. 7, pp. 298-302.

Kearsey, K. 2002, "Nurses lift the lid on illiteracy", *Registered Nurse Journal,* vol. 14, no. 5, pp. 14-16.

Keeney, S., Hasson, F. & McKenna, H. 2006, "Consulting the oracle: ten lessons from using the Delphi technique in nursing research", *Journal of Advanced Nursing,* vol. 53, no. 2, pp. 205-212.

Keeney, S., Hasson, F. & McKenna, H.P. 2001, "A critical review of the Delphi technique as a research methodology for nursing", *International Journal of Nursing Studies*, vol. 38, no. 2, pp. 195-200.

Keikelame, M.J. & Swartz, L. 2013, "Lost opportunities to improve health literacy: Observations in a chronic illness clinic providing care for patients with epilepsy in Cape Town South Africa", *Epilepsy & Behavior*, vol. 26, no. 1, pp. 36-41.

Kendall, J. 1989, "Child psychiatric nursing and the family. A critical theory perspective", *Journal of Child and Adolescent Psychiatric and Mental Health Nursing*, vol. 2, no. 4, pp. 145-153.

Kickbusch, I. 2008, *Healthy Societies: Addressing 21st Century Health Challenges*. Available: http://www.publications.health.sa.gov.au/cgi/viewcontent.cgi?article=1034&context=hprom&sei-redir [2009, June/12].

Kickbusch, I. 2001, "Health literacy: addressing the health and education divide", *Health Promotion International*, vol. 16, no. 3, pp. 289-297.

Kickbusch, I. & Maag, D. 2008, "Health Literacy", *International Encyclopedia of Public Health*, vol. 3, pp. 204-211.

Kickbusch, I., Wait, S. & Maag, D. 2005, *Navigating health: the role of health literacy*, Alliance for Health and the Future, International Longevity Centre-UK.

Kilroy, D. & Discoll, P. 2006, "Determination of required anatomical knowledge for clinical practice in emergency medicine: national curriculum planning using a modified Delphi technique", *Journal of Emergency Medicine*, vol. 23, no. 9, pp. 693-696.

Kim, H.S. 1999, "Critical reflective inquiry for knowledge development in nursing practice", *Journal of advanced nursing*, vol. 29, no. 5, pp. 1205-1212.

Kools, S., Gilliss, C. & Tong, E.M. 1999, "Family transitions in congenital heart disease management: The impact of hospitalisation in early adulthood", *Journal of Family Nursing*, vol. 5, no. 4, pp. 427-448.

Kowalski, W.J., Leef, K.H., Mackley, A., Spear, M.L. & Paul, D.A. 2006, "Communicating with parents of premature infants: who is the informant?", *Journal of Perinatology*, vol. 26, no. 1, pp. 44-48.

Kruske, S. & Grant, J. 2012, "Educational preparation for maternal, child and family health nurses in Australia", *International Nursing Review,* vol. 59, no. 2, pp. 200-207.

Kutzleb, J. & Reiner, R. 2006, "The impact of nurse-directed patient education on quality of life and functional capacity in people with heart failure", *Journal of American Academy of Nurse Practitioners,* vol. 18, no. 3, pp. 116-123.

Kwan, B., Frankish, J. & Rootman, I. 2006, *The Development and Validation of Measures of "HealthLiteracy" in Different Populations*, University of British Columbia Institute of Health Promotion Research and Promotion Research, Vancouver.

Lane, S.H. & Kohlenberg, E. 2012, "Emancipated Minors: Health Policy and Implications for Nursing", *Journal of Pediatric Nursing,* vol. 27, no. 5, pp. 533-548.

Lansdown, R. 1996, *Children in Hospital: A Guide for Family and Carers,* Oxford University Press, Oxford.

Latter, S. 1993, "Health education and health promotion in acute ward settings: nurses' perceptions and practices" in *Research in Health Promotion and Nursing*, eds. J. Wilson-Barnett & J. Macleod Clark, The Macmillan Press, Houndmills, pp. 72-79.

Latter, S., Macleod-Clark, J., Wilson-Barnett, J. & Maben, J. 1992, "Health education in nursing perceptions of practice in acute settings", *Journal of Advanced Nursing,* vol. 17, no. 2, pp. 164-172.

Laurent, C. 1990, "Building for the future: The case for paediatric nurses", *Nursing Times,* vol. 86, no. 10, pp. 70-72.

Lee, K.H. 2008, "The hospitalist movement--a complex adaptive response to fragmentation of care in hospitals", *ANNALS Academy of Medicine Singapore,* vol. 37, no. 2, pp. 145-150.

Leininger, M.M. 2006, "Ethnonursing: A research method with enablers to study the theory of culture care" in *Culture care Diversity and Universality*, eds. M. Leininger & M. McFarland, Johns and Bartlett Publishers, Sudbury, M.A., pp. 43-82.

Lewis, C.E. & Lewis, M.A. 1982, "Children's health-related decision making", *Health Education Quarterly,* vol. 9, no. 2-3, pp. 225-237.

Lincoln, Y.S. & Guba, E.G. 1985, *Naturalistic Inquiry,* Sage, London.

Lindau, S., Tomori, C., Lyons, T., Langseth, L., Bennett, C. & Garcia, P. 2002, "The association of health literacy with cervical cancer prevention knowledge and health behaviours in a multiethnic cohort of women", *American Journal of Obstetrics and Gynaecology,* vol. 186, no. 5, pp. 938-943.

Lindeman, C. 1973, "Influencing recovery through pre-operative teaching", *Heart and Lung,* vol. 2, no. 4, pp. 515-520.

Lindeman, C.A. 1975, "Delphi survey of priorities in clinical nursing research", *Nursing Research,* vol. 24, no. 6, pp. 434-441.

Linstone, H.A. & Turoff, M. 1975, "Introduction" in *The Delphi method: Techniques and applications,* eds. H.A. Linstone & M. Truoff, Addison-Wesley Publishing Company, Massachusetts, pp. 1-35.

Logan, R. 2007, "Clinical, classroom, or personal education: attitudes about health literacy", *Journal of the Medical Library Association,* vol. 95, no. 2, pp. 127-137.

Lolas, F. 2002, "Information, communication, and equity: Dilemmas in health", *Pan-American Journal of Public Health,* vol. 11, no. 5-6, pp. 430-434.

Looman, W.S., Presler, E., Erickson, M.M., Garwick, A.W., Cady, R.G., Kelly, A.M. & Finkelstein, S.M. 2013, "Care Coordination for Children With Complex Special Health Care Needs: The Value of the Advanced Practice Nurse's Enhanced Scope of Knowledge and Practice", *Journal of Pediateric Health Care,* vol. 27, no. 4, pp. 293-303.

Loughlin, K.G. & Moore, L.F. 1979, "Using Delphi to achieve congruent objectives and activities in a paediatrics department", *Journal of Medical Education,* vol. 54, no. 2, pp. 101-106.

Lowes, L. 1996, "Paediatric nursing and children's autonomy", *Journal of Clinical Nursing,* vol. 5, no. 6, pp. 367-372.

Macabasco-O'Connell, A. & Fry-Bowers, E. 2011, "Knowledge and Perceptions of Health Literacy Among Nursing Professionals", *Journal of Health Communication: International Perspectives,* vol. 16, no. supplement 3, pp. 295-307.

Macleod-Clark, J. 1988, "Communication; the continuing challenge", *Nursing Times,* vol. 84, no. 23, pp. 24-27.

Macleod-Clark, J., Haverty, S. & Kendall, S. 1990, "Helping people to stop smoking: a study of the nurse's role", *Journal of Advanced Nursing*, vol. 15, no. 3, pp. 357-363.

Macleod-Clark, J., Wilson-Barnett, J., Latter, S. & Maben, J. 1992, *Health education and health promotion in nursing: a study of practice in acute areas. Report of a 2 year Department of Health funded project*, King's College, London.

Mallik, M. 1997, "Advocacy in nursing–a review of the literature", *Journal of Advanced Nursing*, vol. 25, no. 1, pp. 130-138.

Manderson, L. & Allotey, P. 2003, "Storytelling, Marginality, and Community in Australia: How Immigrants Position Their Difference in Health Care Settings", *Medical Anthropology*, vol. 22, no. 1, pp. 1-21.

Manley, K. & McCormack, B. 2003, "Practice development: purpose, methodology, facilitation and evaluation", *Nursing in Critical Care*, vol. 8, no. 1, pp. 22-29.

Mason, D.J. 2001, "Promoting Health Literacy", *AJN, American Journal of Nursing*, vol. 101, no. 2, pp. 7.

May, B.K. & Sparks, M. 1983, "School age children: are their needs recognised and met in the hospital setting?", *Children's Health Care,* vol. 11, no. 3, pp. 118-121.

Mayall, B. 1996, *Children, Health and the Social Order*, Open University Press, Buckingham.

Mayall, B. 1995, "The changing context of childhood: children's perspectives on health care resources including services" in *The Health of our Children*, ed. B. Botting, HMSO, London, pp. 21-27.

Mayall, B. 1994, *Children's Childhoods: Observed and Experienced,* The Falmer Press, London.

McAllister, J.W., Presler, E. & Cooley, W.C. 2007, "Practice-based care coordination: A medical home essential", *Pediatrics*, vol. 120, no. 3, pp. e723-e733.

McBride, A. 1994, "Health promotion in hospitals: attitudes, beliefs & practices of hospital nurses", *Journal of Advanced Nursing*, vol. 20, no. 1, pp. 92-100.

McCarthy, T. 1978, *The critical theory of Jurgen Habermas*, Hutchinson, London.

McKenna, H.P. 1994, "The Delphi technique: a worthwhile research approach for nursing", *Journal of Advanced Nursing*, vol. 19, no. 6, pp. 1221-1225.

McKenzie, J.F., Neiger, B.L. & Thackeray, R. 2009, *Planning, implementing and evaluating health promotion programs: A primer*, 5th edn, Pearson Benjamin Cummings, San Francisco, CA.

McKinlay, E., Mackie, S., Arcus, K. & Nelson, K. 2012, "Work and wellness hand-in-hand: the role of the New Zealand PATHS program nurse in improving health and employment outcomes", *Rehabilitation Nursing*, vol. 37, no. 4, pp. 185-194.

McLaughlin, F.E. & Marascuilo, L.A. 1990, *Advanced nursing and health care research: quantification approaches*, Saunders, Philadelphia.

Mead, D. & Moseley, L. 2001, "The use of the Delphi as a research approach", *Nurse Researcher*, vol. 8, no. 4, pp. 4-23.

Mezirow, J. 1981, "A critical theory of adult learning and education", *Adult Education Quarterly*, vol. 32, no. 1, pp. 3-24.

Miller, M.M. 1992, "Patient teaching" in *Emergency Nursing: Principles and Practice*, ed. S.S. Sheeby, CV Mosby, St Louis.

Moore, J.B. 1993, "Predictors of children's self-care performance: testing the theory of self-care deficit", *Scholarly Inquiry for Nursing Practice*, vol. 7, no. 3, pp. 199-212.

Moore, J.B. & Mosher, R.B. 1997, "Adjustment responses of children and their mothers to cancer: selfcare and anxiety", *Oncology Nursing Forum*, vol. 24, no. 3, pp. 519-525.

Morgan, A.K. 1994, "Client education experiences in professional nursing practice -- a phenomenological perspective", *Journal of Advanced Nursing*, vol. 19, no. 4, pp. 792-801.

Moseley, L. & Mead, D. 2001, "Considerations in using the Delphi approach: design, questions and answers", *Nurse Researcher*, vol. 8, no. 4, pp. 24-37.

Moss-Morris, R. & Paterson, J. 1995, "Understanding children's concepts of health and illness: Implications for developmental therapists", *Physical and Occupational Therapy in Pediatrics*, vol. 14, no. 3-4, pp. 95-108.

Mullen, P. 2003, "Delphi: myths and reality", *Journal of Health Organisation and Management*, vol. 17, no. 1, pp. 37-52.

Murdaugh, C. 1980, "Effects of nurses' knowledge of teaching learning pineapples on knowledge of coronary care unit patients", *Heart and Lung*, vol. 9, no. 6, pp. 1073-1078.

Murphy, M.K., Black, N.A., Lamping, D.L., McKee, C.M., Sanderson, C.F.B., Askham, J. & Marteau, T. 1998, "Consensus development methods and their use in clinical guidelines development" in *Health technology assessment, NHS R&D HTA Programme* Department of Health, London, pp. 1-88.

Murphy-Knoll, L. 2007, "Low health literacy pits patients at risk: The joint commission proposes solutions to a national problem", *Journal of Nursing Care Quality*, vol. 22, no. 3, pp. 205-509.

Mustard, F. 2007, *Investing in the Early Years: Closing the gap between what we know and what we do* [Homepage of Government of South Australia], [Online]. Available: http://www.thinkers.sa.gov.au/lib/pdf/Mustard_Final_Report.pdf. [2013, December/20th].

National Health and Medical Research Council (NHMRC), Australian Research Council (ARC) & Australian Vice-Chancellors' Committee (AVCC) 2007b, *National Statement on Ethical Conduct in Human Research*, Australian Government, Canberra.

National Health and Medical Research Council (NHMRC), Australian Research Council (ARC) & Australian Vice-Chancellors' Committee (AVCC) 2007a, *Australian Code for the Responsible Conduct of Research*, Australian Government, Canberra.

National Nursing and Nursing Education Taskforce 2006, *National Nursing and Nursing Education Taskforce Final Report* [Homepage of National Nursing and Nursing Education Taskforce], [Online]. Available: http://www.nnnet.gov.au/downloads/n3et_final_report.pdf. [2013, November/26th].

Nightingale, F. 1967, *Nursing is an art. To the Editor*, Macmillan's Magazine.

Nightingale, F. 1859, *Notes on nursing: what it is and what it is not*, Lippincott, Philadelphia.

Norbeck, J.S. & Tilden, V.P. 1983, "Life stress, social support and emotional disequilibrium in complications of pregnancy: a prospective multivariate study", *Journal of Health and Social Behaviour*, vol. 34, no. 1, pp. 30-46.

Norrish, B.R. & Rundall, T.G. 2001, "Hospital Restructuring and the Work of Registered Nurses", *The Milbank Quarterly*, vol. 79, no. 1, pp. pp. 55-79.

Norton, L. 1998, "Health promotion and health education: what role should the nurse adopt in practice?", *Journal of Advanced Nursing*, vol. 28, no. 6, pp. 1269-1275.

Noyes, J. 2000, "Enabling young 'ventilator-dependent' people to express their views and experiences of their care in hospital", *Journal of Advanced Nursing*, vol. 31, no. 5, pp. 1206-1215.

NSW Department of Health 2006, *First report on the Models of Care project* [Homepage of NSW Department of Health], [Online]. Available: http://www0.health.nsw.gov.au/pubs/2006/pdf/models_of_care.pdf. [2013, November/26th].

Nursing and Midwifery Board of Australia 2013, *National competency standards for the registered nurse* [Homepage of Australian Health Practitioner Regulation Agency AHPRA], [Online]. Available: http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#competencystandards [2013, November/20th].

Nutbeam, D. 2008, "The evolving concept of health literacy", *Social Science & Medicine*, vol. 67, pp. 2072-2078.

Nutbeam, D. 2000, "Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century", *Health Promotion International*, vol. 15, no. 3, pp. 259-267.

Nutbeam, D. 1999b, "Literacies across the lifespan: health literacy", *Literacy and Numeracy Studies*, vol. 9, no. 2, pp. 47-55.

Nutbeam, D. 1999a, "Health literacy in a multi-cultural context", *Integration: the Magazine for Vietnamese & Multicultural Issues*, vol. 15, pp. 58-60.

Nyamanthi, A. & Shuler, P. 1990, "Focus group interview: a research technique for informed nursing practice", *Journal of Advanced Nursing*, vol. 15, no. 11, pp. 1281-1288.

O'Cathain, A. & Thomas, K. 2006, "Combining qualitative and quantitative methods" in *Qualitative Research in Health Care*, eds. C. Pope & N. Mays, 3rd edn, Blackwell, Oxford, UK, pp. 102-111.

Oberst, M. 1978, "Priorities in cancer nursing research", *Cancer Nursing*, vol. 1, no. 4, pp. 281-290.

O'Connell, B., Baker, L. & Prosser, A. 2003, "The educational needs of caregivers of stroke survivors in acute and community settings", *Journal of Neuroscience Nursing*, vol. 35, no. 1, pp. 21-28.

Oldfield, C. & Fowler, C. 2004, *Mapping Children and Young People's Participation in England* [Homepage of Department for Education and Skills, Health], [Online]. Available: http://dera.ioe.ac.uk/5226/1/RR584.pdf. [2013, November/26th].

Olson, R.M., Blank, D., Cardinal, E., Hopf, G. & Chalmers, R.K. 1996, "Understanding medication-related needs of low-literacy patients", *Journal of the American Pharmaceutical Association (Wash)*, vol. NS36, no. 7, pp. 424-429.

Onwuegbuzie, A.J. & Johnson, R.B. 2006, "The validity issue in mixed research", *Research in the Schools*, vol. 13, no. 1, pp. 48-63.

Orton, H.D. 1981, "Ward learning climate and student nurse response", *Nursing Times Occasional Papers*, vol. 77, no. 17.

Patel, V.L., Arocha, J.F. & Zhang, J. 2005, "Thinking and reasoning in medicine" in *Thinking and Reasoning*, eds. K.J. Holyoak & R.G. Morrison, Cambridge University Press, Cambridge, pp. 727-750.

Pelling, M., Berridge, V., Harrison, M. & Weindling, P. 1993, "The era of public health, 1848-1918" in *Caring for health: history and diversity*, ed. C. Webster, Open University Press, Buckingham, pp. 63-86.

Peplau, H.E. 1988, "The Art and Science of Nursing: Similarities, Differences, and Relations", *Nursing science quarterly*, vol. 1, no. 1, pp. 8-15.

Peterson, L. 1989, "Coping by children undergoing stressful medical procedures: some conceptual, methodological and therapeutic issues ", *Journal of Consulting and Clinical Psychology*, vol. 57, no. 3, pp. 380-387.

Phillips, C.B., Pearce, C., Hall, S., Kljakovic, M., Sibbald, B., Dwan, K., Porritt, J. & Yates, R. 2009, "Enhancing care, improving quality: the six roles of the general practice nurse", *The Medical Journal of Australia*, vol. 191, no. 2, pp. 92-97.

Pill, J. 1971, "The Delphi method: substance, context, a critique and an annotated bibliography", *Socio-Economic Planning Sciences*, vol. 5, no. 1, pp. 57-71.

Polit, D.F., Beck, C.T. & Hungler, B.P. 2001, *Essentials of nursing research. Methods, Appraisal, & Utilization,* 5th edn, J.B. Lippincott Company, Philadelphia. New York. Baltimor.

Polit-O'Hara, D. & Hungler, B.P. 1989, *Essentials of nursing research: methods, appraisal, and utilization,* 2nd edn, Lippincott, Philadelphia.

Porter, S. 1994, "New nursing: the road to freedom?", *Journal of Advanced Nursing,* vol. 20, no. 2, pp. 269-274.

Powell, C. 2003, "The Delphi technique: myths and realities", *Journal of Advanced Nursing,* vol. 41, no. 4, pp. 376-382.

Prilleltensky, I., Nelson, G. & Peirson, L. 2001, "The role of power and control in children's lives: an ecological analysis of pathways toward wellness, resilience and problems", *Journal of Community and Applied Social Psychology,* vol. 11, no. 2, pp. 143-158.

Rafferty, D. 1991, "Of primary importance", *Senior Nurse,* vol. 11, no. 6, pp. 4-8.

Rankin, S.H. & Duffy, K.L. 1983, *Patient education issues, principles and guideline,* J.B. Lippincott, Philadelphia.

Rankin, S.H., Stallings, K.D. & London, F. 2005, *Patient education in heath and illness,* 5th edn, Lippincott Williams & Wilkins, 530 Walnut Street, Philadelphia PA.

Raphael, D. 2009, *Social Determinants of Health: Canadian Perspectives,* 2nd edn, Canadian Scholars Press Inc, Toronto.

Ratcliffe, J. 1998, "Provision of intensive care for children", *British Medical Journal,* vol. 316, no. 7144, pp. 1547-1548.

Ratzan, S.C. & Parker, R. 2000, in *National academics of medicine current bibliographies in medicine: health literacy,* eds. C.R. Selden, M. Zorn, S.C. Ratzan & R.M. Parker, National Institutes of Health, U.S. Department of Health and Human Services, Bethesda, MD, pp. Introduction.

Rauch, W. 1979, "The decision Delphi", *Technological Forecasting and Social Change,* vol. 15, no. 3, pp. 159-169.

Redelmeier, D.A. 1991, "Cognitive psychology and medical judgement: some downfalls of studying pitfalls", *Medical Decision Making,* vol. 11, no. 3, pp. 169-170.

Redelmeier, D.A. & Shafir, E. 1995, "Medical decision making in situations that offer multiple alternatives", *JAMA: The Journal of the American Medical Association,* vol. 273, no. 4, pp. 302-305.

Redman, B.K. 2007, *The Practice of Patient Education: A Case Study Approach,* Mosby Elsevier, St. Louis.

Reid, N. 1988, "The Delphi technique: its contribution to the evaluation of professional practice" in *Professional competence and quality assurance in the caring professions,* ed. R. Ellis, Chapman & Hall, New York, pp. 230-262.

Reissland, N. 1983, "Cognitive maturity and the experience of fear and pain in hospital", *Social Science and Medicine,* vol. 17, no. 18, pp. 1389-1395.

Rice, P. & Ezzy, D. 1999, *Qualitative research methods: a health focus,* Oxford University Press, Melbourne.

Ritzer, G. 2011, *The McDonaldization of society 6,* [6th] edn, SAGE/Pine Forge, Los Angeles.

Robinson, J.L.D., Calmes, D.P. & Bazargan, M. 2008, "The Impact of Literacy Enhancement on Asthma-Related Outcomes among Underserved Children", *Journal of the National Medical Association,* vol. 100, no. 8, pp. 892-6.

Robinson, S.E. & Hill, Y. 1999, "Our healthier hospital? The challenge for nursing", *Journal of Nursing Management,* vol. 7, no. 1, pp. 13-17.

Roche, J. 1999, "Children: Rights, participation and citizenship", *Childhood,* vol. 6, no. 4, pp. 475-493.

Roderick, R. 1986, *Habermas and the foundations of critical theory,* Macillan, London.

Roe, B.H. 1990, "Study of the effects of education on the management of urine drainage systems by patients and carers", *Journal of Advanced Nursing,* vol. 15, no. 5, pp. 517-524.

Rolfe, G. 2006, "Nursing praxis and the science of the unique", *Nursing Science Quarterly,* vol. 19, no. 1, pp. 39-43.

Rootman, I. 2004, "Health promotion and literacy: implications for nursing", *Canadian Journal of Nursing Research,* vol. 36, no. 1, pp. 13-21.

Rootman, I., Kaszap, M., Frankish, J., Dupéré, S., Pederson, A. & Rootman, I. 2006, "Health and literacy: a new avenue " in *Health Promotion in Canada,* ed. M. O'Neill, Presses de l'Université Laval, Québec, pp. 81-97.

Rothman, R.L., Yin, H.S., Mulvaney, S., Co, J.P.T., Homer, C. & Lannon, C. 2009, "Health literacy and quality: Focus on chronic illness care and patient safety", *Pediatrics,* vol. 124, no. supplement 3, pp. S315-S326.

Rowe, G., Wright, G. & Bolger, F. 1991, "Delphi: a re-evaluation of research and theory", *Technical Forecasting Social Change,* vol. 39, no. 3, pp. 235-251.

Rowe, J. & Barnes, M. 2006, "The role of child health nurses in enhancing mothering know-how", *Collegian,* vol. 13, no. 4, pp. 22-26.

Royal College of Nursing 2003b, *Defining nursing,* Royal College of Nursing, 20 Cavendish Square London.

Royal College of Nursing 2003a, *Children and Young People's Nursing: A Philosophy of Care* [Homepage of RCN], [Online]. Available: http://www.rcn.org.uk/__data/assets/pdf_file/0003/78573/002012.pdf. [2013, November/26th].

Rudd, R., Mneykens, B. & Colton, T. 1999, "Health and literacy: a review of the medical and public health literature" in *Annual review of adult learning and literacy,* eds. J. Comings, B. Garner & C. Smith, Jossey-Bass, San Francisco.

Runeson, I., Enskar, K., Elander, G. & Hermeren, G. 2001, "Professionals' perceptions of children's participation in decision making in health care", *Journal of Clinical Nursing,* vol. 10, no. 1, pp. 70-78.

Sackman, H. 1975, *Delphi critique,* Lexington Books, Lexington, MA.

Safeer, R.S. & Keenan, J. 2005, "Health Literacy: The gap between physicians and patients", *American Family Physician,* vol. 72, no. 3, pp. 463-468.

Sanders, L.M., Thompson, V.T. & Wilkinson, J.D. 2007, "Caregiver health literacy and the use of child health services", *Pediatrics,* vol. 119, no. 1, pp. e86-e92.

Saucier, C.P. 1984, "Self concept and self-care management in school-age children with diabetes", *Pediatric Nursing Journal,* vol. 10, no. 2, pp. 135-138.

Sayers, J.M. & DiGiacomo, M. 2010, "The nurse educator role in Australian hospitals: Implications for health policy", *Collegian,* vol. 17, no. 2, pp. 77-84.

Scheckel, M., Emery, N. & Nosek, C. 2010, "Addressing health literacy: the experiences of undergraduate nursing students", *Journal of Clinical Nursing,* vol. 19, no. 5-6, pp. 794-802.

Scheibe, M., Skutch, M. & Schofer, J. 1975, "Experiemnts in Delphi methodology" in *The Delphi method: Techniques and applications,* eds. H.A. Linstone & M. Truoff, Addison-Wesley Publishing Company, Massachusetts, pp. 262-282.

Schlichting, J.A., Quinn, M.T., Heuer, L.J., Schaefer, C.T., Drum, M.L. & Chin, M.H. 2007, "Provider perceptions of limited health literacy in community health centers", *Patient Education and Counseling,* vol. 69, no. 1–3, pp. 114-120.

Scott, J.P. 1978, "Critical social theory: An introduction and critique", *The British Journal of Sociology,* vol. 29, no. 1, pp. 1-21.

Scudder, L. 2006, "Words and well-being: How literacy affects patient health", *The Journal for Nurse Practitioners,* vol. 2, no. 1, pp. 28-35.

Senate Community Affairs Committee. 2007, *Highway to health: Better access for rural, regional and remote patients,* Commonwealth of Australia, Canberra.

Shiminski-Maher, T. 1993, "Physician-patient-parent communication problems", *Pediatric Neurosurgery,* vol. 19, no. 2, pp. 104-108.

Shonkoff, J., Boyce, W. & Mcewen, B. 2009, "Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention", *The Journal of the American Medical Association,* vol. 301, no. 21, pp. 2252-2259.

Silverman, D. 1987, *Communication and Medical Practice: Social Relations in the Clinic,* Sage, London.

Silverstein, M., Iverson, L. & Lozano, P. 2002, "An English-language clinic-based literacy program is effective for a multilingual population", *Paediatrics,* vol. 109, no. 5, pp. 1-6.

Skipper, J.K. & Leonard, R. 1968, "Children, stress and hospitalisation: a field experiment", *Journal of Health and Social Behaviour*, vol. 9, no. 4, pp. 275-287.

Soanes, C. & Stevenson, A. 2005, *The new oxford English dictionary*, 2nd edn, Oxford English Press, Oxford.

Soller, W. 2006, "An integrated approach to teaching health literacy in the clinical pharmacy curriculum", *Journal of Pharmacy Teaching*, vol. 13, no. 1, pp. 17-28.

Speros, C. 2005, "Health literacy: concept analysis", *Journal of Advanced Nursing*, vol. 50, no. 6, pp. 633-640.

Speros, C.I. 2011, "Promoting Health Literacy: A Nursing Imperative", *Nursing Clinics of North America*, vol. 46, no. 3, pp. 321-333.

Stephenson, L. 2006, "Health literacy: are you doing enough to communicate with your patients?", *Iowa Medicine*, vol. 96, no. 4, pp. 16-17.

Stewart, D.W., Shamdasani, P.N. & Rook, D.W. 2007, *Focus groups. Theory and practice*, 2nd edn, Sage Publications, Thousand Oaks, CA.

Stiles, E. 2011, "Promoting health literacy in patients with diabetes", *Nursing Standard*, vol. 26, no. 8, pp. 35-40.

Stockton, P.L. 2004, "Improving health literacy", *AMWA Journal*, vol. 19, no. 3, pp. 101-104.

Stömberg, A. 2002, "Educating nurses and patients to manage heart failure", *European Journal of Cardiovascular Nursing*, vol. 1, no. 1, pp. 33-40.

Strong, P.M. 1979, *The Ceremonial Order of the Clinic: Parents, Doctors and Medical Bureaucracies*, Routledge, London.

Styles, M.M., Moccia, P. & Evans, N.G. 1993, *On nursing : a literary celebration : an anthology*, National League for Nursing Press, New York.

Sumsion, T. 1998, "The Delphi technique: an adaptive research tool", *British of Ocuupational Therapy*, vol. 61, no. 4, pp. 153-156.

Talbot, L. & Verrinder, G. 2010, *Promoting health: The primary health care approach*, 4th edn, Churchill Livingstone, Elsevier, Australia.

Taylor, B. 2004, "Technical, Practical, and Emancipatory Reflection for Practicing Holistically", *Journal of Holistic Nursing*, vol. 22, no. 1, pp. 73-84.

Taylor, J.S. 1997, "Nursing ideology: identification and legitimation", *Journal of Advanced Nursing*, vol. 25, no. 3, pp. 442-446.

The Free Dictionary [Homepage of Farlex], [Online]. Available: http://www.thefreedictionary.com/a+priori [2011, August/9].

The Health Foundation 2011, *Evidence: Helping people help themselves* [Homepage of The Health Foundation], [Online]. Available: http://www.health.org.uk/public/cms/75/76/313/2434/Helping%20people%20help%20themselves.pdf?realName=8mh12J.pdf. [2013, December/21st].

The Joint Commission 2007, "The joint commission calls for comprehensive action on poor health literacy", *Disease Management Advisor*, vol. 13, no. 3, pp. 34-35 & 25.

The Library of Congress 2014, January/31st/2014-last update, *Children's Rights: Australia* [Homepage of The Library of Congress], [Online]. Available: http://www.loc.gov/law/help/child-rights/australia.php [2014, February/17th].

Therborn, G. 1999, *The ideology of power and the power of ideology*, Verso, London.

Thompson, J.B. 1984, *Studies in the Theory of Ideology*, Polity Press, Cambridge.

Thompson, M.L. 1994, "Information-seeking coping and anxiety in school-age children anticipating surgery", *Children's Health Care,* vol. 23, no. 2, pp. 87-97.

Tones, K. 1997, "Health education as empowerment" in *Debates and Dilemmas in Promoting Health*, eds. M. Sidell, L. Jones, J. Katz & A. Peberdy, The Open University, London, pp. 33-42.

Tones, K. & Tilford, S. 1994, *Health education: effectiveness, efficiency and equity*, 2nd edn, Chapman & Hall, London.

Tones, K., Tilford, S. & Robinson, Y. 1990, *Health education: effectiveness and efficiency*, 2nd edn, Chapman & Hall, London.

Twinn, S.F. & Lee, D.T. 1997, "The practice of health education in acute care setting in Hong Kong: an exploratory study of the contribution of registered nurses", *Journal of Advanced Nursing*, vol. 25, no. 1, pp. 178-185.

United Kingdom Department of Health 2013, , *Giving all children a healthy start in life* [Homepage of UK Department of Health], [Online]. Available: https://www.gov.uk/government/policies/giving-all-children-a-healthy-start-in-life. [2013, November/26th].

United Nations General Assembly 1989, *Conventions on the Rights of the Child*, United Nations, New York.

van der Gaag, J. 2002, "From Child Development to Human Development" in *From Early Child Development to Human Development: Investing in Our Children's Future*, ed. M.E. Young, The World Bank, Washington, pp. 63-80.

Van Dulmen, A.M. 1998, "Children's contribution to pediatric outpatient encounters", *Pediatrics,* vol. 102, no. 3 Pt 1, pp. 563-568.

Visintainer, M.A. & Wolfer, J.A. 1975, "Psychological preparation for surgical pediatric patients: the effect on children's and parents' stress responses and adjustment", *Pediatrics,* vol. 56, no. 2, pp. 187-202.

Visser, A., Deccache, A. & Bensing, J. 2001, "Patient education in Europe: united differences", *Patient Education and Counseling,* vol. 44, no. 1, pp. 1-5.

Walker, A.M. & Selfe, J. 1996, "The Delphi method: A useful tool for the allied health researcher", *British Journal of Therapy and Rehabilitation,* vol. 3, no. 12, pp. 677-681.

Wallace, L.S., Rogers, E.S., Roskos, S.E., Holiday, D.B. & Weiss, B.D. 2006, "BRIEF REPORT: Screening Items to Identify Patients with Limited Health Literacy Skills", *Journal of General Internal Medicine,* vol. 21, no. 8, pp. 874-877.

Walsh, K. & Kowanko, I. 2002, "Nurses? and patients? perceptions of dignity", *International Journal of Nursing Practice,* vol. 8, no. 3, pp. 143-151.

Weithorn, L.A. & Campbell, S.B. 1982, "The competency of children and adolescents to make informed treatment decisions", *Child Development,* vol. 53, no. 6, pp. 1589-1598.

Whitehead, D. 2008, "An international Delphi study examining health promotion and health education in nursing practice, education and policy", *Journal of Clinical Nursing,* vol. 17, no. 7, pp. 891-900.

Whitehead, D. 2005, "Health promoting hospitals: the role and function of nursing", *Journal of Clinical Nursing,* vol. 14, no. 1, pp. 20-27.

Whitehead, D. 2001, "Health education, behavioural change and social psychology: nursing's contribution to health promotion?", *Journal of Advanced Nursing*, vol. 34, no. 6, pp. 822-832.

Whitehead, D. 2004, "Health promotion and health education: advancing the concepts", *Journal of Advanced Nursing*, vol. 47, no. 3, pp. 311-320.

WHO 2013c, *Health Literacy.The solid facts* [Homepage of WHO], [Online]. Available: http://www.euro.who.int/__data/assets/pdf_file/0008/190655/e96854.pdf [2013, November/26th].

WHO 2013b, *Maternal, newborn, child and adolescent health: Early child development* [Homepage of WHO], [Online]. Available: http://www.who.int/maternal_child_adolescent/topics/child/development/en/index.html [2013, November/26th].

WHO 2013a, *Non-communicable diseases* [Homepage of WHO], [Online]. Available: http://www.who.int/mediacentre/factsheets/fs355/en/ [2013, November/26th].

WHO 2011, *Noncommunicable diseases country profiles 2011*. Available: http://www.who.int/nmh/publications/ncd_profiles2011/en/index.html [2014, February/1st].

WHO 2007, "The Bangkok Charter for Health Promotion in a Globalized World", *Health Promotion International*, vol. 21, no. S1, pp. 10-14.

WHO 1998, *Health promotion glossary: health promotion international*, WHO, Geneva.

Whyte, R.E., Watson, H.E. & McIntosh, J. 2006, "Nurses' opportunistic interventions with patients in relation to smoking", *Journal of Advanced Nursing*, vol. 55, no. 5, pp. 568-577.

Williams, M.V., Baker, D.W., Honig, E.G., Lee, T.M. & Nowlan, A. 1998, "Inadequate literacy is a barrier to asthma knowledge and self-care", *Chest*, vol. 114, no. 4, pp. 1008-1015.

Williams, P.L. & Webb, C. 1994, "The Delphi technique: A methodological discussion", *Journal of Advanced Nursing*, vol. 19, no. 1, pp. 180-186.

Wilson, H.S. 1989, *Research in nursing*, 2nd edn, Addison-Wesley, Redwood City, Calif.

Wilson-Barnett, J. & Macleod-Clark, J. 1993, *Research in Health Promotion and Nursing*, The Macmillan Press, Houndmills.

Wingard, R. 2005, "Patient education and the nursing process: meeting the patient's needs", *Nephrology Nursing Journal*, vol. 32, no. 2, pp. 212-214.

Winslow, E.H. 1976, "The role of the nurse in patient education", *Nursing Clinics of North America*, vol. 11, no. 2, pp. 213-222.

Wissema, J.G. 1982, "Trends in technology forecasting", *R & D Management*, vol. 12, no. 1, pp. 27-36.

Wood, M.R. & Bolyard, D. 2011, "Making education count: the nurse's role in asthma education using a medical home model of care", *Journal of Pediatric Nursing*, vol. 26, no. 6, pp. 552-558.

Woodward, C., Chambers, L. & Smith, K. 1991, *Guide to improved data collection in health and health care surveys (personal interview, telephone interview, and mail surveys)*, Canadian Public Health Association, Ottawa.

Wyness, A.M. 1990, "Evaluation of an educational programme for patients taking warfarin", *Journal of Advanced Nursing*, vol. 15, no. 9, pp. 1052-1063.

Youmans, S.L. & Schillinger, D. 2003, "Functional health literacy and medication use: The pharmacist's role", *The Annals of Pharmacotherapy*, vol. 37, no. 11, pp. 1726-1729.

Young, P. 2008, "Toward an inclusive science of nursing education: An examination of five approaches to nursing education research", *Nursing Education Perspectives*, vol. 29, no. 2, pp. 94-99.

Zanchetta, M., Taher, Y., Fredericks, S., Waddell, J., Fine, C. & Sales, R. 2012, "Undergraduate nursing students integrating health literacy in clinical settings", *Nurse Education Today*, vol. 33, no. 9, pp. 1026-1033.

Zanchetta, M.S., Perreault, M., Kaszap, M. & Viens, C. 2007, "Patterns in information strategies used by oldermen to understand and dealwith prostate-cancer-related information: an application of the modélisation qualitative research design", *International Journal of Nursing Studies*, vol. 44, no. 6, pp. 961-972.

Zhang, Z., Luk, W., Arthur, D. & Wong, T. 2001, "Nursing competencies: personal characteristics contributing to effective nursing performance", *Journal of Advanced Nursing,* vol. 33, no. 4, pp. 467-474.

# Appendix A Ethics Approval for the Study

- University of South Australia Human Research Ethics Approval (a)
- University of South Australia Human Research Ethics Approval (b)
- University of South Australia Human Research Ethics Approval (c)
- WCHN Human Research Ethics Committee Approval

# University of South Australia Human Research Ethics Approval (a)

**Kutah, Ola Ahmad Abd Al-Rahman - kutoa001**

| | |
|---|---|
| **From:** | Alice Granger |
| **Sent:** | Tuesday, 23 December 2008 12:09 PM |
| **To:** | Kay Price |
| **Cc:** | Kutah, Ola Ahmad Abd Al-Rahman - kutoa001; Helen McCutcheon |
| **Subject:** | Ethics Protocol P068/07 "A critical analysis of the importance of health literacy to paediatric nursing and child care and youth health" |
| **Attachments:** | Conditions September 2008.doc |

Dear Kay,

Re: **Ethics Protocol P068/07 "A critical analysis of the importance of health literacy to paediatric nursing and child care and youth health"**

Thank you for submitting the variations to your original protocol for approval. The Chairperson of the University's Human Research Ethics Committee has assessed this request and approved the survey content (as detailed in your email dated 12 December 2008).

Please regard this email as formal notification of approval.

Ethics approval is always made on the basis of a number of conditions detailed in the attachment; it is important that you are familiar with, and abide by, these conditions. It is also essential that you conduct all research according to UniSA guidelines, which can be found at http://www.unisa.edu.au/res/ethics/default.asp

Best wishes for your research.

Kind regards

Alice

*Alice Granger*
Compliance Officer
Research and Innovation Services
University of South Australia
Mawson Lakes Campus
Tel: 08 8302 3523
email: alice.granger@unisa.edu.au

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# University of South Australia Human Research Ethics Approval (b)

**Kutah, Ola Ahmad Abd Al-Rahman - kutoa001**

| | |
|---|---|
| **From:** | Alice Granger |
| **Sent:** | Tuesday, 16 June 2009 4:53 PM |
| **To:** | Kay Price |
| **Cc:** | Kutah, Ola Ahmad Abd Al-Rahman - kutoa001; Helen McCutcheon |
| **Subject:** | Ethics Protocol P068/07 "A critical analysis of the importance of health literacy to paediatric nursing and child care and youth health" |
| **Attachments:** | Conditions September 2008.doc |

Dear Kay,

Re: **Ethics Protocol P068/07 "A critical analysis of the importance of health literacy to paediatric nursing and child care and youth health"**

Thank you for submitting the variations to your original protocol for approval. The Chairperson of the University's Human Research Ethics Committee has assessed this request and the changes to conduct focus groups with registered paediatric and child and youth health nurses from the Child, Youth and Women's Health Services (as detailed in your email dated 1st June 2009) are approved subject to:

- Amending the information sheet by replacing the final paragraph with the following statement: "This project has been approved by the University of South Australia's Human Research Ethics Committee. If you have any ethical concerns about the project or questions about your rights as a participant please contact the Executive Officer of this Committee, Tel: +61 8 8302 3118; Email: Vicki.allen@unisa.edu.au".
- Adding the following dot point to the consent form for focus groups: "I agree to maintain the confidentiality of focus group discussions and preserve the identification of focus group participation".

Please regard this email as formal notification of assessment.

**Under the national guidelines, you must not begin your research using the variations listed above before receiving final approval.** Once you have submitted the necessary amendments, and they have been accepted, your approval will be finalised and you may commence your research using the amended protocol.

Ethics approval is always made on the basis of a number of conditions detailed in the attachment; it is important that you are familiar with, and abide by, these conditions. It is also essential that you conduct all research according to UniSA guidelines, which can be found at http://www.unisa.edu.au/res/ethics/human.asp. These guidelines should assist you with the formulation of necessary papers such as the information sheet and the consent form.

We look forward to receiving your amendments in the near future. In the meantime, please contact me if you have any questions

Kind regards

Alice

*Alice Granger*
Compliance Officer
Research and Innovation Services
University of South Australia
Mawson Lakes Campus
Tel: 08 8302 3523
email: alice.granger@unisa.edu.au

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# University of South Australia Human Research Ethics Approval (c)

**Kutah, Ola Ahmad Abd Al-Rahman - kutoa001**

**From:** Alice Granger
**Sent:** Friday, 31 July 2009 1:22 PM
**To:** Kay Price
**Cc:** Kutah, Ola Ahmad Abd Al-Rahman - kutoa001
**Subject:** Ethics Protocol P068/07 "A critical analysis of the importance of health literacy to paediatric nursing and child care and youth health"
**Attachments:** Conditions September 2008.doc

Dear Kay,

Re: **Ethics Protocol P068/07 "A critical analysis of the importance of health literacy to paediatric nursing and child care and youth health"**

Thank you for submitting the additional information requested by the Deputy Chairperson of the University's Human Research Ethics Committee. Your request to vary your original protocol by conducting focus groups with registered paediatric and child and youth health nurses from the Child, Youth and Health Services (as detailed in your email dated 1st June 2009 and 27th July 2009) are approved.

Please regard this email as formal notification of approval.

Ethics approval is always made on the basis of a number of conditions detailed in the attachment; it is important that you are familiar with, and abide by, these conditions. It is also essential that you conduct all research according to UniSA guidelines, which can be found at http://www.unisa.edu.au/res/ethics/default.asp

Best wishes for your research.

Kind regards

Alice

*Alice Granger*
Compliance Officer
Research and Innovation Services
University of South Australia
Mawson Lakes Campus
Tel: 08 8302 3523
email: alice.granger@unisa.edu.au

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## WCHN Human Research Committee Ethics Approval

18th August 2009

Ms O Kutah
6 Sunshine Ave
WARRADALE SA 5046

Dear Ms Kutah

**Re: A critical analysis of the construction of health literacy by paediatric and child and youth health RNs. REC2184/6/12**

I refer to your email dated 27th July 2009 in which you responded to matters raised by the CYWHS Human Research Ethics Committee at its June 2009 meeting. I am pleased to advise that your protocol has been granted full ethics approval and meets the requirements of the *National Statement on Ethical Conduct in Human Research.*

I note that you have provided signed Confidentiality Agreement/s and National Police Certificate/s for non-CYWHS staff involved in the study. If in the future, the study involves other non CYWHS staff or students, a signed Confidentiality Agreement will be required and, if they visit any CYWHS site or access identifiable patient information, a National Police Certificate provided to the Ethics Committee and the Human Resources Department. The study may proceed on this proviso.

I remind you approval is given subject to:
- immediate notification of any serious or unexpected adverse events to subjects;
- immediate notification of any unforeseen events that might affect continued ethical acceptability of the project;
- submission of any proposed changes to the original protocol. Changes must be approved by the Committee before they are implemented;
- immediate advice, giving reasons, if the protocol is discontinued before its completion;
- submission of an annual report on the progress of the study, and a final report when it is completed. It is your responsibility to provide these reports – without reminder from the Ethics Committee.

Approval is given for three years only. If the study is more prolonged than this, an extension request should be submitted unless there are significant modifications, in which case a new submission may be required. Please note the approval number above indicates the month and year in which approval expires and it should be used in any future communication.

If University of Adelaide personnel are involved in this project, you, as chief investigator must submit a Human Research Approval notification form online at http://www.adelaide.edu.au/ethics/human/guidelines/ within 14 days of receiving this ethical clearance to ensure compliance with University requirements and appropriate indemnification.

Yours sincerely

# Appendix B Letters of Invitation

**Delphi Survey**

- Letter of Invitation (Pilot Group)
- Letter of Invitation to Heads of School (Nursing)
- Letter of Invitation to Directors of Nursing
- Letter of Invitation to Leaders of Nursing Organisations
- Flyer – Delphi Survey Rd 1
- Letter of invitation to potential participants
- Letter of reply to interested staff

**Focus Group**

- Letter of invitation to Director of Nursing (the Children, Youth & Women's Health Service)
- Flyer – Focus Group
- Letter of invitation to potential participants
- Letter of reply to interested staff

## Letter of Invitation (Pilot Group)

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Dear .....

My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery. My research project is entitled **'Exploring how health literacy is understood by registered nurses'.** I am focusing specifically on paediatric and child and youth nurses.

Your name has been given to me by my supervisors as a person who may be willing to participate in the pilot for this project. Attached please find:

- Information Sheet
- Consent Form
- Pilot Delphi Survey

If you agree to participate in the pilot, your assistance would be greatly appreciated. As a participant in this pilot study it would be appreciated if you would complete the questionnaire and indicate how clear, realistic, biased or too complex you found it to be. I would also appreciate knowing how long the survey took you to complete. I am estimating it takes approximately 30 minutes.

Should you agree to participate in the pilot project your identity will be kept confidential, and all identifying features will be removed from any publications and reports that emerge from the study. I am hoping that you will be happy to support my doctoral research. For more information about the project, please refer to the attached Information Sheet.

My supervisors and I am very happy to answer any questions or queries you may have. If you agree to participate, please respond accordingly by return email or sign the Consent Form attached and return it to me my mail box on Level 4.

Thank you for your attention and support.

Yours Sincerely

Ola Kutah
PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide
S.A, 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

## Letter of Invitation to Heads of Schools (Nursing)

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Head of Nursing School
Professor……..
Address……

Day/Month/2008

Dear Professor…….

My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery at the University of South Australia. My research project is entitled **'Exploring how health literacy is understood by registered nurses'.** I am focusing specifically on paediatric and child and youth nurses.

Your name has been selected from publicly available information. I am writing to ask if you would be willing to participate in my doctoral project. Your assistance in my project would be greatly appreciated. Please find attached to this email the following documents:

- Information Sheet
- Consent Form
- Project Flyer

I invite you to participate in a Delphi survey. A Delphi survey is a structured, indirect interaction method which uses a series of rounds to collect data. These rounds are continued until consensus amongst a panel of experts is reached. This means that you may be asked to complete the survey at least 2 times but not more than four times. The survey takes approximately 30 minutes to complete. The survey seeks to identify how a panel of experts related to paediatric and child and youth health, understand the concept of health literacy and the importance of this concept to clinical practice and to the health of children and young adults.

Should you agree to participate in the research project your identity and the identity of your organization will be kept confidential, and all identifying features will be removed from any publications and reports that emerge from the study. I am hoping that you will be happy to support my doctoral research. For more information about the project, please refer to the attached Information Sheet. If you agree to participate, please inform me as such by return email and/or sign the Consent Form attached. I can forward you the Delphi Survey as a hard copy or electronically via email so please indicate your preference in your email reply.

Additionally, I would like to invite academic staff members who are Registered Nurses teaching paediatric nursing and child and youth health within your school in the postgraduate and undergraduate areas to participate in the Delphi survey. I would be very grateful if you could distribute the attached Project Flyer and Information Sheet via email to your staff so that they may volunteer to participate. If you would prefer me to send you hard copies of the flyer to distribute to staff then please let me know as I will willingly forward them to you.

Thank you for your attention and support. My supervisors and I am very happy to answer any questions or queries you may have.

Yours Sincerely
Ola Kutah
PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide
S.A, 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

## Letter of Invitation to Directors of Nursing

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Director of Nursing
Prof. / Dr. /Mr. / Mrs. / Ms / Miss
Address.....

Day/Month/2008

Dear .....

My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery at the University of South Australia. My research project is entitled **'Exploring how health literacy is understood by registered nurses'.** I am focusing specifically on paediatric and child and youth nurses.

Your name has been selected from publicly available information. I am writing to ask if you would be willing to participate in my doctoral project. Your assistance in my project would be greatly appreciated. Please find attached to this email the following documents:

- Information Sheet
- Consent Form
- Project Flyer

I invite you to participate in a Delphi survey. A Delphi survey is a structured, indirect interaction method which uses a series of rounds to collect data. These rounds are continued until consensus amongst a panel of experts is reached. This means that you may be asked to complete the survey at least 2 times but not more than four times. The survey takes approximately 30 minutes to complete. The survey seeks to identify how a panel of experts related to paediatric and child and youth health, understand the concept of health literacy and the importance of this concept to clinical practice and to the health of children and young adults.

Should you agree to participate in the research project your identity and the identity of your organization will be kept confidential, and all identifying features will be removed from any publications and reports that emerge from the study. I am hoping that you will be happy to support my doctoral research. For more information about the project, please refer to the attached Information Sheet. If you agree to participate, please inform me as such by return email and/or sign the Consent Form attached. I can forward you the Delphi Survey as a hard copy or electronically via email so please indicate your preference in your email reply.

Additionally, I would like to invite senior members of your clinical nursing staff (clinical nurse consultant/ practitioner/ nurse specialist) to participate in the Delphi survey. I would be very grateful if you could distribute the attached Project Flyer and Information Sheet via email to your staff so that they may volunteer to participate. If you would prefer me to send you hard copies of the flyer to distribute to staff then please let me know as I will willingly forward them to you.

Thank you for your attention and support. My supervisors and I am very happy to answer any questions or queries you may have.

Yours Sincerely

Ola Kutah
PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide
S.A, 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

## Letter of Invitation to Leaders of Nursing Organisations

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Head of …….
Prof. / Dr. /Mr. / Mrs. / Ms / Miss
Address……

Day/Month/2008

Dear ……

My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery at the University of South Australia. My research project is entitled **'Exploring how health literacy is understood by registered nurses'.**

Your name has been selected from publicly available information. I am writing to ask if you would be willing to participate in my doctoral project. Your assistance in my project would be greatly appreciated. Please find attached to this email the following documents:

- Information Sheet
- Consent Form
- Project Flyer

I invite you to participate in a Delphi survey. A Delphi survey is a structured, indirect interaction method which uses a series of rounds to collect data. These rounds are continued until consensus amongst a panel of experts is reached. This means that you may be asked to complete the survey at least 2 times but not more than four times. The survey takes approximately 30 minutes to complete. The survey seeks to identify how a panel of experts related to paediatric and child and youth health, understand the concept of health literacy and the importance of this concept to clinical practice and to the health of children and young adults.

Should you agree to participate in the research project your identity and the identity of your organization will be kept confidential, and all identifying features will be removed from any publications and reports that emerge from the study. I am hoping that you will be happy to support my doctoral research. For more information about the project, please refer to the attached Information Sheet. If you agree to participate, please inform me as such by return email and/or sign the Consent Form attached. I can forward you the Delphi Survey as a hard copy or electronically via email so please indicate your preference in your email reply.

Additionally, I would like to invite staff members (either academic nursing staff, or clinical nurse consultant/ practitioner/ nurse specialist staff) of your organisation to participate in the Delphi survey. I would be very grateful if you could distribute the attached Project Flyer and Information Sheet via email to your staff so that one may contact me and volunteer to participate. If you would prefer me to send you hard copies of the flyer to distribute to staff then please let me know as I will willingly forward them to you.

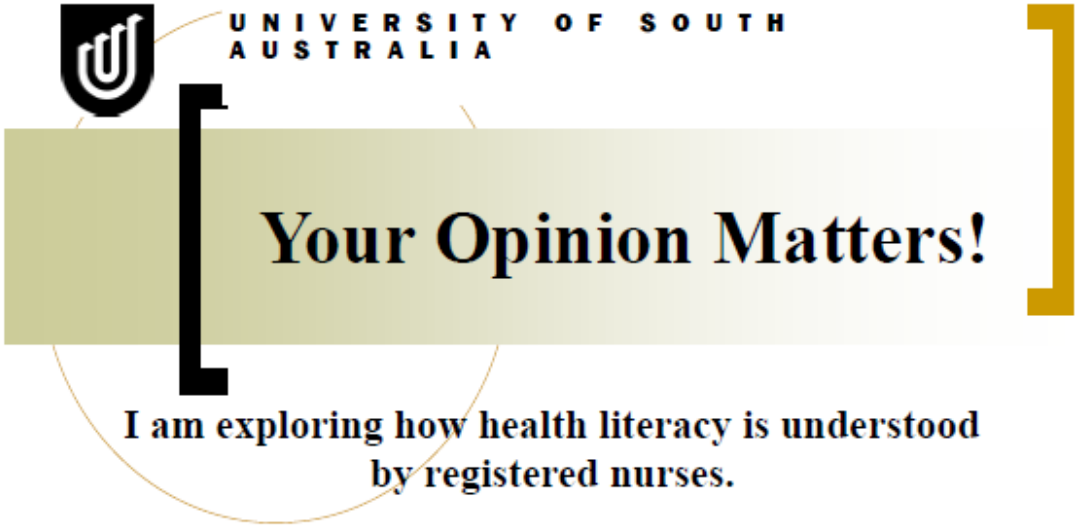
I would also very much appreciate your assistance in forwarding to me the contact person in your organisation's state branches so that I may invite them to participate in the research. If you are able to send this email with attachments to them I would be very grateful. If you would prefer to send me their email or postal addresses then I will invite them to participate.

Thank you for your attention and support to my doctoral studies.

Yours Sincerely

Ola Kutah
PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide
S.A, 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

**Flyer – Delphi Survey**




## Volunteers needed!

Are you:

- an experienced paediatric and child and youth health nurses
- an academic nursing staff
- a clinical nurse consultant/ practitioner nurse specialist

I invite you to participate in a ***Delphi Survey***
that takes approximately 30 minutes to complete

If you would like to assist a colleague to complete her PhD and contribute to advancing knowledge about health literacy , please contact me: Ola Kutah on (08) 8302 1158 or email ola.kutah@postgrads.unisa.edu.au .

## Letter of Invitation to potential participants (Delphi Survey)

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Research Participant
Name:
Address:

Day/Month/2008

Dear Mr. / Mrs. / Ms / Miss .....

My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery at the University of South Australia. My research project is entitled **'Exploring how health literacy is understood by registered nurses'.** I am focusing specifically on paediatric and child and youth nurses.

Thank you for your interest in my research. If you agree to participate in my project, your assistance to complete a Delphi survey is much appreciated. A Delphi survey is a structured, indirect interaction method which uses a series of rounds to collect data. These rounds are continued until consensus amongst a panel of experts is reached. This means that you may be asked to complete the survey 2 times at least but not more than four times. The survey takes approximately 30 minutes to complete. . I can forward you the Delphi Survey as a hard copy or electronically via email so please indicate your preference in your email reply.

Should you agree to participate in the research project please be assured that your identity and the identity of your organisation will be kept confidential, and all identifying features will be removed from any publications and reports that emerge from the study. I am hoping that you will be happy to support my doctoral research. For more information about the project, please refer to the attached information sheet. My supervisors and I am very happy to answer any questions or queries you may have. If you agree to participate, please respond accordingly by reply email or sign the Consent Form attached and return it to me.

Thank you for your attention and support.

Yours Sincerely

Ola Kutah
PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide
S.A, 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

## Letter of Reply to Interested Staff (Delphi Survey)

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Research Participant
Name:
Address:

Day/Month/2008

Dear Mr. / Mrs. / Ms / Miss …….

My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery at the University of South Australia. My research project is entitled **'Exploring how health literacy is understood by registered nurses'.** I am focusing specifically on paediatric and child and youth nurses.

Thank you for your interest in my research. If you agree to participate in my project, your assistance to complete a Delphi survey is much appreciated. A Delphi survey is a structured, indirect interaction method which uses a series of rounds to collect data. These rounds are continued until consensus amongst a panel of experts is reached. This means that you may be asked to complete the survey 2 times at least but not more than four times. The survey takes approximately 30 minutes to complete. . I can forward you the Delphi Survey as a hard copy or electronically via email so please indicate your preference in your email reply.

Should you agree to participate in the research project please be assured that your identity and the identity of your organisation will be kept confidential, and all identifying features will be removed from any publications and reports that emerge from the study. I am hoping that you will be happy to support my doctoral research. For more information about the project, please refer to the attached information sheet. My supervisors and I am very happy to answer any questions or queries you may have. If you agree to participate, please respond accordingly by reply email or sign the Consent Form attached and return it to me.

Thank you for your attention and support.

Yours Sincerely

Ola Kutah
PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide
S.A, 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

## Letter of Invitation to Directors of Nursing (CYWHS)

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Dear .....

My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery at the University of South Australia. My research project is entitled **'Exploring how health literacy is understood by registered nurses'.** I am focusing specifically on paediatric and child and youth nurses.

I am writing to you to seek your support to recruit child and youth health nurses of the Child, Youth and Women's Health Service to participate in focus group discussions.

My doctoral research program explores how registered paediatric and child and youth health nurses view health literacy and its importance to their clinical practice. Preliminary findings from my Delphi Survey have identified that how registered paediatric and child and youth health nurses recognize the concept of health education may be a significant issue in understanding how they view health literacy. I am now seeking to explore how registered paediatric and child and youth health nurses understand the concept of health education and its relationship to health literacy and their views about how these concepts influence their roles.

The study has been granted ethics approval by the Ethics Committee of the University of South Australia and the Children, Youth & Women's Health Service (CYWHS) Human Research Ethics Committee (HREC).

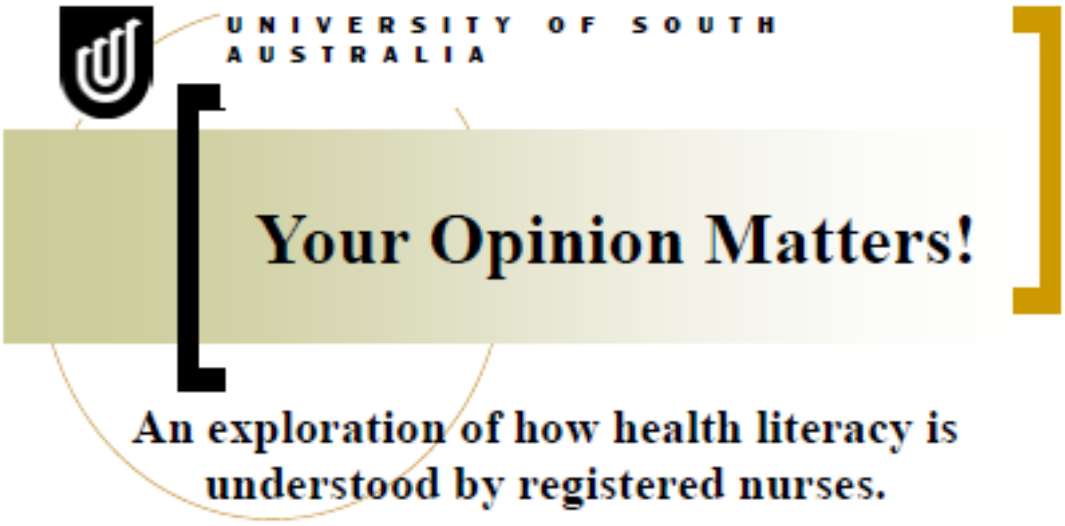
With your permission, I seek to distribute an invitation letter and information sheet to registered nurses at your hospital to participate in a focus group discussion in their own time. I have spoken with Dr Jennifer Fereday, Management Facilitator at the Research & Practice Development Department who has indicated her willingness to arrange the distribution of these materials, and organize a venue and discussion time for the focus groups if you agree to this.

Thank you for your consideration of my proposal. My supervisors and I are very happy to answer any questions or queries you may have.

Yours Sincerely

Ola Kutah
PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide
S.A, 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

**Flyer – Focus Group**




## [Volunteers needed!]

Are you:

- an experienced paediatric and child and youth health RN ?
- an educator of RNs ?
- a clinical nurse consultant/ practitioner nurse specialist ?

I seek volunteer RNs to participate in a ***Focus Group***
that will take approximately 60 minutes to complete.

Where:

When: 20th of August 2009 at ?? pm

If you would like to assist a fellow nurse to complete her PhD and contribute to advancing knowledge about health literacy , please contact me: Ola Kutah on (08) 8302 1158 or email ola.kutah@postgrads.unisa.edu.au .

Note: refreshments will be provided

## Letter of Invitation to Potential Participants (Focus Groups)

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Dear ……

My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery at the University of South Australia. My research project is entitled **'Exploring how health literacy is understood by registered nurses'.** I am focusing specifically on paediatric and child and youth health nurses.

I am inviting you to attend a focus group discussion with registered nurses from the Child, Youth and Women's Health Service.

My doctoral research program explores how registered paediatric and child and youth health nurses view health literacy and its importance to their clinical practice. Preliminary findings from my Delphi Survey have identified that how registered paediatric and child and youth health nurses recognize the concept of health education may be a significant issue in understanding how they view health literacy. I am now seeking to explore how registered paediatric and child and youth health nurses understand the concept of health education and its relationship to health literacy and their views about how these concepts influence their roles.

I anticipate that a focus group may take between 60 - 90 minutes and my principal supervisor, Dr Kay Price, will co-facilitate the discussion with me. To enable an analysis of the discussion, I seek your permission to audio-tape the session so that I can have the discussion transcribed.

Please note that the time commitment to the study will be in your own time not during your hours of work.

As this is part of my doctoral research program, I am unable to provide any honorarium but I do greatly appreciate you contributing your time.

Should you agree to participate in the research project your identity and the identity of your organization will be kept confidential, and all identifying features will be removed from any publications and reports that emerge from the study. I am hoping that you will be happy to support my doctoral research. For more information about the project, please refer to the attached Information Sheet. If you agree to participate, please inform me as such by return email.

My supervisors and I are very happy to answer any questions or queries you may have.

Yours Sincerely

Ola Kutah
PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide
S.A, 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

**Potential Participants**

## Letter of Reply to Interested Staff (Focus Group)

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Dear Mr. / Mrs. / Ms / Miss …….

Thank you for your interest in my research. My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery at the University of South Australia. My research project is entitled 'Exploring how health literacy is understood by registered nurses'. I am focusing specifically on paediatric and child and youth health nurses.

My doctoral research program explores how registered paediatric and child and youth health nurses view health literacy and its importance to their clinical practice. Preliminary findings from my Delphi Survey have identified that how registered paediatric and child and youth health nurses recognize the concept of health education may be a significant issue in understanding how they view health literacy. I am now seeking to explore how registered paediatric and child and youth health nurses understand the concept of health education and its relationship to health literacy and their views about how these concepts influence their roles.

You are invited to attend a focus group discussion with other registered nurses from the Child, Youth and Women's Health Service. Focus groups will be conducted at the following times and location:

- …….
- …….

I anticipate that a focus group may take between 60 - 90 minutes and my principal supervisor, Dr Kay Price, will co-facilitate the discussion with me. To enable an analysis of the discussion, I seek your permission to audio-tape the session so that I can have the discussion transcribed.

Please note that the time commitment to the study will be in your own time not during your hours of work.

As this is part of my doctoral research program, I am unable to provide any honorarium but I do greatly appreciate you contributing your time.

Should you agree to participate in the research project, please be assured that your identity will be kept confidential, and all identifying features will be removed from any publications and reports that emerge from the study.

My supervisors and I are very happy to answer any questions or queries you may have.

Yours Sincerely

Ola Kutah
PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide
S.A, 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

## Letter of Reply to Interested Staff (Focus Groups)

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Dear Mr. / Mrs. / Ms / Miss …….

Thank you for your interest in my research. My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery at the University of South Australia. My research project is entitled 'Exploring how health literacy is understood by registered nurses'. I am focusing specifically on paediatric and child and youth health nurses.

My doctoral research program explores how registered paediatric and child and youth health nurses view health literacy and its importance to their clinical practice. Preliminary findings from my Delphi Survey have identified that how registered paediatric and child and youth health nurses recognize the concept of health education may be a significant issue in understanding how they view health literacy. I am now seeking to explore how registered paediatric and child and youth health nurses understand the concept of health education and its relationship to health literacy and their views about how these concepts influence their roles.

You are invited to attend a focus group discussion with other registered nurses from the Child, Youth and Women's Health Service. Focus groups will be conducted at the following times and location:

- …….
- …….

I anticipate that a focus group may take between 60 - 90 minutes and my principal supervisor, Dr Kay Price, will co-facilitate the discussion with me. To enable an analysis of the discussion, I seek your permission to audio-tape the session so that I can have the discussion transcribed.

Please note that the time commitment to the study will be in your own time not during your hours of work.

As this is part of my doctoral research program, I am unable to provide any honorarium but I do greatly appreciate you contributing your time.

Should you agree to participate in the research project, please be assured that your identity will be kept confidential, and all identifying features will be removed from any publications and reports that emerge from the study.

My supervisors and I are very happy to answer any questions or queries you may have.

Yours Sincerely

Ola Kutah
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School of Nursing and Midwifery
University of South Australia
Adelaide
S.A, 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

# Appendix C Information Sheets

- Information Sheet Delphi Survey participants
- Information Sheet Focus Group participants

## Information Sheet Delphi Survey Participants

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

**Information Sheet**

**Exploring how health literacy is understood by registered nurses.**

**Researcher:** Ms Ola Kutah, PhD Candidate, School of Nursing and Midwifery, University of South Australia (City East Campus).
**Supervisors:** Dr. Kay Price, University of South Australia and Professor Helen McCutcheon University of South Australia.

**Why this study?**
The relationship between health and education has been the concern of health care professionals, educators and researchers all over the world. This research is being undertaken acknowledging that health education and life skills preparation, when appropriately designed and employed have the potential to promote positive behavioral changes. It is premised on the view that health literacy is as vital to children as to adults to ensure reasonable measures are taken to assist children and young adults maintain a healthy life. Inadequate health literacy may lead people including children and young adults to be less aware of their health conditions including their treatment options, as well as being at greater risk of hospitalization.

The study aims to describe and explore how paediatric and child and youth health registered nurses understand the concept of health literacy and the importance of this concept to their clinical practice and to the health of children and young adults.

This study has the full approval of the University of South Australia's Human Research Ethics Committee. The specific research question being addressed is: ***How is health literacy constructed by paediatric and child and youth health RNs and what is the role for nurses that is promoted?***

**About the study**
This study will employ a critical approach. It will be conducted in two stages.

**Stage 1: Describing the context & interpreting recurrent themes**
Using literature reviewed from national and international publications, and by conducting a Delphi survey inviting experts to participate, I will seek to describe how nurses in Australia understand the concept of health literacy and the importance of this concept to the health of children and young adults.

**Stage 2: Applying a critical lens**
Using the information gained from Stages 1, and analyzing it in the context of critical theory and primary health care, I will propose a response to my question: *How is health literacy constructed by paediatric and child and youth health RNs and what is the role for nurses that is promoted?*

**Information Sheet Delphi Survey Participants – *cont'd***

**Your role in the study?**
I am inviting you to participate in a Delphi survey. A Delphi survey is a structured, indirect interaction method which uses a series of rounds to collect data. These rounds are continued until consensus amongst a panel of experts is reached. This means that you may be asked to complete the survey at least 2 times but not more than four times. The survey takes approximately 30 minutes to complete. The survey seeks to identify how a panel of experts from the fields of paediatric and child and youth health understand the concept of health literacy, and the importance of this concept to clinical practice and to the health of children and young adults.

**Please note that to participate efficiently in the research you will need ongoing email access, and to check your emails at a minimum of once per week.**

**How will confidentiality and anonymity be assured?**
Your participation in this study is entirely voluntary; you are free to withdraw from the study at any time without consequence. **You** and/or the **university/ hospital/ organization** will **not be identified** in any way in the reports and publications arising from the study. All identifying information will be removed during the data analysis. For example, individual participant names will be replaced with Participant 1, 2, 3 etc and identifying documents and/or University/hospital/ organization names by University/ hospital/ organization A, B, C etc. Your anonymity and confidentiality will be preserved at all times.

All research materials collected as part of this study will be stored in a locked filing cabinet in a secure office at the School of Nursing and Midwifery, University of South Australia (City East Campus) for a period of five years. Only the researcher and her supervisors will have access to the research data.

The researcher will take every care to remove responses from survey material as early as possible. Likewise individuals' responses will be kept confidential by the researcher. However the researcher cannot guarantee the confidentiality or anonymity of material transferred by email or the internet.

**Questions and Concerns:**
If you have any further questions regarding this study or require further information please do not hesitate to contact me (**Ola Kutah**) on **(08) 8302 1158** or email ola.kutah@postgrads.unisa.edu.au . Alternatively, you can contact my Principle Supervisor, **Dr Kay Price** on **(08) 8302 2721** or email kay.price@unisa.edu.au

If you have any ethical concerns regarding this project, particularly in relation to matters related to policies or information about the conduct of the study, please contact the University of South Australia's Ethics Officer Ms Vicki Allen on 8302 3118 or email: Vicki.Allen@unisa.edu.au

## Information Sheet Focus Group Participants

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

**Information Sheet**

### Exploring how health literacy is understood by registered nurses.

**Researcher:** Ms Ola Kutah, PhD Candidate, School of Nursing and Midwifery, University of South Australia (City East Campus).
**Supervisors:** Dr. Kay Price, University of South Australia and Professor Helen McCutcheon, University of South Australia.

**Why this study?**
I am PhD student in the School of Nursing and Midwifery at the University of South Australia. My doctoral research program explores how registered paediatric and child and youth health nurses understand health literacy and its importance to their clinical practice. Preliminary findings from my Delphi Survey have identified that how registered paediatric and child and youth health nurses recognize the concept of health education may be a significant issue in understanding how they view health literacy. I am now seeking to explore how registered paediatric and child and youth health nurses understand the concept of health education and its relationship to health literacy and their views about how these concepts influence their roles.

**Your role in the study?**
If you would like to be a participant in this study you will be asked to share your thoughts, ideas and knowledge in a focus group discussion. I anticipate that a focus group may take between 60 - 90 minutes and my principal supervisor, Dr Kay Price, will co-facilitate the discussion with me. To enable an analysis of the discussion, the session will be audio-taped and transcribed. Please note that the time commitment to the study will be in your own time not during your hours of work. As this is part of my doctoral research program, I am unable to provide any honorarium but I do greatly appreciate you contributing your time.

**How will confidentiality and anonymity be assured?**
Your participation in this study is entirely voluntary; should you agree to join a focus group you would be free to withdraw at any time without consequence. **You** will **not be identified** in any way in the reports and publications arising from the study. All identifying information will be removed during data analysis. For example, individual participant names will be replaced with Participant 1, 2, 3 etc.

All identifying details and information provided by you, including audio-tapes and transcription of focus group discussions will be kept in a locked filing cabinet in a secure office at the School of Nursing and Midwifery, University of South Australia (City East Campus) for a period of fifteen years. If a transcriber is used they will be required to sign a confidentiality agreement.

**Questions and Concerns:**
If you have any further questions regarding this study or require further information please do not hesitate to contact me (**Ola Kutah**) on **(08) 8302 1158** or email ola.kutah@postgrads.unisa.edu.au . Alternatively, you can contact my Principle Supervisor, **Dr Kay Price** on **(08) 8302 2721** or email kay.price@unisa.edu.au

This project has been approved by the University of South Australia's Human Research Committee and the Children, Youth & Women's Health Service (CYWHS) Human Research Ethics Committee (HREC). If you have any ethical concerns regarding this project, particularly in relation to matters related to policies or information about the conduct of the study, please contact the University of South Australia's Ethics Officer Ms Vicki Allen on 8302 3118 or email: Vicki.Allen@unisa.edu.au and/or the Children, Youth & Women's Health Service (CYWHS) Ethics Committee (HREC) Secretary Ms Brenda Penny on 81616521.

# Appendix D Consent Forms

- Consent Form (Delphi Survey)
- Consent Form (Focus Group)

## Consent Form (Delphi Survey)

**CONSENT FORM**

**I …… (name) of ……(address)**

**hereby consent to my involvement in the research project entitled:**

**Exploring how health literacy is understood by registered nurses.**

**Researcher**: Mrs Ola Kutah (PhD Candidate), School of Nursing and Midwifery, University of South Australia.

**Supervisors:** Dr. Kay Price (Principal Supervisor), University of South Australia and Professor Helen McCutcheon (Associate Supervisor), University of South Australia.

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1. I understand the nature and purpose of the research project described on the attached Information Sheet, and agree to take part.
2. I understand that I may not directly benefit by taking part in this study.
3. I understand that while information gained in the study may be published, I will not be identified. All information will be confidential.
4. I understand that I can withdraw from the study at any stage and that this will not affect me, or my relationship with the University of South Australia or my place of employment in any way.
5. I understand that there will be no payment to me for taking part in this study.
6. I am aware that I should retain a copy of the Consent Form, when completed, and the Information Sheet.
7. I confirm that I am over 18 years of age.
8. I understand that all the research materials collected as a part of the study will be stored in a locked filing cabinet at the School of Nursing and Midwifery at the University of South Australia, City East Campus for a period of 5 years following the completion of the research project. I understand that the data collected will only be available for review by the researcher and research supervisors named on the information sheet.

Signed: ……

Full name of Participant: .....

Date: .....

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I certify that I have explained the study to the participant and consider that he/she understands what is involved.

Signed: ..... Title: ..... Date: ……

Any questions or compliant about your participation in this research project can be directed to the Executive Officer, HREC, Research Services, Mawson Lakes Campus, UniSA 5095 Tel: 08 8302 3118

## Consent Form (Focus Group)

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

### Exploring how health literacy is understood by registered nurses.

**CONSENT FORM FOR INTERVIEW (by listening device) and SUBSEQUENT USE OF DATA**

On the understanding that my identity will not be divulged, I ..... (name) give permission for Ola Kutah to audiotape and use this interview for research and publication in her thesis and any publications that follow from it.

I understand that while information gained in the study may be published, I will not be identified. All information will be confidential.

I acknowledge that I have received, read and understood the information sheet provided to me about this study.

I understand that I may not directly benefit by taking part in this study.

I understand that there will be no payment to me for taking part in this study.

I confirm that I am over 18 years of age.

I understand that the time commitment to the study will be in my own time not during my hours of work.

I agree to maintain the confidentiality of focus group discussions and preserve the identification of focus group participation.

I understand that I can withdraw from the study at any stage and that this will not affect me, or my relationship with the University of South Australia or my place of employment in any way.

I am aware that the study is being conducted with approval from Ethics Committee from the University of South Australia, and the Children, Youth & Women's Health Service (CYWHS) Human Research Ethics Committee (HREC), and that the researcher is answerable to these committees for appropriate and ethical conduct of the research.

I understand that all identifying details and information provided by participants, including audio-tapes and transcription of focus group discussions will be kept in a locked filing cabinet in a secure office at the School of Nursing and Midwifery, University of South Australia (City East Campus). All data will be retained in accordance with Ethics regulations of the University of South Australia, and Function 6 of the Records Disposal for South Australian public Hospitals for a period of 15 years following the completion of the research project. I understand that the data collected will only be available for review by the researcher and research supervisors named on the information sheet.

Signed: .....

Full name of Participant: .....

Date: .....

---

I certify that I have explained the study to the participant and consider that he/she understands what is involved.

Signed: ..... Title: ..... Date: .....

Any questions or compliant about your participation in this research project can be directed to the Executive Officer, HREC, Research Services, Mawson Lakes Campus, UniSA 5095 Tel: 08 8302 3118

# Appendix E Correspondence Dr Logan

- Formal e-mail approaching Dr Logan
- Formal letter requesting Dr Logan's permission to use the Statements
- Dr Logan's Permission E-mail to use the Statements

# Formal E-mail Approaching Dr Logan

**Kutah, Ola Ahmad Abd Al-Rahman - kutoa001**

**From:** Kutah, Ola Ahmad Abd Al-Rahman - kutoa001
**Sent:** Friday, 11 July 2008 1:34 PM
**To:** 'logan@nlm.nih.gov'
**Cc:** Kay Price
**Subject:** Interested in your research paper
**Attachments:** Letter to Dr Logan.doc

**Importance:** High

Dear Dr Logan,
I am a PhD candidate at the University of South Australia, School of Nursing an Midwifery. During my review of related publications I came across your research paper titled: **Clinical, classroom, or personal education: attitudes about health literacy**(J Med Libr Assoc. 2007 April; 95(2): 127-137, e48). I found your paper to be extremely interesting and relevant to my research. I have attached a formal letter requesting your permission to apply some of your statements to my current Delphi survey.

*Best Regards*
*Ola Kutah*

*PhD Candidate*
*School of Nursing and Midwifery*
*City East Campus - C4:39*
*University of South Australia*
*ola.kutah@postgrads.unisa.edu.au*
*Office: (61 8) 83021158*
*Mobile: 0422742537*

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## Formal Letter Requesting Dr Logan's Permission to Use the Statements

**Ola A Kutah**
School of Nursing and Midwifery
University of South Australia
City East Campus C4-39
Adelaide SA 5001
G.P.O Box 2471
Mobile: +61 8 422742537
Office: +61 8 8302 1158
Ola.kutah@postgrads.unisa.edu.au

10-07-2008

Dr. Robert A Logan
Lister Hill National Center for Biomedical Communications
US National Library of Medicine
8600 Rockville Pike, Building 38A, Room 9S914
Bethesda, Maryland 20894

Dear Dr. Logan:

I am a PhD candidate at the University of South Australia, School of Nursing and Midwifery. My research project is titled: ***A critical analysis of the importance of health literacy to paediatric nursing and child and youth health.*** The aim of my doctoral research is to interrogate and explore how paediatric and child and youth health registered nurses understand the concept of health literacy and the importance of this concept to their clinical practice and to the health of children and young adults.

During my review of related publications I came across your research paper titled: Clinical, classroom, or personal education: attitudes about health literacy (*J Med Libr Assoc.* 2007 April; 95(2): 127-137, e48). I found your paper to be extremely interesting and relevant to my research.

I am currently developing a Delphi Survey tool that will be distributed to registered nurses working in paediatric and child and youth health and many of my statements are similar to those that you developed. Indeed I consider some of your statements to be worded extremely well and I would like to ask for your permission to use those that are appropriate in my Delphi survey. I will, of course, reference your work both on the actual survey and in my research thesis or any research papers that may be produced in the future.

I would also appreciate knowing if you have published further in this area.

If you have any further questions regarding this study or require further information please do not hesitate to contact me or my Principal Supervisor, **Dr Kay Price** on **(08) 8302 2721** or email kay.price@unisa.edu.au

Whatever your decision, please accept my sincere thanks for your time and consideration of my request.

Yours sincerely,

Ola Kutah

## Dr Logan's Permission E-mail to Use the Statements

**Kutah, Ola Ahmad Abd Al-Rahman - kutoa001**

**From:** Logan, Robert (NIH/NLM) [E] [rlogan@mail.nih.gov]
**Sent:** Friday, 11 July 2008 10:31 PM
**To:** Kutah, Ola Ahmad Abd Al-Rahman - kutoa001
**Cc:** Kay Price
**Subject:** RE: Interested in your research paper

You have my permission to use the statements in the article cited below. The paper is public record and it would be the epitome of hypocrisy for a senior scientist at the U.S. National Library of Medicine to thwart the fair use of materials we publish. I request appropriate citation and full acknowledgement, which you graciously offered in your letter.

In return, I will be interested in the methods regarding how you transfer Q statements to Delphi and apply it to a target population. When you are ready to implement the project, I would be quite interested in finding out how you did it. I suspect the international community of scholars who do Q methodology will be interested in your dissertation. It is more difficult to predict reactions from the health literacy community in the U.S. and Australia. Incidentally, I attended an international medical informatics meeting in Brisbane a year ago where health literacy issues were discussed frequently.

Also, please find out if the U. of South Australia permits external faculty to serve on doctoral committees. While it is premature to detail this type of arrangement, the first step is to find out if it is possible at your end.

I have not followed up research using the same instrument. I remain very active in related areas and will send you some new cites later.

Most sincerely,

Rob Logan, U.S. National Library of Medicine

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# Appendix F Nursing Curricula Documents

- Australian Universities (2011) Postgraduate Nursing Courses
- Australian Universities (2011) Undergraduate Nursing Courses

**Australian Universities 2011/ Postgraduate Nursing Courses**

| **Australian Universities 2011/ Postgraduate Nursing Courses:**<br>• Graduate Certificates<br>• Graduate Diplomas<br>• Masters by coursework<br>• PhD by coursework | A specific course with the word "Health literacy" in its title is evident in postgraduate nursing curricula documents. | A specific course with the word "Health Promotion" in its title is evident in postgraduate nursing curricula documents. | A specific course with the word "Health Education" in its title is evident in postgraduate nursing curricula documents. | A specific course with the word "Health" in its title is evident in postgraduate nursing curricula documents. | A specific course with the word "Health literacy" in its description of the content regardless of how the course is titled. In postgraduate nursing curricula documents. | A specific course with the word "Health Promotion" in its description of the content regardless of how the course is titled. | A specific course with the word "Health Education" in its description of the content regardless of how the course is titled. | A specific course with the word "Health" in its description of the content (regardless of how the course is titled. |
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| **ACT** | | | | | | | | |
| **University of Canberra**<br><br>University of Canberra 2011, *Graduate Certificate in Critical Care Nursing (870AA),* Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/gc/health/domestic-only/870aa>.<br><br>University of Canberra 2011, *Graduate Certificate in Health Research (133JA),* Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/gc/health/133ja>. | | | | 6997 Research Design for Health Practitioners PG<br><br>7488 Mental Health Nursing : Professional Parameters PG<br><br>8046 Multiple Perspectives in Healthcare PG<br><br>7490 Mental Health Nursing | | | 6486 Research Planning PG<br><br>6997 Research Design for Health Practitioners PG<br><br>7488 Mental Health Nursing : Professional Parameters PG<br><br>8046 Multiple Perspectives in Healthcare PG |

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|---|---|---|---|
| University of Canberra 2011, *Graduate Certificate in Mental Health Nursing (161JA)*, Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses/index.cfm?action=detail&courseid=161JA&year=2011>.<br><br>University of Canberra 2011, *Postgraduate Diploma in Advanced Nursing Practice (911AA)*, Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/pgd/health/domestic-only/911aa/course-outline>.<br><br>University of Canberra 2011, *Postgraduate Diploma in Critical Care Nursing (357AA)*, Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/pgd/health/domestic-only/gdccn/course-outline>.<br><br>University of Canberra 2011, *Postgraduate Diploma in Mental Health Nursing (359AA)*, Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/pgd/health/domestic-only/359aa/course-outline>.<br><br>University of Canberra 2011, *Postgraduate Diploma in Health Research (134JA)*, Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/pgd/health/134ja/course-outline>.<br><br>University of Canberra 2011, *Master of Advanced Nursing Practice (634AA)*, Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/m-coursework/health/domestic-only/634aa/course-outline>.<br><br>University of Canberra 2011, *Master of Critical Care Nursing (662AA)*, | Practicum 1 PG<br><br>7491 Mental Health Nursing Practicum 2 PG<br><br>7223 Research Methods for Health Practitioners PG<br><br>7494 Counselling Skills for Health Care Practitioners PG<br><br>7493 Clinical Supervision in Health Care Practice PG<br><br>8568 Perinatal Mental Health PG<br><br>8565 Mental Health Assessment and Intervention PG<br><br>8566 Health Specialty Topic 1 PG<br><br>8567 Health Practice Evaluation PG<br><br>6997 Research Design for Health Practitioners PG | 7490 Mental Health Nursing Practicum 1 PG<br><br>7491 Mental Health Nursing Practicum 2 PG<br><br>7223 Research Methods for Health Practitioners PG<br><br>7494 Counselling Skills for Health Care Practitioners PG<br><br>7493 Clinical Supervision in Health Care Practice PG<br><br>8568 Perinatal Mental Health PG<br><br>8565 Mental Health Assessment and Intervention PG<br><br>8566 Health Specialty Topic 1 PG<br><br>8046 Multiple Perspectives in Healthcare PG<br><br>7212 Pathophysiology of Critical Illness PG<br><br>8050 Critical Care Nursing |

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|---|---|---|---|---|
| Canberra, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/m-coursework/health/domestic-only/662aa/course-outline>.<br><br>University of Canberra 2011, *Master of Mental Health Nursing (162JA)*, viewed 21 July 2011, <http://www.canberra.edu.au/courses-units/m-coursework/health/domestic-only/162ja/course-outline> | | | | Practice PG<br><br>8567 Health Practice Evaluation PG<br><br>6997 Research Design for Health Practitioners PG |
| **NSW** | | | | |
| **Avondale College**<br><br>Avondale College 2011, *Faculty of Nursing and Health*, viewed 21 July 2011, <http://www.avondale.edu.au/Main::Information::handbook::2011::postgraduate::8_FR_PGCS_Coursework_Higher_Degrees_Nursing_And_Health.pdf><br><br>Avondale College 2011, *Postgraduate Unit Synopses*, viewed 21 July 2011, <http://www.avondale.edu.au/Main::Information::handbook::2011::postgraduate::10_FRPGSS_SubjSynopses.pdf> | NUCT56000 Promoting Health | CHST50600 Spirituality and Health in Society<br><br>CHST50600 Spirituality and Health in Society | NURS56000 Promoting Health | CHST50600 Spirituality and Health in Society<br><br>NURS56000 Promoting Health<br><br>LAMC57200 Organisational Processes and Change<br><br>NUIP51000 Independent Project<br><br>NUPN59200 Independent Project in Nursing<br><br>NUCT58600 Clinical Teaching<br><br>NUPN59200 Independent Project in |

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| | | | | | | Nursing<br><br>NUCN59500 Current Trends in Clinical Nursing<br><br>NULM59600 Current Trends in Leadership and Management |
| **Charles Sturt University**<br><br>Charles Sturt University 2011, *Master of Nursing*, viewed 21 July 2011, <http://www.csu.edu.au/courses/postgraduate/nursing_master/course-structure><br><br>Charles Sturt University 2011, *Postgraduate Certificate in Chronic Care Nursing Practice*, viewed 21 July 2011, <http://www.csu.edu.au/courses/postgraduate/chronic_care_nursing/course-structure><br><br>Charles Sturt University 2011, *Postgraduate Certificate in Mental Health Nursing*, viewed 21 July 2011, <http://www.csu.edu.au/courses/postgraduate/mental_health_nursing/course-structure><br><br>Charles Sturt University 2011, *Postgraduate Certificate in Nursing Education*, viewed 21 July 2011, <http://www.csu.edu.au/courses/postgraduate/nursing_education/course-structure> | HLT401 Contexts of Health Promotion | HLT405 Issues in Clinical Education | HLT505 Research Methods in Health Science A<br><br>HLT506 Health Master's Proposal<br><br>HSM409 Epidemiology & Public Health<br><br>HLT401 Contexts of Health Promotion<br><br>NRS523 Rural Health Practice<br><br>NRS512 Perspectives of Mental Health Nursing<br><br>HSM401 Perspectives on Health Care Systems<br><br>HSM402 Human Resources Management (Health Services) | HLT401 Contexts of Health Promotion<br><br>GER402 Ageing Bodies, Ageing Minds | HLT402 Learning in Health Contexts<br><br>NRS513 The Nurse as a Health Teacher<br><br>HLT405 Issues in Clinical Education<br><br>NRS515 The Nurse as a Clinical Teacher<br><br>GER401 Choices and Options in Later Life | NRS520 Transcultural Nursing<br><br>HSM409 Epidemiology & Public Health<br><br>HLT401 Contexts of Health Promotion<br><br>NRS523 Rural Health Practice<br><br>NRS512 Perspectives in Mental Health Nursing<br><br>HSM402 Human Resources Management (Health Services)<br><br>HSM404 Management of Health and Aged Care Services<br><br>HSM512 Evaluating Health Services |

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| | **HSM404 Management in Health Services**<br><br>**HSM512 Evaluating Health Services**<br><br>**HLT402 Learning in Health Context**<br><br>**NRS513 The Nurse as a Health Teacher**<br><br>**HLT512 Perspectives and policies in mental health**<br><br>**HSM401 Perspectives on Health Care Systems**<br><br>**HSM402 Human Resources Management (Health Services)**<br><br>**HSM404 Management in Health Services**<br><br>**HSM512 Evaluating Health Services**<br><br>**HLT402 Learning in Health Context**<br><br>**NRS513 The Nurse as a Health Teacher** | **HLT402 Learning in Health Contexts**<br><br>**HLT512 Perspectives and policies in mental health**<br><br>**NRS408 Psychosocial Interventions in Mental Health Nursing 1**<br><br>**NRS409 Psychosocial Interventions in Mental Health Nursing 2**<br><br>**NRS517 Advanced Nursing Skills - Group Process and Therapy**<br><br>**NRS420 Perspectives of Managing Chronic and Complex Conditions**<br><br>**NRS421 Chronic Care Nursing Practice 1**<br><br>**NRS422 Chronic Care Nursing Practice 2**<br><br>**NRS423 Advanced Chronic Care Nursing** |

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| | | **HLT512 Perspectives and policies in mental health**<br><br>**NRS408 Psychosocial Interventions in Mental Health Nursing 1**<br><br>**NRS409 Psychosocial Interventions in Mental Health Nursing 2**<br><br>**NRS408 Psychosocial Interventions in Mental Health Nursing 1**<br><br>**NRS409 Psychosocial Interventions in Mental Health Nursing 2**<br><br>**NRS512 Perspectives in mental health nursing**<br><br>**NRS513 The Nurse as Health Teacher**<br><br>**NRS523 Rural Health Practice**<br><br>**NRS408 Psychosocial Interventions in Mental Health Nursing 1**<br><br>**NRS409** | **GER401 Choices and Options in Later Life**<br><br>**GER402 Ageing Bodies, Ageing Minds**<br><br>**GER501 Contemporary Issues in Gerontology**<br><br>**HLT403 Clinical Teaching Techniques**<br><br>**HLT404 Clinical Education Planning**<br><br>**HLT510 Clinical Issues in Health**<br><br>**HLT512 Perspectives and Policies in Mental Health** |

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| | | **Psychosocial Interventions in Mental Health Nursing 2**<br><br>**NRS408 Psychosocial Interventions in Mental Health Nursing 1**<br><br>**NRS409 Psychosocial Interventions in Mental Health Nursing 2**<br><br>**NRS512 Perspectives in mental health nursing**<br><br>**NRS513 The Nurse as Health Teacher**<br><br>**NRS523 Rural Health Practice**<br><br>**HLT505 Research Methods in Health Science A**<br><br>**HLT506 Health Master's Proposal**<br><br>**HSM409 Epidemiology & Public Health**<br><br>**NRS523 Rural Health Practice**<br><br>**NRS512 Perspectives of Mental Health Nursing** |

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| | HLT510 Clinical Issues in Health<br><br>HLT512 Perspectives and Policy Issues in Mental Health<br><br>NRS401 The Ecology of Child Health Care | | |
| **Southern Cross University** | They do not offer postgraduate nursing degrees by coursework | | |
| **The University of Newcastle**<br><br>The University of Newcastle 2011, *Master of Nursing (Advanced Practice)*, viewed 21 July 2011, <http://www.newcastle.edu.au/program/11682.html><br><br>The University of Newcastle 2011, *Master of Mental Health Nursing*, viewed 21 July 2011, <http://www.newcastle.edu.au/program/12197.html#directed_courses><br><br>The University of Newcastle 2011, *Master of Applied Management (Nursing) (Online),* viewed 21 July 2011, <http://www.newcastle.edu.au/program/11249.html#directed_courses> | NURS6620 Biophysical Processes and Health Assessment<br><br>PUBH6210 Qualitative Methods in Health Research<br><br>NURS6810 Alteration in Child Health<br><br>NURS6818 Disorders and Interventions in Child & Adolescent Mental Health Nursing<br><br>NURS6070 Mental Health | NURS6091 Community Mental Health Nursing | EPID6420 Epidemiology A - Basic Methods<br><br>PUBH6210 Qualitative Methods in Health Research<br><br>NURS6810 Alteration in Child Health<br><br>NURS6813 Families in Society<br><br>NURS6814 Pregnancy Birth and the Family<br><br>NURS6815 Special Care of the Newborn |

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| **The University of Newcastle 2011, *Master of Nursing (Nurse Practitioner)*, viewed 21 July 2011, <http://www.newcastle.edu.au/program/11383.html>** | | **Nursing of Older People**<br><br>**NURS6061 Contemporary Mental Health Nursing**<br><br>**MEDI6145 Motivating Health Behaviour Change**<br><br>**MEDI6400 Mental Health Emergency Care**<br><br>**NURS6055 Mental Health Nursing in Acute Care**<br><br>**NURS6095 Mental Health Nursing in Community Settings**<br><br>**NURS6060 Drug & Alcohol Issues in Mental Health Nursing Practice**<br><br>**NURS6061 Contemporary Mental Health Nursing**<br><br>**NURS6091 Community Mental Health Nursing** | **NURS6070 Mental Health Nursing of Older People**<br><br>**NURS6061 Contemporary Mental Health Nursing**<br><br>**MEDI6145 Motivating Health Behaviour Change**<br><br>**MEDI6295 Managing Challenging Behaviours: Psychological Solutions**<br><br>**MEDI6400 Mental Health Emergency Care**<br><br>**NURS6055 Mental Health Nursing in Acute Care**<br><br>**NURS6095 Mental Health Nursing in Community Settings**<br><br>**NURS6060 Drug & Alcohol Issues in Mental Health Nursing Practice**<br><br>**NURS6061 Contemporary Mental Health Nursing** |

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| | | | | | | NURS6091 Community Mental Health Nursing |
| **University of New England**<br><br>University of New England 2011, *Graduate Certificate in Mental Health Practice*, viewed 21 July 2011, <http://www.une.edu.au/courses/2011/courses/GCMHP/program-of-study.html><br><br>University of New England 2011, *Graduate Diploma in Acute Care Nursing*, viewed 21 July 2011, <http://www.une.edu.au/courses/2011/courses/GDACN><br><br>University of New England 2011, *Master of Nursing For candidates admitted under Rule (a) or (c)*, viewed 21 July 2011, <http://www.une.edu.au/courses/2011/courses/MN/program-of-study-rule(a)(c).html><br><br>University of New England 2011, *Master of Nursing For candidates admitted under Rule (b)*, viewed 21 July 2011, <http://www.une.edu.au/courses/2011/courses/MN/program-of-study-rule(b).html><br><br>University of New England 2011, *Master of Nursing Practice*, viewed 21 July 2011, <http://www.une.edu.au/courses/2011/courses/MNP/program-of-study.html> | HSMH424 Mental Health Promotion, Prevention, Intervention<br><br>HSHM501 Health Education and Promotion<br><br>HSNS464 Cardiac Rehabilitation, Education and Health Promotion | HSHM501 Health Education and Promotion<br><br>HSNS464 Cardiac Rehabilitation, Education and Health Promotion | HSMH422 Introduction to Mental Health Care<br><br>HSMH423 Focused Psychological Strategies in Mental Health<br><br>HSNS423 Theories and Models of Teaching and Learning in Health<br><br>HSNS424 Reflective Teaching and Learning in Health<br><br>HSNS400 Comprehensive Health Assessment<br><br>HSNS432 Cardiac Health Assessment<br><br>HSHM445 Community Analysis and Health Care Planning<br><br>IDIG506 Aboriginal | HSHM501 Health Education and Promotion<br><br>HSNS464 Cardiac Rehabilitation, Education and Health Promotion<br><br>HSGR429 Special Topics in Gerontology<br><br>HSNS201 Nursing Practice Development 1<br><br>HSNS202 Nursing Practice Development 2<br><br>HSNS203 Nursing Practice Development 3<br><br>HSNS205 Introduction to Mental Health Nursing<br><br>HSNS314 Chronic and Palliative Care Nursing | HSHM501 Health Education and Promotion<br><br>HSNS464 Cardiac Rehabilitation, Education and Health Promotion<br><br>HSNS205 Introduction to Mental Health Nursing | HSMH421 Foundational Counselling and Assessment Skills<br><br>HSMH422 Introduction to Mental Health Care<br><br>HSMH423 Focused Psychological Strategies in Mental Health<br><br>HSMH424 Mental Health Promotion, Prevention, Intervention<br><br>HSNS423 Theories and Models of Teaching and Learning in Health<br><br>HSNS424 Reflective Teaching and Learning in Health<br><br>HS454 Reading Course<br><br>HSNS400 Comprehensive |

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| | | **Health**<br><br>**HSHM505 The Law, Advocacy and Health Care**<br><br>**HSNS469 A Lifespan Approach to Female Reproductive Health**<br><br>**HSHM402 Policy Management in Health**<br><br>**HSHM412 The Dynamics of Health and Health Care Systems**<br><br>**HSHM421 Financial Management in Health Services I**<br><br>**HSHM440 Law in Health Service Management**<br><br>**HSHM441 Management of Health Services**<br><br>**HSHM443 Health Information Management**<br><br>**HSHM447 Contemporary Issues in International Health**<br><br>**HHSC147 Fundamentals of** | **Health Assessment**<br><br>**HSNS432 Cardiac Health Assessment**<br><br>**HSNS452 Care of the Cardiac Patient**<br><br>**HSHM445 Community Analysis and Health Care Planning**<br><br>**HSGR429 Special Topics in Gerontology**<br><br>**IDIG506 Aboriginal Health**<br><br>**HSHM505 The Law, Advocacy and Health Care**<br><br>**HSNS469 A Lifespan Approach to Female Reproductive Health**<br><br>**HSHM400 Leadership and Change**<br><br>**HSHM402 Policy Management in Health**<br><br>**HSHM412 The Dynamics of Health and Health Care** |

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| | | **Health Science 2**<br><br>**HHSC246 Health Science 1**<br><br>**HHSC247 Health Science 2**<br><br>**HSNS205 Introduction to Mental Health Nursing** | **Systems**<br><br>**HSHM421 Financial Management in Health Services I**<br><br>**HSHM440 Law in Health Service Management**<br><br>**HSHM441 Management of Health Services**<br><br>**HSHM447 Contemporary Issues in International Health**<br><br>**HHSC246 Health Science 1**<br><br>**HHSC247 Health Science 2**<br><br>**HSNS201 Nursing Practice Development 1**<br><br>**HSNS202 Nursing Practice Development 2**<br><br>**HSNS203 Nursing Practice Development 3**<br><br>**HSNS204 Critical Enquiry in Nursing**<br><br>**HSNS205 Introduction to Mental Health Nursing** |

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| | | | | | | HSNS206 Career Transition to Australian Nursing Practice<br><br>HSNS312 Community Nursing<br><br>HSNS322 Professional Issues in Nursing 1 |
| **The University of Sydney**<br><br>The University of Sydney 2011, *Units of study for the Master of Nursing (Graduate Entry)*, viewed 21 July 2011, <http://sydney.edu.au/nursing/course_information/gem/mnursing_index.shtml ><br><br>The University of Sydney 2011, *Units of study for the Bachelor of Nursing (Post-registration) On-Shore (full-time or part-time) & Singapore Off-Shore* , viewed 21 July 2011, <http://sydney.edu.au/nursing/course_information/postregistration/postregistration_units_study.shtml><br><br>The University of Sydney 2011, *Unit of study descriptions for the Postgraduate courses and specialty areas*, viewed 21 July 2011, <http://sydney.edu.au/nursing/course_information/specialty_courses/units_study_advanced_learning.shtml > | | NURS3003 Clinical and Patient Education | NURS3002 Health Illness & Care<br><br>SNGP3010 Law and Ethics in Health Care<br><br>NURS5002 Social Contexts of Health<br><br>NURS5063 Mental Health Nursing A<br><br>NURS5065 Mental Health Nursing B<br><br>NURS5064 Mental Health & Illness in Context<br><br>NURS5069 Research in Nursing and Health Care<br><br>NURS5075 Expanding Practice in | NURS5085 Mental Health Nursing Practice<br><br>NURS6022 Community Health Nursing<br><br>NURS5064 Mental Health & Illness in Context<br><br>HSBH1008 Health Determinants and Interventions<br><br>NURS6024 Global Health & Nursing | NURS3003 Clinical and Patient Education<br><br>NURS5091 Simulation-based Learning in Health | HSBH1006 Foundations of Health Science<br><br>HSBH1007 Health Science and Research<br><br>HSBH1008 Health Determinants and Interventions<br><br>HSBH1009 Health Care Resources and Systems<br><br>NURS5083 Human Bioscience in Health<br><br>NURS6019 High Acuity Nursing<br><br>NURS3005 Nursing Management & Clinical Governance |

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| | | Mental Health<br><br>NURS5083 Human Bioscience in Health<br><br>NURS5084 Nursing the Acutely Ill Person<br><br>NURS5085 Mental Health Nursing Practice<br><br>NURS5091 Simulation-Based Learning in Health<br><br>NURS6004 Nursing and the Politics of Health Care<br><br>NURS6022 Community Health Nursing (Prerequisites: High Acuity Nursing & Care & Chronic Conditions)<br><br>NURS6024 Global Health and Nursing (Prerequisite: Social Contexts of Health)<br><br>NURS6025 Mental Health<br><br>HSBH1006 Foundations of Health Science | NURS3002 Health Illness & Care: Int'l Perspective<br><br>NURS3003 Clinical and Patient Education<br><br>NURS3006 Current Issues in Nursing<br><br>CLIN3021 Nursing, Knowledge and Practice<br><br>NURS5002 Social Contexts of Health<br><br>NURS5012 Assessment and Clinical Judgement<br><br>NURS5061 Expanding Clinical Nursing Practice<br><br>NURS5062 Clinical Practice and Nursing Work<br><br>NURS5063 Mental Health Nursing A<br><br>NURS5064 Mental Health & Illness in Context<br><br>NURS5065 |

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| | | HSBH1007 Health Science and Research<br><br>HSBH1008 Health Determinants and Interventions<br><br>HSBH1009 Health Care Resources and Systems | Mental Health Nursing B<br><br>NURS5069 Research in Nursing and Health Care<br><br>NURS5070 Creating a Culture of Safety and Quality<br><br>NURS5074 Expanding Practice in the ICU and ED<br><br>NURS5075 Expanding Practice in Mental Health<br><br>NURS5076 Pathophysiological Phenomena in Nursing<br><br>NURS5081 Introduction to Nursing Practice<br><br>NURS5084 Nursing the Acutely Ill Person<br><br>NURS5085 Mental Health Nursing Practice<br><br>NURS5086 Drug Therapy, Disease & Nursing Practice<br><br>NURS5089 Assessment and Diagnostic |

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| | | | | | | Reasoning<br><br>NURS5091 Simulation-Based Learning in Health<br><br>NURS6004 Nursing & the Politics of Health Care<br><br>NURS6018 Care and Chronic Conditions<br><br>NURS6022 Community Health Nursing<br><br>NURS6023 Professional Practice of Nursing<br><br>NURS6024 Global Health & Nursing<br><br>NURS6025 Nursing Practice (Mental Health Option)<br><br>NURS6026 Nursing Practice (Paediatrics Option)<br><br>NURS6028 Nursing Practice (Clinical Nursing Option) |
| | 92721 Health Promotion and | 92721 Health Promotion and | 92713 Health Breakdown | 92721 Health Promotion and | 92869 Specialty Clinical Practice | 92713 Health Breakdown |

# University of Technology – Sydney

University of Technology – Sydney 2011, *Postgraduate coursework*, viewed 21 July 2011, <http://datasearch2.uts.edu.au/nmh/courses-subjects/postgraduate.cfm>

University of Technology – Sydney 2011, *C04228v1 Master of Nursing*, viewed 21 July 2011, <http://handbook.uts.edu.au/courses/c04228.html>

University of Technology – Sydney 2011, *C07044v3 Graduate Diploma in Nursing*, viewed 21 July 2011, <http://handbook.uts.edu.au/courses/c07044.html>

University of Technology – Sydney 2011, *C11116v4 Graduate Certificate in Perioperative Nursing*, viewed 21 July 2011, <http://handbook.uts.edu.au/courses/c11116.html>

University of Technology – Sydney 2011, *C11117v4 Graduate Certificate in Anaesthetics and Recovery Room Nursing*, viewed 21 July 2011, <http://handbook.uts.edu.au/courses/c11117.html>

University of Technology – Sydney 2011, *Graduate Certificate in Critical Care Nursing (C11118v3)*, viewed 21 July 2011, <http://datasearch2.uts.edu.au/nmh/courses-subjects/postgraduate-detail.cfm?spk_cd=C11118&spk_ver_no=3>

University of Technology – Sydney 2011, *C11119v3 Graduate Certificate in Neuroscience Nursing*, viewed 21 July 2011, <http://handbook.uts.edu.au/courses/c1111

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| Health Education | Health Education<br><br>015356 Learning in Diabetes Education | 92606 Issues in Australian Health Services<br><br>92612 Research in Health<br><br>92050 Policy, Power and Politics in Health Care<br><br>92887 Organisational Management in Health Care<br><br>92603 Managing Quality, Risk and Cost in Health Care<br><br>92847 Planning and Evaluating Health Services<br><br>92023 Health Services Resource Management<br><br>92604 Mental Health Assessment<br><br>92876 Therapeutic Interventions in Mental Health Care<br><br>92605 Therapeutic Interventions in Mental Health Care 2 | Health Education<br><br>92611 Complex Case Management<br><br>92613 Principles of Child and Family Health Nursing<br><br>92620 Family and Community Health Practice<br><br>HSGR429 Special Topics in Gerontology | 92721 Health Promotion and Health Education<br><br>92983 Specialty Practice<br><br>015356 Learning in Diabetes Education | 92606 Issues in Australian Health Services<br><br>92721 Health Promotion and Health Education<br><br>92612 Research in Health<br><br>92050 Policy, Power and Politics in Health Care<br><br>92932 Management for Clinicians<br><br>92023 Health Services Resource Management<br><br>92876 Therapeutic Interventions in Mental Health Care<br><br>92605 Therapeutic Interventions in Mental Health Care 2<br><br>92608 Advanced Assessment and Diagnosis<br><br>92611 Complex Case Management<br><br>92887 Organisational |

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| 9.html><br><br>University of Technology – Sydney 2011, *C11194v1 Graduate Certificate in Children's Nursing*, viewed 21 July 2011, <http://handbook.uts.edu.au/courses/c11194.html><br><br>University of Technology – Sydney 2011, *C11200v2 Graduate Certificate in Child and Family Health Nursing*, viewed 21 July 2011, <http://handbook.uts.edu.au/courses/c11200.html><br><br>University of Technology – Sydney 2011, *C11106v3 Graduate Certificate in Mental Health Nursing*, viewed 21 July 2011, <http://handbook.uts.edu.au/courses/c11106.html><br><br>University of Technology – Sydney 2011, *C11196v1 Graduate Certificate in Neonatal Nursing*, viewed 21 July 2011, <http://handbook.uts.edu.au/courses/c11196.html> | | 92885 Leadership and Change in Health Care<br><br>92917 Using Health Care Data for Decision Making<br><br>92933 Health Care Regulation and Policy<br><br>92964 Child and Adolescent Mental Health Disorders<br><br>92296 Epidemiology and Population Health<br><br>92022 Improving Quality and Safety in Health Care<br><br>92297 Health Systems and Change<br><br>92051 Health Services Management and Legal Issues<br><br>26703 Introductory Health Economics<br><br>92295 Advanced Health Services Planning<br><br>78150 Law and | Management in Health Care<br><br>92603 Managing Quality, Risk and Cost in Health Care<br><br>92871 Perinatal Development<br><br>92878 Care of the Child in Illness and Disability<br><br>92895 Issues in Neonatal Care<br><br>92902 Care of the Acutely Ill Child<br><br>92910 Counselling and Group Skills<br><br>92917 Using Health Care Data for Decision Making<br><br>92926 Information Management Application<br><br>92933 Health Care Regulation and Policy<br><br>92964 Child and Adolescent Mental Health Disorders<br><br>92296 Epidemiology |

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| | | **Mental Health**<br><br>**92845 Primary Health Care**<br><br>**92613 Principles of Child and Family Health Nursing**<br><br>**92614 Child and Family Health Nursing 1**<br><br>**92615 Child and Family Health Nursing 2**<br><br>**92620 Family and Community Health Practice**<br><br>**92972 Health Care Research Methodology**<br><br>**92973 Developing Health Care Theory**<br><br>**92974 Investigating Health Care Change**<br><br>**93002 Knowledge Utilisation and Policy in Health Services and Practice**<br><br>**93004 Research Design and Analysis in Health Services and Practice** | **and Population Health**<br><br>**92022 Improving Quality and Safety in Health Care**<br><br>**92297 Health Systems and Change**<br><br>**92051 Health Services Management and Legal Issues**<br><br>**26703 Introductory Health Economics**<br><br>**92295 Advanced Health Services Planning**<br><br>**77734 Law and Medicine**<br><br>**78144 Contemporary Issues in Health Law**<br><br>**78150 Law and Mental Health**<br><br>**92845 Primary Health Care**<br><br>**92613 Principles of Child and Family Health Nursing**<br><br>**92614 Child and Family Health Nursing 1** |

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| | 93005 Leading Change in Health Services and Practice<br><br>HSNS415 Community Health Nursing Practice | | 92615 Child and Family Health Nursing 2<br><br>92620 Family and Community Health Practice<br><br>92972 Health Care Research Methodology<br><br>92973 Developing Health Care Theory<br><br>92974 Investigating Health Care Change<br><br>93005 Leading Change in Health Services and Practice<br><br>HSNS415 Community Health Nursing Practice<br><br>HSGR429 Special Topics in Gerontology |
| **University of Western Sydney**<br><br>University of Western Sydney 2011, *Nursing Postgraduate Courses*, viewed 21 July 2011, | Graduate Diploma in Nursing (Mental Health)<br><br>Master Child and Family Health (Karitane) | Master Child and Family Health (Karitane) | Master of Nursing<br><br>Master of Mental Health Nursing (Nurse Practitioner)<br><br>Graduate |

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| <http://www.uws.edu.au/future-students/postgraduate/postgraduate/postgraduate_courses/nursing_courses><br><br>University of Western Sydney 2011, *Master of Nursing*, viewed 21 July 2011, <http://www.uws.edu.au/future-students/postgraduate/postgraduate/postgraduate_courses/nursing_courses/nursing><br><br>University of Western Sydney 2011, Master of Nursing (Clinical Leadership), viewed 21 July 2011, <http://www.uws.edu.au/future-students/postgraduate/postgraduate/postgraduate_courses/nursing_courses/nursing_clinical_leadership><br><br>University of Western Sydney 2011, *Master Child and Family Health (Karitane)*, viewed 21 July 2011, <http://www.uws.edu.au/future-students/postgraduate/postgraduate/postgraduate_courses/nursing_courses/m_nursing_karitane><br><br>University of Western Sydney 2011, *Master of Mental Health Nursing (Nurse Practitioner)*, viewed 21 July 2011, <http://www.uws.edu.au/future-students/postgraduate/postgraduate/postgraduate_courses/nursing_courses/nursing_mental_health_nurse_practice><br><br>University of Western Sydney 2011, *Graduate Diploma in Nursing (Mental Health)*, viewed 21 July 2011, <http://www.uws.edu.au/future-students/postgraduate/postgraduate/postgraduate_courses/nursing_courses/grad_dip_nursing_mental_health><br><br>University of Western Sydney 2011, *Master of Primary Health Care*, viewed 21 July 2011, <http://www.uws.edu.au/future-students/postgraduate/postgraduate/postgraduate_courses/nursing_courses/primary_health_care> | Master of Primary Health Care<br><br>Graduate Diploma in Primary Health Care | Diploma in Nursing (Mental Health)<br><br>Master of Primary Health Care<br><br>Graduate Diploma in Primary Health Care |

University of Western Sydney 2011, *Graduate Diploma in Primary Health Care*, viewed 21 July 2011, <http://www.uws.edu.au/future-students/postgraduate/postgraduate/postgraduate_courses/nursing_courses/grad_dip_primary_health_care>

## University of Wollongong

University of Wollongong 2011, *Graduate Certificate in Nursing*, viewed 21 July 2011, <http://www.uow.edu.au/handbook/yr2011/pg/hbs/H10006801.html>

University of Wollongong 2011, *Graduate Certificate in Practice Nursing*, viewed 21 July 2011, <http://www.uow.edu.au/handbook/yr2011/pg/hbs/H10006802.html>

University of Wollongong 2011, *Master of Nursing*, viewed 21 July 2011, <http://www.uow.edu.au/handbook/yr2011/pg/hbs/H10006790.html>

University of Wollongong 2011, *Master of Nursing (Mental Health)*, viewed 21 July 2011, <http://www.uow.edu.au/handbook/yr2011/pg/hbs/H10006791.html>

SHS 934 Health Promotion

SHS 941 Public Health Research Methodology

CHIP915 Essential Skills for Health Research

SHS941 Public Health Research Methodology

GHMB923 Legal and Professional Issues

SHS 941 Public Health Research Methodology

SHS 933 Social Determinants of Health

SHS 936 Public Health Nutrition

GHMB902 Effective Management in

SHS 934 Health Promotion

GHMB958 Advancements in Dementia Care

GHMB944 Community Resource Planning

GHMB938 Practice Nursing

CHIP912 Advanced Studies in Behaviour Change

GHMB928 Introduction to Ophthalmic Nursing

GHMB901 Infection Control Nursing

GHMB948 Hand Management, Therapy and Rehabilitation

GHMB944 Community Resource Planning

CHIP912 Advanced Studies in Behaviour Change

GHMB901 Infection Control Nursing

SHS 941 Public Health Research Methodology

CHBC918 Critical Appraisal

CHIP915 Essential Skills for Health Research

SHS941 Public Health Research Methodology

GHMB923 Legal and Professional Issues

SHS 941 Public Health Research Methodology

GHMB956 Policy and Practice in the Care of Older People

SHS 933 Social Determinants of

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| | | **Health**<br><br>**GHMB925 Effective Leadership in Health**<br><br>**GHMB926 Coaching Skills for Healthcare Leaders**<br><br>**GHMB989 Mental Health Nursing: Clinical Principles and Practice**<br><br>**GHMB934 Assessment and Diagnosis in Mental Health**<br><br>**GHMB935 Case Management in Mental Health**<br><br>**CHBC919 Evaluative Research Methodology**<br><br>**GHMB943 Health and Human Ecology**<br><br>**GHMB941 Indigenous Health Patterns**<br><br>**CHIP911 Social Marketing for Health**<br><br>**SHS 931 Public Health Communication** | **Health**<br><br>**SHS 936 Public Health Nutrition**<br><br>**GHMB902 Effective Management in Health**<br><br>**GHMB925 Effective Leadership in Health**<br><br>**GHMB926 Coaching Skills for Healthcare Leaders**<br><br>**SHS 932 Epidemiology**<br><br>**GHMB903 Scientific and Qualitative Development in Acute Care Nursing**<br><br>**GHMB989 Mental Health Nursing: Clinical Principles and Practice**<br><br>**CHBC919 Evaluative Research Methodology**<br><br>**GHMB940 Indigenous Family Studies**<br><br>**GHMB943 Health and** |

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| | | and Data Skills | Human Ecology<br><br>GHMB941<br>Indigenous<br>Health Patterns<br><br>GHMB944<br>Community<br>Resource<br>Planning<br>GHMB937<br><br>Context of<br>General Practice<br><br>CHIP910<br>Critical<br>Marketing and<br>Media Analysis<br><br>CHIP911<br>Social Marketing<br>for Health<br><br>CHIP913<br>Social Marketing<br>Practice*<br><br>SHS 931<br>Public Health<br>Communication<br>and Data Skills<br><br>GHMB901<br>Infection Control<br>Nursing |
| **NT**<br><br>**Charles Darwin** | | **EXTENDED HEALTH PRACTICE 1** | **CONTEXT FOR EXTENDED PROFESSIONAL** |

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| **University**<br><br>Charles Darwin University 2011, Postgraduate (PG) Nursing & Child and Family Health (CFH), viewed 21 July 2011, <http://www.cdu.edu.au/ehs/health/nursing/postg-nursing.html#p7tpc1_3><br><br>Charles Darwin University 2011, *Master of Health Practice (Nurse Practitioner)*, viewed 21 July 2011, <http://www.cdu.edu.au/ehs/health/nursing/documents/Courseflyer_MHPNP2011.pdf><br><br>Charles Darwin University 2011, *Master of Nursing*, viewed 21 July 2011, <http://www.cdu.edu.au/ehs/health/nursing/documents/Courseflyer_MNUR2011.pdf><br><br>Charles Darwin University 2011, *Postgraduate (PG) Nursing & Child and Family Health (CFH)*, viewed 21 July 2011, <http://www.cdu.edu.au/ehs/health/nursing/postg-nursing.html#p7tpc1_3><br><br>Charles Darwin University 2011, *Graduate Diploma in Nursing*, viewed 21 July 2011, <http://www.cdu.edu.au/ehs/health/nursing/documents/Courseflyer_GDNUR2011.pdf> | | | (HEA520)<br><br>EXTENDED HEALTH PRACTICE 2 (HEA540)<br><br>SNP402 Pharmacology for Health Professionals<br><br>HEA423 Financial management for health care managers<br><br>HEALTH ASSESSMENT IN A BIO/PSYCHO/SOCIAL CONTEXT (HEA408) | | PRACTICE (HEA511)<br><br>EXTENDED HEALTH PRACTICE 2 (HEA540)<br><br>HEALTH ASSESSMENT IN A BIO/PSYCHO/SOCIAL CONTEXT (HEA408) |
| **QLD** | | | | | |
| **ACU National**<br><br>ACU National 2011, *Master of Health Science (Clinical Education)*, viewed 21 July 2011, | HLSC608 Theoretical Foundations of Clinical Education | HLSC604 Quality in Health Care<br><br>HLSC605 Governance in Health Care | NRSG635 Specialty Practice 2 | HLSC608 Theoretical Foundations of Clinical Education<br><br>HLSC610 | HLSC608 Theoretical Foundations of Clinical Education<br><br>HLSC609 |

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|---|---|---|---|---|
| <http://www.acu.edu.au/courses/unit_courses2?PROGRAM=MHSCED><br><br>ACU National 2011, *Master of Health Science (Clinical Practice)*, viewed 21 July 2011, <http://www.acu.edu.au/courses/unit_courses2?PROGRAM=MHSCPR><br><br>ACU National 2011, *Master of Nursing (Practice Inquiry)*, viewed 21 July 2011, <http://www.acu.edu.au/courses/unit_courses2?PROGRAM=MNPRIN><br><br>ACU National 2011, *Master of Nursing (Management), Master of Nursing (Practice)*, viewed 21 July 2011, <http://www.acu.edu.au/about_acu/publications/handbooks/2009/faculty_of_health_sciences/coursecampus_table/postgraduate_courses/master_of_nursing_management,_master_of_nursing_practice/><br><br>ACU National 2011, *Course Enrolment Guide 2011 Master of Health Science (Clinical Education) and Graduate Certificate in Clinical Education Online Course*, viewed 21 July 2011, <http://www.acu.edu.au/__data/assets/pdf_file/0009/283194/Master_of_Health_Science_and_Grad_Cert_Clinical_Education_2011.pdf><br><br>ACU National 2011, *Course Enrolment Guide 2011 Master of Health Science (Clinical Practice) and Graduate Certificate in Clinical Practice Online Course*, viewed 21 July 2011, <http://www.acu.edu.au/__data/assets/pdf_file/0020/283205/Master_of_Health_Science_and_Grad_Cert_Clinical_Practice_2011.pdf><br><br>ACU National 2011, *Course Enrolment Guide 2011 Master of Health Science (Health Administration) and Graduate Certificate in Health Administration Brisbane (McAuley Campus) QLD and Nationally Online*, viewed 21 July 2011, | | HLSC607 Policy and Planning in Health Care<br><br>NRSG640 Interpreting Health Research<br><br>NRSG607 Quality in Health Care<br><br>NRST613 Leadership and Health Care<br><br>NRSP616 Technology in Health Care | Assessment and Evaluation | Facilitating Learning in Clinical Settings<br><br>HLSC611 Clinical Consultation and Negotiation<br><br>NRSG634 Dimensions of Specialty Practice<br><br>NRSG635 Specialty Practice 2<br><br>HLSC603 Organisational Contexts and Management<br><br>HLSC604 Quality in Health Care<br><br>HLSC605 Governance in Health Care<br><br>HLSC600 Ethics in Contemporary<br><br>HLSC602 Advanced Decision Making<br><br>HLSC607 Policy and Planning in Health Care<br><br>NRSG626 Inquiry into Nursing Practice<br><br>NRSG607 Quality in Health Care<br><br>NRST615 Policy |

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| <http://www.acu.edu.au/__data/assets/pdf_file/0004/283216/Master_of_Health_Science_and_Grad_Cert_Health_Administration_2011.pdf> | | and Planning in Nursing<br><br>NRST622 Resource Management in Nursing<br><br>NRSP601 Clinical Decision Making<br><br>NRSP616 Technology in Health Care |
| **Central Queensland University**<br><br>Central Queensland University 2011, *Graduate Certificate in Mental Health Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/program/show/50><br><br>Central Queensland University 2011, *Master of Mental Health Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/program/show/12><br><br>Central Queensland University 2011, *Graduate Diploma of Mental Health Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/program/show/49><br><br>Central Queensland University 2011, *Master of Clinical Practice (Specialisation)*, viewed 21 July 2011, <http://degrees.cqu.edu.au/program/show/493> | They offer postgraduate nursing degrees by coursework but they do not provide access to the degree structures and their unit descriptions | |

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Acute Cardiac Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/141>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Catheter Laboratory Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/142>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Peri-operative Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/143>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Child and Adolescent Health*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/144>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Wound Management*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/145>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Gerontological Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/146>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - General Practice Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/147>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Mental Health*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/148>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Paediatric Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/149>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Rehabilitation*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/150>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Surgical Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/151>

Central Queensland University 2011, *Master of Clinical Practice (Specialisation) - Medical Nursing*, viewed 21 July 2011, <http://degrees.cqu.edu.au/programSpecialization/show/152>

## Griffith University

Griffith University 2011, *Postgraduate programs offered in Nursing,* viewed 21 July 2011, <http://www17.griffith.edu.au/cis/p_cat/programsubarea.asp?cat=Health&subcat=nursing&display=open>

Griffith University 2011, *Graduate Certificate in Acute Care Nursing - Nathan*, viewed 21 July 2011, < http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=3224&Type=overview>

Griffith University 2011, *Graduate Certificate in Community and Primary Health Care - Gold Coast*, viewed 21 July 2011, <

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| 7116PBH Health Promotion Intervention Management | 7002HLS Integrating Educational Theory in Practice<br><br>7901NRS Teaching for Learning in Clinical Settings | 7009HSV Health, Ageing and Disability<br><br>7410PBH Managing Workplace Health and Safety<br><br>8021NRS Health Leadership & Management<br><br>8016NRS Community Practice for Health Professionals<br><br>7005HLS Assessment and | 8016NRS Community Practice for Health Professionals<br><br>7116PBH Health Promotion Intervention Management<br><br>8023NRS Independent Practice Study<br><br>7054PBH Public Health Nutrition<br><br>7001CSR Contemporary Suicide Prevention | 7002HLS Integrating Educational Theory in Practice<br><br>7901NRS Teaching for Learning in Clinical Settings<br><br>7004HLS Effective Communication Skills in Professional Practice<br><br>7005HLS Assessment and Evaluation in Health | 7009HSV Health, Ageing and Disability<br><br>7025HSV Ethics and Disability<br><br>7410PBH Managing Workplace Health and Safety<br><br>8952NRS Advanced Clinical Assessment<br><br>7021NRS Research Evidence and Clinical Practice |

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| http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=3195&Type=overview><br><br>Griffith University 2011, *Graduate Certificate in Critical Care Nursing - Gold Coast*, viewed 21 July 2011, <http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=3073&Type=overview><br><br>Griffith University 2011, *Graduate Certificate in Emergency Nursing - Gold Coast*, viewed 21 July 2011, <http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=3070&Type=overview><br><br>Griffith University 2011, *Graduate Certificate in Gerontology - Nathan*, viewed 21 July 2011, <http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=3196&Type=overview><br><br>Griffith University 2011, *Graduate Certificate in Infection Prevention and Control - Logan*, viewed 21 July 2011, <http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=3072&Type=overview><br><br>Griffith University 2011, *Graduate Certificate in Mental Health Nursing - Gold Coast*, viewed 21 July 2011, < http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=3197&Type=overview><br><br>Griffith University 2011, *Graduate Certificate in Palliative Care - Gold Coast*, viewed 21 July 2011, <http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=3198&Type=overview><br><br>Griffith University 2011, *Graduate Certificate in Sexual Health - Logan*, viewed 21 July | | Evaluation in Health Professional Education<br><br>7035HSV Understanding Mental Health: Theories and Practice<br><br>8923NRS Practical Mental Health Nursing Skills 1<br><br>8924NRS Practical Mental Health Nursing Skills<br><br>8017NRS Working with Families in Illness and Health<br><br>8906NRS Introduction to Sexual Health and STI<br>8913NRS Sexual Health in the Community<br><br>8914NRS Sexual Health Practice<br><br>9915NRS Misc Studies Challenge Mode Sexual Health Practice RPL 1 (Beg)<br><br>9916NRS Misc Studies Challenge Mode | Practice 1 | Professional Education<br><br>8923NRS Practical Mental Health Nursing Skills 1<br><br>8923NRS Practical Mental Health Nursing Skills 1* | 8021NRS Health Leadership & Management<br><br>7021NRS Research Evidence and Clinical Practice<br><br>8016NRS Community Practice for Health Professionals<br><br>8010NRS Critical Care Nursing Interventions 3<br><br>8988NRS: Challenges in Ageing<br><br>8848NRS Human Dimension of Infection Control<br><br>8849NRS Contemporary Infection Control Practice<br><br>8923NRS Practical Mental Health Nursing Skills 1<br><br>8924NRS Practical Mental Health Nursing Skills<br><br>8922NRS Counselling<br><br>8925NRS Theories of |

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|---|---|---|---|
| 2011, < http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=3106&Type=overview><br><br>Griffith University 2011, *Graduate Certificate in Mental Health Nursing - Gold Coast*, viewed 21 July 2011, <http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=5424&Type=overview><br><br>Griffith University 2011, *Master of Advanced Practice with Honours - Gold Coast, Logan and Nathan*, viewed 21 July 2011, <http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=5425&Type=overview><br><br>Griffith University 2011, *Master of Nursing - Gold Coast and Nathan*, viewed 21 July 2011, <http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=5570&Type=overview><br><br>Griffith University 2011, *Master of Nursing (Nurse Practitioner) - Gold Coast*, viewed 21 July 2011, <http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=5553&Type=overview> | | Sexual Health Practice RPL 2 (Adv)<br><br>8017NRS Working with Families in Illness and Health<br><br>7324PBH Health Finance and Project Planning<br><br>7301PBH Health Policy and Planning<br><br>7411PBH Capacity Building for Public Health Action<br><br>7311PBH Social and Behavioural Determinants of Health<br><br>7410PBH Managing Workplace Health and Safety<br><br>8906NRS Introduction to Sexual Health and STI<br><br>8853NRS Infection Control for Public Health and Primary Care<br><br>8923NRS Practical Mental Health Nursing Skills 1* | Counselling<br><br>8017NRS Working with Families in Illness and Health<br><br>8906NRS Introduction to Sexual Health and STI<br><br>8912NRS Gender and Sexuality<br><br>8913NRS Sexual Health in the Community<br><br>8914NRS Sexual Health Practice<br><br>9915NRS Misc Studies Challenge Mode Sexual Health Practice RPL 1 (Beg)<br><br>9916NRS Misc Studies Challenge Mode Sexual Health Practice RPL 2 (Adv)<br><br>8017NRS Working with Families in Illness and Health<br><br>7116PBH Health Promotion Intervention Management |

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| | | **7054PBH Public Health Nutrition**<br><br>**7210PBH Indigenous Health** | **7324PBH Health Finance and Project Planning**<br><br>**7301PBH Health Policy and Planning**<br><br>**7411PBH Capacity Building for Public Health Action**<br><br>**7311PBH Social and Behavioural Determinants of Health**<br><br>**7410PBH Managing Workplace Health and Safety**<br><br>**8023NRS Independent Practice Study**<br><br>**8906NRS Introduction to Sexual Health and STI**<br><br>**8853NRS Infection Control for Public Health and Primary Care**<br><br>**8923NRS Practical Mental Health Nursing Skills 1***<br><br>**7054PBH Public Health Nutrition**<br><br>**7312PBH Epidemiology,** |

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| | | | | | | and introduction<br><br>8922NRS Counselling<br><br>8952NRS Advanced Clinical Assessment<br><br>7210PBH Indigenous Health |
| **James Cook University**<br><br>James Cook University 2011, *Graduate Diploma of Forensic Mental Health*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=72907->.<br><br>James Cook University 2011, *Graduate Certificate of Forensic Mental Health*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=72911->.<br><br>James Cook University 2011, *Master of Forensic Mental Health*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=73204->.<br><br>James Cook University 2011, *Master of Nursing (Nurse Practitioner)*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=75904-&mainContent=subjects >.<br><br>James Cook University 2011, *Master of Nursing Leadership*, viewed 21 July 2011, | | TM5528 Health Promotion<br><br>TM5568 Health Promotion Needs Assessment and Planning<br><br>TM5569 Health Promotion Strategies and Methods<br><br>TM5570 Health Promotion Research and Evaluation | NS5360 Issues in Forensic Mental Health 1<br><br>NS5362 Issues in Forensic Mental Health 2<br><br>NS5365 Ethical Considerations in Forensic Mental Health<br><br>NS5901 Extended Health Assessment for Nurse Practitioners<br><br>NS5607 Clinical Management of the Older Adult in Health Care Facilities<br><br>NS5710 Nursing Management Across the Health Sector<br><br>NS5880 Managing | NS5226 Infant Feeding and Nutrition<br><br>NS5606 Clinical Management of the Older Adult in the Community<br><br>TM5502 Tropical Public Health<br><br>TM5510 Aboriginal and Torres Strait Islander Health<br><br>TM5528 Health Promotion<br><br>TM5541 Managing Effective Health Programs<br><br>TM5542 Clinical Travel Medicine<br><br>TM5554 Theory and Practice of Public Health | NS5606 Clinical Management of the Older Adult in the Community<br><br>TM5502 Tropical Public Health<br><br>TM5542 Clinical Travel Medicine | NS5901 Extended Health Assessment for Nurse Practitioners<br><br>NS5905 Professional Issues for Nurse Practitioners<br><br>NS5202 Research: Proposal Writing<br><br>NS5230 Clinical Governance Project<br><br>NS5501 Contemporary Issues in Acute Care Nursing<br><br>NS5604 Contemporary Issues in Care of the Older Adult<br><br>NS5605 Advanced Assessment of |

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| <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=76904-&mainContent=subjects><br><br>James Cook University 2011, *Master of Nursing Studies*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=74904-&mainContent=subjects><br><br>James Cook University 2011, *Postgraduate Certificate of Mental Health Practice*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=83111-&mainContent=subjects><br><br>James Cook University 2011, *Postgraduate Certificate of Nursing Science (Advanced Clinical Practice)*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=75511-&mainContent=subjects><br><br>James Cook University 2011, *Postgraduate Certificate of Nursing Science (Cardiac Nursing)*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=75911-&mainContent=subjects><br><br>James Cook University 2011, *Postgraduate Certificate of Nursing Science (Care of the older adult)*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=73311-&mainContent=subjects><br><br>James Cook University 2011, *Postgraduate Certificate of Nursing Science (Clinical Teaching)*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=73411- | | Mental Health in General Health Settings<br><br>HS5411 Community Rehabilitation for Health Professionals<br><br>TM5502 Tropical Public Health<br><br>TM5510 Aboriginal and Torres Strait Islander Health<br><br>TM5513 Public Health Management<br><br>TM5514 Environmental Health<br><br>TM5536 Refugee Health<br><br>TM5540 Occupational Health<br><br>TM5541 Managing Effective Health Programs<br><br>TM5554 Theory and Practice of Public Health<br><br>TM5555 Infection Control in Health Care Settings<br><br>TM5557 Disaster | TM5568 Health Promotion Needs Assessment and Planning<br><br>TM5569 Health Promotion Strategies and Methods<br><br>TM5570 Health Promotion Research and Evaluation<br><br>NS5740 Advanced Medical Nursing | the Older Adult<br><br>NS5606 Clinical Management of the Older Adult in the Community<br><br>NS5607 Clinical Management of the Older Adult in Health Care Facilities<br><br>NS5710 Nursing Management Across the Health Sector<br><br>NS5750 Dispute Resolution: A Nursing and Midwifery Perspective<br><br>NS5770 Nursing Leadership<br><br>NS5880 Managing Mental Health in General Health Settings<br><br>HS5411 Community Rehabilitation for Health Professionals<br><br>TM5002 Infectious Diseases<br><br>TM5502 Tropical Public Health |

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|---|---|---|---|
| &mainContent=subjects><br><br>James Cook University 2011, *Postgraduate Certificate of Nursing Science (Intensive Care)*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=75611-&mainContent=subjects><br><br>James Cook University 2011, *Postgraduate Certificate of Nursing Science (Neonatal Care)*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=76911-><br><br>James Cook University 2011, *Postgraduate Certificate of Nursing Science (Perioperative Care)*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=75811-&mainContent=subjects><br><br>James Cook University 2011, *Postgraduate Certificate of Nursing Science (Renal Nursing)*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=77011-&mainContent=subjects><br><br>James Cook University 2011, *Postgraduate Certificate of Nursing Science (Specialist Paediatric Care)*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=103611-&mainContent=subjects><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-ARM&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing-Cardiac Nursing*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index | Health Management<br><br>TM5526 Public Health Economics<br><br>NS5604 Contemporary Issues in Care of the Older Adult<br><br>NS5602 Assessment of Altered Health Status in the Aged<br><br>NS5604 Contemporary Issues in Ageing and Health<br><br>NS5710 Nursing Management Across the Health Sector<br><br>WS5104 Mental Health<br><br>NS5360 Issues in Forensic Mental Health 1<br><br>NS5362 Issues in Forensic Mental Health 2<br><br>TM5515 Epidemiology for Public Health | TM5510 Aboriginal and Torres Strait Islander Health<br><br>TM5512 Travel Medicine<br><br>TM5513 Public Health Management<br><br>TM5514 Environmental Health<br><br>TM5525 Communicable Disease Control<br><br>TM5528 Health Promotion<br><br>TM5536 Refugee Health<br><br>TM5540 Occupational Health<br><br>TM5541 Managing Effective Health Programs<br><br>TM5542 Clinical Travel Medicine<br><br>TM5554 Theory and Practice of Public Health<br><br>TM5555 Infection Control in Health Care Settings<br><br>TM5557 Disaster |

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| .htm?userText=100507-PDN-CDN&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing-Care of the Older Adult*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-COA&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –Clinical Teaching*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-CLT&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –Disaster and Refugee Health*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-DRH&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –Emergency*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-EME&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –General Practice*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-GPR&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –Health Promotion*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-HPR&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –Infection Control*, viewed 21 July 2011, <http://www- | | Health Management<br><br>TM5568 Health Promotion Needs Assessment and Planning<br><br>TM5569 Health Promotion Strategies and Methods<br><br>NS5407 Contemporary Issues in Nurse Education<br><br>NS5730 Advanced Surgical Nursing<br><br>TM5526 Public Health Economics<br><br>NS5604 Contemporary Issues in Care of the Older Adult<br><br>NS5001 Applied Physiological Assessment<br><br>NS5604 Contemporary Issues in Ageing and Health<br><br>NS5710 Nursing Management Across the Health Sector<br><br>WS5104 Mental Health |

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| public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-INC&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –Intensive Care*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-ICN&mainContent=major><br><br>James Cook University 2011, Postgraduate Diploma of Nursing –Isolated and Rural, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-IRP&mainContent=major><br><br>James Cook University 2011, Postgraduate Diploma of Nursing –Mental Health, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-MEH&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –Neonatal Care*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-NNC&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –Nursing Leadership*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-NLE&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –Oncology*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-ONC&mainContent=major><br><br>James Cook University 2011, *Postgraduate Diploma of Nursing –Perioperative Care*, | | NS5361 The Law, Social Policy and the Mentally Ill Offender<br><br>NS5362 Issues in Forensic Mental Health 2<br><br>PY5017 Psychosocial Elements of Ageing<br><br>WS5102 Counselling Children and Adolescents<br><br>NS5801 Cardiac Nursing 1<br><br>NS5511 Intensive Care Nursing 1<br><br>NS5512 Intensive Care Nursing 2<br><br>TM5515 Epidemiology for Public Health |

viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-PCA&mainContent=major>

James Cook University 2011, *Postgraduate Diploma of Nursing –Public health*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-PUH&mainContent=major>

James Cook University 2011, *Postgraduate Diploma of Nursing –Renal Nursing*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-REN&mainContent=major>

James Cook University 2011, *Postgraduate Diploma of Nursing –Specialist Paediatric Care*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-SPC&mainContent=major>

James Cook University 2011, *Postgraduate Diploma of Nursing –Travel Medicine*, viewed 21 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100507-PDN-TRM&mainContent=major>

## Queensland University of Technology

Queensland University of Technology 2011, *Graduate Certificate in Nursing (NS32)*, viewed 21 July 2011, <http://www.courses.qut.edu.au/cgi-

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| PUP034 Advanced Studies and Practice in Health Promotion<br><br>PUP038 Contemporary Health Promotion | HLN720 Clinical Education in Health | HLN720 Clinical Education in Health<br><br>PUN105 Health Statistics<br><br>PUN632 Leadership in Health Management<br><br>PUN213 | PUP032 Intervention Design and Theories of Change | NSN821 Promoting Healthy Ageing<br><br>PUP032 Intervention Design and Theories of Change | NSN005 Community Child and Youth Health Nursing<br><br>HLN720 Clinical Education in Health | NSN516 Sexual and Reproductive Health<br><br>NSN421 Assessment and Diagnosis in Extended Practice<br><br>NSN423 Nurse Practitioner Role |

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| bin/WebObjects/Courses.woa/wa/selectMajorFromMain?pres=sf&courseID=12556&structureID=all#all><br><br>Queensland University of Technology 2011, *Master of Nursing Science (Nurse Practitioner) (NS86)*, viewed 21 July 2011, <http://www.courses.qut.edu.au/cgi-bin/WebObjects/Courses.woa/wa/selectMajorFromMain?pres=sf&courseID=12620><br><br>Queensland University of Technology 2011, *Graduate Diploma in Nursing (NS64)* , viewed 21 July 2011, <http://www.courses.qut.edu.au/cgi-bin/WebObjects/Courses.woa/wa/selectMajorFromMain?pres=sf&courseID=12555#36004> | | Introduction to Quality Management in Health<br><br>PUN214 Systems of Quality and Safety in Health Care<br><br>PUN219 Leadership of Quality and Safety in Health Care<br><br>PUN451 Introduction To Health Disaster Management<br><br>PUN452 Health Disaster Planning and Preparedness<br><br>PUN453 Health Disaster Response and Recovery<br><br>PUN454 Health Leadership in Disaster Management<br><br>PUN363 Environmental Health Law<br><br>PUN467 Public Health Risk Assessment<br><br>PUN620 Concepts of Environmental Health | Development<br><br>HLN405 Qualitative Research<br><br>HLN710 Fundamentals of Epidemiology and Research Design<br><br>PUN105 Health Statistics<br><br>PUN632 Leadership in Health Management<br><br>PUN213 Introduction to Quality Management in Health<br><br>NSN626 Studies in Dementia<br><br>NSN821 Promoting Healthy Ageing<br><br>PUN452 Health Disaster Planning and Preparedness<br><br>PUN454 Health Leadership in Disaster Management<br><br>PUN363 Environmental Health Law<br><br>PUN465 |

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| | | **PUN632 Leadership in Health Management**<br><br>**PUN640 Health Care Delivery and Reform**<br><br>**PUN688 International Health Policy and Management**<br><br>**PUN210 Fundamentals of Health Management**<br><br>**PUN211 Health Care Finance and Economics**<br><br>**PUN212 Understanding Health Information**<br><br>**PUN213 Introduction to Quality Management in Health**<br><br>**PUP037 Health Program Evaluation**<br><br>**LWN164 Health Care Law and Ethics**<br><br>**PUN106 Population Health** | **Environmental Protection**<br><br>**PUN466 Communicable diseases**<br><br>**PUN467 Public Health Risk Assessment**<br><br>**PUN620 Concepts of Environmental Health**<br><br>**PUN632 Leadership in Health Management**<br><br>**PUN640 Health Care Delivery and Reform**<br><br>**PUN688 International Health Policy and Management**<br><br>**PUN210 Fundamentals of Health Management**<br><br>**PUN211 Health Care Finance and Economics**<br><br>**PUP032 Intervention Design and Theories of Change**<br><br>**PUP116 Ergonomics** |

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| | | **PUN301 Occupational Health and Safety Law and Management**<br><br>**PUP415 Occupational Health**<br><br>**PUN467 Public Health Risk Assessment**<br><br>**PUN211 Health Care Finance and Economics**<br><br>**NSN516 Sexual and Reproductive Health**<br><br>**NSN517 Women's Health Issues**<br><br>**NSN701 Advanced Health Assessment**<br><br>**NSN002 Key Issues in Child and Youth Health Nursing**<br><br>**NSN003 Principles of Paediatric, Child and Youth Health Nursing**<br><br>**NSN006 Specialisation in Paediatric, Child and Youth Health Nursing** | **NSN517 Women's Health Issues**<br><br>**PUN554 Food Policy and Sustainability**<br><br>**PUN103 Advanced Epidemiology**<br><br>**PUN106 Population Health**<br><br>**NSN701 Advanced Health Assessment**<br><br>**NSN724 Advanced Nursing Practice**<br><br>**NSN726 Advanced Clinical Practice**<br><br>**NSN725 Specialisation in Medical/Surgical and Cancer Nursing**<br><br>**NSN721 Key Issues in Emergency and Intensive Care Nursing**<br><br>**NSN722 Principles of Intensive Care Nursing**<br><br>**NSN723 Specialisation in** |

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| | | **NSN005 Community Child and Youth Health Nursing** | **Critical Care Nursing**<br><br>**NSN002 Key Issues in Child and Youth Health Nursing**<br><br>**NSN003 Principles of Paediatric, Child and Youth Health Nursing**<br><br>**NSN006 Specialisation in Paediatric, Child and Youth Health Nursing**<br><br>**NSN004 Acute Paediatric Nursing**<br><br>**NSN005 Community Child and Youth Health Nursing**<br><br>**NSN324 Critical Issues in Neonatal Care**<br><br>**NSN523 Clinical Studies**<br><br>**NSN422 Pharmacology and Therapeutics in Extended Nursing Practice**<br><br>**NSN004 Acute Paediatric Nursing** |

## The University of Queensland

The University of Queensland 2011, *Graduate Certificate in Nursing (GCN) - Course List* , viewed 21 July 2011, <http://www.uq.edu.au/study/program_list.html?acad_prog=5392>

The University of Queensland 2011, *Master of Nurse Practitioner Studies (MNPractSt) - Course List* , viewed 21 July 2011, <http://www.uq.edu.au/study/program_list.html?acad_prog=5383>

The University of Queensland 2011, *Master of Nursing (MN) - Course List*- Course List , viewed 21 July 2011, <http://www.uq.edu.au/study/program_list.html?acad_prog=5490>

The University of Queensland 2011, *Master of Nursing Studies (MNursSt) - Course List*, viewed 21 July 2011, <http://www.uq.edu.au/study/program_list.html?acad_prog=5491>

HLTH7204 Education in Clinical Nursing & Midwifery

PUBH7650 Evidence Based Health Care

NURS7301 Professional Practice in Child Health Nursing

NURS7600 Foundations of Primary Health Care Nursing

NURS7601 Triage & Acute Care in the Primary Health Care Context

NURS7200 Health Assessment Skills for Specialist Nursing Practice

HLTH7001 Healthcare in Cyberspace

INDH7002 Issues in Aboriginal & Torres Strait Islander Health

PUBH7003 Qualitative Research Methods in Health

PUBH7012 Delivering Health Care in Communities

NURS7600 Foundations of Primary Health Care Nursing

PUBH7123 Determinants of Health Behaviours

PXMH7041 Non-clinical Practice in Community Mental Health

NURS7102 Middle Lifespan Nursing

NURS7105 Cardiovascular & Respiratory Nursing

NURS7106 Musculoskeletal Health & Injury Prevention

NURS7107 Neuroendocrine & MH Nursing

NURS7600 Foundations of Primary Health Care Nursing

NURS7012 Advanced Clinical Practice Roles in Inflammatory Bowel Disease

PXMH7041 Non-clinical Practice in Community Mental Health

HLTH7204 Education in Clinical Nursing & Midwifery

NURS7102 Middle Lifespan Nursing

NURS7105 Cardiovascular & Respiratory Nursing

NURS7106 Musculoskeletal Health & Injury Prevention

NURS7107 Neuroendocrine & MH Nursing

NURS7300 Professional Practice in Acute Paediatric Nursing

NURS7301 Professional Practice in Child Health Nursing

NURS7600 Foundations of Primary Health Care Nursing

NURS7601 Triage & Acute Care in the Primary Health Care Context

NURS7700 Foundations of Gastroenterology Nursing

NURS7701 Gastroenterology Nursing Specialist Practice

NURS7200 Health Assessment Skills for Specialist Nursing Practice

HLTH7001 Healthcare in Cyberspace

HLTH7003 Clinical Online Communication

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| | | **NURS7013 Foundations of Mental Health Nursing Practice**<br><br>**NURS7014 Mental Health Nursing Practice**<br><br>**PUBH7123 Determinants of Health Behaviours**<br><br>**SOCY7179 Sex, Drugs and Disease: Health of the Marginalised**<br><br>**NURS7017 Mental Health Nursing Practice with Special Populations**<br><br>**NURS7071 Nurse Practitioner Care in MHN**<br><br>**NURS7072 Advanced Clinical Practice in Mental Health Nursing**<br><br>**NURS7073 Professional Practice Project in Mental Health Nursing**<br><br>**PXMH7039 Community Mental Health With Special Populations** | **INDH7002 Issues in Aboriginal & Torres Strait Islander Health**<br><br>**PUBH7003 Qualitative Research Methods in Health**<br><br>**PUBH7600 Introduction to Epidemiology**<br><br>**SPCH7201 Human Communication & its Disorders: A Guide for the Rural Health Practitioner**<br><br>**HLTH7012 Chronic Conditions & Palliative Care: Client Management Issues**<br><br>**NURS7011 Managing Inflammatory Bowel Disease**<br><br>**NURS7013 Foundations of Mental Health Nursing Practice**<br><br>**NURS7014 Mental Health Nursing Practice**<br><br>**PUBH7123 Determinants of** |

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| | | **PXMH7041 Non-clinical Practice in Community Mental Health**<br><br>**DENT7901 Dental & Oral Health**<br><br>**PUBH7026 Mental Health Policy & Services**<br><br>**NURS7051 Nurse Practitioner Care in Young People's Health**<br><br>**NURS7052 Advanced Clinical Practice in Young People's Health**<br><br>**NURS7053 Professional Practice Project in Young People's Health**<br><br>**PUBH7122 Health Behaviour Interventions: Concepts & Applications**<br><br>**PXMH7000 2 Comprehensive Systems of Mental Health Care**<br><br>**NURS7602 Primary Health Care, Nursing,** | **Health Behaviours**<br><br>**NURS7017 Mental Health Nursing Practice with Special Populations**<br><br>**NURS7071 Nurse Practitioner Care in MHN**<br><br>**NURS7072 Advanced Clinical Practice in Mental Health Nursing**<br><br>**NURS7073 Professional Practice Project in Mental Health Nursing**<br><br>**PXMH7039 Community Mental Health With Special Populations**<br><br>**PXMH7041 Non-clinical Practice in Community Mental Health**<br><br>**PUBH7026 Mental Health Policy & Services**<br><br>**NURS7051 Nurse Practitioner Care in Young People's Health** |

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| | | **Policy, Politics & Economics**<br><br>**NURS7603 Chronic Disease Management in the Primary Health Care Context**<br><br>**NURS7106 Musculoskeletal Health & Injury Prevention**<br><br>**NURS7107 Neuroendocrine & MH Nursing** | **NURS7052 Advanced Clinical Practice in Young People's Health**<br><br>**NURS7053 Professional Practice Project in Young People's Health**<br><br>**NURS7302 Contemporary Nursing of Children & Young People**<br><br>**PUBH7122 Health Behaviour Interventions: Concepts & Applications**<br><br>**PXMH7000 2 Comprehensive Systems of Mental Health Care**<br><br>**HLTH7225 Leadership & Management in Nursing & Midwifery**<br><br>**NURS7303 Working in Partnership with Families**<br><br>**NURS7502 Rural and Remote Nursing: High Acuity Practice**<br><br>**NURS7602** |

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| | | | | Primary Health Care, Nursing, Policy, Politics & Economics<br><br>NURS7603 Chronic Disease Management in the Primary Health Care Context<br><br>NURS7103 Adult & Elder Nursing<br><br>NURS7106 Musculoskeletal Health & Injury Prevention<br><br>NURS7107 Neuroendocrine & MH Nursing<br><br>NURS7108 Clinical Nursing Practice 2<br><br>NURS7109 Interprofessional Practice Project |
| **University of Southern Queensland**<br><br>University of Southern Queensland 2011, *Graduate Certificate in Indigenous Mental Health and Well-Being (GCIW) - GradCertIMHWB*, viewed 21 July 2011, <http://www.usq.edu.au/handbook/2011/p | | IMH5001 Concepts of Aboriginal and Torres Strait Islander Health<br><br>IMH5002 Indigenous Australian Mental Health Today<br><br>IMH5003 | MGT8015 Corporate Occupational Health and Safety | IMH5001 Concepts of Aboriginal and Torres Strait Islander Health<br><br>IMH5003 Culturally Appropriate Intervention Strategies in Indigenous Mental Health |

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| dfs/GCIW.pdf><br><br>University of Southern Queensland 2011, *Master of Mental Health Nursing (MMHN) - MMHlthNurs*, viewed 21 July 2011, <http://www.usq.edu.au/handbook/2011/pdfs/MMHN.pdf><br><br>University of Southern Queensland 2011, *Master of Nursing (MNRS) - MN*, viewed 21 July 2011, <http://www.usq.edu.au/handbook/2011/pdfs/MNRS.pdf><br><br>University of Southern Queensland 2011, *Postgraduate Certificate in Advanced Nursing Practice (Rural and Remote) (PCNP) - PGradCertANP(R&R)*, viewed 21 July 2011, <http://www.usq.edu.au/handbook/2011/pdfs/PCNP.pdf> | | Culturally Appropriate Intervention Strategies in Indigenous Mental Health<br><br>MHN5120 Advanced Mental Health Nursing 1<br><br>NUR8340 The Law and Health Care Practice<br><br>MHN5160 Advanced Mental Health Nursing 2<br><br>NUR8060 Health Policy Analysis and Review<br><br>NUR8340 The Law and Health Care Practice<br><br>ANP8003 Management in Health Care Practice<br><br>MGT8015 Corporate Occupational Health and Safety<br><br>ANP5004 Emergency Mental Health and Reproductive Health Care<br><br>NUR8060 Health | MHN5120 Advanced Mental Health Nursing 1<br><br>MHN5130 Counselling and Group Work<br><br>NUR8340 The Law and Health Care Practice<br><br>MHN5160 Advanced Mental Health Nursing 2<br><br>MHN5170 Healing and Therapeutics<br><br>ANP8001 Cultural Awareness and Safety<br><br>NUR8060 Health Policy Analysis and Review<br><br>NUR8340 The Law and Health Care Practice<br><br>ANP8001 Cultural Awareness and Safety<br><br>ANP8003 Management in Health Care Practice<br><br>MGT8015 Corporate |

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| | | | Policy Analysis and Review<br><br>NUR8340 The Law and Health Care Practice | | | | Occupational Health and Safety<br><br>ANP5001 Introduction to Rural and Remote Nursing Practice<br><br>ANP5004 Emergency Mental Health and Reproductive Health Care<br><br>NUR8060 Health Policy Analysis and Review<br><br>ANP8001 Cultural Awareness and Safety<br><br>NUR8340 The Law and Health Care Practice<br><br>ANP5002 Immunisation Nursing |
| | PUB271 Health Promotion Principles<br><br>PUB252 Health Promotion Needs Assessment and Planning<br><br>PUB351 Health Promotion | NUR708 Learning and Teaching in the Practice Environment | PUB112 Public Health Foundations<br><br>NUR751 Advanced Health Assessment<br><br>NUR721 Research in Health Care | PUB271 Health Promotion Principles<br><br>PUB112 Public Health Foundations<br><br>PUB252 Health Promotion Needs Assessment and | NUR708 Learning and Teaching in the Practice Environment<br><br>PUB272 Health Promotion Settings | PUB271 Health Promotion Principles<br><br>PUB112 Public Health Foundations<br><br>PUB252 Health Promotion Needs Assessment and | |

**University of the Sunshine Coast**

University of the Sunshine Coast 2011, *Graduate Certificate in Health Promotion*, viewed 21 July 2011, <http://www.usc.edu.au/students/handbook/Postgrad/SC511/>

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|---|---|---|---|---|
| University of the Sunshine Coast 2011, *Graduate Certificate in Nursing (General Practice)*, viewed 21 July 2011, <http://www.usc.edu.au/students/handbook/Postgrad/SC505/><br><br>University of the Sunshine Coast 2011, *Postgraduate Certificate in Nursing (Advanced Practice)*, viewed 21 July 2011, <http://www.usc.edu.au/students/handbook/Postgrad/SC540/SC540.htm><br><br>University of the Sunshine Coast 2011, *Graduate Diploma in Health Promotion*, viewed 21 July 2011, <http://www.usc.edu.au/students/handbook/Postgrad/SC611/><br><br>University of the Sunshine Coast 2011, *Master of Advanced Nursing Practice*, viewed 21 July 2011, <http://www.usc.edu.au/students/handbook/Postgrad/SC740/SC740.htm><br><br>University of the Sunshine Coast 2011, *Master of Advanced Nursing Practice (Emergency Care)*, viewed 21 July 2011, <http://www.usc.edu.au/students/handbook/Postgrad/SC741/SC741.htm><br><br>University of the Sunshine Coast 2011, Master of Health Promotion, viewed 21 July 2011, <http://www.usc.edu.au/students/handbook/Postgrad/SC711/><br><br>University of the Sunshine Coast 2011, *Master of Mental Health Nursing*, viewed 21 July 2011, <http://www.usc.edu.au/students/handbook/Postgrad/SC720/SC720.htm> | Implementation and Evaluation<br><br>PUB272 Health Promotion Settings<br><br>PUB725 Health Promotion Independent Study | NUR720 Mental Health Contexts of Care<br><br>NUR722 Assessment in Mental Health<br><br>PUB104 Introduction to Behavioural Health<br><br>PUB352 Public Health Project<br><br>NUR726 Perspectives in Mental Health<br><br>NUR728 Reflective Mental Health Practice<br><br>SCS707 Counselling and Mental Health | Planning<br><br>PUB351 Health Promotion Implementation and Evaluation<br><br>NUR551 Practice Nursing Contexts<br><br>PUB272 Health Promotion Settings<br><br>PUB725 Health Promotion Independent Study | Planning<br><br>NUR751 Advanced Health Assessment<br><br>NUR708 Learning and Teaching in the Practice Environment<br><br>NUR721 Research in Health Care<br><br>NUR712 Midwifery in a Social Context<br><br>NUR704 Leadership in Practice Development<br><br>NUR703 Infant Care<br><br>NUR720 Mental Health Contexts of Care<br><br>NUR722 Assessment in Mental Health<br><br>PUB104 Introduction to Behavioural Health<br><br>PUB272 Health Promotion Settings<br><br>NUR707 Global Emergency Issues |

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| | | | | | | | PUB352 Public Health Project<br><br>NUR726 Perspectives in Mental Health<br><br>SCS707 Counselling and Mental Health |
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| **Flinders University**<br><br>Flinders University 2011, *Nursing Postgraduate Program Courses* , viewed 21 July 2011, <http://www.flinders.edu.au/courses/postgrad/ng/nursing_home.cfm><br><br>Flinders University 2011, *Graduate Certificate in Health*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch_home.cfm><br><br>Flinders University 2011, *Specialisation - Aged Care Nursing Studies*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-aged.cfm><br><br>Flinders University 2011, *Specialisation - Child and Family Health Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-cafh.cfm><br><br>Flinders University 2011, *Specialisation* - | | NURS8731 Diabetes Health Promotion | MHSC8113 Education and Training for Chronic Conditions Self Management | NURS9533 Primary Health Care for Mental Health<br><br>NURS9539 Mental Health Nursing Practice 1<br><br>MHSC8023 Co-morbid Mental Health Substance Abuse Disorders<br><br>NURS9125 Population Health<br><br>NURS9126 Leadership in Health Studies<br><br>NURS8821 Health Maintenance for Infants, Children and Young | NURS8731 Diabetes Health Promotion<br><br>NURS8822 Primary Health Care for Child and Family Health Nursing<br><br>NURS9533 Primary Health Care for Mental Health | NURS8731 Diabetes Health Promotion<br><br>NURS8702 Continence: Clinical Practicum<br><br>MHSC8113 Education and Training for Chronic Conditions Self Management | NURS9533 Primary Health Care for Mental Health<br><br>NURS9539 Mental Health Nursing Practice 1<br><br>MHSC8023 Co-morbid Mental Health Substance Abuse Disorders<br><br>MHSC8111 Managing Chronic Conditions - Self-Management Support Approaches<br><br>MHSC8112 Perspectives on Chronic Diseases Management |

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| *Clinical Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-clin.cfm><br><br>Flinders University 2011, *Specialisation - Continence Nurse Advisor*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-ctna.cfm><br><br>Flinders University 2011, *Specialisation - Critical Care Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-crcn.cfm><br><br>Flinders University 2011, *Specialisation - Diabetes Management and Education*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-dmed.cfm><br><br>Flinders University 2011, *Specialisation - Emergency Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-emgn.cfm><br><br>Flinders University 2011, *Specialisation - General Practice Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-gprn.cfm><br><br>Flinders University 2011, *Specialisation - Mental Health Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-mnhn.cfm><br><br>Flinders University 2011, *Specialisation - Mental Health Sciences*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-mhsc.cfm><br><br>Flinders University 2011, *Specialisation - Self Management*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-sfmg.cfm><br><br>Flinders University 2011, *Graduate Diploma* | | People<br><br>NURS8822 Primary Health Care for Child and Family Health Nursing<br><br>NURS9707 Policy and Political Context of Health and Ageing<br><br>NURS9708 Social Context of Health and Ageing<br><br>NURS8823 Clinical Practice for Child and Family Health Nursing | MHSC8114 The Persons Experience of Self-Management<br><br>MHSC8113 Education and Training for Chronic Conditions Self - Management<br><br>MHSC8115A Chronic Conditions Management for Specific Conditions, Contexts or Populations A<br><br>NURS8824 Introduction to Working with Infants, Children and Families<br><br>NURS8505 Adult Emergency Nursing<br><br>NURS9125 Population Health<br><br>NURS9126 Leadership in Health Studies<br><br>NURS9709 Advanced Nursing Assessment<br><br>NURS8731 Diabetes Health Promotion |

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|---|---|---|
| *in Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gdpng_home.cfm><br><br>Flinders University 2011, *Graduate Diploma in Nursing (Aged Care Nursing Studies)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gdpng/gdpng-aged.cfm><br><br>Flinders University 2011, *Graduate Diploma in Nursing (Child and Family Health Nursing)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gdpng/gdpng-cafh.cfm><br><br>Flinders University 2011, *Graduate Diploma in Nursing (Clinical Nursing)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gdpng/gdpng-clin.cfm><br><br>Flinders University 2011, *Graduate Diploma in Nursing (Continence Nurse Advisor)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gdpng/gdpng-ctna.cfm><br><br>Flinders University 2011, *Graduate Diploma in Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gdpng_home.cfm#coursework><br><br>Flinders University 2011, *Graduate Diploma in Nursing (Critical Care Nursing)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gdpng/gdpng-crcn.cfm><br><br>Flinders University 2011, *Graduate Diploma in Nursing (Diabetes Management and Education)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gdpng/gdpng-dmed.cfm><br><br>Flinders University 2011, *Graduate Diploma in Nursing (Emergency Nursing)* , viewed 21 July 2011, | | NURS8821 Health Maintenance for Infants, Children and Young People<br><br>NURS8822 Primary Health Care for Child and Family Health Nursing<br><br>NURS9709 Advanced Nursing Assessment<br><br>NURS9710 The 3 Ds Dementia, Delirium and Depression<br><br>NURS8702 Continence: Clinical Practicum<br><br>NURS8823 Clinical Practice for Child and Family Health Nursing<br><br>NURS8606 General Practice Nursing 1<br><br>NURS8607 General Practice Nursing 2<br><br>MMED9101 Principles of Pharmacology and Therapeutics |

**<http://www.flinders.edu.au/courses/rules/postgrad/gdpng/gdpng-emgn.cfm>**

**Flinders University 2011, *Graduate Diploma in Nursing (General Practice Nursing)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gdpng/gdpng-gprn.cfm>**

**Flinders University 2011, *Master of Nursing by Coursework*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/mngc/mngc.cfm>**

**Flinders University 2011, *Master of Nursing by Coursework (Coursework)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/mngc/mngc-cswk.cfm>**

**Flinders University 2011, *Master of Nursing by Coursework (Coursework and Clinical)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/mngc/mngc-cwcl.cfm>**

**Flinders University 2011, *Master of Nursing by Coursework (Clinical)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/mngc/mngc-clin.cfm>**

**Flinders University 2011, *Master of Nursing by Coursework (Coursework and Research)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/mngc/mngc-cwrs.cfm>**

**Flinders University 2011, *Master of Nursing by Coursework (Clinical and Research)*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/mngc/mngc-clrs.cfm>**

**Flinders University 2011, *Specialisation - Aged Care Nursing Studies*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/**

postgrad/gch/gch-aged.cfm>

Flinders University 2011*Specialisation - Continence Nurse Advisor*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-ctna.cfm>

Flinders University 2011, *Specialisation - Child and Family Health Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-cafh.cfm>

Flinders University 2011, *Specialisation - Clinical Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-clin.cfm>

Flinders University 2011, *Specialisation - Critical Care Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-crcn.cfm>

Flinders University 2011, *Specialisation - Diabetes Management and Education*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-dmed.cfm>

Flinders University 2011, *Specialisation - Emergency Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-emgn.cfm>

Flinders University 2011, *Specialisation - General Practice Nursing*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/rules/postgrad/gch/gch-gprn.cfm>

Flinders University 2011, *Nursing (Nurse Practitioner) A postgraduate program*, viewed 21 July 2011, <http://www.flinders.edu.au/courses/postgrad/ngnp/nursing-nurse-practitioner_home.cfm>

## The University of Adelaide

They offer postgraduate nursing degrees by coursework but they do not provide access to the degree structures


The University of Adelaide 2011, *Programs*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/students/future/programs/>

The University of Adelaide 2011, *Master Of Clinical Nursing* , viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/program_mcn.pdf>

The University of Adelaide 2011, *Graduate Certificate In Nursing Science (Apheresis Nursing)*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/gc_apheresis.pdf>

The University of Adelaide 2011, *Graduate Certificate In Nursing SCIENCE (Evidence - Based Practice )*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/gc_ebp.pdf>

The University of Adelaide 2011, *Graduate Certificate In Nursing Science (Hyperbaric Nursing)*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/gc_hyperbaric.pdf>

The University of Adelaide 2011, *Graduate Certificate In Nursing Sci Ence (Infection Control)*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/gc_infection.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Acute Care Nursing) - Stage*

*1*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_acute.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Anaesthetic & Recovery Nursing) - Stage 1*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_a&r.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Burns Nursing) - Stage 1*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_burns.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Cardiac Nursing ) - Stage 1* , viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_cardiac.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Community Health And Primary Care ) - STAGE 1*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_community.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Emergency Nursing ) - Stage 1*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_emergency.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Gerontological Nursing ) - STAGE 1*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_gerontology.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Infection Control Nursing) - Stage 1*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_infection.pdf>

The University of Adelaide 2011, *Master Of*

*Nursing Science (Intensive Care Nursing) - Stage 1*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_intensive.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Mental Health Nursing) - Stage 1*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_mental.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Oncology Nursing ) - Stage*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_oncology.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Orthopaedic Nursing) - Stage 1*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_orthopaedics.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Perioperative Nursing) - Stage*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_perioperative.pdf>

The University of Adelaide 2011, *Graduate Diploma In Addiction and Mental Health*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/gd_addiction.pdf>

The University of Adelaide 2011, *Master Of Nursing Science (Stage 2)*, viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/mnurs_stage2.pdf>

The University of Adelaide 2011, *Master Of Nurse Practitioner Overview* , viewed 21 July 2011, <http://health.adelaide.edu.au/nursing/pub/master_np.pdf>

## University of South Australia

University of South Australia 2011, *Program Plans*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program-plan-list.asp?Program=ICNG&Year=2011>

University of South Australia 2011, *Graduate Certificate in Nursing* , viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=ICNG&Plan=N%2FA%2DICNG&Year=2011>

University of South Australia 2011, *Graduate Certificate in Nursing (Cardiovascular Nursing)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=ICNG&Plan=CARDI%2DICNG&Year=2011>

University of South Australia 2011, *Graduate Certificate in Nursing (Critical Care Nursing)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=ICNG&Plan=CRITC%2DICNG&Year=2011>

University of South Australia 2011, *Graduate Certificate in Nursing (Health and Ageing)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=ICNG&Plan=HLTH%2DICNG&Year=2011>

University of South Australia 2011, *Graduate Certificate in Nursing (Immunisation)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=ICNG&Plan=IMMUN%2DICNG&Year=2011>

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|---|---|---|---|---|
| | Collaborative Approaches to Health HLTH 5136 | Frameworks for Practice in the Care of Older People NURS 5129 | Frameworks for Practice in the Care of Older People NURS 5129 | Collaborative Approaches to Health HLTH 5136 |
| | Determinants of Health NURS 5138 | Ageing with Chronic and Complex Conditions NURS 5131 | Ageing with Chronic and Complex Conditions NURS 5131 | Becoming a Nurse Practitioner NURS 5136 |
| | Advanced Health Assessment, Diagnostics and Investigations NURS 5135 | Primary and Secondary Prevention in Cardiovascular Health NURS 5128 | Primary and Secondary Prevention in Cardiovascular Health NURS 5128 | Determinants of Health NURS 5138 |
| | Facilitating Practice-Based Learning in the Health Environment HLTH 5137 | Healthy Ageing NURS 5130 | Healthy Ageing NURS 5130 | Advanced Health Assessment, Diagnostics and Investigations NURS 5135 |
| | Health Economics BUSS 5185 | Health of Adults M NURS 5143 | Health of Adults M NURS 5143 | Alcohol and Other Drugs: Practical responses to contemporary issues NURS 5094 |
| | Health Ethics HLTH 5002 | | | Frameworks for Practice in the Care of Older People NURS 5129 |
| | Leadership and Management in Health 1 NURS 5111 | | | Ageing with Chronic and Complex Conditions NURS 5131 |
| | Primary and Secondary Prevention in Cardiovascular Health NURS 5128 | | | Health Economics BUSS 5185 |
| | Healthy Ageing NURS 5130 | | | Health Ethics HLTH 5002 |
| | Complex Health Problems in Rural Settings | | | |

| | | | |
|---|---|---|---|
| University of South Australia 2011, *Graduate Certificate in Nursing (Leadership and Management)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=ICNG&Plan=LEAD%2DICNG&Year=2011><br><br>University of South Australia 2011, *Graduate Certificate in Nursing (Nurse Education)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=ICNG&Plan=NURED%2DICNG&Year=2011><br><br>University of South Australia 2011, *Graduate Certificate in Nursing (Research Methodologies)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=ICNG&Plan=RES%2DICNG&Year=2011><br><br>University of South Australia 2011, *Search results - Program Plans*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program-plan-list.asp?Program=IGML&Year=2011><br><br>University of South Australia 2011, *Graduate Diploma in Mental Health Nursing*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IGML&Plan=MHNSG%2DIGML&Year=2011><br><br>University of South Australia 2011, *Graduate Diploma in Mental Health*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IGML&Plan=MH%2DIGML&Year=2011><br><br>University of South Australia 2011, *Search results - Program Plans*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program-plan-list.asp?Program=IGNG&Year=2011><br><br>University of South Australia 2011, *Graduate* | | HLTH 5152<br><br>Facilitating Practice-Based Learning in the Health Environment HLTH 5137<br><br>Issues in Indigenous Health HLTH 5121<br><br>Pharmacology for Health Professionals PHAR 5041<br><br>Advanced Health Assessment and Nursing Diagnostics NURS 5033<br><br>Health of Older Adults M NURS 5145<br><br>Health of Adults M NURS 5143<br><br>Health of Infants, Children and Young People M NURS 5144<br><br>Nursing Practice in Health Systems and Organisations NURS 5142 | Leadership and Management in Health 1 NURS 5111<br><br>Primary and Secondary Prevention in Cardiovascular Health NURS 5128<br><br>Healthy Ageing NURS 5130<br><br>Immunisation NURS 5081<br><br>Adult Learning for Nurse Education NURS 5134<br><br>Alcohol and Other Drugs: Practical responses to contemporary issues NURS 5094<br><br>Complex Health Problems in Rural Settings HLTH 5152<br><br>Issues in Indigenous Health HLTH 5121<br><br>Wound Management NURS 5133<br><br>Health of Older Adults M NURS 5145 |

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|---|---|---|
| *Diploma in Nursing*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IGNG&Plan=N%2FA%2DIGNG&Year=2011><br><br>University of South Australia 2011, *Graduate Diploma in Nursing (Cardiovascular Nursing)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IGNG&Plan=CARDI%2DIGNG&Year=2011><br><br>University of South Australia 2011, *Graduate Diploma in Nursing (Critical Care Nursing)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IGNG&Plan=CRITC%2DIGNG&Year=2011><br><br>University of South Australia 2011, *Graduate Diploma in Nursing (Health and Ageing)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IGNG&Plan=HLTH%2DIGNG&Year=2011><br><br>University of South Australia 2011, *Graduate Diploma in Nursing (Immunisation)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IGNG&Plan=IMMUN%2DIGNG&Year=2011><br><br>University of South Australia 2011, *Graduate Diploma in Nursing (Leadership and Management)* , viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IGNG&Plan=LEAD%2DIGNG&Year=2011><br><br>University of South Australia 2011, *Graduate Diploma in Nursing (Nurse Education)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IGNG&Plan=NURED%2DIGNG&Year=2011><br><br>University of South Australia 2011, *Graduate* | | Health of Adults M NURS 5143<br><br>Health of Infants, Children and Young People M NURS 5144<br><br>Nursing Practice in Health Systems and Organisations NURS 5142 |

*Diploma in Nursing (Research Methodologies)* , viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IGNG&Plan=RES%2DIGNG&Year=2011>

University of South Australia 2011, *Master of Nursing* , viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=OMNG&Year=2011>

University of South Australia 2011, *Master of Nursing (Nurse Practitioner)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNS&Year=2011&Plan=N/A-IMNS>

University of South Australia 2011, *Search results - Program Plans*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program-plan-list.asp?Program=IMNG&Year=2011>

University of South Australia 2011, *Master of Nursing*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNG&Plan=NURS%2DIMNG&Year=2011>

University of South Australia 2011, *Master of Mental Health Nursing*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNG&Plan=MHN%2DIMNG&Year=2011>

University of South Australia 2011, *Master of Nursing (Cardiovascular Nursing)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNG&Plan=CARDI%2DIMNG&Year=2011>

University of South Australia 2011, *Master of Nursing (Critical Care Nursing)*, viewed 21 July 2011,

**<http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNG&Plan=CRITC%2DIMNG&Year=2011>**

**University of South Australia 2011, *Master of Nursing (Health and Ageing)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNG&Plan=HLTH%2DIMNG&Year=2011>**

**University of South Australia 2011, *Master of Nursing (Immunisation)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNG&Plan=IMMUN%2DIMNG&Year=2011>**

**University of South Australia 2011, *Master of Nursing (Leadership and Management)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNG&Plan=LEAD%2DIMNG&Year=2011>**

**University of South Australia 2011, *Master of Nursing (Nurse Education)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNG&Plan=NURED%2DIMNG&Year=2011>**

**University of South Australia 2011, *Master of Nursing or Master of Mental Health Nursing or Master of Midwifery (Research Methodologies)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNG&Plan=NURES%2DIMNG&Year=2011>**

**University of South Australia 2011, *Master of Nursing Practice (Graduate Entry)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNR&Year=2011&Plan=N/A-IMNR>**

**University of South Australia 2011, *Master***

| | | | | | |
|---|---|---|---|---|---|
| *of Nursing Science (Nurse Practitioner)*, viewed 21 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IMNP&Year=2011> | | | | | |
| **TAS** | | | | | |
| **University of Tasmania**<br><br>University of Tasmania 2011, *Courses and Units 2011*, viewed 21 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,33239&_dad=portal&_schema=PORTAL&P_UNIT_CODE=CNA727&P_YEAR=2011&P_CONTEXT=NEW><br><br>University of Tasmania 2011, *Graduate Diploma of Nursing(H6F)*, viewed 21 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H6F&P_SCHEDULE_CODE=H6F4&P_YEAR=2011&P_CONTEXT=OLD><br><br>University of Tasmania 2011, *Graduate Certificate in Nursing(H5F)*, viewed 21 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H5F&P_SCHEDULE_CODE=H5F&P_YEAR=2011&P_CONTEXT=OL><br><br>University of Tasmania 2011, *Graduate Diploma of Nursing(H6F)*, viewed 21 July 2011, | | CNA738 Biological Therapies in Mental Health Care<br><br>CNA739 Psychological Therapies in Mental Health Care<br><br>CNA740 Foundations of Mental Health Nursing Theory 1<br><br>CNA741 Foundations of Mental Health Nursing Theory 2<br><br>CNA742 Foundations of Mental Health Nursing Practice 1<br><br>CNA743 Foundations of Mental Health Nursing Practice 2 | CNA524 Alcohol & Other Drugs 2<br><br>CNA512 Oncology Nursing 2<br><br>CNA542 Rural & Remote Nursing Practice 3 | CNA606 Cardiovascular Rehabilitation Nursing | CNA672 Research for Clinical Practice A<br><br>CNA729 Violence and Health<br><br>CNA788 Context in Which Women Live<br><br>CNA783 The Politics of Acute Nursing<br><br>CNA513 Foundations of Community Nursing Practice<br><br>CNA751 Health Assessment and Ageing<br><br>CNA524 Alcohol & Other Drugs 2<br><br>CNA526 Alcohol & Other Drugs 3<br><br>CNA534 Anaesthetic & |

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| <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H6F&P_SCHEDULE_CODE=H6F1&P_YEAR=2011&P_CONTEXT=OLD><br><br>University of Tasmania 2011, *Graduate Diploma of Nursing(H6F)*, viewed 21 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H6F&P_SCHEDULE_CODE=H6F2&P_YEAR=2011&P_CONTEXT=OLD><br><br>University of Tasmania 2011, *Graduate Diploma of Nursing(H6F)*, viewed 21 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H6F&P_SCHEDULE_CODE=H6F4&P_YEAR=2011&P_CONTEXT=OLD><br><br>University of Tasmania 2011, *Master of Clinical Nursing(H7F)*, viewed 21 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H7F&P_SCHEDULE_CODE=H7F&P_YEAR=2011&P_CONTEXT=OL> | | CNA750 Healthy Ageing<br><br>CNA751 Health Assessment and Ageing<br><br>CNA515 Foundations of Health and Wellbeing in the Community<br><br>CNA728 Food, Culture and Health<br><br>CNA740 Foundations of Mental Health Nursing Theory 1<br><br>CNA741 Foundations of Mental Health Nursing Theory 2<br><br>CNA743 Foundations of Mental Health Nursing Practice 2<br><br>CNA613 Project Management for Health Professionals<br><br>CNA729 Violence and Health<br><br>CNA759 Theoretical Aspects of Child and Family Health Nursing | Recovery Nursing 2<br><br>CNA515 Foundations of Health and Wellbeing in the Community<br><br>CNA787 Triage & Complex Management of the Emergency & Trauma Patient<br><br>CNA728 Food, Culture and Health<br><br>CNA522 Cultural Aspects of Immigration Nursing<br><br>CNA740 Foundations of Mental Health Nursing Theory 1<br><br>CNA742 Foundations of Mental Health Nursing Practice 1<br><br>CNA741 Foundations of Mental Health Nursing Theory 2<br><br>CNA743 Foundations of Mental Health Nursing Practice 2<br><br>CNA538 Neuroscience |

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| | | **CNA758 Foundations of Child & Family Health Nursing**<br><br>**CNA752 Child and Family Health Nursing: Clinical Practice 1**<br><br>**CNA753 Child and Family Health Nursing: Clinical Practice 2** | **Nursing 3**<br><br>**CNA528 Orthopaedic Nursing 1**<br><br>**CNA576 Self-Management in Renal Nursing**<br><br>**CNA504 Rehabilitation Nursing 2**<br><br>**CNA539 Rural & Remote Nursing Practice 1**<br><br>**CNA507 Introduction to Wound Management**<br>**CNA542 Rural & Remote Nursing Practice 3**<br><br>**CNA530 Special Care of the Newborn Theory**<br><br>**CNA613 Project Management for Health Professionals**<br><br>**CNA604 Diabetes Mellitus Nursing: interventions and outcomes**<br><br>**CNA605 Respiratory Nursing: Improving self-management for clients** |

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| | | | | | CNA759 Theoretical Aspects of Child and Family Health Nursing<br><br>CNA758 Foundations of Child & Family Health Nursing<br><br>CNA752 Child and Family Health Nursing: Clinical Practice 1<br><br>CNA753 Child and Family Health Nursing: Clinical Practice 2 |
| **VIC** | | | | | |
| **Deakin University**<br><br>Deakin University 2011, *Graduate Diploma of Nursing Practice*, viewed 21 July 2011, <http://www.deakin.edu.au/future-students/courses/course.php?course=H675&stutype=local&keywords=nursing><br><br>Deakin University 2011, *Graduate Diploma of Nursing Practice (Perioperative)*, viewed 21 July 2011, <http://www.deakin.edu.au/future-students/courses/course.php?course=H672&stutype=local&keywords=nursing> | | HMF701 Agricultural Health and Medicine *<br><br>HND731 Learning and Teaching for Health Professionals<br><br>HNN734 Advanced Primary Health Care Practice<br><br>HNN746 Nursing, | HND731 Learning and Teaching for Health Professionals<br><br>HND732 Diabetes in Professional Contexts<br><br>HND731 Learning and Teaching for Health Professionals | HND731 Learning and Teaching for Health Professionals<br><br>HND731 Learning and Teaching for Health Professionals | HMF701 Agricultural Health and Medicine *<br><br>HND732 Diabetes in Professional Contexts<br><br>HNN714 Ethical Dimensions of Nursing<br><br>HNN729 Trends and Nursing Futures |

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|---|---|---|---|---|---|
| Deakin University 2011, *Master of Nursing Practice*, viewed 21 July 2011, <http://www.deakin.edu.au/future-students/courses/course.php?course=H771&stutype=local&keywords=nursing><br><br>Deakin University 2011, *Master of Nursing Practice (Nurse Practitioner)*, viewed 21 July 2011, <http://www.deakin.edu.au/future-students/courses/course.php?course=H773&stutype=local&keywords=nursing><br><br>Deakin University 2011, *Graduate Certificate of Diabetes Education*, viewed 21 July 2011, <http://www.deakin.edu.au/future-students/courses/course.php?course=H520&stutype=local&keywords=nursing> | | | Cultural Diversity and Politics of Health Care<br><br>HNN760 Advanced Family Health Practice<br><br>HND731 Learning and Teaching for Health Professionals | | HNN734 Advanced Primary Health Care Practice<br><br>HNN746 Nursing, Cultural Diversity and Politics of Health Care<br><br>HNN749 Patient Safety and Risk Management<br><br>HNN741 Nursing Inquiry for Specialist Practice<br><br>HNN733 Advanced Practice Development<br><br>HND701 The Pathophysiology of Diabetes |
| **La Trobe University**<br><br>La Trobe University 2011, *Postgraduate Nursing Courses*, viewed 21 July 2011, <http://www.latrobe.edu.au/courses/nursing/postgraduate><br><br>La Trobe University 2011, *Graduate Certificate in Mental Health Nursing and Postgraduate Diploma of Nursing Sciences in Mental Health*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/rcmhn.htm?appendurl | NSG4OMH Health Promotion in Mental Health Nursing1 | NSG4IMH Interventions in Mental Health Nursing Practice1<br><br>NSG4AMH Assessment in Mental Health Nursing Practice1<br><br>NSG4CIM Contemporary Issues in Mental Health Nursing1 | NSG4OMH Health Promotion in Mental Health Nursing1<br><br>NSG4NLC/NSG5 NLC Nursing People with Lung Cancer<br><br>NSG4NPC/NSG5 NPC Prostate Care Nursing<br><br>NSG4SBC/NSG5SBC Specialty | NSG4NLC/NSG5 NLC Nursing People with Lung Cancer<br><br>NSG4NPC/NSG5 NPC Prostate Care Nursing<br><br>NSG4CPC/NSG5CPC Principles of Cancer/Palliative Care Nursing | NSG4IMH Interventions in Mental Health Nursing Practice1<br><br>NSG4AMH Assessment in Mental Health Nursing Practice1<br><br>NSG4CIM Contemporary Issues in Mental Health Nursing1 |

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| =current/postgraduate/health-sciences/coursework/rcmhn.htm><br><br>La Trobe University 2011, *Master of Nursing*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmn.htm?appendurl=current/postgraduate/health-sciences/coursework/hmn.htm><br><br>La Trobe University 2011, *Master of Nursing (Acute Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnac.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnac.htm><br><br>La Trobe University 2011, *Master of Nursing (Breast Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnbc.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnbc.htm><br><br>La Trobe University 2011, *Master of Nursing (Cancer/Palliative Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmncp.htm?appendurl=current/postgraduate/health-sciences/coursework/hmncp.htm><br><br>La Trobe University 2011, *Master of Nursing (Cardiac Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnca.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnca.htm><br><br>La Trobe University 2011, *Master of Nursing (Critical Care),* viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health- | | NSG4OMH Health Promotion in Mental Health Nursing1<br><br>NSG4CAM Child and Adolescent Mental Health<br><br>NSG5CLH Clinical Leadership in Healthcare<br><br>NSG4/5CHA Comprehensive Health Assessment1<br><br>GER4HWA Health and Wellbeing for Older People A<br><br>GER5HWB Health and Wellbeing for Older People B<br><br>PHE4HOR Healthy Organisations<br><br>PHE4HRM Health Services Resource Management<br><br>NSG4ECH1/NSG5 ECH1 Early Childhood Health: New Directions in Policy and Practice<br><br>NSG4CPI1/NSG5 CPI1 MCH | Breast Care Nursing Practice<br><br>NSG4CPC/NSG5C PC Principles of Cancer/Palliative Care Nursing<br><br>NSG5ECH1 Early Childhood Health: New Directions in Policy and Practice<br><br>NSG4MCH1 Introduction to MCH Practice | NSG4OMH Health Promotion in Mental Health Nursing1<br><br>NSG4CAM Child and Adolescent Mental Health<br><br>NSG4/5CHA Comprehensive Health Assessment1<br><br>GER4CSS Care and Support Services for Older People<br><br>NSG4NCI Narratives of Chronic Illness<br><br>NSG5ACP Advanced Clinical Practice<br><br>NSG4ASP/NSG5A SP Acute Spinal Cord Injuries Nursing Practice<br><br>NSG4CCN/NSG5 CCN Complex Cardiac Care Nursing Practice<br><br>NSG4CEN/NSG5C EN Complex Emergency Nursing Practice<br><br>NSG4CIN/NSG5C IN Complex Intensive Care Nursing Practice |

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| sciences/coursework/hmncc.htm?appendurl=current/postgraduate/health-sciences/coursework/hmncc.htm><br><br>La Trobe University 2011, *Master of Nursing (Emergency Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnec.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnec.htm><br><br>La Trobe University 2011, *Master of Nursing (Intensive Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnic.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnic.htm><br><br>La Trobe University 2011, *Master of Nursing (Neonatal Intensive Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnnic.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnnic.htm><br><br>La Trobe University 2011, *Master of Nursing (Nurse Practitioner)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnnp.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnnp.htm><br><br>La Trobe University 2011, *Master of Nursing (Perianaesthetic Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnpa.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnpa.htm><br><br>La Trobe University 2011, *Master of Nursing (Perioperative Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/201 | | Clinical Practice Issues<br><br>NSG4MCH1 Introduction to MCH Practice | NSG4RDM/NSG5 RDM Renal Disease and Management<br><br>NSG4RTN/NSG5 RTN Renal Therapies<br><br>NSG4SIA/NSG5SI A Specialty Practice Issues for Acute Care<br><br>NSG4SRP/NSG5S RP Spinal Cord Injuries Rehabilitation Nursing Practice<br><br>NSG4SUC/NSG5S UC Specialty Urological and Continence Nursing Practice<br><br>NSG4TUC/NSG5T UC Therapeutic Approaches in Urological and Continence Nursing<br><br>NSG4ECH1/NSG5 ECH1 Early Childhood Health: New Directions in Policy and Practice<br><br>NSG4CPI1/NSG5 CPI1 MCH Clinical Practice Issues<br><br>NSG4MCH1 Introduction to |

1/postgraduate/health-sciences/coursework/hmnpo.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnpo.htm>

La Trobe University 2011, *Master of Nursing (Renal Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnrc.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnrc.htm>

La Trobe University 2011, *Master of Nursing (Research Methods)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnrm.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnrm.htm>

La Trobe University 2011, *Master of Nursing Science in Child, Family and Community*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmcfc.htm?appendurl=current/postgraduate/health-sciences/coursework/hmcfc.htm>

La Trobe University 2011, *Master of Nursing (Spinal Care)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnsc.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnsc.htm>

La Trobe University 2011, *Master of Nursing (Urology & Continence)*, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hmnucd.htm?appendurl=current/postgraduate/health-sciences/coursework/hmnucd.htm>

La Trobe University 2011, *Postgraduate Diploma of Nursing Science in Child, Family*

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| ***and Community***, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/hpcfc.htm?appendurl=current/postgraduate/health-sciences/coursework/hpcfc.htm><br><br>La Trobe University 2011, ***List A - Non-Clinical Subjects Group***, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/list-a.htm><br><br>La Trobe University 2011, ***List B - Clinical Subjects Group***, viewed 21 July 2011, <http://www.latrobe.edu.au/handbook/2011/postgraduate/health-sciences/coursework/list-b.htm> | | | | | | |
| **Monash University**<br><br>Monash University 2011, ***Master of Nursing***, viewed 21 July 2011, <http://www.med.monash.edu.au/nursing/info-4-students/postgraduate/courseinfo/mon.html><br><br>Monash University 2011, ***3884 - Graduate Certificate of Nursing (Forensic)***, viewed 21 July 2011, <http://www.monash.edu.au/pubs/handbooks/courses/3884.html> | **NUR5844 Health promotion and education** | **NUR5844 Health promotion and education** | **MPH2068 Financial issues in health care management**<br><br>**NUR5008 Cognitive behavioural therapy (CBT) for mental health professionals**<br><br>**NUR5211 Case management in health care**<br><br>**NUR5215 Mental health concepts and practice**<br><br>**NUR5703 Advanced pathophysiology and health assessment**<br><br>**MPH2067** | **NUR5844 Health promotion and education** | **NUR5844 Health promotion and education** | **MPH2068 Financial issues in health care management**<br><br>**NUR5008 Cognitive behavioural therapy (CBT) for mental health professionals**<br><br>**NUR5209 Education program development**<br><br>**NUR5215 Mental health concepts and practice**<br><br>**NUR5227 Integrated mental health care**<br><br>**NUR5703** |

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| | | Principles of health care quality improvement | | | Advanced pathophysiology and health assessment<br><br>GHS5850 Nursing practice and management<br><br>MPH2067 Principles of health care quality improvement<br><br>NUR5844 Health promotion and education |
| **RMIT University**<br><br>RMIT University 2011, *GD158 - Graduate Diploma in Mental Health Nursing*, viewed 21 July 2011, <http://www.rmit.edu.au/browse;ID=EPSGD158AUSBU;STATUS=A?QRY=%2Btype%3Dflexible%20%2Bsubtype%3Deps%20%2Bnotes%3D(%20\|%22MC017%22%20\|%22GD013%22%20\|%22GD158%22%20\|%22GD159%22%20\|%22GC086%22%20\|%22GC087%22%20\|%22GC089%22)&STYPE=ENTIRE><br><br>RMIT University 2011, *GD159 - Graduate Diploma in Child and Family Health Nursing*, viewed 21 July 2011, <http://www.rmit.edu.au/browse;ID=EPSGD159AUSBU;STATUS=A?QRY=%2Btype%3Dflexible%20%2Bsubtype%3Deps%20%2Bnotes%3D(%20\|%22MC017%22%20\|%22GD013%22%20\|%22GD158%22%20\|%22GD159%22%20\|%22GC086%22%20\|%22GC087%22%20\|%22GC089%22)&STYPE=ENTIRE> | | Comm and Counselling for Health Care Professionals<br><br>Professional Development In Health Practice<br><br>Assessment Analysis In Mental Health Service Deliv<br><br>Contemporary Issues in Nursing and Health Care<br><br>Nursing Ethics and Health Care<br><br>Philosophic Inquiry in Mental Health Nursing<br><br>Primary Health and Assessment | Food as Medicine<br><br>Wellness and Complementary and Alternative Medicine (CAM<br><br>Family Studies<br><br>Primary Health and Assessment of the Young Child | Philosophic Inquiry in Mental Health Nursing<br><br>Family Studies<br><br>Primary Health and Assessment of the Young Child | Comm and Counselling for Health Care Professionals<br><br>Mental Illness and Treatment<br><br>Professional Development In Health Practice<br><br>Research in Nursing and Midwifery<br><br>Contemporary Issues in Nursing and Health Care<br><br>Nursing Ethics and Health Care<br><br>Clinical Teaching in Nursing Practice |

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| RMIT University 2011, *GC086 - Graduate Certificate in Critical Care Nursing*, viewed 21 July 2011, <http://www.rmit.edu.au/browse;ID=EPSGC086P6AUSBU;STATUS=A?QRY=%2Btype%3Dflexible%20%2Bsubtype%3Deps%20%2Bnotes%3D(%20|%22MC017%22%20|%22GD013%22%20|%22GD158%22%20|%22GD159%22%20|%22GC086%22%20|%22GC087%22%20|%22GC089%22)&STYPE=ENTIRE><br><br>RMIT University 2011, *GD158 - Graduate Diploma in Mental Health Nursing*, viewed 21 July 2011, <http://www.rmit.edu.au/browse;ID=EPSGD158DEAUSBU;STATUS=A?QRY=%2Btype%3Dflexible%20%2Bsubtype%3Deps%20%2Bnotes%3D(%20|%22MC017%22%20|%22GD013%22%20|%22GD158%22%20|%22GD159%22%20|%22GC086%22%20|%22GC087%22%20|%22GC089%22)&STYPE=ENTIRE><br><br>RMIT University 2011, *GC087 - Graduate Certificate in Emergency Nursing*, viewed 21 July 2011, <http://www.rmit.edu.au/browse;ID=EPSGC087P6AUSBU;STATUS=A?QRY=%2Btype%3Dflexible%20%2Bsubtype%3Deps%20%2Bnotes%3D(%20|%22MC017%22%20|%22GD013%22%20|%22GD158%22%20|%22GD159%22%20|%22GC086%22%20|%22GC087%22%20|%22GC089%22)&STYPE=ENTIRE><br><br>RMIT University 2011, *GD013 - Graduate Diploma in Nursing*, viewed 21 July 2011, <http://www.rmit.edu.au/browse;ID=EPSGD013P6AUSBU;STATUS=A?QRY=%2Btype%3Dflexible%20%2Bsubtype%3Deps%20%2Bnotes%3D(%20|%22MC017%22%20|%22GD013%22%20|%22GD158%22%20|%22GD159%22%20|%22GC086%22%20|%22GC087%22%20|%22GC089%22)&STYPE=ENTIRE><br><br>RMIT University 2011, *MC017 - Master of Nursing*, viewed 21 July 2011, <http://www.rmit.edu.au/browse;ID=EPSMC017P6AUSBU;STATUS=A?QRY=%2Btype%3Dflexible%20%2Bsubtype%3Deps%20%2Bno | of the Young Child | Philosophic Inquiry in Mental Health Nursing<br><br>Breastfeeding and Human Lactation<br><br>Advanced Clinical Nursing Practice: Stroke Management<br><br>Wellness and Lifestyle<br><br>Wellness and Complementary and Alternative Medicine (CAM<br><br>Clinical Issues for Children in the Community<br><br>Family Studies<br><br>Primary Health and Assessment of the Young Child<br><br>Emergency Nursing Studies 1<br><br>Professional Development Emergency Nursing Practice<br><br>Neuroscience Nursing Studies 1<br><br>Professional Development in Neuroscience Nursing Practice |

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| tes%3D(%20|%22MC017%22%20|%22GD013%22%20|%22GD158%22%20|%22GD159%22%20|%22GC086%22%20|%22GC087%22%20|%22GC089%22)&STYPE=ENTIRE> | | | | | | Minor Thesis |
| **University of Ballarat**<br><br>University of Ballarat 2011, *Nursing Programs*, viewed 21 July 2011, <http://www.ballarat.edu.au/schools/school-of-health/nursing> | They offer postgraduate nursing degrees by coursework but they do not provide access to the degree structures | | | | | |
| **The University of Melbourne**<br><br>The University of Melbourne 2011, *Master of Nursing Science Degree structure*, viewed 21 July 2011, <http://www.nursing.unimelb.edu.au/future_students/becoming_a_nurse/degree_structure><br><br>The University of Melbourne 2011, *Master of Advanced Nursing Practice*, viewed 21 July 2011, <http://www.nursing.unimelb.edu.au/future_students/specialty_and_advanced_practice/master_of_advanced_nursing_practice><br><br>The University of Melbourne 2011, *Nurse Practitioner Endorsement*, viewed 21 July 2011, <http://www.nursing.unimelb.edu.au/future_students/specialty_and_advanced_practice/nurse_practitioner_endorsement> | NURS90049 Health Education and Nursing | NURS50001 Nursing and the Health Care System 1<br><br>NURS50008 Mental Health and Illness<br><br>NURS90053 Clients with Complex Health States<br><br>NURS90051 Koori Health for Nurses<br><br>NURS90054 Nursing and the Health Care System 2<br><br>NURS90056 Mental Health Nursing<br><br>NURS90013 Community | NURS90049 Health Education and Nursing<br><br>NURS70006 Decision Making in Advanced Practice<br><br>NURS90031 Complexity in Cancer & Palliative Care<br><br>GENP90014 Preventive Health Care | NURS90049 Health Education and Nursing<br><br>NURS70001 Applications of Clinical Pharmacology II<br><br>NURS70006 Decision Making in Advanced Practice | NURS50001 Nursing and the Health Care System 1<br><br>NURS50004 Nursing Assessment & Care<br><br>NURS50007 Clients with Acute and Chronic Illness<br><br>NURS50008 Mental Health and Illness<br><br>NURS90049 Health Education and Nursing<br><br>NURS90053 Clients with Complex Health States<br><br>NURS90051 |

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| The University of Melbourne 2011, *Postgraduate Diploma in Nursing Practice*, viewed 21 July 2011, <http://www.nursing.unimelb.edu.au/future_students/specialty_and_advanced_practice/postgraduate_diploma_in_nursing_practice><br><br>The University of Melbourne 2011, *Postgraduate Diploma in Nursing*, viewed 21 July 2011, <http://www.nursing.unimelb.edu.au/future_students/specialty_and_advanced_practice/postgraduate_diploma_in_nursing><br><br>The University of Melbourne 2011, *Postgraduate Diploma in Primary Care Nursing*, viewed 21 July 2011, <http://www.nursing.unimelb.edu.au/future_students/specialty_and_advanced_practice/postgraduate_diploma_in_primary_care_nursing><br><br>The University of Melbourne 2011, *Postgraduate Certificate in Nursing Practice*, viewed 21 July 2011, <http://www.nursing.unimelb.edu.au/future_students/specialty_and_advanced_practice/postgraduate_certificate_in_nursing_practice> | | Mental Health<br><br>NURS90015 Mental Health Theory 1<br><br>NURS90017 Mental Health Theory 2<br><br>NURS90014 Foundations in Mental Health 1<br><br>NURS90016 Foundations in Mental Health 2<br><br>GENP90015 Youth Health in Primary Care<br><br>GENP90009 Significant Issues in Women's Health<br><br>POPH90037 Sexual and Reproductive Health<br><br>GENP90014 Preventive Health Care | Koori Health for Nurses<br><br>NURS90054 Nursing and the Health Care System 2<br><br>NURS90055 Nursing as Practice<br><br>NURS90056 Mental Health Nursing<br><br>NURS70004 Preparing Clinicians for Evid Based Prac<br><br>NURS90013 Community Mental Health<br><br>NURS90015 Mental Health Theory 1<br><br>NURS70008 Advanced Nursing Practice in Context 1<br><br>NURS70007 Health Assessment for Advanced Practice<br><br>NURS70006 Decision Making in Advanced Practice<br><br>NURS70005 Leading Advanced |

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| | | **Practice**<br><br>**NURS90017 Mental Health Theory 2**<br><br>**NURS90018 Consumer Perspective and Participation**<br><br>**NURS90014 Foundations in Mental Health 1**<br><br>**NURS90016 Foundations in Mental Health 2**<br><br>**GENP90015 Youth Health in Primary Care**<br><br>**GENP90009 Significant Issues in Women's Health**<br><br>**NURS90043 Advanced Nursing Practice in Primary Care**<br><br>**POPH90037 Sexual and Reproductive Health**<br><br>**GENP90014 Preventive Health Care**<br><br>**NURS90030 Applied Concepts-Cancer & Palliative Care** |

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| **Victoria University**<br><br>**WA** | They do not offer postgraduate nursing degrees by coursework | | | | |
| **Curtin University of Technology**<br><br>Curtin University of Technology 2011, *Master of Nursing (Nurse Practitioner)*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/Master-NursePractitioner><br><br>Curtin University of Technology 2011 *Postgraduate Diploma in Child and Adolescent Health Nursing*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/PGDip-ChildHealth><br>Flinders University 2011, *Master of Nursing*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/Master-Nursing><br><br>Curtin University of Technology 2011, *Postgraduate Diploma in Nursing*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/PGDip-Nursing><br><br>Curtin University of Technology 2011, *Master of Nursing Practice*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/Master-NursingPractice> | 306934 Advanced Nursing Practice - Promoting Health 561 | 306931 Advanced Nursing Practice - Primary Health Care 561<br><br>301950 Research and Evaluation in International Health 600<br><br>4712 Qualitative Methods in Health Research 582<br><br>13152 Health Research Methods 681<br><br>307495 Developmental Health 561<br><br>13162 Public Health Nutrition 681<br><br>301948 International Health and Primary Health Care 600 | 306934 Advanced Nursing Practice - Promoting Health 561<br><br>311576 Diabetes Professional Practice 514 | 306934 Advanced Nursing Practice - Promoting Health 561 | 306931 Advanced Nursing Practice - Primary Health Care 561<br><br>307499 Child and Adolescent Nursing Practice 562<br><br>307498 Child and Adolescent Nursing Specialisation 562<br><br>4712 Qualitative Methods in Health Research 582<br><br>306934 Advanced Nursing Practice - Promoting Health 561<br><br>307495 Developmental Health 561<br><br>301948 International Health and |

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| Curtin University of Technology 2011, *Master of Clinical Nursing*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/Master-ClinicalNursing><br><br>Curtin University of Technology 2011, *Graduate Certificate in Diabetes*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/GCert-Diabetes><br><br>Curtin University of Technology 2011, *Graduate Diploma in Diabetes*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/GDip-Diabetes><br><br>Curtin University of Technology 2011, *Master of Science (Diabetes)*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/Master-Diabetes><br><br>Curtin University of Technology 2011, *Graduate Certificate in Health Improvement*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/GCert-HealthImprovement><br><br>Curtin University of Technology 2011, *Graduate Diploma in Health Improvement*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/GDip-HealthImprovement><br><br>Curtin University of Technology 2011, *Master of Leadership in Health Improvement*, viewed 21 July 2011, <http://courses.curtin.edu.au/course_overview/postgraduate/Master-HealthImprovement> | 301952 Maternal and Child Health in Developing Countries 600<br><br>306933 Cross-Cultural Perspectives of Health Care Practice 561<br><br>308427 Refugee and Migrant Health 600<br><br>310475 Health Project 691<br><br>310476 Health Project 692<br><br>308409 Health Project Preparation 591<br><br>301413 Health Contract 590<br><br>11099 Health Planning and Evaluation 582<br><br>13154 Health Policy 681<br><br>6115 Health Services Management 584 | 301952 Primary Health Care 600<br><br>301952 Maternal and Child Health in Developing Countries 600<br><br>306933 Cross-Cultural Perspectives of Health Care Practice 561<br><br>308427 Refugee and Migrant Health 600<br><br>311225 Clinical Leadership 561<br><br>307484 Diagnostics 561<br><br>310475 Health Project 691<br><br>310476 Health Project 692<br><br>309619 Domiciliary Nursing Specialisation 562<br><br>311575 Chronic Illness 521<br><br>310510 Advanced Clinical Practice 532<br><br>311573 Diabetes Mellitus 511 |

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| **Edith Cowan University** | | | | | | **311576 Diabetes Professional Practice 514**<br><br>**311572 Living with Diabetes 512**<br><br>**312276 Human Factors and Patient Safety 591**<br><br>**11099 Health Planning and Evaluation 582**<br><br>**13154 Health Policy 681**<br><br>**6115 Health Services Management 584**<br><br>**312274 Leadership in Clinical Practice Improvement 692**<br><br>**312114 Clinical Management Science 561**<br><br>**312115 Clinical Operational Management 561** |
| | **CMH5104 Mental Health Education and Promotion** | **CMH5104 Mental Health Education and Promotion** | **GPN4102 Advanced Health Assessment**<br><br>**NNT4101 Paediatric Health Assessment and** | **GPN4100 General Practice Nursing 1**<br><br>**CMH5104 Mental Health Education and** | **CMH5104 Mental Health Education and Promotion** | **GPN4100 General Practice Nursing 1**<br><br>**CNG4100 Nursing Governance** |

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| Edith Cowan University 2011, *Graduate Certificate in Practice Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMjQxMCUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEG9wbGV2ZWwmYWxsPTE%3D><br><br>Edith Cowan University 2011, *Graduate Certificate in Transition Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMjgwNCUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEG9wbGV2ZWwmYWxsPTE%3D><br><br>Edith Cowan University 2011, *Graduate Certificate of Paediatric Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMjgzNSUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEG9wbGV2ZWwmYWxsPTE%3D><br><br>Edith Cowan University 2011, *Graduate Diploma of Occupational Medicine, Health and Safety*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMjkyMCUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEG | Care Planning<br><br>NNT4102 Quality Communication in Paediatric Health Care<br><br>DCP5102 Allied Health in Palliative Care<br><br>NNS5202 Advanced Nursing Science 2<br><br>NUR5113 Evaluating Practice in Health<br><br>MHP5101 Master Health Project<br><br>MHP5202 Master Health Project<br><br>DCP5102 Allied Health in Palliative Care<br><br>MMP5103 Ethical and Legal Issues for Health Professionals<br><br>NNS5105 Contemporary Issues in Mental Health Care<br><br>NSP5110 Mental Health Nursing Practice 1<br><br>CMH5102 | Promotion | NNT4101 Paediatric Health Assessment and Care Planning<br><br>MCP5010 Disease Processes<br><br>DCP5102 Allied Health in Palliative Care<br><br>NNS5202 Advanced Nursing Science 2<br><br>NUR5113 Evaluating Practice in Health<br><br>DCP5203 Symptom Control in Palliative Care<br><br>NNI5101 Professional Issues in Clinical Nursing<br><br>DCP5102 Allied Health in Palliative Care<br><br>MMP5103 Ethical and Legal Issues for Health Professionals<br><br>NNS5105 Contemporary Issues in Mental Health Care |

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| vbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEdG9wbGV2ZWwmYWxsPTE%3D><br><br>Edith Cowan University 2011, *Graduate Diploma of Palliative Care*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMDY5MSUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEG9wbGV2ZWwmYWxsPTE%3D><br><br>Edith Cowan University 2011, *Master of Clinical Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMTI4NCUyNmFjdGlvbiUzRGRpc2NpcGxpbmVzJTI2bG9jYXRpb24lM0R0b3BsZXZlbCZhbGw9MQ%3D%3D><br><br>Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Critical Care Nursing - Coronary Care / Cardiothoracic*, viewed 21 July 2011, < http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmZjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpQJmFsbD0x><br><br>Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Critical Care Nursing - High Dependency*, viewed 21 July 2011, < http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsP | Mental Health Assessment and Management<br><br>NFS5101 Forensic Mental Health Nursing<br><br>NSP5210 Mental Health Nursing Practice 2<br><br>CMH5106 Child and Adolescent Development and Mental Health<br><br>CMH5107 Early Intervention and Nursing Care of Children and Adolescents with Mental Health Problems<br><br>CMH5108 Contemporary Issues in Child and Adolescent Mental Health and Service Provision<br><br>CMH5103 Mental Health Clinical Interventions | NSP5110 Mental Health Nursing Practice 1<br><br>CMH5102 Mental Health Assessment and Management<br><br>NSP5210 Mental Health Nursing Practice 2<br><br>CMH5106 Child and Adolescent Development and Mental Health<br><br>CMH5107 Early Intervention and Nursing Care of Children and Adolescents with Mental Health Problems<br><br>CMH5108 Contemporary Issues in Child and Adolescent Mental Health and Service Provision<br><br>CMH5103 Mental Health Clinical Interventions<br><br>CMH5101 Minimising the Risk of Suicide and Self Harm<br><br>NFS5102 Assessment of Mentally |

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| Wh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpSJmFsbD0x> | | Disordered Offenders |
| Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Critical Care Nursing - Intensive Care*, viewed 21 July 2011, < http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpQJmFsbD0x> | | |
| Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Advanced Nursing*, viewed 21 July 2011, < http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpaJmFsbD0x> | | |
| Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Chronic Disease Management*, viewed 21 July 2011, < http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpOJmFsbD0x> | | |
| Edith Cowan University 2011, *Master of* | | |

*Clinical Nursing, Area of Specialisation in Emergency Nursing*, viewed 21 July 2011, < http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpTJmFsbD0x>

Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Gerontological Nursing*, viewed 21 July 2011, < http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUVPJmFsbD0x>

Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Nephrology Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpZJmFsbD0x>

Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Neuroscience Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpUJmFsbD0x>

Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Neuroscience Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpUJmFsbD0x>

MjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpYJmFsbD0x>

Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Oncology Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpVJmFsbD0x>

Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Orthopaedic Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpXJmFsbD0x>

Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Palliative Care Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUVUJmFsbD0x>

Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Perioperative Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsP

Wh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpXJmFsbD0x>

Edith Cowan University 2011, *Master of Clinical Nursing, Area of Specialisation in Transition Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDEyODQlMjZpZF91bml0c2V0JTNEU1BBQUpOJmFsbD0x>

Edith Cowan University 2011, *Master of Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmFjdGlvbiUzRGRpc2NpcGxpbmVzX3ZpZXclMjZpZCUzRDAwMDAwMDMyMDAwMDAwMDAw

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| students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMjA1NyUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEG9wbGV2ZWwmYWxsPTE%3D><br><br>Edith Cowan University 2011, *Postgraduate Certificate in Child and Adolescent Mental Health Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMTI4MiUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEG9wbGV2ZWwmYWxsPTE%3D><br><br>Edith Cowan University 2011, *Postgraduate Certificate in Community Mental Health Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMjMzNiUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEG9wbGV2ZWwmYWxsPTE%3D><br><br>Edith Cowan University 2011, *Postgraduate Certificate in Forensic Mental Health Nursing*, viewed 21 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMTQwMCUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEG9wbGV2ZWwmYWxsPTE%3D> | |

## Murdoch University

They do not offer postgraduate nursing degrees by coursework

## The University of Notre Dame

**Primary Health Nursing**

**Primary Health**

**NS4000 Advanced Health Assessment**


The University of Notre Dame 2011, *Graduate Certificate in Acute Mental Health UNDA Course Code 4016, CRICOS Code 049354C*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GCAcutMntlHlth%202011%20151110.pdf>

The University of Notre Dame 2011, *Graduate Certificate in Aged Care Nursing Fremantle Campus , ND Code: 4001, CRICOS Code (Fremantle): 049349M*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GCAgedCareNsg%202011%20151110.pdf>

The University of Notre Dame 2011, *Graduate Certificate in Clinical Governance UNDA Course Code 4107*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GCClinGov%202011%20151110.pdf>

The University of Notre Dame 2011, *Graduate Certificate in Clinical Nursing UNDA Course Code 4092*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GCClinNsg%202011%20151110.

pdf>

The University of Notre Dame 2011, *Graduate Certificate in Nursing Education UNDA Course Code 4017*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GCNsgEduc%202011%20151110.pdf>

The University of Notre Dame 2011, *Graduate Certificate in Nursing, UNDA Course Code 4117* , viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GCNsg%202011%20151110.pdf>

The University of Notre Dame 2011, *Graduate Certificate in Orthopaedic Nursing UNDA Course Code 4018*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GCOrthoNsg%202011%20151110.pdf>

The University of Notre Dame 2011, *Graduate Diploma of Clinical Nursing UNDA Course Code 4108*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GDClinNsg%20251110.pdf>

The University of Notre Dame 2011, *Graduate Diploma of Forensic Nursing UNDA Course Code 4116*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GDForenNsg%202011%20151110.pdf>

The University of Notre Dame 2011, *Graduate Diploma of Nursing, UNDA Course Code 4086, CRICOS Code 057679D*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GDNsg%202011%20151110.pdf>

The University of Notre Dame 2011, *Graduate Diploma of Perioperative Nursing*

*UNDA Course Code 4091*, viewed 21 July 2011, http://www.nd.edu.au/downloads/courses/fremantle/GDPeriopNsg%202011%20151110.pdf

The University of Notre Dame 2011, *Master of Nursing (Coursework), UNDA Course Code 5080*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/MastersCourswk%202011%20151110.pdf>

The University of Notre Dame 2011, Master of Nursing (Coursework and Thesis), UNDA Course Code 5108, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/MastersCourswkThesis%202011%20151110.pdf>

The University of Notre Dame 2011, *Graduate Certificate in Rural and Remote Area Nursing, UNDA Course Code 4113, CRICOS Code 049354C*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/fremantle/GCRuralRemoteAreaNursing%202011%20151110.pdf>

The University of Notre Dame 2011, *Graduate Certificate in Grief and Loss UNDA Course Code 4104*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/sydney/2010%20Semester%201/postgrad/Grad%20Cert%20-%20Grief%20&%20Loss%20JAN%2010.pdf>

The University of Notre Dame 2011, *Graduate Certificate in Neurodegenerative Disorders, UNDA Course Code 4103*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/sydney/2010%20Semester%201/postgrad/Grad%20Cert%20-%20Neurodegenerative%20Disorders%20JAN%2010.pdf>

The University of Notre Dame 2011,

***Graduate Certificate in Clinical Nursing UNDA Course Code 4092 – CRICOS Code 062360G*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/sydney/2010%20Semester%201/postgrad/Grad%20Cert%20-%20Clinical%20Nursing%20JAN%2010.pdf>**

**The University of Notre Dame 2011, Graduate Certificate in Mental Health Nursing, UNDA Course Code 4119, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/sydney/2010%20Sem2/Postgrad/GradCertMentalHealthNursingAUG10[1].pdf>**

**The University of Notre Dame 2011, *Graduate Certificate in Substance Use Nursing, UNDA Course Code 4120*, viewed 21 July 2011, <http://www.nd.edu.au/downloads/courses/sydney/2010%20Sem2/Postgrad/GradCertSubstanceUseNursingAUG10[2].pdf>**

**Postgraduate Universities 2011/ Undergraduate Nursing Courses**

| Australian Universities 2011/ Undergraduate Nursing Courses | A specific course with the word "Health literacy" in its title is evident. | A specific course with the word "Health Promotion" in its title is evident. | A specific course with the word "Health Education" in its title is evident. | A specific course with the word "Health" in its title is evident. | A specific course with the word "Health literacy" in its description of the content regardless of how the course is titled. | A specific course with the word "Health Promotion" in its description of the content regardless of how the course is titled. | A specific course with the word "Health Education" in its description of the content regardless of how the course is titled. | A specific course with the word "Health" in its description of the content (regardless of how the course is titled. |
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| **ACT** | | | | | | | | |
| **University of Canberra**<br><br>University of Canberra 2011, *Bachelor of Nursing (885AA)*, viewed 22 July 2011, <http://www.canberra.edu.au/courses-units/ug/health-community/885aa/course-outline> | | | | 7435 Child and Adolescent Health and Illness<br><br>7951 Ethics and Law for Health Professionals<br><br>7427 Social Concepts of Health and Illness<br><br>7554 Mental Health<br>6088 Psych Approaches to Health Care | 7431 Analysing Disease Part 1<br><br>7433 Analysing Disease Part 2<br><br>7433 Analysing Disease Part 2<br><br>7431 Analysing Disease Part 1 | | | 7437 Clinical Governance<br><br>7951 Ethics and Law for Health Professionals<br><br>7427 Social Concepts of Health and Illness<br><br>7429 Theoretical Foundations in Nursing<br><br>7554 Mental Health |

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| | | Practice<br><br>7434 Indigenous Health: Contemporary Issues<br><br>7435 Child and Adolescent Health and Illness | 7437 Clinical Governance<br><br>6088 Psych Approaches to Health Care Practice<br><br>7434 Indigenous Health: Contemporary Issues |
| **NSW** | | | |
| **Avondale College**<br><br>Avondale College 2011, *Faculty of Nursing and Health, Bachelor of Nursing* , viewed 22 July 2011, <http://www.avondale.edu.au/Main::Information::handbook::2011::undergraduate::12_UG_Faculty_of_Nursing_and_Health.pdf><br><br>Avondale College 2011, *Undergraduate Unit Synopses*, viewed 22 July 2011, <http://www.avondale.edu.au/Main::Information::handbook::2011::undergraduate::13_UG_synopses_2011.pdf> | | NURS10100 Foundations of Health and Nursing<br><br>HESC14700 Health Science I<br><br>HESC14800 Health Science II<br><br>CSTD10400 Spiritual Care in Health<br><br>HESC14900 Health Science III<br><br>NURS10300 Primary Health Care<br><br>NURS20800 Promoting Holistic Health | NURS10100 Foundations of Health and Nursing<br><br>HESC14700 Health Science I<br><br>NURS10200 Clinical Practice II<br><br>NURS10300 Primary Health Care<br><br>NURS20200 Medical/Surgical Nursing A<br><br>NURS20800 Promoting Holistic Health<br><br>Clinical Practice IV |

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| | | | NURS20600 Mental Health<br><br>NURS21900 Maternal, Child and Family Health<br><br>Community Health Nursing<br><br>NURS31900 Health Care of the Ageing Adult | | | NURS20500 Medical/Surgical Nursing B<br><br>NURS20600 Mental Health<br><br>NURS21900 Maternal, Child and Family Health<br><br>NURS30200 Medical/Surgical Nursing C<br><br>Community Health Nursing<br><br>NURS31900 Health Care of the Ageing Adult |
| **Charles Sturt University**<br><br>Charles Sturt University 2011, *Bachelor of Health Science (Mental Health)*, viewed 22 July 2011, <http://www.csu.edu.au/courses/undergraduate/mental_health/course-structure><br><br>Charles Sturt University 2011, *Bachelor of Nursing*, viewed 22 July 2011, <http://www.csu.edu.au/courses/undergraduate/nursing/course-structure><br><br>Charles Sturt University 2011, | NRS191 Primary Health Care Nursing 1: Health Promotion and Education<br><br>NRS325 Child Health Care and Promotion<br><br>HLT401 Contexts of Health Promotion | NRS191 Primary Health Care Nursing 1: Health Promotion and Education | NRS191 Primary Health Care Nursing 1: Health Promotion and Education<br><br>NRS192 Primary Health Care Nursing 2: Fundamentals of Nursing Practice<br><br>SOC108 Sociology of Health and Health Care<br><br>NRS192 Primary Health Care Nursing 2: Fundamentals of Nursing Practice<br><br>NRS194 | NRS191 Primary Health Care Nursing 1: Health Promotion and Education<br><br>NRS375 Health Optimisation 1: Gerontic Nursing Care<br><br>MHP105 Introduction to Primary Health Care: Mental Health<br><br>NRS325 Child Health Care and Promotion<br><br>HLT401 Contexts of Health | NRS191 Primary Health Care Nursing 1: Health Promotion and Education<br><br>HLT402 Learning in Health Contexts<br><br>HLT405 Issues in Clinical Education | NRS191 Primary Health Care Nursing 1: Health Promotion and Education<br><br>NRS192 Primary Health Care Nursing 2: Fundamentals of Nursing Practice<br><br>NRS193 Discipline of Nursing 1: Contexts of Nursing<br><br>SOC108 Sociology of Health and Health Care<br><br>NRS192 Primary Health Care |

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| *Bachelor of Nursing (Re-entry)*, viewed 22 July 2011, <http://www.csu.edu.au/courses/undergraduate/nursing_reentry/course-structure><br><br>Charles Sturt University 2011, *Bachelor of Nursing Science*, viewed 22 July 2011, <http://www.csu.edu.au/courses/undergraduate/nursing_science/course-structure> | | Indigenous Culture, Health and Nursing<br><br>NRS291 Health Challenges 1: Nursing Interventions and Rehabilitation<br><br>NRS292 Health Challenges 2: Nursing Interventions and Rehabilitation<br><br>NRS295 Discipline of Nursing 2: Health, Law and Ethics<br><br>NRS375 Health Optimisation 1: Gerontic Nursing Care<br><br>NRS376 Health Optimisation 2: Mental Health Nursing<br><br>NRS377 Health Optimisation 3: Chronic and Complex Nursing Care<br><br>NRS378 Health Optimisation 4: Family, Community and Rural Nursing<br><br>PSY214 Health Psychology<br><br>SOC108 Sociology | Promotion | Nursing 2: Fundamentals of Nursing Practice<br><br>NRS194 Indigenous Culture, Health and Nursing<br><br>NRS195 Psychosocial Nursing<br><br>NRS291 Health Challenges 1: Nursing Interventions and Rehabilitation<br><br>NRS292 Health Challenges 2: Nursing Interventions and Rehabilitation<br><br>NRS293 Clinical Nursing Practice 1<br><br>NRS294 Clinical Nursing Practice 2<br><br>NRS296 Discipline of Nursing 3: Inquiry and Research<br><br>NRS375 Health Optimisation 1: Gerontic Nursing Care<br><br>NRS376 Health Optimisation 2: Mental Health Nursing<br><br>NRS378 Health |

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| | | of Health and Health Care<br><br>NRS325 Child Health Care and Promotion<br><br>NRS401 The Ecology of Child Health Care<br><br>BMS323 Infection and Immunity in Complementary Health<br><br>HLT402 Learning in Health Contexts<br><br>NRS184 International Indigenous Cultures, Health & Nursing<br><br>BMS323 Infection and Immunity in Complementary Health<br><br>MHP101 Introduction to Mental Health<br><br>MHP103 Mental Health Across the Life Span 1<br><br>MHP105 Introduction to Primary Health Care: Mental Health<br><br>MHP106 Mental Health Across the Life Span 2 | Optimisation 4: Family, Community and Rural Nursing<br><br>NRS379 Discipline of Nursing 4: Transition to Professional Nursing Practice<br><br>NRS381 Clinical Nursing Practice 3<br><br>NRS382 Clinical Nursing Practice 4<br><br>PSY214 Health Psychology<br><br>SOC108 Sociology of Health and Health Care<br><br>NRS132 Nursing and Communities<br><br>NRS237 Management and the Nurse<br><br>BMS323 Infection and Immunity in Complementary Health<br><br>HLT401 Contexts of Health Promotion<br><br>HLT402 Learning in Health Contexts<br><br>HLT403 Clinical Teaching Techniques |

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| | | **MHP109 Body, Illness and Health**<br><br>**MHP209 Mental Health, Law and Ethics**<br><br>**MHP205 Primary Health Care: Mental Health 2**<br><br>**MHP301 Research in Mental Health**<br><br>**MHP302 Professional Issues in Aboriginal and Torres Strait Islander Mental Health**<br><br>**MHP304 Mental Health and Substance Use**<br><br>**MHP306 Forensic Mental Health** | **HLT404 Clinical Education Planning**<br><br>**NRS184 International Indigenous Cultures, Health & Nursing**<br><br>**BMS323 Infection and Immunity in Complementary Health**<br><br>**MHP101 Introduction to Mental Health**<br><br>**MHP105 Introduction to Primary Health Care: Mental Health**<br><br>**MHP106 Mental Health Across the Life Span 2**<br><br>**MHP109 Body, Illness and Health**<br><br>**MHP201 Assessment, Diagnosis and Management in Psychiatry**<br><br>**MHP202 Crisis Management**<br><br>**MHP209 Mental Health, Law and Ethics**<br><br>**MHP205 Primary Health Care:** |

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| | | | | Mental Health 2<br><br>MHP208 Working with Children and Adolescents<br><br>MHP302 Professional Issues in Aboriginal and Torres Strait Islander Mental Health<br><br>MHP304 Mental Health and Substance Use<br><br>MHP305 Working with Families<br><br>MHP306 Forensic Mental Health |
| **Southern Cross University**<br><br>Southern Cross University 2011, *Bachelor of Nursing*, viewed 22 July 2011, <http://www.scu.edu.au/coursesin2012/?action=matrix&command=matrix_temp_load&spk_no=10204> | CMM10471 - Nursing and Health Promotion | CUL00408 - Health and Indigenous Australian Peoples<br><br>NRS10462 - Community Health Nursing<br><br>NRS10453 - Foundation Studies in Mental Health Nursing<br><br>CMM10464 - Psychosocial Contexts of Health<br><br>NRS10456 - Family Health Nursing<br><br>NRS10459 - Mental Health | NRS10456 - Family Health Nursing<br><br>CMM10471 - Nursing and Health Promotion | CUL00408 - Health and Indigenous Australian Peoples<br><br>NRS10452 - Contexts of Nursing Practice<br><br>NRS10462 - Community Health Nursing<br><br>NRS10463 - Clinical Nursing II<br><br>NRS10453 - Foundation Studies in Mental Health Nursing<br><br>CMM10464 - Psychosocial |

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| | | | Nursing Assessment and Intervention<br><br>CMM10469 - Enquiry and Critique in Health | | | | Contexts of Health<br><br>NRS10456 - Family Health Nursing<br><br>CMM10469 - Enquiry and Critique in Health |
| **The University of Newcastle**<br><br>The University of Newcastle 2011, *Nursing and Midwifery Courses*, viewed 22 July 2011, <http://www.newcastle.edu.au/school/nursing-midwifery/courses.html> | NURS1162 Mental Health Literacy and Mental Health First Aid | | NURS1102 Primary Health Care<br><br>NURS1161 Concepts of Health & Wellness<br><br>NURS1162 Mental Health Literacy and Mental Health First Aid<br><br>NURS1171 Introduction to Health Clinical Practice<br><br>NURS1272 Partnerships in Health Practice<br><br>NURS1291 Nursing Therapeutics & Health Breakdown<br><br>NURS2162 Health, Social Disadvantage and Substance Abuse<br><br>NURS2163 Complementary Therapies in Healthcare | NURS1162 Mental Health Literacy and Mental Health First Aid | NURS1120 Nursing Practice 1B<br><br>NURS1161 Concepts of Health & Wellness<br><br>NURS2210 Clinical Practicum 2A<br><br>NURS2130 Nursing Practice 2A<br><br>NURS2140 Nursing Practice 2B<br><br>NURS2150 Nursing Practice 2C<br><br>NURS6580 Midwifery Practice Issues<br><br>NURS6590 The Childbearing Woman and her Family | NURS1120 Nursing Practice 1B<br><br>NURS6590 The Childbearing Woman and her Family<br><br>NURS6772 Specialty Nursing A (parenting education)<br><br>NURS6773 Specialty Nursing B (parenting education) | NURS1020 Foundation Studies in Nursing 1B<br><br>NURS1101 Foundations of Professional Practice 1A<br><br>NURS1102 Primary Health Care<br><br>NURS1120 Nursing Practice 1B<br><br>NURS1130 Nursing Practice 1A<br><br>NURS1161 Concepts of Health & Wellness<br><br>NURS1162 Mental Health Literacy and Mental Health First Aid<br><br>NURS1210 Clinical Practicum 1A<br><br>NURS1220 Clinical Practicum 1B<br><br>NURS1272 |

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| | | **NURS2295 Mental Health Nursing Therapeutics**<br><br>**NURS3198 Health Breakdown Among Indigenous Populations**<br><br>**NURS6055 Mental Health Nursing in Acute Care**<br><br>**NURS6060 Drug & Alcohol Issues in Mental Health Nursing Practice**<br><br>**NURS6061 Contemporary Mental Health Nursing**<br><br>**NURS6070 Mental Health Nursing of Older People**<br><br>**NURS6091 Community Mental Health Nursing**<br><br>**NURS6095 Mental Health Nursing in Community Settings**<br><br>**NURS6620 Biophysical Processes and Health Assessment**<br><br>**NURS6810 Alteration in Child Health** | **Partnerships in Health Practice**<br><br>**NURS1291 Nursing Therapeutics & Health Breakdown**<br><br>**NURS2010 Foundation Studies in Nursing 2A**<br><br>**NURS2020 Foundation Studies in Nursing 2B**<br><br>**NURS2140 Nursing Practice 2B**<br><br>**NURS2150 Nursing Practice 2C**<br><br>**NURS2162 Health, Social Disadvantage and Substance Abuse**<br><br>**NURS2193 Nursing Therapeutics and Aged Clients**<br><br>**NURS2210 Clinical Practicum 2A**<br><br>**NURS2230 Clinical for International Nurses**<br><br>**NURS2295 Mental Health Nursing Therapeutics**<br><br>**NURS2296 Cardiovascular /Respiratory Nursing** |

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| | | **NURS6812 Disord & Interv in Child & Adol Mental Hlth Nurs**<br><br>**NURS6818 Disorders and Interventions in Child & Adolescent Mental Health Nursing** | **Therapeutics**<br><br>**NURS3130 Nursing Practice 3A**<br><br>**NURS3140 Nursing Practice 3B**<br><br>**NURS3163 Sexuality & Families**<br><br>**NURS3184 Prudence & Professional Nursing**<br><br>**NURS3197 Emergency Nursing Therapeutics**<br><br>**NURS3198 Health Breakdown Among Indigenous Populations**<br><br>**NURS3210 Clinical Practicum 3A**<br><br>**NURS3220 Clinical Practicum 3B**<br><br>**NURS4020 Design and Method for Qualitative Research in Nursing**<br><br>**NURS4030 Introductory Epidemiology and Biostatistics**<br><br>**NURS4130 Knowledge and** |

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| | | **Theory Development in Nursing B**<br><br>**NURS6030 Counselling 1**<br><br>**NURS6055 Mental Health Nursing in Acute Care**<br><br>**NURS6060 Drug & Alcohol Issues in Mental Health Nursing Practice**<br><br>**NURS6061 Contemporary Mental Health Nursing**<br><br>**NURS6070 Mental Health Nursing of Older People**<br><br>**NURS6091 Community Mental Health Nursing**<br><br>**NURS6095 Mental Health Nursing in Community Settings**<br><br>**NURS6590 The Childbearing Woman and her Family**<br><br>**NURS6591 Optimising Childbearing**<br><br>**NURS6610 Issues in Critical Care Nursing** |

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| | | | | | | NURS6620 Biophysical Processes and Health Assessment<br><br>NURS6810 Alteration in Child Health<br><br>NURS6812 Disord & Interv in Child & Adol Mental Hlth Nurs<br><br>NURS6813 Families in Society<br><br>NURS6814 Pregnancy Birth and the Family<br><br>NURS6815 Special Care of the Newborn<br><br>NURS6816 Neonatal Intensive Care Nursing<br><br>NURS6817 Adolescent Development<br><br>NURS6818 Disorders and Interventions in Child & Adolescent Mental Health Nursing |
| University of | HSNS464 Cardiac Rehabilitation, Education and | HSNS464 Cardiac Rehabilitation, Education and | HHSC146 Fundamentals of Health Science 1 | HSNS123 Health Facilitation in Nursing | HSNS123 Health Facilitation in Nursing | HHSC246 Health Science 1 |

## New England

University of New England 2011, *Bachelor of Nursing For candidates admitted under Rule (a)*, viewed 22 July 2011, <http://www.une.edu.au/courses/2011/courses/BNURS/program-of-study-rule(a).html>

University of New England 2011, *Bachelor of Nursing For candidates admitted under Rule (b)*, viewed 22 July 2011, <http://www.une.edu.au/courses/2011/courses/BNURS/program-of-study-rule(b).html>

University of New England 2011, *Bachelor of Nursing For candidates admitted under Rule (C)*, viewed 22 July 2011, <http://www.une.edu.au/courses/2011/courses/BNURS/program-of-study-rule(c).html>

University of New England 2011, *Bachelor of Nursing For candidates admitted under Rule (d)*, viewed 22 July 2011, <http://www.une.edu.au/courses/2011/courses/BNURS/program-of-study-rule(d).html>

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| | Health Promotion | Health Promotion | Fundamentals of Health Science 2<br><br>HHSC246 Health Science 1<br><br>HHSC247 Health Science 2<br><br>HSNS123 Health Facilitation in Nursing<br><br>HSNS205 Introduction to Mental Health Nursing<br><br>HHSC384 The Biology of Human Ageing<br><br>HSHM445 Community Analysis and Health Care Planning<br><br>HSNS423 Theories and Models in Teaching and Learning in Health<br><br>HSNS424 Reflective Teaching and Learning in Health<br><br>HSNS432 Cardiac Health Assessment<br><br>HSNS469 A Lifespan Approach to Female Reproductive | HSNS201 Nursing Practice Development 1<br><br>HSNS202 Nursing Practice Development 2<br><br>HSNS203 Nursing Practice Development 3<br><br>HSNS205 Introduction to Mental Health Nursing<br><br>HSNS314 Chronic and Palliative Care Nursing<br><br>HSNS328 Paediatric Nursing<br><br>HSNS464 Cardiac Rehabilitation, Education and Health Promotion | HSNS205 Introduction to Mental Health Nursing<br><br>HSNS464 Cardiac Rehabilitation, Education and Health Promotion | HHSC247 Health Science 2<br><br>HSNS112 Fundamental Nursing Skills 1<br><br>HSNS114 Human Interactions in Clinical Nursing Practice<br><br>HSNS121 Introduction to Professional Nursing Practice<br><br>HSNS122 Cultural Competence in Australian Nursing Practice<br><br>HSNS123 Health Facilitation in Nursing<br><br>HSNS201 Nursing Practice Development 1<br><br>HSNS202 Nursing Practice Development 2<br><br>HSNS203 Nursing Practice Development 3<br><br>HSNS204 Critical Enquiry in Nursing<br><br>HSNS205 Introduction to Mental Health Nursing<br><br>HSNS322 |

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| | | **Health**<br><br>**HS322 Complementary Therapies in the Health Care System**<br><br>**HSCS313 Counselling in the Health Professions**<br><br>**IDIG306 Aboriginal Health** | **Professional Issues in Nursing 1**<br><br>**HHSC383 Stress and Stress Management Physiology**<br><br>**HHSC384 The Biology of Human Ageing**<br><br>**HSHM200/400 Leadership and Change**<br><br>**HSHM445 Community Analysis and Health Care Planning**<br><br>**HSNS230 Enrolled Nursing Practice**<br><br>**HSNS231 Nursing Australian Indigenous People**<br><br>**HSNS327 Nursing in Rural and Remote Environments**<br><br>**HSNS328 Paediatric Nursing**<br><br>**HSNS330 Introduction to Maternity Care**<br><br>**HSNS423 Theories and Models in Teaching and Learning in Health**<br><br>**HSNS424** |

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| | | | **Reflective Teaching and Learning in Health**<br><br>**HSNS432 Cardiac Health Assessment**<br><br>**HSNS469 A Lifespan Approach to Female Reproductive Health**<br><br>**HS322 Complementary Therapies in the Health Care System**<br><br>**HSCS313 Counselling in the Health Professions**<br><br>**HUMN340 Issues in Human Nutrition II**<br><br>**IDIG306 Aboriginal Health** |
| **The University of Sydney**<br><br>**The University of Sydney 2011, *Bachelor of Nursing (Advanced Studies)**, viewed 22 July 2011, <http://sydney.edu.au/nursing/course_information/bachelor_nursing_advanced/advanced_studies_units_study.shtml>** | | **Health and Human Biology**<br><br>**Health Assessment**<br><br>**Population Health to Personal Health Care**<br><br>**Health Research**<br><br>**Child and Adolescent Health** | **They do not offer course descriptions for their courses** |

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| | | and Care<br><br>Contexts of Health and Disease<br><br>Understanding Mental Health and Illness<br><br>Ageing, Health and Care<br><br>Health and Indigenous Populations<br><br>Clinical Practice in Mental Health<br><br>Leadership in Health Professional Practice<br><br>Community Health Nursing<br><br>Politics, Policy and Health | | |
| **University of Technology – Sydney**<br><br>University of Technology – Sydney 2011, *C10122v10 Bachelor of Nursing*, viewed 22 July 2011, <http://www.handbook.uts.edu.au/2010/courses/c10122.html> | | 92236 Foundations of Mental Health Nursing<br><br>92237 Primary Health Care<br><br>92240 The Family in Health and Illness<br><br>92244 Comprehensive Health | 92313 Assessment and Therapeutics in Health Care 1<br><br>92332 Introduction to Specialty Practice: Community Health Nursing | 92237 Primary Health Care<br><br>92293 Family and Child Health Nursing<br><br>92313 Assessment and Therapeutics in Health Care 1<br><br>92320 Health and Society<br><br>92323 | 91531 Fundamentals of Pathophysiology 1<br><br>91532 Fundamentals of Pathophysiology 2<br><br>92009 The Discipline of Nursing<br><br>92191 Adult Nursing: Cardiovascular |

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| University of Technology – Sydney 2011, *C09018v5 Bachelor of Nursing (Honours)*, viewed 22 July 2011, <http://handbook.uts.edu.au/courses/c09018.html><br><br>University of Technology – Sydney 2011, *C10123v5 Bachelor of Nursing Bachelor of Arts in International Studies*, viewed 22 July 2011, <http://www.handbook.uts.edu.au/2009/courses/c10123.html> | | Assessment<br><br>92002 Practice Development 2: Mental Health Nursing<br><br>92006 Practice Development 3 Mental Health Nursing<br><br>92251 Community Health Nursing<br><br>92254 Mental Health Nursing<br><br>92260 Women's Health<br><br>92264 Australian Indigenous Health Care<br><br>92293 Family and Child Health Nursing<br><br>92313 Assessment and Therapeutics in Health Care 1<br><br>92320 Health and Society<br><br>92314 Assessment and Therapeutics in Health Care 2<br><br>91528 Health and Homeostatsis<br><br>92323 Fundamentals of Mental Health Nursing | Fundamentals of Mental Health Nursing<br><br>92319 Family and Children's Nursing<br><br>92316 Complex Nursing Care: Mental Health<br><br>92332 Introduction to Specialty Practice: Community Health Nursing<br><br>92334 Introduction to Specialty Practice: Family and Child Health Nursing | 92195 Adult Nursing: GIT and Orthopaedic<br><br>92236 Foundations of Mental Health Nursing<br><br>92237 Primary Health Care<br><br>92239 Foundations of Children's Nursing<br><br>92240 The Family in Health and Illness<br><br>92248 Adult Nursing: Neuro-endocrine<br><br>92010 The Discipline of Nursing<br><br>92261 Adult Nursing: Medical<br><br>92262 Adult Nursing: Surgical<br><br>92242 Practice Interactions<br><br>92244 Comprehensive Health Assessment<br><br>92245 Organisational Relationships |

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| | **92317 Contemporary Indigenous Health and Wellbeing**<br><br>**92316 Complex Nursing Care: Mental Health**<br><br>**92332 Introduction to Specialty Practice: Community Health Nursing**<br><br>**92334 Introduction to Specialty Practice: Family and Child Health Nursing**<br><br>**92335 Introduction to Specialty Practice: Mental Health Nursing**<br><br>**92337 Introduction to Specialty Practice: Women's Health**<br><br>**92972 Health Care Research Methodology**<br><br>**92973 Developing Health Care Theory**<br><br>**92974 Investigating Health Care Change** | **92002 Practice Development 2: Mental Health Nursing**<br><br>**92006 Practice Development 3 Mental Health Nursing**<br><br>**92251 Community Health Nursing**<br><br>**92254 Mental Health Nursing**<br><br>**92260 Women's Health**<br><br>**92313 Assessment and Therapeutics in Health Care 1**<br><br>**92326 Understanding the Person: Life Transitions**<br><br>**92320 Health and Society**<br><br>**92324 Professional Identity**<br><br>**92323 Fundamentals of Mental Health Nursing**<br><br>**92315 Nursing Care of the Older Person**<br><br>**92319 Family and Children's Nursing**<br><br>**92317** |

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| | | **Contemporary Indigenous Health and Wellbeing**<br><br>**92318 Evidence for Nursing**<br><br>**92330 Complex Nursing Care: Medical Surgical**<br><br>**92316 Complex Nursing Care: Mental Health**<br><br>**91527 Pathophysiology and Pharmacology 3**<br><br>**92325 Professionalism in Context**<br><br>**92332 Introduction to Specialty Practice: Community Health Nursing**<br><br>**92334 Introduction to Specialty Practice: Family and Child Health Nursing**<br><br>**92335 Introduction to Specialty Practice: Mental Health Nursing**<br><br>**92337 Introduction to Specialty Practice: Women's Health** |

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| | | | | 92341 Introduction to Specialty Practice: Perioperative Nursing<br><br>92973 Developing Health Care Theory<br><br>92974 Investigating Health Care Change |
| **University of Western Sydney**<br><br>University of Western Sydney 2011, *Bachelor of Nursing* , viewed 22 July 2011, <http://future.uws.edu.au/ug/health_sci_nursing_sport/nursing><br><br>University of Western Sydney 2011, *Bachelor of Nursing (Advanced)*, viewed 22 July 2011, <http://future.uws.edu.au/ug/health_sci_nursing_sport/nursing_advanced> | | Nursing for Health and Wellbeing<br><br>Understanding Good Health<br><br>Nursing and Health Breakdown<br><br>Introduction to Health Breakdown<br><br>Nursing and Healthy Communities<br><br>Family Health Care: Health Issues and Australian Indigenous People<br><br>Mental Health Nursing 1<br><br>Family Health Care: Child and Adolescent Nursing | Nursing for Health and Wellbeing<br><br>Nursing and Health Breakdown<br><br>Nursing and Healthy Communities<br><br>Medical-Surgical Nursing 1<br><br>Medical-Surgical Nursing 2<br><br>Family Health Care: Child and Adolescent Nursing<br><br>Family Health Care: High Acuity Nursing<br><br>Family Health Care: Older Adult Nursing | Nursing for Health and Wellbeing<br><br>Nursing and Health Breakdown<br><br>Introduction to Health Breakdown<br><br>Nursing and Healthy Communities<br><br>Knowing Nursing<br><br>Medical-Surgical Nursing 1<br><br>Alterations in Nutrition, Elimination and Sexuality<br><br>Medical-Surgical Nursing 2<br><br>Alterations in |

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| | | **Family Health Care: High Acuity Nursing**<br><br>**Mental Health Nursing 2**<br><br>**Family Health Care: Chronicity and Palliative Care Nursing**<br><br>**Family Health Care: Older Adult Nursing**<br><br>**A Field Study: Comparative Studies of Health Care Delivery**<br><br>**Understanding Good Health**<br><br>**Family Health Care: Health Issues and Australian Indigenous People (Advanced)**<br><br>**Family Health Care: Chronicity and Palliative Care Nursing (Advanced)** | **Breathing, Work/Leisure and Mobility**<br><br>**Mental Health Nursing 1**<br><br>**Family Health Care: Child and Adolescent Nursing**<br><br>**Family Health Care: High Acuity Nursing**<br><br>**Mental Health Nursing 2**<br><br>**Family Health Care: Older Adult Nursing**<br><br>**Maintaining Clinical Currency**<br><br>**A Field Study: Comparative Studies of Health Care Delivery**<br><br>**Family Health Care: Health Issues and Australian Indigenous People (Advanced)**<br><br>**Medical Surgical Nursing 2 (Advanced)**<br><br>**Family Health Care: Chronicity and Palliative Care Nursing (Advanced)** |

## University of Wollongong

University of Wollongong 2011, *Bachelor of Nursing, Bachelor of Nursing Honours,* viewed 22 July 2011, <http://www.uow.edu.au/handbook/yr2011/ug/hbs/H11006100.html>

University of Wollongong 2011, *Bachelor of Nursing (Conversion),* viewed 22 July 2011, <http://www.uow.edu.au/handbook/yr2011/ug/hbs/H11006101.html>

University of Wollongong 2011, *Bachelor of Nursing for Overseas Qualified Nurses,* viewed 22 July 2011, <http://www.uow.edu.au/handbook/yr2011/ug/hbs/H11000059.html>

University of Wollongong 2011, *Bachelor of Nursing Advanced*, viewed 22 July 2011, <http://www.uow.edu.au/handbook/yr2011/ug/hbs/H11000090.html>

**NMIH101** Effective Communication in Health Care Relationships

**NMIH105** Primary Health Care Nursing

**NMIH108** Introduction to Health Behaviour Changes

**NMIH205** Cultural Competencies in Health Care Practice

**NMIH208** Mental Health Nursing 1*

**NMIH302** Mental health Nursing 2*

**NMIH304** Evidence Appreciation and Application in Health Care Practice

**NMIH307** Leadership in Health Care Practice

**NMIH323** Primary and Community Health

**NMIH105** Primary Health Care Nursing

**NMIH323** Primary and Community Health Care Nursing

**NMIH105** Primary Health Care Nursing

**NMIH323** Primary and Community Health Care Nursing

**NMIH101** Effective Communication in Health Care Relationships

**NMIH105** Primary Health Care Nursing

**NMIH108** Introduction to Health Behaviour Changes

**NMIH201** Principles of Episodic Care

**NMIH203** Family Centred Nursing

**NMIH205** Cultural Competencies in Health Care Practice

**NMIH208** Mental Health Nursing 1*

**NMIH301** Nursing Care of People with Chronic Conditions*

**NMIH302** Mental health Nursing 2*

**NMIH304**

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| | | **Care Nursing**<br><br>**NMIH312 Therapeutic Intervention in Mental Health**<br><br>**NMIH314 Mental Health Nursing and the Older Person** | **Evidence Appreciation and Application in Health Care Practice**<br><br>**NMIH305 Nursing Care of People with Complex Conditions**<br><br>**NMIH306 Challenges of Ageing**<br><br>**NMIH307 Leadership in Health Care Practice**<br><br>**NMIH328 Management in Nursing**<br><br>**NMIH325 Community Development Nursing: Theory and Practice**<br><br>**NMIH323 Primary and Community Health Care Nursing**<br><br>**NMIH315 Practice Development and Person Centred Nursing**<br><br>**NMIH316 Innovation in Clinical Practice**<br><br>**NMIH312** |

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| | | | Therapeutic Intervention in Mental Health |
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| **Charles Darwin University**<br><br>Charles Darwin University 2011, *Bachelor of Nursing (Pre-Registration) BNUR*, viewed 22 July 2011, <http://www.cdu.edu.au/ehs/health/nursing/BNUR-enrolment-information-2011.pdf><br><br>Charles Darwin University 2011, *Semester 1 & 2 2011 Bachelor of Nursing (Pre-registration) BNURSE Enrolment Information & Clinical Information Pack, Vital information regarding your enrolment at Charles Darwin University*, viewed 22 July 2011, <http://www.cdu.edu.au/ehs/health/nursing/BNURSE-continuing-students.pdf> | | NUR115 - Fundamentals of Primary Health Care<br><br>NUR219 - Mental Health Nursing<br><br>NUR248 - Research and Evidence-based Health<br><br>NUR210 - Health Sociology<br><br>NUR329 - Public Health Challenges in Chronic and Complex Nursing<br><br>NUR111 Health and Health Professions<br><br>SID175 Applied Science Concepts in Health Care 1<br><br>NUR326 Health Assessment (external only)<br><br>NUR325 Maternal Health & | They do not offer course descriptions for their courses |

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| | | Paediatric Care<br><br>NUR210 Health Sociology<br><br>NUR318 Introduction to Remote Area Health<br><br>NUR327 Community Mental Health<br><br>NUR328 Mental Health Issues Across the Lifespan | | |
| **QLD** | | | | |
| **ACU National**<br><br>ACU National 2011, *Bachelor of Nursing*, viewed 22 July 2011, <http://www.acu.edu.au/courses/health/nursing/undergraduate/bachelor_of_nursing/><br><br>ACU National 2011, *Schedule of Unit (Subject) Offerings Bachelor of Nursing*, viewed 22 July 2011, <http://www.acu.edu.au/courses/unit_courses2?PROGRAM=BN><br><br>ACU National 2011, *Course Enrolment Guide 2011 Bachelor* | | HLSC111 The Person, Health and Wellbeing<br><br>HLSC120 Society, Culture and Health<br><br>HLSC121 Health Assessment<br><br>HLSC122 Inquiry in Health Care<br><br>HLSC210 Mental Health and Illness<br><br>HLSC220 Health Care Ethics<br><br>HLSC241 | NRSG257 Child, Adolescent and Family Nursing<br><br>NRSG259 Promoting Health in Extended Care<br><br>NRPL257 Child, Adolescent and Family Nursing (Practice Leadership)<br><br>NRSG363 Oncology and Palliative Care Nursing Practice<br><br>NRSG364 Aged | BIOL119 Foundation Biological Science 1<br><br>BIOL120 Foundation Biological Science 2<br><br>HLSC110 Beginning Professional Practice<br><br>HLSC111 The Person, Health and Wellbeing<br><br>HLSC120 Society, |

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| *of Nursing*<br>*School of Nursing and Midwifery (Vic) Melbourne (St Patrick's) and Ballarat (Aquinas) Campuses*, viewed 22 July 2011, <http://www.acu.edu.au/__data/assets/pdf_file/0011/282584/Bachelor_of_Nursing_Melbourne_and_Ballarat_2011.pdf><br><br>ACU National 2011, *Course Enrolment Guide 2011 Bachelor of Nursing*<br>*School of Nursing (NSW and ACT) North Sydney (MacKillop Campus) NSW*, viewed 22 July 2011, <http://www.acu.edu.au/__data/assets/pdf_file/0009/284769/Bachelor_of_Nursing_North_Sydney_2011.pdf><br><br>ACU National 2011, *Course Enrolment Guide 2011 Bachelor of Nursing*<br>*School of Nursing (NSW and ACT) Canberra (Signadou Campus) ACT*, viewed 22 July 2011, <http://www.acu.edu.au/__data/assets/pdf_file/0011/284780/Bachelor_of_Nursing_Canberra_2011.pdf><br><br>ACU National 2011, *Course Enrolment Guide 2011 Bachelor of Nursing*<br>*School of Nursing and Midwifery Brisbane (McAuley Campus) QLD*, viewed 22 July 2011, <http://www.acu.edu.au/__data/assets/pdf_file/0011/284789/Bachelor_of_Nursing_Brisbane_2011.pdf><br><br>ACU National 2011, *Schedule of Unit (Subject) Offerings* | | Spirituality in Health Care<br><br>NRSG259 Promoting Health in Extended Care<br><br>NRSG262 Clinical Integration: Mental Health<br><br>NRPL262 Clinical Integration: Mental Health (Practice Leadership)<br><br>NRSG357 Mental Health Nursing Practice<br><br>NRSG361 Paediatric and Child Health Nursing Practice<br><br>NRSG30X Community Engagement in Health Elective<br><br>HLSC241 Spirituality in Health Care<br><br>NRSG212 Mental Health and Substance Abuse<br><br>NRSG226 Health and Healing Practices in Indigenous<br><br>NRSG253 Promoting Family Health | Care Nursing Practice<br><br>NRSG226 Health and Healing Practices in Indigenous<br><br>NRSG253 Promoting Family Health<br><br>NRSG120 Indigenous Culture and Health<br><br>NRSG123 Contexts of Nursing 2<br><br>NRSG240 Contexts of Nursing 4 | Culture and Health<br><br>HLSC121 Health Assessment<br><br>HLSC122 Inquiry in Health Care<br><br>HLSC210 Mental Health and Illness<br><br>HLSC220 Health Care Ethics<br><br>HLSC241 Spirituality in Health Care<br><br>NRSG257 Child, Adolescent and Family Nursing<br><br>NRSG258 Acute Care Nursing 1<br><br>NRSG366 Partnerships in Chronicity<br><br>NRSG367 Transition to Professional Nursing<br><br>NRSG353 Acute Care Nursing 2<br><br>NRPL257 Child, Adolescent and Family Nursing (Practice Leadership)<br><br>NRPL258 Acute Care Nursing 1 (Practice Leadership) |

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| *Bachelor of Nursing (Honours)*, viewed 22 July 2011, <http://www.acu.edu.au/courses/unit_courses2?PROGRAM=BNH><br><br>ACU National 2011, *Course Enrolment Guide 2011 Bachelor of Nursing Practice Leadership School of Nursing (NSW and ACT) North Sydney (MacKillop Campus) NSW*, viewed 22 July 2011, <http://www.acu.edu.au/__data/assets/pdf_file/0008/282275/Bachelor_of_Nursing_Practice_Leadership_North_Sydney_2011.pdf><br><br>ACU National 2011, *Schedule of Unit (Subject) Offerings Bachelor of Nursing / Bachelor of Paramedicine*, viewed 22 July 2011, <http://www.acu.edu.au/courses/unit_courses2?PROGRAM=BNBP><br><br>ACU National 2011, *Course Enrolment Guide 2011 Bachelor of Nursing/Bachelor of Paramedicine School of Nursing and Midwifery (QLD) Brisbane (McAuley Campus)*, viewed 22 July 2011, <http://www.acu.edu.au/__data/assets/pdf_file/0005/284963/Bachelor_Nursing_Bachelor_Paramedicine_Brisbane_2011.pdf><br><br>ACU National 2011, *Course Enrolment Guide 2011 Bachelor of Nursing/Bachelor of Paramedicine School of Nursing and Midwifery (Victoria) Ballarat (Aquinas Campus)*, <http://www.acu.edu.au/__dat | **NRSG120 Indigenous Culture and Health**<br><br>**NRSG238 Mental Health Nursing Practice**<br><br>**NRSG240 Contexts of Nursing 4**<br><br>**NRSG241 Spirituality in Health** | **NRPL367 Transition to Professional Nursing (Practice Leadership)**<br><br>**NRSG137 Introduction to Nursing Practice**<br><br>**NRSG262 Clinical Integration: Mental Health**<br><br>**NRSG261 Clinical Integration: Acute Care**<br><br>**NRSG354 Clinical Integration: Complex Care**<br><br>**NRPL262 Clinical Integration: Mental Health (Practice Leadership)**<br><br>**NRPL261 Clinical Integration: Acute Care (Practice Leadership)**<br><br>**NRPL354 Clinical Integration: Complex Care (Practice Leadership)**<br><br>**NRSG356 Medical Surgical Nursing Practice**<br><br>**NRSG357 Mental Health Nursing Practice** |

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| a/assets/pdf_file/0003/284970/Bachelor_Nursing_Bachelor_Paramedicine_Ballarat_2011.pdf><br><br>ACU National 2011, *Bachelor of Nursing/Bachelor of Business Administration*, viewed 22 July 2011, <http://www.acu.edu.au/courses/health/nursing/undergraduate/bachelor_of_nursingbachelor_of_business_administration/> | | **NRSG358 High Dependency Nursing Practice**<br><br>**NRSG361 Paediatric and Child Health Nursing Practice**<br><br>**NRSG362 Maternity Nursing Practice**<br><br>**HLSC301 Community Engagement**<br><br>**HLSC302 Community Engagement in a Developing Country**<br><br>**HLSC241 Spirituality in Health Care**<br><br>**BIOL228 Applied Science for Practice 3**<br><br>**BIOL229 Applied Science for Practice 4**<br><br>**BIOL326 Applied Science for Practice 5**<br><br>**NRSG136 Introduction to Australian Nursing Practice**<br><br>**NRSG212 Mental Health and** |

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| | | **Substance Abuse**<br><br>**NRSG226 Health and Healing Practices in Indigenous**<br><br>**NRSG234 Traditional Chinese**<br><br>**NRSG343 Ethics for Holistic Practice**<br><br>**NRSG344 Contexts of Nursing 5**<br><br>**NRSG345 Complex Nursing Practice 2**<br><br>**NRSG346 Realising Professional Practice**<br><br>**NRSG348 Towards Professional Practice 1**<br><br>**NRSG253 Promoting Family Health**<br><br>**NRSG119 Nursing Practice Foundations**<br><br>**NRSG120 Indigenous Culture and Health**<br><br>**NRSG121 Contexts of Nursing 1**<br><br>**NRSG124 Introduction to Nursing** |

## Central Queensland University

Central Queensland University 2011, *Bachelor of Nursing*, viewed 22 July 2011, <http://degrees.cqu.edu.au/program/show/307>

NRSG237 Contexts of Nursing 3

NRSG238 Mental Health Nursing Practice

NRSG239 Complex Nursing Practice 1

NRSG240 Contexts of Nursing 4

NRSG241 Spirituality in Health

BIOL117 Applied Science for Practice 1

BIOL118 Applied Science for Practice 2

Could not get access to courses offered and their description

## Griffith

1977NRS Clinical Health Assessment

1801NRS Effective Communication

1977NRS Clinical

| University | | | |
|---|---|---|---|
| Griffith University 2011, *Bachelor of Nursing - Logan*, viewed 22 July 2011, <http://www17.griffith.edu.au/cis/p_cat/require.asp?ProgCode=1165&Type=structure><br><br>Griffith University 2011, *Bachelor of Nursing - Gold Coast*, viewed 22 July 2011, <http://www17.griffith.edu.au/cis/p_cat/require.asp?ProgCode=1162&Type=structure><br><br>Griffith University 2011, *Bachelor of Nursing - Nathan*, viewed 22 July 2011, <http://www17.griffith.edu.au/cis/p_cat/require.asp?ProgCode=1161&Type=structure><br><br>Griffith University 2011, *Bachelor of Nursing - Post-Registration - Off-shore*, viewed 22 July 2011, <http://www17.griffith.edu.au/cis/p_cat/require.asp?ProgCode=1327&Type=structure><br><br>Griffith University 2011, *Bachelor of Nursing - Post-Registration - Off-shore*, viewed 22 July 2011, <http://www17.griffith.edu.au/cis/p_cat/require.asp?ProgCode=1251&Type=requirestructure><br><br>Griffith University 2011, *Bachelor of Nursing - Post-Registration - Gold Coast*, viewed 22 July 2011, <http://www17.griffith.edu.au/cis/p_cat/require.asp?ProgCode | | 5902LAL English Language and Communication for Health<br><br>2976NRS Mental Health Nursing*#<br><br>2972NRS Health Law and Ethics<br><br>2977NRS Research for Health Professionals<br><br>3977NRS Leadership and Management for Health Professionals<br><br>1202NRS Health Law and Ethics<br><br>1203NRS Research for Health Professionals<br><br>2201NRS Clinical Health Assessment<br><br>3928NRS Clinical Teaching for Health Professionals<br><br>2202NRS Psychosocial Health Across the Lifespan | Health Assessment<br><br>1973NRS Founds of Psychosocial Care<br><br>1979NRS Understanding Research in Practice<br><br>2972NRS Health Law and Ethics<br><br>1973NRS Founds of Psychosocial Care<br><br>3121PBH: Indigenous Health<br><br>2978NRS: Child and Family Nursing<br><br>1976NRS: Nursing Practices<br><br>2977NRS Research for Health Professionals<br><br>1204NRS Infection Control: Nursing and Practice<br><br>1100NRS Contemporary Nursing<br><br>3977NRS Leadership and Management for Health Professionals |

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| =1164&Type=structure><br><br>Griffith University 2011, *Bachelor of Nursing - Post-Registration - Nathan*, viewed 22 July 2011, <http://www17.griffith.edu.au/cis/p_cat/require.asp?ProgCode=1163&Type=structure><br><br>Griffith University 2011, *Griffith Health Group Honours Program - Gold Coast, Logan and Nathan*, viewed 22 July 2011, <http://www17.griffith.edu.au/cis/p_cat/require.asp?ProgCode=2080&Type=structure> | | | | 1202NRS Health Law and Ethics<br><br>1203NRS Research for Health Professionals<br><br>2201NRS Clinical Health Assessment<br><br>2202NRS Psychosocial Health Across the Lifespan<br><br>5902LAL English Language and Communication for Health<br><br>1979NRS Understanding Research in Practice |
| **James Cook University**<br><br>James Cook University 2011, *Bachelor of Nursing Science (Graduate Entry)*, viewed 22 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=100508-BNS-GNS-2008&mainContent=subjects><br><br>James Cook University 2011, *Bachelor of Nursing Science* | | NS3350 Health and Illness in the Older Adult<br><br>NS3360 Introduction to Psychiatric Mental Health Nursing<br><br>HS1005 Lifespan Development for Health<br><br>NS1220 Primary Health Care<br><br>HS2000 Social Constructions of | NS1220 Primary Health Care | HS2000 Social Constructions of Health in Australia<br><br>HS2101 Indigenous Health Studies for Nursing and Midwifery<br><br>NS3320 Community Approaches to Care<br><br>NS3322 Nursing in the Tropics |

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| *(Post Registration)*, viewed 22 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=78210U-&mainContent=subjects><br><br>James Cook University 2011, *Bachelor of Nursing Science (Pre-Registration) Flexible Delivery*, viewed 22 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=78110E-BNS-GNS-2008&mainContent=subjects><br><br>James Cook University 2011, *Bachelor of Nursing Science (Pre-Registration)*, viewed 22 July 2011, <http://www-public.jcu.edu.au/courses/course_info/index.htm?userText=78110-BNS-GNS-2008&mainContent=subjects> | | | Health in Australia<br><br>HS2101 Indigenous Health Studies for Nursing and Midwifery | | | NS3350 Health and Illness in the Older Adult<br><br>NS3360 Introduction to Psychiatric Mental Health Nursing<br><br>NS1220 Primary Health Care<br><br>HS2000 Social Constructions of Health in Australia<br><br>NS1211 Clinical Nursing Practice 1<br><br>NS2022 Clinical Nursing Practice 3<br><br>NS2214 Clinical Nursing Practice 4<br><br>NS3360 - Clinical Nursing Practice 5<br><br>NS3224 Clinical Nursing Practice 6<br><br>PP2131 Human Pathophysiology and Pharmacology 1<br><br>PP2231 Human Pathophysiology and Pharmacology 2 |
| **Queensland** | NSB503 Promoting Health in the Community | Clinical Education in Health | NSB113 Diversity and Health: Introduction to Indigenous and | NSB225 Health, Human Development and Ageing | HLN720 Clinical Education in Health | LSB182 Bioscience 1<br><br>NSB113 Diversity |

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| **University of Technology**<br><br>Queensland University of Technology 2011, *Bachelor of Nursing Science (Pre-Registration) Flexible Delivery*, viewed 22 July 2011, <http://www.courses.qut.edu.au/cgi-bin/WebObjects/Courses.woa/wa/selectMajorFromMain?pres=sf&courseID=12616&structureID=36199#36199><br><br>Queensland University of Technology 2011, *Bachelor of Nursing (NS40)*, viewed 22 July 2011, <http://www.courses.qut.edu.au/cgi-bin/WebObjects/Courses.woa/wa/selectMajorFromMain?pres=sf&courseID=12537&structureID=35942#35942><br><br>Queensland University of Technology 2011, *Bachelor of Nursing (NS40)*, viewed 22 July 2011, <http://www.courses.qut.edu.au/cgi-bin/WebObjects/Courses.woa/wa/selectMajorFromMain?pres=sf&courseID=12537&structureID=35946#35946><br><br>Queensland University of Technology 2011, *Bachelor of Nursing (NS40)*, viewed 22 July 2011, <http://www.courses.qut.edu.au/cgi-bin/WebObjects/Courses.woa/wa/selectMajorFromMain?pres | **NSN821 Promoting Healthy Ageing** | **Multicultural Perspectives**<br><br>**NSB117 Nursing and the Health Care System**<br><br>**NSB225 Health, Human Development and Ageing**<br><br>**LSB384 Pharmacology For Health Professionals**<br><br>**NSB324 Health Alterations and Nursing 1**<br><br>**LWS101 Ethics Law and Health Care**<br><br>**NSB223 Mental Health Nursing**<br><br>**NSB423 Health Alterations and Nursing 2**<br><br>**NSB500 Health Alterations and High Dependency Nursing**<br><br>**PUN105 Health Statistics** | **NSB503 Promoting Health in the Community** | **and Health: Introduction to Indigenous and Multicultural Perspectives**<br><br>**NSB117 Nursing and the Health Care System**<br><br>**NSB225 Health, Human Development and Ageing**<br><br>**LSB282 Bioscience 2**<br><br>**NSB118 Foundations of Nursing Practice**<br><br>**LSB384 Pharmacology For Health Professionals**<br><br>**NSB212 Clinical Practice 2**<br><br>**NSB324 Health Alterations and Nursing 1**<br><br>**NSB222 Clinical Practice 3**<br><br>**NSB223 Mental Health Nursing**<br><br>**NSB423 Health Alterations and Nursing 2**<br><br>**NSB322 Clinical Practice 4** |

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| =sf&courseID=12537&structureID=35948#35948><br><br>Queensland University of Technology 2011, *Bachelor of Nursing (Honours) (HL50)*, viewed 22 July 2011, <http://www.courses.qut.edu.au/cgi-bin/WebObjects/Courses.woa/wa/selectMajorFromMain?pres=sf&courseID=12577&structureID=36069#36069> | | | | NSB500 Health Alterations and High Dependency Nursing<br><br>NSB503 Promoting Health in the Community<br><br>NSB600 Introduction to Nursing Children and Childbearing Families<br><br>NSB604 Nursing Practice and the Older Person<br><br>NSB606 Palliative Care Nursing<br><br>HLN405 Qualitative Research<br><br>HLN706 Advanced Quantitative Research Methods<br><br>HLN710 Fundamentals of Epidemiology and Research Design<br><br>PUN105 Health Statistics |
| **The University of Queensland**<br><br>The University of Queensland | NURS1005 Cardiovascular Health<br><br>NURS1006 Respiratory Health | NURS1008 Clinical Practice 2<br><br>NURS2001 Nutritional & Metabolic Health | NURS2001 Nutritional & Metabolic Health<br><br>NURS2002 Immunological Health | NURS1001 Embryology, Neonate & Child<br><br>NURS2001 Nutritional & Metabolic Health |

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| 2011, *Bachelor of Nursing (BN) - Course List*, viewed 22 July 2011, <http://www.uq.edu.au/study/program_list.html?acad_prog=2241> | | NURS1007 Musculo-skeletal Health<br><br>NURS2001 Nutritional & Metabolic Health<br><br>NURS2002 Immunological Health<br><br>NURS2005 Mental Health<br><br>NURS2003 Neuro-endocrine Health<br><br>NURS2007 Healthy Ageing<br><br>NURS3003 Indigenous Health<br><br>NURS3004 Mental Health<br><br>NURS3009 Community Health<br>NURS3010 Rural Health | NURS2002 Immunological Health<br><br>NURS2005 Mental Health | NURS2005 Mental Health | NURS2004 Clinical Practice 3<br><br>NURS2005 Mental Health<br><br>NURS2003 Neuro-endocrine Health<br><br>NURS2006 Injury Prevention<br><br>NURS2007 Healthy Ageing<br><br>NURS2008 Clinical Practice 4<br><br>NURS3001 Clinical Practice 5<br><br>NURS3003 Indigenous Health<br><br>NURS3004 Mental Health<br><br>NURS3005 Acute Medical & Surgical Care<br><br>NURS3006 Aged Care<br><br>NURS3009 Community Health<br><br>NURS3010 Rural Health<br><br>NURS3011 Paediatric Care<br><br>NURS3012 Speciality Clinical |

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| | | | | | Elective - Palliative Care Nursing<br><br>NURS3002 Clinical Practice 6 |
| | | NUR1120 Social Determinants of Health<br><br>NUR2200 Mental Health Nursing Care<br><br>NUR3599 Clinical C: Nursing Care for Mental Health<br><br>NUR3030 Indigenous Health and Cross Cultural Care<br><br>NUR3599 Clinical C: Nursing Care for Mental Health<br><br>NUR3120 Nurses as Leaders in Health Care Settings<br><br>NUR3599 Clinical C: Nursing Care for Mental Health | CMS1008 Building Professional Nursing Attributes A (information literacy) | NUR1120 Social Determinants of Health | NUR3010 Rehabilitation in Community Settings | NSC1500 Biophysical Sciences in Nursing<br><br>MAT1008 Building Professional Nursing Attributes B<br><br>NUR1120 Social Determinants of Health<br><br>NUR1140 Responsible Nursing Practice<br><br>BIO1203 Human Anatomy and Physiology<br><br>NSC2500 Pharmacology and Pathophysiology for Nurses<br><br>NUR2100 Episodes of Nursing Practice<br><br>NUR2200 Mental Health Nursing Care<br><br>NUR3599 Clinical C: Nursing Care for Mental Health<br><br>NUR3010 |

## University of Southern Queensland

University of Southern Queensland 2011, *Bachelor of Nursing (BNUR) - BN*, viewed 22 July 2011, <http://www.usq.edu.au/handbook/2011/pdfs/BNUR.pdf>

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|---|---|---|---|---|---|
| University of the Sunshine | | | | | Rehabilitation in Community Settings<br><br>NUR3200 Managing Complex Care<br><br>NUR3030 Indigenous Health and Cross Cultural Care<br><br>NUR3099 Clinical D: Nursing for Communities<br><br>NUR3020 Transition to Professional Practice<br><br>NUR3120 Nurses as Leaders in Health Care Settings<br><br>NUR2499 Clinical B: Nursing Care in Context<br><br>NUR3599 Clinical C: Nursing Care for Mental Health<br><br>NUR3099 Clinical D: Nursing for Communities |
| | | NUR121 Health, Culture and Society<br><br>NUR142 Holistic Health | NUR212 Caring for Child, Youth and Family<br><br>HLT301 Challenges to Mental Health | HLT301 Challenges to Mental Health<br><br>NUR332 Transcultural Health Practices | LFS103 Introductory Bioscience<br><br>NUR121 Health, Culture and |

## Coast

University of the Sunshine Coast 2011, *Bachelor of Nursing Science*, viewed 22 July 2011, <http://www.usc.edu.au/students/handbook/Undergrad/SC391/SC391.htm>

University of the Sunshine Coast 2011, *Bachelor of Nursing Science: Graduate Entry*, viewed 22 July 2011, <http://www.usc.edu.au/students/handbook/Undergrad/SC392/SC392.htm>

University of the Sunshine Coast 2011, *Bachelor of Nursing Science / Bachelor of Midwifery*, viewed 22 July 2011, <http://www.usc.edu.au/students/handbook/Undergrad/SC394/SC394.htm>

**Assessment**

**NUR131 Research Foundations for Health Practice**

**NUR241 Health Alteration**

**NUR222 Health Law and Ethics**

**NUR331 Acute Health Alteration**

**HLT301 Challenges to Mental Health**

**NUR332 Transcultural Health Practices**

**NUR241 Health Alteration**

**NUR341 Caring for the Older Client**

**NUR141 Nursing, Assessment and Technology**

**Society**

**NUR212 Caring for Child, Youth and Family**

**NUR131 Research Foundations for Health Practice**

**NUR211 Nursing Practicum 2**

**NUR241 Health Alteration**

**NUR222 Health Law and Ethics**

**NUR231 Drug Therapy**

**NUR331 Acute Health Alteration**

**HLT301 Challenges to Mental Health**

**NUR272 Palliative, Rehabilitation and Continuing Care**

**NUR311 Nursing Practicum 4**

**NUR341 Caring for the Older Client**

**NUR332 Transcultural Health Practices**

**NUR312 Life Crisis**

**NUR322 The Child Client**

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| | | | | | NUR241 Health Alteration<br><br>NUR272 Palliative, Rehabilitation and Continuing Care<br><br>LFS103 Introductory Bioscience |
| **SA**<br><br>**Flinders University**<br><br>Flinders University 2011, *Bachelor of Nursing (Pre-Registration)*, viewed 22 July 2011, <http://www.flinders.edu.au/courses/rules/undergrad/bngu.cfm><br><br>Flinders University 2011, *Bachelor of Nursing (Graduate entry)*, viewed 22 July 2011, <http://www.flinders.edu.au/courses/rules/undergrad/bngg.cfm><br><br>Flinders University 2011, *Bachelor of Nursing (Re-Entry)*, viewed 22 July 2011, <http://www.flinders.edu.au/courses/rules/undergrad/bngp.cfm> | NURS2717 Promoting Health and Wellness | NURS1103 Health Across the Lifespan<br><br>NURS1107 Evidence for Health Care Practice 1<br><br>NURS1108 Introduction to Sociology and the Health Care System<br><br>NURS2103 Health Psychology and Health Sociology<br><br>NURS2107 Evidence for Health Care Practice 2<br><br>NURS2108 Mental Health and Mental Illness | NURS2717 Promoting Health and Wellness<br><br>NURS2729 Asthma and Nursing | NURS1101 Nursing 1<br><br>NURS1103 Health Across the Lifespan<br><br>NURS1104 Effective Communication for Practice<br><br>NURS1105 Nursing 2<br><br>NURS1108 Introduction to Sociology and the Health Care System<br><br>NURS2101 Nursing 3<br><br>NURS2103 Health Psychology and Health Sociology |

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|---|---|---|---|
| Flinders University 2011, *Bachelor of Nursing (Post Registration)*, viewed 22 July 2011, <http://www.flinders.edu.au/courses/rules/undergrad/bng.cfm> | | **NURS2724 Indigenous Health Issues for Nurses and Midwives**<br><br>**NURS3426 Child and Family Health Nursing**<br><br>**NURS3906 Sexual Health and Family Planning** | **NURS2104 Ethics and Law Applied to Nursing**<br><br>**NURS2105 Nursing 4**<br><br>**NURS2107 Evidence for Health Care Practice 2**<br><br>**NURS2108 Mental Health and Mental Illness**<br><br>**NURS2109 Professional Nursing Studies**<br><br>**NURS2724 Indigenous Health Issues for Nurses and Midwives**<br><br>**NURS2803 Introduction to Nursing Practice**<br><br>**NURS2804 Foundations of Nursing Knowledge**<br><br>**NURS3101 Nursing 5**<br><br>**NURS3103 Nursing in a Sociopolitical Context**<br><br>**NURS3105 Evidence for Health Care Practice 3**<br><br>**NURS2717** |

**Promoting Health and Wellness**

**NURS2720 Exploring Complementary Therapies and Holistic Nursing**

**NURS2721 Dementia Demystified**

**NURS2729 Asthma and Nursing**

**NURS2730 Nursing & Midwifery Study Abroad**

**NURS3426 Child and Family Health Nursing**

**NURS3438 Wound Management**

**NURS3811 Essential Forensics: An Introduction to Forensic Principles for Nurses**

**NURS3812 Family Violence: Implications for Health Practice**

**NURS3813 Elder Abuse**

**NURS3906 Sexual Health and Family Planning**

## The University of Adelaide

The University of Adelaide 2011, *Bachelor of Nursing* , viewed 22 July 2011, <http://www.adelaide.edu.au/degree-finder/bnurs_bnursing.html>

The University of Adelaide 2011, *Bachelor of Nursing (Honours)*, viewed 22 July 2011, <http://health.adelaide.edu.au/nursing/pub/bnurs_honours.pdf>

The University of Adelaide 2011, Bachelor of Nursing (Post-Registration), viewed 22 July 2011, <http://www.adelaide.edu.au/sg/future/programs/bn.html>

**Health & Illness 1A**

**Health Assessment 1A**

**Health & Illness 1B**

**Health Assessment 1B**

**Child & Youth Health**

**Health Assessment 2B**

**Health Assessment 3A**

**Nursing Patients with Mental Health Problems**

**Health Assessment 3B**

**They do not offer course descriptions for their courses**

## University of South Australia

University of South Australia 2011, *Bachelor of Nursing (Post-Registration) (Registered Nurse Entry)*, viewed 22 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IBNU&Plan=N%2FA%2DPRIBNU&Year=2011>

University of South Australia,

**Being a Health Professional NURS 1033**

**Determining Australia's Health NURS 1035**

**Cultural Perspectives on Health NURS 1036**

**Health of Infants, Children and Young People NURS 2022**

**Being a Health Professional NURS 1033**

**Health of Adults NURS 2023**

**Lifespan Development NURS 1034**

**Being a Health Professional NURS 1033**

**Lifespan Development NURS 1034**

**Determining Australia's Health NURS 1035**

**Cultural Perspectives on Health NURS 1036**

**Health of Infants,**

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| *Bachelor of Nursing*, viewed 22 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IBNU&Plan=N%2FA%2DIBNU&Year=2011><br><br>University of South Australia 2011, *Bachelor of Nursing (Post-Registration) (Registered Midwife Entry)*, viewed 22 July 2011, <http://www.unisanet.unisa.edu.au/programs/program.asp?Program=IBNU&Plan=N%2FAMW%2DIBNU&Year=2011> | | Health of Adults NURS 2023<br><br>Health of Older Adults NURS 2024 | | Children and Young People NURS 2022<br><br>Health of Adults NURS 2023<br><br>Health of Older Adults NURS 2024<br><br>Systems and Organisation of Nursing Care NURS 3032<br><br>Contexts of Nursing Practice NURS 3033 |
| **TAS** | | | | |
| **University of Tasmania**<br><br>University of Tasmania 2011, *Bachelor of Nursing(H3D)*, viewed 22 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H3D&P_SCHEDULE_CODE=H3D&P_YEAR=2011&P_CONTEXT=OLD><br><br>University of Tasmania 2011, *Bachelor of Nursing (Enrolled Nurse Pathway)(H3E)*, viewed | | CNA126 Health Care Where People Live and Work<br><br>HGA138 Society, Culture and Health<br><br>CNA110 Communication and Mental Health<br><br>CNA145 Child and Adolescent Health<br><br>CNA308 Legal and Ethical Issues in Health Care<br><br>CNA316 | CNA126 Health Care Where People Live and Work<br><br>CNA145 Child and Adolescent Health<br><br>CNA316 Community and Mental Health Nursing Practice | CNA126 Health Care Where People Live and Work<br><br>CNA111 Introduction to Nursing Practice<br><br>HGA138 Society, Culture and Health<br><br>CNA110 Communication and Mental Health<br><br>CNA145 Child and Adolescent Health<br><br>CNA205 Research |

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| 22 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H3E&P_SCHEDULE_CODE=H3E&P_YEAR=2011&P_CONTEXT=OLD><br><br>University of Tasmania 2011, *Bachelor of Nursing (Fast Track Hobart)(H3H)*, viewed 22 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H3H&P_SCHEDULE_CODE=H3H1&P_YEAR=2011&P_CONTEXT=OLD><br><br>University of Tasmania 2011, *Bachelor of Nursing (Fast Track Rozelle)(H3R)*, viewed 22 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H3R&P_SCHEDULE_CODE=H3R1&P_YEAR=2011&P_CONTEXT=OLD1><br><br>University of Tasmania 2011, *Bachelor of Nursing (Fast Track St Vincents)(H3V)*, viewed 22 July 2011, <http://courses.utas.edu.au/portal/page?_pageid=53,32959&_dad=portal&_schema=PORTAL&P_COURSE_CODE=H3V&P_SCHEDULE_CODE=H3V1&P_YEAR=2011&P_CONTEXT=OLD> | | Community and Mental Health Nursing Practice | And Evidence-Based Practice in Nursing<br><br>CNA226 Contemporary Nursing Practice<br><br>CNA246 Perspectives on Ageing<br><br>CXA204 Bioscience 1<br><br>CNA308 Legal and Ethical Issues in Health Care<br><br>CNA309 Professional Issues in Nursing Practice<br><br>CNA316 Community and Mental Health Nursing Practice |
| **VIC** | | | |

## Deakin University

Deakin University 2011, *Bachelor of Nursing*, viewed 22 July 2011, <http://www.deakin.edu.au/future-students/courses/course.php?course=H326&stutype=local&keywords=nursing>

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| | HNN301 Mental Health Promotion | HBS107 Understanding Health<br><br>HNN114 Health Assessment<br><br>HBS108 Health Information and Data<br><br>HNN222 Mental Health Nursing<br><br>HBS345 Interprofessional Collaboration in Health Care | HNN112 - Principles of Nursing Care<br><br>HBS107 - Understanding Health<br><br>HNN114 - Health Assessment<br><br>HNN217 - Nursing in Community Settings<br><br>HNN301 Mental Health Promotion<br><br>HNN325 - Comprehensive Nursing Management and Interventions | HBS107 - Understanding Health | HNN112 - Principles of Nursing Care<br><br>HNN120 - The Discipline of Nursing: Contemporary Issues and Trends 1<br><br>HBS109 - Human Structure and Function<br><br>HBS107 - Understanding Health<br><br>HNN114 - Health Assessment<br><br>HBS108 - Health Information and Data<br><br>HNN222 - Mental Health Nursing<br><br>HNN217 - Nursing in Community Settings<br><br>HNN215 - Quality Use of Medicines in Nursing<br><br>HNN319 - Nursing Management of Chronic Illness<br><br>HNN300 - Child and Adolescent Nursing |

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| | | | | HNN301 Mental Health Promotion<br><br>HNN325 - Comprehensive Nursing Management and Interventions<br><br>HBS345 - Interprofessional Collaboration in Health Care<br><br>HNN216 - International Nursing Study Tour |
| **La Trobe University**<br><br>La Trobe University 2011, *Bachelor of Nursing/Bachelor of Midwifery*, viewed 22 July 2011, <http://www.latrobe.edu.au/handbook/2011/undergraduate/health-sciences/double-degrees/hznm.htm?appendurl=current/undergraduate/health-sciences/double-degrees/hznm.htm><br><br>La Trobe University 2011, *Bachelor of Nursing (Division 2 Conversion)*, viewed 22 July 2011, <http://www.latrobe.edu.au/handbook/2011/undergraduate/health-sciences/single- | HLT1PHW Perspectives on Health and Wellbeing<br><br>PHE1IDH Individual Determinants of Health<br><br>PHE1SDH Social Determinants of Health<br><br>NSG2MHN Mental Health Nursing | NSG2COM Community Nursing | NSG2COM Community Nursing | HLT1IPA Interprofessional Practice A<br><br>HLT1PHW Perspectives on Health and Wellbeing<br><br>PHE1IDH Individual Determinants of Health<br><br>TE-SEM-2 HLT1IPB Interprofessional Practice B<br><br>PHE1SDH Social Determinants of Health<br><br>NSG1ENC Essential Nursing Care |

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| degrees/hsbncw.htm?appendurl=current/undergraduate/health-sciences/single-degrees/hsbncw.htm><br><br>La Trobe University 2011, *Bachelor of Nursing (Graduate Entry)*, viewed 22 July 2011, <http://www.latrobe.edu.au/handbook/2011/undergraduate/health-sciences/single-degrees/hbnprg.htm?appendurl=current/undergraduate/health-sciences/single-degrees/hbnprg.htm><br><br>La Trobe University 2011, *Bachelor of Nursing (Post-Registration)*, viewed 22 July 2011, <http://www.latrobe.edu.au/handbook/2011/undergraduate/health-sciences/single-degrees/post-registration.htm?appendurl=current/undergraduate/health-sciences/single-degrees/post-registration.htm><br><br>La Trobe University 2011, *Bachelor of Nursing (pre-registration)*, viewed 22 July 2011, <http://www.latrobe.edu.au/handbook/2011/undergraduate/health-sciences/single-degrees/pre-registration.htm?appendurl=current/undergraduate/health-sciences/single-degrees/pre-registration.htm> | | | | NSG2ACA Acute Care A<br><br>NSG2CAD Clinical Assessment & Decisions<br><br>NSG2ACB Acute Care B<br><br>NSG2MHN Mental Health Nursing<br><br>NSG2COM Community Nursing<br><br>NSG3CCN Complex Care Nursing<br><br>NSG3NOP Nursing Older Person<br><br>NSG3PTN Professional Transitions in Nursing<br><br>NSG3CPC Clinical Practice Consolidation<br><br>NSG3MCC Managing Chronic Conditions<br><br>NSG3CIN Challenging Interactions in Nursing |
| **Monash** | | NUR1101 Perspectives of health and wellness | NUR3003 - Education for Clinical Practice | NUR1003 Nursing, society and culture |

## University

Monash University 2011, *Monash University Handbook 2011 Undergraduate - Course 0727 - Bachelor of Nursing*, viewed 22 July 2011, <http://www.monash.edu.au/pubs/handbooks/courses/0727.html>

Monash University 2011, *Monash University Handbook 2010 Undergraduate - Course 3963 - Bachelor of Nursing Practice*, viewed 22 July 2011, <http://www.monash.edu.au/pubs/2010handbooks/courses/3963.html>

Monash University 2011, *Courses at Berwick, Bachelor of Nursing (Community Health)*, viewed 22 July 2011, <http://berwick.monash.edu.au/Courses/ugrad/community-nursing.html>

**NUR1102 Health assessment in clinical practice**

**NUR2001 Evidenced based health care**

**NUR2003 Contexts of health care**

**NUR2104 Mental health practice 1**

**NUR3104 Mental health practice 2**

**NUR3005 Chronicity in health care**

**NUR1101 Perspectives of health and wellness**

**BMA1912 Human bioscience in nursing**

**NUR1022 - Cultural Responsiveness for Health Care Professionals**

**NUR1102 - Health assessment in clinical practice**

**NUR1202 - Legal issues and concepts**

**NUR2001 - Evidence based health care**

**NUR2003 - Contexts of health care**

**NUR2004 - Nursing practice in context 2**

**NUR2104 - Mental Health practice 1**

**NUR3002 - Nursing Practice in Context 3**

**NUR3003 - Education for Clinical Practice**

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| | | | | NUR3104 - Mental Health practice 2<br><br>NUR3004 - Preparing for practice<br><br>NUR3005 Chronicity in health care |
| **RMIT University**<br><br>RMIT University 2011, *BP032 - Bachelor of Nursing*, viewed 22 July 2011, <http://www.rmit.edu.au/browse;ID=EPSBP032P04D2AUSBU;STATUS=A?QRY=%2Btype%3Dflexible%20%2Bsubtype%3Deps%20%2Bnotes%3D(%20\|%22BP032%22)&STYPE=ENTIRE><br>http://www.rmit.edu.au/browse;ID=EPSBP032P04AUSBU;STATUS=A?QRY=%2Btype%3Dflexible%2Bsubtype%3Deps%2Bnotes%3D(%7C%22BP032%22)&STYPE=ENTIRE | | Mental Health 1: Therapeutic Communication<br><br>Mental Health 2: Psychopathology of Mental Illness for Nurses<br><br>Mental Health 3: Complex Mental Health Presentations<br><br>Public Health for Nurses<br><br>Health Assessment for Health Care Professionals<br><br>Cultural Diversity in Health | Acute Care Nursing 1<br><br>Acute Care Nursing 2<br><br>Clinical Practicum 3<br><br>Public Health for Nurses | Foundations in Nursing Practice 1<br><br>Child and Adolescent Development for Nurses<br><br>Mental Health 1: Therapeutic Communication<br><br>Foundations in Nursing Practice 2<br><br>Clinical Practicum 1<br><br>Acute Care Nursing 1<br><br>Mental Health 2: Psychopathology of Mental Illness for Nurses<br><br>Therapeutics for Nursing Practice<br><br>Clinical Practicum 2<br><br>Acute Care Nursing 2 |

**Ethics and Law for Nurses**

**Clinical Practicum 3**

**Complex Mental Health Presentations**

**Public Health for Nurses**

**Clinical Practicum 5**

**Transition to Nursing Practice**

**Health Assessment for Health Care Professionals**

**Cultural Diversity in Health**

## University of Ballarat

University of Ballarat 2011, *Nursing*, viewed 22 July 2011, <http://www.ballarat.edu.au/schools/school-of-health/nursing>

**They offer undergraduate courses but they do not provide access to the degree structure**

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| **The University of Melbourne** | **They do not offer undergraduate nursing degrees** | | |
| **Victoria University**<br><br>Victoria University 2011, *Bachelor of Nursing*, viewed 22 July 2011, <http://www.vu.edu.au/courses/bachelor-of-nursing-hbbn> | **Health and Diversity in a Global Context [ASE1101]**<br><br>**Health Priorities and Nursing 1 [HNB1202]**<br><br>**Health Priorities and Nursing 2 [HNB2102]**<br><br>**Health Priorities and Nursing 3 [HNB2202]**<br><br>**Health Priorities and Nursing 4 [HNB2204]**<br><br>**Health Priorities and Nursing 5 [HNB3117]**<br><br>**Health Priorities and Nursing 2 [HNB2102]**<br><br>**Health Priorities and Nursing 3 [HNB2202]**<br><br>**Health Priorities and Nursing 4 [HNB2204]**<br><br>**Health Priorities and Nursing 5 [HNB3117]** | **Frameworks for Nursing Practice [HNB1101]**<br><br>**Health Priorities and Nursing 3 [HNB2202]** | **Health and Diversity in a Global Context [ASE1101]**<br><br>**Psychology Across the Lifespan [APT1311]**<br><br>**Frameworks for Nursing Practice [HNB1101]**<br><br>**Working With Families [HNB1201]**<br><br>**Health Priorities and Nursing 1 [HNB1202]**<br><br>**Clinical Practicum 1 [HNB1203]**<br><br>**Working With Evidence in Practice [HNB2101]**<br><br>**Health Priorities and Nursing 2 [HNB2102]**<br><br>**Pathophysiology and Quality Use of Medicines 2 [RBM2205]**<br><br>**Health Priorities and Nursing 3** |

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| | | | | [HNB2202]<br><br>Clinical Practicum 3 [HNB2203]<br><br>Health Priorities and Nursing 4 [HNB2204]<br><br>Health Priorities and Nursing 5 [HNB3117]<br><br>Nursing and Complex Care [HNB3118]<br><br>Clinical Practicum 4 [HNB3119]<br><br>Issues in Professional Practice [HNB3120]<br><br>Nursing Specific Populations [HNB3205] |
| **WA**<br><br>**Curtin University of Technology**<br><br>Curtin University of Technology | | | | |
| | | 313394 Foundations for Professional Health Practice 100<br><br>313398 Imagining Health in Social and Cultural Contexts 100 | 313029 Nursing Practice 162 | 313026 Nursing Practice 161<br><br>313394 Foundations for Professional Health Practice 100<br><br>313398 Imagining |

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| 2011, *Undergraduate Nursing, Bachelor of Science (Nursing) General - BSc(Curtin) - 174910 Health Sciences*, viewed 22 July 2011, <http://courses.curtin.edu.au/course_overview/undergraduate/nursing> | | 312649 Indigenous Culture and Health 130<br><br>313390 Evidence Informed Health Practice 100<br><br>313395 Health and Health Behaviour 100<br><br>313031 Behavioural Health Science for Nursing 263<br><br>313035 Behavioural Health Science for Nursing 264<br><br>313039 Behavioural Health Science for Nursing and Midwifery 365<br><br>313043 Behavioural Health Science for Nursing and Midwifery 366<br><br>313291 Mental Health Wellbeing 467<br><br>313292 Health and Wellbeing in Older People 467<br><br>313293 Global Community Health Nursing 467 | Health in Social and Cultural Contexts 100<br><br>312649 Indigenous Culture and Health 130<br><br>313029 Nursing Practice 162<br><br>313390 Evidence Informed Health Practice 100<br><br>313395 Health and Health Behaviour 100<br><br>313030 Applied Bioscience 263<br><br>313031 Behavioural Health Science for Nursing 263<br><br>313032 Inquiry for Nursing Practice 263<br><br>313034 Applied Bioscience 264<br><br>313036 Inquiry for Nursing Practice 264<br><br>313041 Nursing Practice 365<br><br>313043 Behavioural Health Science for Nursing and Midwifery 366 |

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| | | | | | 313044 Inquiry for Nursing Practice 366<br><br>313045 Nursing Practice 366<br><br>313046 Nursing and Midwifery Capstone 467<br><br>313047 Nursing Practice 467<br><br>2919 Palliative Care 467<br><br>313292 Health and Wellbeing in Older People 467<br><br>313293 Global Community Health Nursing 467 |
| **Edith Cowan University**<br><br>Edith Cowan University 2011, *Bachelor of Science (Nursing)*, viewed 22 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMjc4NCUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY | NNT1107 Social, Indigenous and Cultural Perspectives in Health Care<br><br>NSP1104 Communication in Health Care<br><br>NNI1102 Health and Health Challenges for Older Adults<br><br>NSP1205 Physical Assessment for the Health Sciences | NNT3204 Primary Health Care | NNT3204 Primary Health Care | NNT1107 Social, Indigenous and Cultural Perspectives in Health Care<br><br>NNI1102 Health and Health Challenges for Older Adults<br><br>SCN1106 Biological Science in Nursing 2<br><br>NNT1205 Fundamentals of Nursing Practice<br><br>NNI2204 Ethics |

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| 2F0aW9uJTNEdG9wbGV2ZWwmYWxsPTE%3D ><br><br>Edith Cowan University 2011, *Bachelor of Science (Nursing)*, viewed 22 July 2011, <http://www.ecu.edu.au/future-students/our-courses/search2?sq_content_src=%2BdXJsPWh0dHAlM0ElMkYlMkZ3ZWJzZXJ2aWNlcy53ZWIuZWN1LmVkdS5hdSUyRmZ1dHVyZS1zdHVkZW50cyUyRmNvdXJzZS12aWV3LnBocCUzRmlkJTNEMDAwMDAwMjc4NiUyNmFjdGlvbiUzRHN0cnVjdHVyZSUyNmxvY2F0aW9uJTNEdG9wbGV2ZWwmYWxsPTE%3D> | **NST2106 Mental Health Problems and Disorders**<br><br>**NNI2204 Ethics and Law in Health**<br><br>**NST3209 Evidence Based Practice in Health Care**<br><br>**NST3206 Contemporary Issues in Health Care**<br><br>**NNT3204 Primary Health Care** | | **and Law in Health**<br><br>**NSP2209 Developing Nursing Competencies**<br><br>**NNT2204 Introduction to Paediatrics**<br><br>**NST3209 Evidence Based Practice in Health Care**<br><br>**NSP3200 Advanced Nursing Competencies**<br><br>**NNI3204 Professional Issues in Nursing**<br><br>**NST3206 Contemporary Issues in Health Care**<br><br>**NNT3204 Primary Health Care** |
| **Murdoch University**<br><br>Murdoch University 2011, *Nursing (BNurs) Course Structure - 84 credit points*, viewed 22 July 2011, <http://www.murdoch.edu.au/Courses/Nursing/Course-structure/> | **NUR208 - Holistic Developmental Health Assessment**<br><br>**NUR127 - Introduction to Mental Health**<br><br>**NUR128 - Introduction to Mental Health -- Clinical Placement** | **NUR127 - Introduction to Mental Health** | **NUR100 - Introduction to the Nursing Profession**<br><br>**NUR127 - Introduction to Mental Health**<br><br>**NUR128 - Introduction to Mental Health -- Clinical Placement** |

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| | | **NUR105 - Health and Physical Assessment**<br><br>**NUR115 - Health and Physical Assessment - Clinical Placement**<br><br>**NUR206 - Mental Health Nursing**<br><br>**NUR234 - Indigenous Culture and Health Care**<br><br>**NUR226 - Mental Health Nursing -- Clinical Placement**<br><br>**NUR301 - Family and Community Health**<br><br>**NUR331 - Family and Community Health - Clinical Placement**<br><br>**NUR302 - Maternal and Newborn Health**<br><br>**NUR309 - Contemporary Nursing Management in Health Care**<br><br>**NUR303 - Children and Adolescent Health**<br><br>**NUR3321 - Maternal and Newborn Health -- Clinical Placement** | **NUR103 - Holistic Nursing**<br><br>**NUR206 - Mental Health Nursing**<br><br>**NUR234 - Indigenous Culture and Health Care**<br><br>**NUR226 - Mental Health Nursing**<br><br>**NUR301 - Family and Community Health**<br><br>**NUR331 - Family and Community Health**<br><br>**NUR309 - Contemporary Nursing Management in Health Care** |

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| | | **NUR3331 - Children and Adolescent Health - Clinical Placement**<br><br>**NUR332 - Maternal and Newborn Health -- Clinical Placement**<br><br>**NUR333 - Children and Adolescent Health - Clinical Placement** | |
| **The University of Notre Dame**<br><br>**The University of Notre Dame 2011, *Courses*, viewed 22 July 2011, <http://www.nd.edu.au/courses/index.shtml>**<br><br>**The University of Notre Dame 2011, *Bachelor of Nursing – Broome Campus, UNDA Course Code 3218B, CRICOS Code 032049G*, viewed 22 July 2011, <http://www.nd.edu.au/downloads/broome/courses/2011/Bachelor_of_Nursing_April_11.pd>**<br><br>**The University of Notre Dame 2011, *Bachelor of Nursing – Broome Campus, UNDA Course Code 3218B, CRICOS Code 032049G*, viewed 22 July 2011, <http://www.nd.edu.au/downl** | | **Maternal, Family and Child Health**<br><br>**Contemporary Nursing Care in Mental Health**<br><br>**Aboriginal Health**<br><br>**Management and Leadership within the Australian Health Care System**<br><br>**The Sociology of Health and Illness**<br><br>**Health Across the Lifespan**<br><br>**The Sociology of Health and Illness**<br><br>**Primary Health and Community Care** | **They do not offer course descriptions for their courses** |

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| oads/Bachelor_of_Nursing_(EN%20Conversion)_April_11.pdf><br><br>The University of Notre Dame 2011, *Bachelor of Nursing, UNDA Course Code 3217, CRICOS Code 032049G*, viewed 22 July 2011, <http://www.nd.edu.au/downloads/course_flyers/BNurs_2011_151110.pdf><br><br>The University of Notre Dame 2011, *Bachelor of Nursing, Enrolled Nursing Conversion, UNDA Course Code 3352, CRICOS Code TBA*, viewed 22 July 2011, <http://www.nd.edu.au/downloads/course_flyers/BNurs_EN_Conversion_010310.pdf><br><br>The University of Notre Dame 2011, *Major: Mental Health, Bachelor of Nursing, UNDA Course Code 3217, CRICOS Code 032049G*, viewed 22 July 2011, <http://www.nd.edu.au/downloads/course_flyers/BNurs_MHealth_220210_REVISED.pdf><br><br>The University of Notre Dame 2011, *Major: Palliative Care, Bachelor of Nursing, UNDA Course Code 3217, CRICOS Code 032049G*, viewed 22 July 2011, <http://www.nd.edu.au/downloads/course_flyers/BNurs_Palliative_Care_220210_REVISED.pdf><br><br>The University of Notre Dame 2011, *Bachelor of Nursing UNDA Course Code 3276S – CRICOS Code 056166D*, viewed 22 July 2011, <http://www.nd.edu.au/downloads/course_flyers/syd/B_Nursi | | **Introduction to Public Health**<br><br>**Mental Health Nursing 1**<br><br>**Mental Health Nursing 2**<br><br>**Aboriginal and Torres Strait Islander Health and Culture**<br><br>**Advanced Mental Health Nursing**<br><br>**Nursing, Trends in Healthy Age Clinical** |

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| ng.pdf ><br><br>The University of Notre Dame 2011, *Bachelor of Nursing – Mental Health, UNDA Course Code 3267S – CRICOS Code 056166D*, viewed 22 July 2011, < http://www.nd.edu.au/downloads/course_flyers/syd/BN_Mental_Health_Major.pdf><br><br>The University of Notre Dame 2011, *Bachelor of Nursing (Enrolled Nurse Articulation) UNDA Course Code 3352– CRICOS Code 056166D*, viewed 22 July 2011, <http://www.nd.edu.au/downloads/course_flyers/syd/BN_EN_Articulation.pdf> | |

# Appendix G Articles for Focussed Review of Literature

- Articles collected for the focussed review of literature about health literacy

## Articles collected for the focused review of literature about health literacy

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **1** | Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs 1999, 'Health Literacy: Report of the Council of Scientific Affairs', *Journal of the American Medical Association*, vol. 281, no. 6, pp. 552-557. | *The Journal of American Medical Association* | Consensus Process | The 12 members of the Ad Hoc Committee on Health Literacy, American Medical Association Council on Scientific Affairs, were selected by a key informant process as experts in the field of health literacy from a variety of backgrounds in clinical medicine, medical and health services research, medical education, psychology, adult literacy, nursing, and health education | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public | Patients with inadequate health literacy have a complex array of communications difficulties, which may interact to influence health outcome. These patients report worse health status and have less understanding about their medical conditions and treatment. Preliminary studies indicate inadequate health literacy may increase the risk of hospitalization. Professional and public awareness of the health literacy issue must be increased, beginning with education of medical students and physicians and improved patient-physician communication skills. Future research should focus on optimal methods of screening patients to identify those with poor health literacy, and the causal pathway of how poor health literacy influences health. |
| **2** | Cotugna N & Vickery CE 2003, 'Health literacy education and training: A student-professional collaboration', *Journal of the American Dietetic Association*, vol. 103, no. 7, pp. 878-880. | *Journal of the American Dietetic Association* | Non-experimental descriptive study (Program development) | 24 Junior and senior dietetics students in a 3-cridit nutrition education course that allowed them to learn about the problem of health literacy in nutrition education and gave them an actual public presentation opportunity to share this information with interested nutrition professionals. | Health Literacy | English | Nutrition professionals | Authors of this study developed what they think is a creative way to help students learn about health literacy in nutrition education. This workshop development idea can be applied to many other content areas and provide students with a more real-life experience in nutrition education than the typical method of presenting lessons to each other in class. The costs are minimal, the returns are many, and no problems were evident. They plan to do a similar project in collaboration with the University of Delaware School of Education where the dietetics students will be partnered with student teachers to develop and present nutrition education programs for elementary students.<br>Although all nutrition professionals learn about literacy issues during their formal education, it is apparent that a review of the topic could be beneficial to help focus on the Healthy People 2010 objective of improving health literacy in persons with inadequate or marginal literacy skills. As is often noted, people remember only 10% of what they read, 20% of what they hear, but about 90% of what they do. Active teaching strategies make for a more concrete and complete learning experience on the increasingly important topic of literacy as it relates to health care. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **3** | Wang R 2000, 'Critical health literacy: a case study from China in schistosomiasis control', *Health Promotion International*, vol. 15, no. 3, pp. 269-274. | *Health Promotion International* | Case study | Improving the control of schistosomiasis | Health Literacy | English | Health educators | In response to the changing social environment in China, there is a need to increase critical health literacy in order to successfully address problems, e.g. schistosomiasis. To undertake this new approach requires formative research and the re-training of health educators. Health education programs aimed at increasing critical health literacy involve more than simply the transmission of health information which has been the focus of health education in China in the past. It should also provide information on social, economic and environmental determinants of health as well as assessment of opportunities to promote policy and organizational change. It is within our capabilities to raise the health literacy of communities in need such as those affected by schistosomiasis in China. A commitment to working with communities to prevent and control disease that incorporates empowerment and the improvement of health literacy promises to improve the lives of those in China that suffer needlessly from disease. |
| **4** | Paasche-Orlow MK, Riekert KA, Bilderback A, Chanmugam A 2005b, 'Tailored education may reduce health literacy disparities in asthma self-management', *American Journal of Respiratory and Critical Care Medicine*, vol. 172, iss. 8, pp. 980-986. | *American Journal of Respiratory and Critical Care Medicine* | Prospective cohort study | Adults (age, ≥ 18yr) admitted with a physician diagnosis of asthma exacerbation to two inner-city academic medical centres | Health Literacy | English | Physicians | The findings of this study suggest that inadequate health literacy is a surmountable barrier to learning and remembering key asthma self-management skills. |
| **5** | Santo A, Laizner AM, Shohet L 2005, 'Exploring the value of audiotapes for health literacy: A systematic review', *Patient Education and Counseling*, vol. 58, iss. 3, pp. 235-243. | *Patient Education and Counseling* | Systematic review | Articles that evaluated potential of audiotapes as an educational tool within divers populations | Health Literacy | English | Healthcare professionals | If even the average person is compromised in the context of information exchange, populations with communication barriers are at even greater risk. Research needs to be conducted, aimed at determining whether audiotapes enhance communication between the "hard-to-reach" population and health professionals. |
| **6** | Mancuso CA & Rincon M 2006, 'Impact of health literacy on longitudinal asthma outcomes', *Journal of General Internal Medicine*, vol. 21, no. 8, pp. 813-817. | *Journal of General Internal Medicine* | Longitudinal cohort | Adult asthma patients | Health Literacy | English | Physicians | Less health literacy was associated with poor longitudinal asthma outcomes. This relationship was both direct and indirect through effects on other independent variables, particularly patients' knowledge of asthma and self-management. Efforts to improve asthma outcomes should focus on improving literacy skills that are required to learn, understand, and implement effective self-management. |

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| **7** | Gansler T, Henley SJ, Stein K, Nehl EJ, Smigal C & Slaughter E 2005, 'Sociodemographic determinants of cancer treatment health literacy', *Cancer*, vol. 104, no. 3, pp. 653-660. | *Cancer* | Non-experimental descriptive study (Telephone survey) | U.S. adults who reported that they had never been diagnosed with cancer | Health Literacy | English | Healthcare professionals | The prevalence of at least three of the five cancer misconceptions was unacceptably high, and varied by several sociodemographic factors. These beliefs may increase the risk for cancer morbidity and mortality because of poor adherence to treatment regimens. |
| **8** | Gazmararian JA, Baker DW, Williams MV, Parker RM, Scott TL, Green DC, Fehrenbach SN, Ren J & Koplan JP 1999, 'Health literacy among Medicare enrollees in a managed Care organization', *JAMA: The Journal of the American Medical Association*, vol. 281, no. 6, pp. 545-551. | *The Journal of the American Medical Association* | Cross-sectional survey | New Medicare enrollees aged 65 years or older | Health Literacy | English | Healthcare professionals | Elderly managed care enrolees may not have the literacy skills necessary to function adequately in the health care environment. Low health literacy may impair elderly patients' understanding of health messages and limit their ability to care for their medical problems. |
| **9** | Howard DH, Sentell T & Gazmararian JA 2006, 'Impact of health literacy on socioeconomic and racial differences in health in an elderly population', *Journal of General Internal Medicine*, vol. 21, no. 8, pp. 857-861. | *Journal of General Internal Medicine* | Retrospective cohort study | Noninitialised elderly persons enrolling in a Medicare managed care plan in 1997 in Cleveland | Health Literacy | English | Healthcare professionals | The authors of this study found that health literacy explained a small to moderate fraction of the differences in health status and, to a lesser degree, receipt of vaccinations that would normally be attributed to educational attainment and/or race if literacy was not considered. |

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| **10** | Cutilli CC 2005a 'Do your patients understand? Determining your patients' health literacy skills', *Orthopaedic Nursing*, vol. 24, no. 5, pp. 372-377. | *Orthopaedic Nursing* | Case Study | Nurse<br>Client | Health Literacy | English | Nurses | In the ideal healthcare setting, M. G. would have had health literacy testing and the nurse would have been able to give him information at his literacy level. Striving for this ideal situation is a goal for all healthcare providers. To ensure that patients understand their healthcare information, it must be provided in a manner that matches their health literacy skills. In addition, nurses need to evaluate the patients' comprehension, which is easily accomplished by asking the patient to describe and/or demonstrate aspects of their healthcare.<br>The type of test that is used to assess the literacy levels of patients depends on the specificity of literacy information that is needed and time available for testing. The tests described in this article have various literacy level delineations and required testing times. Each healthcare professional must decide what type of literacy assessment is suitable for his or her patients.<br>Patients and nurses alike value effective and pertinent healthcare information. Nurses have an obligation as patient advocates to identify patient literacy issues and seek information that corresponds to the patients skills. In the future, nurses should not have to ponder the question, "Do your patients understand?" Nurses will know the answer to that question through the use of health literacy assessment, appropriate teaching methods, and the evaluation of healthcare knowledge.<br>The patient benefits of effective teaching are numerous; however, the benefits to society cannot be ignored. Patients who understand and effectively manage their health issues use healthcare resources wisely. One could conclude that providing effective healthcare education leads to restrained healthcare costs and a healthier society. |
| **11** | Scott TL, Gazmararian JA, Williams MV & Baker DW 2002, 'Health literacy and preventive health care use among Medicare enrollees in a managed care organization', *Medical Care*, vol. 40, no. 5, pp. pp. 395-404. | *Medical Care* | Cross-sectional survey<br>Home interviews | Medicare, managed-care enrollees 65-79 years old in four US cities | Health Literacy | English | Healthcare professionals | Among Medicare managed care enrolees, inadequate health literacy is independently associated with lower use of preventative health services. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **12** | Baker DW, Wolf MS, Feinglass J, Thompson JA, Gazmararian JA & Huang J 2007, 'Health literacy and mortality among elderly persons', *Archives of Internal Medicine*, vol. 167, no. 14, pp. 1503-1509. | *Archives of Internal Medicine* | Cohort study | Medicare, managed-care enrolees | Health Literacy | English | Physicians | Inadequate health literacy, as measured by reading fluency, independently predicts all-cause mortality and cardiovascular death among community-dwelling elderly persons. Reading fluency is a more powerful variable than education for examining the association between socioeconomic status and health. |
| **13** | Wolf MS, Gazmararian JA & Baker DW 2007, 'Health literacy and health risk behaviors among older adults', *American Journal of Preventive Medicine*, vol. 32, no. 1, pp. 19-24. | *American Journal of Preventative Medicine* | Cross-sectional survey | New Medicare, managed-care enrollees | Health Literacy | English | Physicians | Among community-dwelling elderly, limited health literacy was not independently associated with health risk behaviours after controlling for relevant covariates. |
| **14** | Miller MJ, Degenholts HB, Gazmararian JA, Lin CJ, Ricci EM, Sereika SM 2007, 'Identifying elderly at greatest risk of inadequate health literacy: A predictive model for population-health decision makers', *Research in Social and Administrative Pharmacy*, vol. 3, iss. 1, pp. 70-85. | *Research in Social and Administrative Pharmacy* | Non-experimental descriptive study (A multiple regression model to estimate FHL development and validation) | Literature | Inadequate Health Literacy | English | Healthcare professionals | This study was the first to quantitatively model and substantiate the high national prevalence of inadequate functional health literacy in the elderly. The proposed quantitative model can be used in subsequent research to efficiently risk-stratify individuals by functional health literacy level in large data set to assess the relationships between functional health literacy and health status, utilization, expenditures, and satisfaction. Furthermore, the model can be used to identify individual at high risk of inadequate functional health literacy, which will enable targeting of educational interventions that address functional health literacy deficiencies. |
| **15** | Wallace LS, Rogers ES, Roskos SE, Holiday DB & Weiss BD 2006, 'BRIEF REPORT: Screening items to identify patients with limited health literacy skills', *Journal of General Internal Medicine*, vol. 21, no. 8, pp. 874-877. | *Journal of General Internal Medicine* | Non-experimental descriptive study (3-mintutes oral interview) | English-speaking adults attending a university-based primary care clinic | Limited Health Literacy | English | Physicians | One screening question may be sufficient for detecting limited and marginal health literacy skills in clinic populations |

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| **16** | Chew LD, Bradley KA, Flum DR, Cornia PB & Koepsell TD 2004b, 'The impact of low health literacy on surgical practice', *The American Journal of Surgery*, vol. 188, no. 3, pp. 250-253. | *The American Journal of Surgery* | Cohort study | Patients at Veterans Affairs | Low Health Literacy | English | Physicians | Low health literacy was common among older patients and appeared to be associated with lower adherence to preoperative medication instructions. |
| **17** | Paasche-Orlow MK, Parker RM, Gazmararian JA, Nielsen-Bohlman LT & Rudd RR 2005a, 'The prevalence of limited health literacy', *Journal of General Internal Medicine*, vol. 20, no. 2, pp. 175-184. | *Journal of General Internal Medicine* | Systematic review of literature | U.S. Studies examining the prevalence of limited health literacy | Limited Health Literacy | English | Physicians | A pooled analysis of published reports on health literacy cannot provide a nationally representative prevalence estimate. This systematic review exhibits that limited health literacy, as depicted in the medical literature, is prevalent and is consistently associated with education, ethnicity, and age. It is essential to simplify health services and improve health education. Such changes have the potential to improve the health of Americans and address the health disparities that exist today. |
| **18** | Chew LD, Bradley KA & Boyko EJ 2004a, 'Brief questions to identify patients with inadequate health literacy', *Family Medicine*, vol. 36, no. 8, pp. 588-5. | *Family Medicine* | Non-experimental descriptive study<br>(In-person interviews and the STOFHLA instrument administration) | English-speaking patients at the preoperative clinic of the VA Puget Sound Health care System in Seattle | Inadequate Health Literacy | English | Physicians | Three questions were each effective screening tests for inadequate health literacy in this population. |
| **19** | Schlichting JA, Quinn MT, Heuer LJ, Schaefer CT, Drum ML & Chin MH 2007, 'Provider perceptions of limited health literacy in community health centers', *Patient Education and Counseling*, vol. 69, no. 1–3, pp. 114-120. | *Patient Education and Counseling* | Non-experimental descriptive study (Surveys) | Health care providers in a community health centre | Limited Health Literacy | English | Healthcare professionals | This study is the first to our knowledge that examines health care providers' perceptions of limited health literacy's effect on their patients, and to gather their opinions and experiences regarding methods they use or would like to use to help their patients overcome limited health literacy. The study also identified several barriers providers foresaw that could be addressed if their centre tried to implement a health literacy program. This study serves as a first step in determining future health literacy interventions in health centres, which will ultimately lead to better care and improved health outcomes for medically vulnerable patients.<br>Providers estimate limited health literacy to be highly prevalent in their health centres, and use various techniques to assist patients. |

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| **20** | Ellins J 2005, 'Soapbox: Low health literacy must be tackled', *Pulse*, September 2005, viewed 7 February 2012, http://business.highbeam.com/409992/article-1G1-136139250/soapbox-low-health-literacy-must-tackled. | *Pulse Newspaper* | Opinion | | Low Health Literacy | English | Physicians | The author argues that we urgently need to focus our attention on the issue of health literacy, in order to establish both the scale of the problem and how it can be best addressed. Failure to do so will make it difficult for large numbers of patients to make genuine and informed choices about the care and services offered in the NHS. |
| **21** | Cole MR 2000, 'The high risk of low health literacy, *Nursing Spectrum*, vol. 9, pp. 1-6. | *Nursing Spectrum* | Opinion | | Low Health Literacy | English | Nurses | Effective communication is the cornerstone of nursing interventions. The goal of patient education has become the empowerment of consumers in a market-driven healthcare system. In today's savvy environment, it has become clear that the best prescription we can offer our patients is culturally and linguistically appropriate health education. |
| **22** | Mayer GG & Villaire M 2004, 'Low health literacy and its effects on patient care', *Journal of Nursing Administration*, vol. 34, no. 10, pp. 440-442. | *Journal of Nursing Administration* | Opinion | | Low Health Literacy | English | Nurse administrators | The nurse administrator can take a leadership role in bringing the problem of low health literacy to the forefront of nursing and medical practice. Because health literacy remains an essentially new concept for many health professionals, arranging for key individuals to attend continuing education programs on the topic might be a first step.<br><br>All existing health information materials should be tested to determine at what grade reading level they are written. If the materials test at higher than a 5th-grade reading level, they should be rewritten to a lower level. This will require an allocation of resources to bring all materials to a comprehensible level. Resistance will likely be encountered for such an allocation, particularly if patient education materials recently have been redesigned and printed. The fact remains that no matter how well designed materials are graphically, they are of little use if the recipient is unable to read or understand the contents.<br><br>The process of rewriting materials to a lower grade level should be done by, or in collaboration with, someone who has had experience in writing and testing such materials. This is particularly true when translating materials into another language. Translated health education materials must be field tested to ensure that they not only retain low literacy levels, but also remain culturally appropriate and meaningful. Appointment of a diversity committee can be instrumental for ensuring that the needs of the population receiving care at the facility are met in a compassionate and comprehensive manner. |

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| **23** | Riley JB, Cloonan P & Norton C 2006, 'Low health literacy: A challenge to critical care', *Critical Care Nursing Quarterly*, vol. 29, no. 2, pp. 174-178. | *Critical Care Nursing Quarterly* | Opinion | | Low Health Literacy | English | Critical care nurses | Addressing the health literacy demands of patients and families is one of the most pressing issues critical care nurses must face across today's healthcare system. Low health literacy is a significant problem with important implications for healthcare outcomes and satisfaction. The special challenges encountered by patients and families with low health literacy may be overlooked in the fast-paced, high-technology critical care environment. Critical care nurses must be cognizant of these problems and take the lead to mitigate the negative impact of low health literacy. Clear and comprehensible communication techniques and an interactive education strategy are among the tools that critical care nurses can employ to improve care or these most vulnerable patients. |
| **24** | Devereux J 2004, Low health literacy: a covert barrier to patient self-management', *HIV Clinician*, Winter, pp. 12-14. | *HIV Clinician* | Opinion | | Low Health Literacy | English | Healthcare professionals | There are a number of strategies the clinicians may employ when teaching patients who have lower literacy skills. First, focus on the key information which must be conveyed to the patient. Speak in the present tense, us e the active voice and a conversational style, and explain to the patient the purpose or use of this new information and how it will fit into the context of his life. Use simple words and lay terms, when possible, and use the same words consistently throughout an exchange. Avoid using statistics or complex graphs and charts; emphasize pertinent skills and behaviours rather than inessential facts. Because patients with lower literacy may have difficulty framing questions, employ a "show me" approach, frequently asking the patient to demonstrate or describe what has just been shown or said to him. When possible, support verbal instructions with low literacy print materials and pictographs, audio or video tapes, and in-person or telephone follow-up. It has been estimated that less than 10% of adults who might benefit from a literacy program actually ever participate in one. The clinician might consider familiarizing himself with literacy resources available in the community, and referring patients to these as appropriate. |

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| **25** | The challenge of inadequate health literacy, 2001, *Managed Care Interface*, vol. 14, no. 8, pp. 30-31 | *Managed Care Interface* | Opinion | | Inadequate Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public | The problem of insufficient health literacy leads to the utilization of more health services. The National Adult Literacy Survey found that among all users of the health system, those found to have low health literacy used significantly more hospital and physician services than those with adequate health literacy. in conducting the study, the National Academy on an Aging Society, based in Washington, DC, found that of adults who experienced a one-night stay in a hospital in 1994, those with inadequate health literacy skills had an average 6% more hospital stays and stayed nearly two days longer than patients with higher health literacy skills. The Academy also conducted an assessment of the costs of low literacy, finding that total costs could be as high as $69 billion annually. As one might expect, Medicare bears the greatest portion of these costs. |
| **26** | Schwartzberg JG 2002, 'Low health literacy: What do your patients really understand?' *Nursing Economic$*, vol. 20, no. 3, pp. 145-147. | *Nursing Economic$* | Opinion | | Low Health Literacy | English | Healthcare professionals | As increasingly complex health care activities are turned over to patients to carry out on their own, the risks to patient safety caused by limited literacy and poor understanding are too great to be ignored. Health professionals will need to become better patient educators and ensure that patients have actually learned all the information they have been given. While we wait for further research to identify the most effective techniques to communicate and educate patients with low health literacy, there are many simple ways we can alter the health care environment and our personal interactions to improve our patients' overall health and health care experiences. |
| **27** | 'The joint commission calls for comprehensive action on poor health literacy', 2007, *Disease Management Advisor*, vol. 13, no. 3, pp. 34-35 & 25. | *Disease Management Advisor* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public. | In its accreditation work, The Joint Commission plans to refine its own standards with regards to National Patient Safety Goals so that surveyors focus more attention on communications strategies that organizations employ to circumvent poor patient-literacy skills and other communication barriers. |

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| **28** | Brown L 2006, 'Low health literacy: what pharmacists can do to help', *Journal of the American Pharmacists Association,* vol. 46, no. 1, pp. 4-9. | *Journal of the American Pharmacists Association* | Opinion | | Low Health Literacy | English | Pharmacists, practitioners and researchers | Pharmacists can no longer depend on the physician to make sure their patients completely understand how to take their medications. Prescriptions and non-prescriptions medications are the domain of pharmacists, and as such, pharmacists have a responsibility to do their best to make sure that they are taken correctly. In addition, pharmacy researchers have a responsibilities in the most effective and time-efficient manner possible. Health literacy is a public health issue, and it is up to all practitioners and researchers to do their part to make things better. |
| **29** | Primack BA, Bui T & Fertman CI 2007, 'Social marketing meets health literacy: Innovative improvement of health care providers' comfort with patient interaction', *Patient Education and Counseling,* vol. 68, no. 1, pp. 3-9. | *Patient education and Counseling* | Experimental Study (Pre and post intervention) | First-year medical students from the Clinical Experience s Course at the University | Health Literacy | English | Physicians | A brief intervention involving social marketing and health literacy can improve skills that improve medical students' comfort with patients of diverse background. |
| **30** | Jones M, Lee JY & Rozier RG 2007, 'Oral health literacy among adult patients seeking dental care', *The Journal of the American Dental Association,* vol. 138, no. 9, pp. 1199-1208. | *The Journal of the American Dental Association* | Non-experimental descriptive study (Interviews and the short version of the rapid Estimate of Adult Literacy in Dentistry-30 (REALD-30) instrument administration) | Adult patients in two privet dental offices | Health Literacy | English | Dentists | A significant number of patients may have a low level of oral health literacy, which possibly interferes with their ability to process and understand oral health information. |

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| **31** | Baker DW, Parker RM, Williams MV & Clark WS 1998, 'Health literacy and the risk of hospital admission', *Journal of General Internal Medicine*, vol. 13, no. 12, pp. 791-798. | *Journal of General Internal Medicine* | Prospective cohort study | Emergency department patients | Health Literacy | English | Physicians | In this study population, patients with inadequate functional health literacy had an increased risk of hospital admission. |
| **32** | Kim S, Love F, Quistberg DA & Shea JA 2004, 'Association of health literacy with self-management behavior in patients with diabetes", *Diabetes Care*, vol. 27, no. 12, pp. 2980-2982. | *Diabetes Care* | Prospective observational study | Patients enrolled in diabetes education classes at the hospital of the University of Pennsylvania | Health Literacy | English | Physicians | Patients with limited health literacy benefit from diabetes education and show similar or better improvement in self-management behaviours compared with those with adequate health literacy. Future efforts should focus on improving educational outreach for patients with low literacy skills. |
| **33** | Boswell C, Cannon S, Aung K & Eldridge J 2004, 'An application of health literacy research', *Applied Nursing Research*, vol. 17, no. 1, pp. 61-64. | *Applied Nursing Research* | Pilot research project | Clients from four urban primary care clinics with rural connections who are:<br>Age above 18 years<br>Ability to understand English or Spanish<br>Physically capable of participating in the study<br>Mentally competent<br>Had vision acuity above 20/100 | Health Literacy | English | Nurses | This article presents a pilot research project used to investigate the mastery of educational information by clients in a West Texas area. The research project is used as the foundation for discussion of several interesting facets resulting from the initial research. Ideas are presented as a direction for implementation for practice within the health care community. Low health literacy is a grave challenge, which currently is not understood nor considered by the nurse at the bedside. Practicing health care providers need the opportunity to carefully and specifically investigate the role of health care literacy in producing positive client outcomes. |
| **34** | Sanders LM, Thompson VT & Wilkinson JD 2007, 'Caregiver health literacy and the use of child health services', *Pediatrics*, vol. 119, no. 1, pp. e86-e92. | *Pediatrics* | Cross-sectional study | Children aged between 12 months to 12 years | Health Literacy | English | Physicians | One in 5 caregivers of young children has low health literacy. Caregiver health literacy, however, was not associated with disparities in the use of child health services in this inner-city, ethnic minority population. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **35** | Soller W 2006, 'An integrated approach to teaching health literacy in the clinical pharmacy curriculum', *Journal of Pharmacy Teaching*, vol. 13, no. 1, pp. 17-28. | *Journal of Pharmacy Teaching* | Non-experimental descriptive study (Assessment of the USCF clinical pharmacy curriculum. The assessment included a literature review, a detailed review of course syllabi, in-depth interviews with workshops, and expert consultation) | Literature on health literacy and pharmacy<br>Clinical pharmacy curriculum<br>UCSF School of Pharmacy senior faculty member of 15 senior and mi-level faculty.<br>All clinical pharmacy faculty | Health Literacy | English | pharmacists | An assessment of the UCSF clinical pharmacy curriculum was undertaken to raise awareness about health literacy among faculty and students, and as needed catalyse curricular change. The assessment included a literature review, a detailed review of course syllabi, in-depth interviews with mid-level and senior faculty, an all-school lecture and by-invitation workshop, and expert consultation. Outcomes of this process included, among other things, development of an overarching conceptual framework for health literacy proficiency for health professionals and a strategic approach to moving forward with curricular change and faculty development. |
| **36** | Harper K, Thompson-Robinson M & Lewis M 2003, 'Health literacy assessments of patients in rural Florida', *Texas Journal of Rural Health*, vol. 21, no. 3, pp. 3-8. | *Texas Journal of Rural Health* | Non-experimental descriptive pilot study (Interview and the STOFHLA instrument administration) | Rural minority population in Gadsden Country | Health Literacy | English | Healthcare professionals | Twenty-nine participants out of 30 (93%) had adequate functional health literacy. The Short Test of Functional Health Literacy in Adults (STOFHLA) is a reliable and valid instrument for measuring functional health literacy. |
| **37** | Gazmararian JA, Williams MV, Peel J & Baker DW 2003, 'Health literacy and knowledge of chronic disease', *Patient Education and Counseling*, vol. 51, no. 3, pp. 267-275. | *Patient Education and Counseling* | Non-experimental descriptive study (In-person and telephone survey) | New Medicare enrollees aged 65 years or older who had at least on chronic disease (asthma, diabetes, congestive heart failure, hypertension) | Health Literacy | English | Healthcare professionals and health educators | Respondents with inadequate health literacy knew significantly less about their disease than those with adequate literacy. Multivariate analysis indicated that health literacy was inadequately related to disease knowledge. There are many opportunities to improve patients' knowledge of their chronic disease(s), and efforts need to consider their health literacy skills. |
| **38** | Baker DW, Gazmararian JA, Sudano J & Patterson M 2000, 'The association between age and health literacy among elderly persons', *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, vol. 55, no. 6, pp. S368-S374. | *Journal of Gerontology* | Non-experimental descriptive study<br>(Home interviews<br>The Short Test of Functional Health Literacy in Adults (S-TOFHLA) administration<br>The Mini Mental State Examination (MMSE)) | Community-dwelling elderly persons | Health Literacy | English | Healthcare professionals | Functional health literacy was markedly lower among older groups even after adjusting for different in MMSE performance, newspaper reading frequency, health status, and visual acuity. Future studies should prospectively examine whether functional literacy declines with age and whether this is explained by declines in cognitive function. |

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| **39** | Baker DW, Williams MV, Parker RM, Gazmararian JA & Nurss J 1999, 'Development of a brief test to measure functional health literacy', *Patient Education and Counseling*, vol. 38, no. 1, pp. 33-42. | *Patient Education and Counseling* | Non-experimental descriptive study (The TOFHLA instrument administration) | Patients attended the Urgent care Center and Medical Clinic at Grady Memorial Hospital | Functional Health Literacy | English | Health educators | The authors described the development of an abbreviated version of the Test of Functional Health Literacy in Adults (TOFHLA). The S-TOFHLA is a practical measure of functional health literacy with good reliability and validity that can be used by health educators to identify individuals who require special assistance to achieve learning goals. |
| **40** | Gausman Benson J & Forman WB 2002, 'Comprehension of written health care information in an affluent geriatric retirement community: Use of the test of functional health literacy', *Gerontology*, vol. 48, no. 2, pp. 93-97. | *Gerontology* | Non-experimental descriptive study (The test of functional health literacy in adults (TOFHLA) administration) | Residents from Albuquerque retirement apartment community | Functional Health Literacy | English | Physicians | The authors argue that two recent studies, one in an emergency room setting and the other among Medicare enrolees, demonstrated similar results to theirs. The high prevalence of poor comprehension in these groups should alert providers to the need to develop additional or different communication skills that can address the problem of poor reading comprehension across at least three diverse groups of people, with particular attention to those over the age of 65. |
| **41** | Montalto NJ & Spiegler GE 2001, 'Functional health literacy in adults in a rural community health center', *West Virginia Medical Journal*, vol. 97, iss. 2, pp. 111-114. | *West Virginia medical Journal* | Non-experimental descriptive study (The TOFHLA instrument administration) | Adult patients at a rural community health center | Functional Health Literacy | English | Physicians | Approximately 15 percent of participants agreeing to take the TOFHLA achieved scores indicating they would be likely to have difficulty interacting with an increasingly complex health care system. Similarly, about 15 percent of the patients choosing not to participate gave a reason which aroused a heightened index of suspicion for literacy/numeracy deficit. As a result, no systematic effort to tailor communications for these patients could be identified in a review of the medical records for participants with low scores.<br><br>Study weaknesses suggest the rate of literacy/numeracy deficit may be understated in the predominantly rural population studied. Further study of the manner in which patients with literacy/numeracy deficit interact with the health care system are warranted. Future questions to be addressed include the influence of these deficits on medical outcomes, costs of care, and self-reported quality of life. In addition, appropriate interventions to meet the needs of this population should be evaluated. |

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| **42** | Georges CA, Bolton LB & Bennett C 2004, 'Functional health literacy: an issue in African-American and other ethnic and racial communities', *Journal of National Black Nurses' Association*, vol. 15, no. 1, pp. 1-4. | *Journal of National Black Nurses Association* | Exploratory descriptive | Adult people (African-Americans and Hispanics) | Functional Health Literacy | English | Nurses | Patients who have marginal or inadequate functional health literacy will have difficulty reading, understanding, and interpreting most written health texts and instructions. In addition, patients with marginal or inadequate functional health literacy scores are more likely to misunderstanding directions for health care. Consequently, these patients are also more likely to take medications incorrectly and more likely to fail to follow a prescribed diet or treatment regimen. |
| **43** | Chisolm DJ & Buchanan L 2007, 'Measuring adolescent functional health literacy: A pilot validation of the test of functional health literacy in adults', *Journal of Adolescent Health*, vol. 41, no. 3, pp. 312-314. | *Journal of Adolescent Health* | A pilot validation of the Test of functional health literacy in adults | Adolescents | Functional Health Literacy | English | Physician | The TOFHLA can facilitate the study of relationships between adolescent health literacy and issues including disease self-management, information-seeking, and decision-making. Additional research is needed regarding the use of the TOFHLA-N. The primary limitation of this study is that it was conducted using volunteers who may not reflect the diversity of adolescent literacy levels. Because our recruitment materials mentioned a reading activity, it is possible that youth or parents of youth with poor reading skills chose not to volunteer. A more comprehensive validation will require the use of a representative sample. |
| **44** | Artinian NT, Lange MP, Templin TN, Stallwood LG & Hermann CE 2003, 'Functional health literacy in an urban primary care clinic', *The Internet Journal of Advanced Nursing Practice*, vol. 5, no. 2, pp. 1-11. | *The Internet Journal of Advanced Nursing Practice* | Non-experimental descriptive study (The TOFHLA instrument administration) | Adult patients treated in 1 of 5 primary care clinics | Functional Health Literacy | English | Nurses | A sizable minority of primary care outpatients have low levels of functional health literacy which limits their understanding of health information and potentially leads to poor health outcomes. It I essential that nurse practitioners or clinical specialists use relevant cues to assess for illiteracy and modify their methods of providing health information when appropriate. |
| **45** | Erlen JA 2004, 'Functional health illiteracy', *Orthopaedic Nursing*, vol. 23, no. 2, pp. 150-153. | *Orthopaedic Nursing* | Opinion | | Functional Health Illiteracy | English | Healthcare professionals | The purposes of this article are to provide an overview of the problem of inadequate functional health literacy and consider ethical concerns that may arise when nurses care for patients who are unable to understand healthcare information. Selected, relevant nursing implications are discussed. Nurses are in a unique position to identify gaps in their patients' understanding of their health needs and also to serve as advocates, mediators, and translators for patients. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **46** | Hixon AL 2004, 'Functional health literacy: Improving health outcomes', *American Family Physician*, vol. 69, no. 9, pp. 2077-8. | *American Family Physician* | Opinion | | Functional Health Literacy | English | Healthcare professionals | As we contemplate addressing health disparities, cost-effective care for an aging population, and reducing medical errors, it will be essential to understand and address the issue of health literacy. While waiting for further research to clarify the associations linking poor reading ability to health, we will all need to shape our clinical environments to support the health of our less literate patients. |
| **47** | Youmans SL & Schillinger D 2003, 'Functional health literacy and medication use: The pharmacist's role', *The Annals of Pharmacotherapy*, vol. 37, no. 11, pp. 1726-1729. | *The Annals of Pharmacotherapy* | Opinion | | Functional Health Literacy | English | Pharmacists | Functional health literacy is an important public health and clinical issue. The assessment and promotion of medication adherence for patients with inadequate functional health literacy presents unique challenges to pharmacists and other healthcare providers. The pharmacy profession has an obligation to increase awareness, educate its membership, and advocate for innovation in healthcare communication. Further research is needed to fully understand the impact of functional health literacy on safe and appropriate medication use, to develop adherence assessment tools and adherence-promoting interventions, and evaluate their impact on clinical and economic outcomes. |
| **48** | Cuban S 2006, 'Following the physician's recommendations faithfully and accurately: Functional health literacy, compliance, and the knowledge-based economy', *The Journal for Critical Education Policy Studies*, vol. 4, no. 2, pp. 1-13. | *The Journal for Critical Education Policy studies* | Critical analysis of the functional health literacy concept definition | Literature | Functional Health Literacy | English | Adult literacy practitioners,<br>Health care professional and lawyers | The functional health literacy discourse does not eliminate compliance, but instead promotes it as a part of Choice Theory, while overlooking how people's selections are already limited, and disparaging them if they don't make the right decisions. They have low functional health literacy.<br>Functional health literacy is for those who cannot afford to pay for services. People with highest incomes don't have to read the signs or look for good doctors. They simply tap into their social networks, query their friends, pay for boutique doctors, and receive help to navigate around the system. The accountant explains the bills when they are difficult to read or understand. They get the best care of all. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **49** | Fok MS & Wong TK 2002, 'What does health literacy mean to children?' *Contemporary Nurse*, vol. 3, no. 2-3, pp. 249-258. | *Contemporary Nurse* | Non-experimental descriptive study (Surveys) | **The First Phase**<br>Children between the ages of 6 and 12 years old<br>**The Second Phase**<br>Two doctors that specialises in child physical/mental health<br>A nurse working in the Department of Health<br>A clinical psychologist who specialises in child health<br>Two primary school teachers<br>A student counsellor who is experienced in working with school students<br>Two parents of primary school children. They are active members of the parent-teacher committee organised by school. | Health Literacy | English | Healthcare professional , school teachers, school counsellors and children parents | To assist individuals in reaching optimal physical and psycho-social well-being, health literacy should be promoted in children's early develop-mental stages. Before promoting health to adults and the elderly, health should be promoted to children to possibly prevent the development of chronic diseases. The findings of this study serve as a reference for developing healthy children. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **50** | Freebody P & Freiberg J 1999, 'Health literacy and social practice: response to Nutbeam', *Literacy and Numeracy Studies*, vol. 9, no. 2, pp. 57-66. | *Literacy and Numeracy Studies* | Opinion | | Health Literacy | English | Health care professional, academicians, researchers, policymakers and general public. | The nature, value, significance and productivity of various literacy practices are shaped by the nature of the social relationship between institutional providers, such as doctors, and their clienteles. Literacy practices themselves derive their moral significance from the enactment and maintenance of institutional relationships within the local setting of, in this case, the doctor's surgery.<br>The approach outlined by Nutbeam seems to have much to offer to debates about literacy and health. It focuses attention on the everyday communicative patterns that make up people's attempts to maintain and enhance their own and their community members' health; it acknowledges that health practices for at-risk groups are always embedded in patterns of cultural and technical authority and dominance; and it tries to show how everyday communicative patterns act to position people with respect to relevant knowledge and thus to the health profession in general. It also calls into question the notion that people simply lack or possess literacy, pointing to the ways in which otherwise highly literate people may behave with considerable literate capability at various times. What needs to be attended to is the local details of individuals' or communities' needs for, and barriers and access to, certain areas of knowledge that, for some, are associated with their relationship to specialised people and knowledge. Thus, the institutional and ideological connections of some forms of literate activity may determine the communicative practices in which those activities are acted out, rather than strictly the measurable 'literacy' capabilities of the community and the difficulty of the written or spoken texts. |
| **51** | Marx E, Hudson N, Deal TB, Pateman B & Middleton K 2007, 'Promoting health literacy through the health education assessment project', *Journal of School Health*, vol. 77, no. 4, pp. 157-163. | *Journal of School Health* | Product review | Literature | Health Literacy | English | School educators | State education agencies and school districts can use State Collaborative on Assessment and Student Standards Health Education Assessment Project (SCASS-HEAP) materials for assessment and, perhaps more importantly, to help teachers modify and improve instruction at the classroom level for increased student learning. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **52** | Cutilli CC 2007, 'Health literacy in geriatric patients: An integrative review of the literature', *Orthopaedic Nursing*, vol. 26, no. 1, pp. 43-48. | *Orthopaedic Nursing* | Systematic integrative review | Research on health literacy and the geriatric patient population | Health Literacy | English | Healthcare professionals | Providing healthcare information to individuals with low health literacy is a challenge and mandate for all healthcare professionals. This systematic integrative review of the literature on heath literacy and the elderly has provided foundational information about this topic for healthcare providers. |
| **53** | Brown SL, Teufel JA & Birch DA 2007, 'Early adolescents perceptions of health and health literacy', *Journal of School Health*, vol. 77, no. 1, pp. 7-15. | *Journal of School Health* | Non-experimental descriptive study (computer systems (Classroom Response System or Audience Response System) that combine data from multiple students responding via individual electronic keypads) | 9 to 13 years old students | Health Literacy | English | School teachers | Programs and curricula should be designed to increase student interest in health issues and their self-efficacy in controlling their own health destinies. Educators should also teach students to more effectively use nonconventional health information sources such as the Internet, parents, and medical professionals. |
| **54** | Gray NJ, Klein JD, Noyce PR, Sesselberg TS & Cantrill JA 2005, 'The Internet: A window on adolescent health literacy', *Journal of Adolescent Health*, vol. 37, no. 3, pp. 243.e1-243.e7. | *Journal of Adolescent Health* | Non-experimental descriptive study (focus group interviews) | Adolescent students, aged 11-19 | Health Literacy | English | Healthcare professionals and school teachers | Exploring the challenges faced when adolescents search for online health information indicates deficiencies regarding health literacy skills. Difficulties regarding functional, critical, and interactive skills were all present. The Internet may offer opportunities for identifying such deficiencies and building better health literacy skills among adolescents, as part of health curriculum interventions to improve the population's future health. |
| **55** | Peterson FL, Cooper RJ & Laird JM 2001, 'Enhancing teacher health literacy in school health promotion: A vision for the new millennium', *Journal of School Health*, vol. 71, no. 4, pp. 138-144 | *Journal of School Health* | Model review | Literature | Health Literacy | English | School teachers | As the new millennium begins, efforts to enhance the health of children and adolescents via innovative approaches to school health instruction need to continue. The goal of motivating youth to become lifelong health learners will be facilitated by assuring high quality elementary and secondary teacher education, both preservice and inservice, that enhances teacher health literacy. Education for health literacy for the provider (teacher) should be as important as for the consumer (student). The Child and Adolescent Health Logic Framework is presented as an instructional tool and vision for enhancing teacher health literacy in the new millennium. |

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| **56** | Naito M, Nakayama T & Hamajima N 2007, 'Health literacy education for children: acceptability of a school-based program in oral health', *Journal of Oral Science*, vol. 49, no. 1, pp. 53-59. | *Journal of Oral Science* | Non-experimental descriptive study (group discussions) | Students aged 11-12 | Health Literacy | English | Dentists and school teachers | Health literacy programs for children will need to be developed and administered through collaboration between education and health professionals. |
| **57** | Wood FG 2005, 'Health literacy in a rural clinic', *Online Journal of Rural Nursing and Health Care*, vol. 5, no. 1, pp. 9-18. | *Online Journal of Rural Nursing and Health Care* | Non-experimental descriptive study (Surveys) | Rural clinic patients | Health Literacy | English | Healthcare professionals | Health literacy is a significant barrier to effective health care for many rural dwellers, particularly males. Health care providers can minimize the negative consequences of limited health literacy by assessing the literacy of their population and adjusting written and verbal communications accordingly. |
| **58** | Speros C 2005, 'Health literacy: concept analysis', *Journal of Advanced Nursing*, vol. 50, no. 6, pp. 633-640. | *Journal of Advanced Nursing* | Nursing, medical, public health and social science literature | Concept analysis | Health Literacy | English | Nurses | An analysis of the concept of health literacy enhances nurses' ability to assess more accurately their clients' levels of health literacy, thus identifying those at risk for misunderstanding health care instructions, shame associated with inadequate reading skills, and inability to adhere to health care recommendations. |
| **59** | Andrus MR & Roth MT 2002, 'Health literacy: A review', *Pharmacotherapy*, vol. 22, no. 3, pp. 282-302. | *Pharmacotherapy* | Literature review | Literature | Health Literacy | English | Pharmacists and other healthcare professionals | It is important for all health care professionals to be educated about the prevalence and consequences of inadequate health literacy so that individuals who struggle with this problem can be compassionately identified. Once identified, we can work to assist these patients in overcoming the barriers that may be limiting their ability to function adequately in the health care environment. Additional studies are needed to advance our understanding of inadequate health literacy, and continued research is necessary to determine effective strategies for improving the functional health literacy status of our patients and measuring the impact of such interventions on health care. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **60** | Logan R 2007, 'Clinical, classroom, or personal education: Attitudes about health literacy', *Journal of the Medical Library Association*, vol. 95, no. 2, pp. 127-137. | *Journal of the Medical Library Association* | Non-experimental descriptive study (Delphi Survey) | Medical Librarians | Health Literacy | English | Medical Librarians | This study explores how diverse attitudes about health literacy are assessed by medical librarians and other health care professionals.<br>An online survey of thirty-six items was conducted using Q methodology in two phases in spring 2005 and winter 2006. Respondents (n = 51) were non randomly self-selected from a convenience sample of members of the Medical Library Association and a group of environmental health consultants to the National Library of Medicine.<br>Three factors were identified. Factor 1 is optimistic and supportive of health literacy's transformative sociocultural and professional potential, if clinical settings become a launching point for health literacy activities. Factor 2 is less optimistic about health literacy's potential to improve clinical or patient outcomes and prefers to focus health literacy initiatives on classroom education settings. Factor 3 supports improving the nation's health literacy but tends to support health literacy initiatives when people privately interact with health information materials.<br>Each factor's attitudes about the appropriate educational venue to initiate health literacy activities are different and somewhat mutually exclusive. This suggests that health literacy is seen through different perceptual frameworks that represent a possible source of professional disagreement. |
| **61** | Brown DR, Ludwig R, Buck GA, Durham D, Shumard T & Graham SS 2004, 'Health literacy: Universal precautions needed', *Journal of Allied Health*, vol. 33, no. 2, pp. 150-5. | *Journal of Allied Health* | Pilot study | Members of the Health Professions Network (HPN) and to subscribers to the National Network of Health Career Programs in Two Year Colleges (NN2) listserv from August 6 through 18, 2003 | Health Literacy | English | Allied health practitioners | The results of this project indicated that there is substantial opportunity to increase awareness of the impact of health literacy, to develop and assess institutional policies toward health literacy, and to create new resources to promote health literacy within the allied health professions. Any approach to improving health literacy must be universal by involving all health care professionals and all patients in the intervention. |
| **62** | Rudd RE 2007, 'Health literacy skills of U.S. adults', *American Journal of Health Behavior*, vol. 31, no. Supplement 1, pp. S8-S18. | *American Journal of Health Behavior* | Literature review | Literature | Health Literacy | English | Health communicators | The distribution of health literacy is not independent of general literacy skills at population or subpopulation levels. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **63** | Birch DA 2000, 'A cooperative approach to promoting health literacy: The Current Health Issues Project', *The Journal of School Health*, vol. 70, no. 2, pp. 69-71. | *Journal of School Health* | Non-experimental descriptive study | Students responsible for the Current Health Issues Project | Health Literacy | English | Health educators | A lesson plan for teaching current health issues is presented.<br>**Topic:**<br>Current Health Issues<br>**Lesson Objectives:**<br>1. Students will identify credible print sources and web sites related to a current health issue.<br>2. Students will analyse and present data gathered from individuals who are not members of their class.<br>3. Students will identify critical questions related to the issue.<br>4. Students will synthesize information related to the issue and present in a Health Issues Information Sheet.<br>5. Students will verbally communicate important aspects of the issue to other students. |
| **64** | Lee SD, Arozullah AM & Cho YI 2004, 'Health literacy, social support, and health: A research agenda', *Social Science & Medicine*, vol. 58, no. 7, pp. 1309-1321. | *Social Science & Medicine* | Non-experimental descriptive study | Empirical studies of health literacy | Health Literacy | English | Healthcare professionals | This article proposes research hypotheses to address two questions: (1) What are the causal pathways or intermediate steps that link low health literacy to poor health status and high utilization of expensive services such as hospitalization and emergency care? (2) What impact does social support have on the relationships between health literacy and health service utilization? Empirical studies of health literacy are reviewed to indicate the limitations of current literature and to highlight the importance of the proposed research agenda. In particular, we note the individualistic premise of current literature in which individuals are treated as isolated and passive actors. Thus, low health literacy is considered simply as an individual trait independent of support and resources in an individual's social environment. To remedy this, research needs to take into account social support that people can draw on when problems arise due to their health literacy limitations. Examination of the proposed agenda will make two main contributions. First, we will gain a better understanding of the causal effects of health literacy and identify missing links in the delivery of care for patients with low health literacy. Second, if social support buffers the adverse effects of low health literacy, more effective interventions can be designed to address differences in individuals' social support system in addition to individual differences in reading and comprehension. More targeted and more cost-efficient efforts could also be taken to identify and reach those who not only have low health literacy but also lack the resources and support to bridge the unmet literacy demands of their health conditions. |

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| **65** | Safeer RS & Keenan J 2005, 'Health literacy: The gap between physicians and patients', *American Family Physician*, vol. 72, no. 3, pp. 463-468. | *American Family Physician* | Opinion | | Health Literacy | English | Physicians | Health literacy is basic reading and numerical skills that allow a person to function in the health care environment. Even though most adults read at an eighth-grade level, and 20 percent of the population reads at or below a fifth-grade level, most health care materials are written at a 10th-grade level. Older patients are particularly affected because their reading and comprehension abilities are influenced by their cognition and their vision and hearing status. Inadequate health literacy can result in difficulty accessing health care, following instructions from a physician, and taking medication properly. Patients with inadequate health literacy are more likely to be hospitalized than patients with adequate skills. Patients understand medical information better when spoken to slowly, simple words are used, and a restricted amount of information is presented. For optimal comprehension and compliance, patient education material should be written at a sixth-grade or lower reading level, preferably including pictures and illustrations. All patients prefer reading medical information written in clear and concise language. Physicians should be alert to this problem because most patients are unwilling to admit that they have literacy problems. |
| **66** | Levin-Zamir D & Peterburg Y 2001, 'Health literacy in health systems: Perspectives on patient self-management in Israel', *Health Promotion International*, vol. 16, no. 1, pp. 87-94. | *Health Promotion International* | Opinion | | Health Literacy | English | Healthcare professionals | Using the concept of health literacy to guide the development of self-management skills offers a solution to the challenge faced by health systems in achieving good health outcomes while struggling with rising costs. Improving health literacy, and thereby achieving improved self-management outcomes, will prove beneficial for both the individual as well as the health system.<br>Health care providers need to examine where their patients are getting information on disease and self-management, whether or not that information is reliable, and inform their patients of the best sources of information and its use. The improved collaboration with patient and consumer groups whose goals are to promote rights and self-management capabilities, and advocate for improved health services, can be very beneficial. Patients need to have a level of health literacy that allows for critical analysis of information on their own and make certain decisions regarding their care. Provider training and the resulting patient/provider relationship is critical in improving health literacy. Finally, indicators such as the understanding of the local health care system, the sense of empowerment in making rational health decisions as well as health consumerism indicators including use of hospitalization services, consuming of prescription and over-the-counter medication, and cooperation with the health care team must be adopted in order to establish benchmarks, measure trends and evaluate interventions aimed at improving the determinants of health and sustaining the health outcomes. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **67** | Ratzan SC 2001, 'Health literacy: communication for the public good, *Health Promotion International*, vol. 16, no. 2, pp. 207-214. | *Health Promotion International* | Opinion | | Health Literacy | English | Health promoters, consumers, government, healthcare professionals, patient advocacy groups, healthcare organizations, media, industry, policymakers, and community-based organizations | This article builds upon a presentation at the Fifth Global Health Conference on Health Promotion (Mexico City, 9 June 2000), seeking to advance the development of health literacy through effective communication. First, it offers a timely reflection for health promotion epistemology in particular, and the potential approach to framing health promotion activities in general, with health literacy as a bridging concept. The concept of health literacy is briefly explained and defined, followed by identification of some promising communication interventions to diffuse health literacy. Four predominant areas within the communication field are described that shed light on approaches for developing health literacy: integrated marketing communication, education, negotiation and social capital. Each component can contribute to strategic science-based communication. Finally, the article elucidates that communication and developing health literacy are not simple solutions. Communication is not simply message repetition, but includes the development of an environment for community involvement to espouse common values of humankind. With effective communication, worldwide health literacy can become a reality in the 21st century, embodying health as a central tenet of human life. |
| **68** | Stephenson L 2006, 'Health literacy: are you doing enough to communicate with your patients?' *Iowa Medicine*, vol. 96, no. 4, pp. 16-17. | *Iowa Medicine* | Opinion | | Health Literacy | English | Physicians | The author argues that there are thing physicians can do and should be doing better in their practice to help their patients understand their medical conditions. What may surprise physician, though, is that working to improve health literacy isn't as time consuming and costly as they might think. Excellent resources are available to guide them and their staff toward simple things they can do to improve how they communicate with their patients. |
| **69** | Jackson R 2005-2006, 'Health literacy: an introduction of the literature', *Journal of the Indiana Dental Association*, vol. 84, no. 4, pp. 10-13. | *Journal of Indiana Dental Association* | Opinion | | Health Literacy | English | Dentists | Dentists should be aware that a significant proportion of their patients may have poor literacy skills. As a result, these patients may not be able to understand fully and follow written instructions for the treatment of their dental disease. While certain groups have been identified as being more likely that others to have poor health literacy skills, the dentist and his or her staff should be aware that poor health literacy skills are found in persons from all walks of life. To improve the health outcomes of their patients, dentist should be willing to evaluate the literacy skills of patients they suspects of having difficulty. Practitioners should then modify their educational programs to meet the needs of individual patients based on their literacy skills. Written materials, including informed consent statements and pamphlets, should be evaluated to ensure that these materials can be understood readily.<br><br>Assessing health literacy and providing appropriate materials geared to the literacy level of the patient will lead to improvement in health education and health communication. Improving health literacy will result in the patient being able to take an active part in his or her own health care as an informed member of the health care team. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **70** | Mason DJ 2001, 'Promoting Health Literacy', *American Journal of Nursing*, vol. 101, no. 2, pp. 7. | *The American Journal of Nursing* | Opinion | | Health Literacy | English | Nurses | Patient education should be a core component of every provider's role if patients and family members are to participate in health care.<br>The author is urging against accepting the purging of patient teaching form the nursing role. |
| **71** | Parker RM, Ratzan SC & Lurie N 2003, 'Health literacy: A policy challenge for advancing high-quality health care', *Health Affairs*, vol. 22, no. 4, pp. 147-153. | *Health Affairs* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public | This paper defines health literacy as an important policy issue and offers strategies for creating a health-literate America.<br>Improving health literacy is a tool for improving health and health care in America. It is both a process and an outcome. Creating a truly health-literate America is a challenge requiring leadership, strategy, cooperation, and most importantly, a democracy with citizens who are well informed. It may not be easy, but it is the right goal for health policy. |
| **72** | Pawlak R 2005, 'Economic consideration of health literacy', *Nurse Economy*, vol. 23, no. 4, pp. 173-180. | *Nursing Economy* | Opinion | | Health Literacy | English | Consumers, government, healthcare professionals, patient advocacy groups, healthcare organizations, media, industry, policymakers, and community-based organizations | This article focuses on the role of health literacy in the U.S. Health literacy is increasingly important to help people navigate complex health systems and better manage their own health. Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Differences in the ability to obtain, process and understand materials related to health services appear to contribute to health disparities. Strategies and incentives for population health improvement affected by health literacy are recommended. |
| **73** | Nutbeam D 2000, 'Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century', *Health Promotion International*, vol. 15, no. 3, pp. 259-267. | *Health Promotion International* | Opinion | | Health Literacy | English | Health promoters, consumers, government, healthcare professionals, patient advocacy groups, healthcare organizations, media, industry, policymakers, and community-based organizations | Improving health literacy in a population involves more than the transmission of health information, although that remains a fundamental task. Helping people to develop confidence to act on that knowledge and the ability to work with and support others will best be achieved through more personal forms of communication, and through community-based educational outreach. If we are to achieve the ultimate goal that is reflected in that definition of health literacy—trying to promote greater independence and empowerment among the individuals and communities we work with—we will need to acknowledge and understand the political aspects to education, focused on overcoming structural barriers to health. |

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| **74** | Kickbusch, I. 2002, 'Health literacy: a search for new categories', *Health Promotion International*, vol. 17, no. 1, pp. 1-2. | *Health Promotion International* | Opinion | | Health Literacy | English | Consumers, government, healthcare professionals, patient advocacy groups, healthcare organizations, media, industry, policymakers, and community-based organizations | In the health arena at present, both at the country and global levels, dual systems do exist: one for those with resources, and a safety net for those without. Short-term efficiency gains in health care reform are constantly highlighted, but investments in those areas that really create health rarely make the agenda. Health literacy as a major health investment and health development strategy needs long-term commitment, strong partnerships and powerful spokespeople. The new global alliances that concern themselves with eradicating disease and developing new vaccines need to be complemented by a strong commitment to increase overall health literacy in close cooperation with a public policy commitment at country level. Health literacy demands the awareness, just as the digital divide does, that if we do not close the health literacy gap, the whole of society, indeed the global community, will suffer. |
| **75** | St Leger L 2001, 'Schools, health literacy and public health: Possibilities and challenges', *Health Promotion International*, vol. 16, no. 2, pp. 197-205. | *Health Promotion International* | Opinion | | Health Literacy | English | School teachers | Most schools do address health literacy, albeit at basic levels. Many schools in countries throughout the world have achieved substantial outcomes in health literacy using the health promoting schools framework or similar models. Health literacy as a concept is very compatible with the health promoting school concept and could form an acceptable outcome by which the success of a health promoting school could be assessed.<br><br>There is now sufficient prima facie evidence to suggest that it is possible to attain the changes needed in school structures and practices to achieve better education and health outcomes, and that they do in fact work under many different conditions. But increasing the number of schools capable of making such changes will require governments to invest more in three core areas: professional development for teachers, research into school health frameworks and their effects, and dissemination of the evidence of effective school health initiatives to a wider school-based audience. There will also need to be recognition of the fact that schools and education systems change slowly, and are under constant pressure from competing societal demands.<br><br>A great deal has been achieved in school health in the last 20 years. The evidence base of what is effective has increased considerably. Producing changes in schools to reflect 'best practice' in school health is still a major challenge. Health literacy is a very important concept, which shows us how education and health can collaborate to achieve both public health outcomes and high levels of skills and knowledge in students. Schools can achieve all three levels of health literacy, and the attainment of level three—critical health literacy—will be easier if schools adopt the health promoting school approach. Increased and widespread empowerment of students through health literacy concepts is possible, but only if there is a will to support schools in their efforts. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **76** | Tappe MK & Galer-Unti RA 2001, 'Health educators' role in promoting health literacy and advocacy for the 21st century', *Journal of School Health*, vol. 71, no. 10, pp. 477-482. | *Journal of School Health* | Opinion | | Health Literacy | English | Health educators | For health educators to reach their vision of promoting health literacy and thereby "promoting, supporting, and enabling healthy lives and communities", 3 health educators need to lead the way in advocating for health and health education. Health educators need to show the way to many different groups of people: to children and adolescents by providing them with quality, comprehensive school health education; to families of children and adolescents by involving them in comprehensive school health education; to school personnel, families, and community members by involving them in coordinated school health programs; to the public by providing them with quality, comprehensive health education services in an array of settings; to undergraduate and graduate health students by providing them with quality professional preparation programs that enable them to develop the knowledge and skills to provide quality health education services and to advocate for health and health education; to their colleagues by providing ongoing opportunities for professional development related to health education services and advocacy for health and health education; and to health educators involved in professional preparation by providing them with technical assistance to provide quality training experiences to preservice and inservice personnel. When health educators learn and accept their roles in health advocacy, they will move closer to achieving the goal of a health-literate citizenry. |
| **77** | Johnston Lloyd LL, Ammary NJ, Epstein LG, Johnson R & Rhee K 2006, 'A transdisciplinary approach to improve health literacy and reduce disparities', *Health Promotion Practice*, vol. 7, 3: pp. 331-335. | *Health Promotion Practice* | Opinion | | Health Literacy | English | Healthcare professionals | It is important that key stakeholders are aware of racial and ethnic disparities in health care and that they recognise the role of patient-provider communication, self-management skills, and transdisciplinary care in improving health literacy and in eliminating disparities. In addition, the link between the cultural competency skills of providers and health literacy has been cited as a strategy for improving the knowledge, attitudes and skills of health professionals. Policy implications suggest the need for (a) reimbursement for time spent to improve health literacy and patient education (b) support for training for transdisciplinary teams, (c) funding for demonstration programs that promote self-management, development of health literacy skills, and formation of transdisciplinary models. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **78** | Ross J 2007, 'Health Literacy and Its Influence on Patient Safety', *Journal of PeriAnesthesia Nursing*, vol. 22, iss. 3. pp. 220-222. | *Journal of PeriAnesthesia Nursing* | Opinion | | Health Literacy | English | Healthcare professionals | It is through identifying health literacy needs of the patient and their families that patient care can be improved and errors minimized. Health care providers also need to conduct a self-evaluation of their own literacy and identify where additional education, such as improving cultural competency, would be beneficial to them. Improved communication promotes patient safety and improves outcomes, which is the underlying goal for nursing. |
| **79** | Kickbusch, I. & Ratzan, S.C. 2001, 'Health Literacy: Making a Difference in the USA', Journal of Health Communication, vol. 6, iss. 2, pp. 87-88. | *Journal of Health Communication* | Editorial | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public | This editorial proposes health literacy as an opportunity for cooperation of the United States Department of Health and Human Services and Department of Education and the private sector. Relationship between education and health care; Role of health literacy in applying literacy skills to the health care setting; Possible effect of health literacy programs on citizens eligible for health services plans. |
| **80** | Cutilli CC 2005b, 'Health literacy what you need to know', *Orthopaedic Nursing*, vol. 24, no. 3, pp. 227-233. | *Orthopaedic Nursing* | Opinion | | Health Literacy | English | Nurses | As nurses, we are mandated to provide healthcare and information that all patients and families can understand. The first step toward achieving this mandate is to assist all segments of society in promoting health literacy and find creative ways to effectively teach individuals with limited health literacy. |
| **81** | Parker RM & Schwartzberg JG 2001, 'What patients do--and don't--understand. Widespread ignorance has triggered a silent epidemic', *Postgraduate Medicine*, vol. 109, no. 5, pp. 13-15. | *Postgraduate Medicine* | Opinion | | Health Literacy | English | Healthcare professionals | The low health literacy of almost half the American population is becoming recognized as a major public health issue for the 21st century. The federal government's public policy initiative Healthy People 2010 includes health literacy among its health indicators and objectives. Critical public advocacy and research are components of a successful approach to this problem. It is time for individual physicians to consider how patients' health literacy affects their overall health and healthcare experiences. |
| **82** | Mika VS, Kelly PJ, Price MA, Franquiz M & Villareal R 2005, 'The ABCs of health literacy', *Family & Community Health*, vol. 28, no. 4, pp. 351-357. | *Family & Community Health* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public | Health literacy is a well-documented problem in the United States. Public health researchers need to develop meaningful interventions that can tackle the problem and improve health outcomes. Health workers must also work to assist patients to reach critical health literacy so that personal and community empowerment can be reached and unfavourable health outcomes can be changed. Directing efforts to health literacy problems will provide an imperative contribution to the resolution of health disparities in the United States today. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **83** | Porr C, Drummond J & Richter S 2006, 'Health literacy as an empowerment tool for low-income mothers', *Family & Community Health*, vol. 29, no. 4, pp. 328-335. | *Family & Community Health* | Opinion | | Health Literacy | English | Healthcare professionals | Health Canada and the National Literacy Secretariat collaborate to explore ways of addressing issues related to literacy and health. Imagine if strategies included healthcare professionals playing a greater role "moving" their clients from a place of powerlessness and dependency to a place of empowerment and autonomy? The mediating process could be the progressive level of literacy, personal, and social skills along Nutbeam's health literacy continuum.<br><br>One cannot argue that the first level, functional health literacy, is important to ensure patients access the healthcare system appropriately and maximize the utility of health information. However, to address the all-encompassing complex nature of health as mental, social psycho-emotional and physical well-being, healthcare professionals should promote the capacity for health. When working with low-income mothers, nurses, borrowing from the social work literature, need to be advocates, that is, brokers, advisors, champions, representatives, and enablers.<br><br>When promoting interactive health literacy, the nurse-advocate does not visit the low-income mother to impose upon her a model of a "good mother," but strives to enhance the mother's knowledge, skills, competence, and coping abilities to parent effectively, as best she can within the constraints of economic disadvantage.<br><br>The mandate of critical health literacy requires that the nurse-advocate enable increasing levels of personal and community empowerment by building on the mother's newfound self-efficacy and competence. Freire's model of empowerment education creates opportunity for critical thought and reflection about the possible economic and social structures and policies underlying the daily struggles of a group of low-income mothers. Within the context of group dialogue, mothers glean insights and over time develop the collective efficacy necessary for campaigns of change to act upon the sources of disparity. Conceivably they may go on to form linkages with other groups, culminating in community interventions for health, expanding the sphere of social action and laying the foundation for neighbourhood social capital. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **84** | Barrett SE & Puryear JS 2006, 'Health literacy: Improving quality of care in primary care settings', *Journal of Health Care for the Poor and Underserved*, vol. 17, no. 4, pp. 690-697. | *Journal of Health Care for the Poor and Underserved* | Opinion | | Health Literacy | English | Clinicians | Raising awareness about the implications of low health literacy among clinicians and providing tools and resources to address these issues is important. Health facilities can conduct Lunch and Learn sessions where clinicians can get lunch time training on health literacy, culture, and strategies they can use to communicate with patients. More intensive trainings can include cross-training, role playing, and case study discussion. E-mail reminders, bulletin board reminders, and bathroom reminders are all ways health facilities can keep health literacy a priority of their clinicians.<br>Improving patient-communication involves systemic changes that involve health systems giving clinicians time during medical encounters to interact with the patient in a shame-free environment. It also involves patients being aware of their rights and being equipped with the knowledge that they are allowed to be, and are encouraged to be involved in their health care and it involves clinicians having the skills to communicate and interact with patients.<br>There is still much work that must be done to ensure patients and clinicians are able to communicate effectively given varying health literacy levels, cultures, and linguistic backgrounds. However, it is encouraging to learn that many primary care health facilities, especially those serving underserved communities are aware of the problem and are using what resources they have to help patients understand and care for their health condition. |
| **85** | Parker R & Kreps GL 2005, 'Library outreach: overcoming health literacy challenges', *Journal of the Medical Library Association*, vol. 93, no. 4 Supplement, pp. S81-S85. | Journal of the Medical Library Association | Non-experimental descriptive study (Strategies evaluation) | | Health Literacy | English | Librarians | This paper examines strengths and weaknesses of different programs for addressing health literacy problems, including educational programs, message design programs, and strategic communication training and intervention programs.<br>The paper evaluates strategies that can be implemented throughout the modern health care system to address problems of health literacy by improving health information access, processing, and understanding. It concludes by examining several strategies that libraries can adopt to overcome many health literacy challenges. |

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| **86** | Scudder L 2006, 'Words and well-being: How literacy affects patient health', *The Journal for Nurse Practitioners*, vol. 2, no. 1, pp. 28-35. | The Journal for Nurse Practitioners | Opinion | | Health Literacy | English | Nurses | Nurses will find the recent focus of the medical community on patient understanding to be a bit ironic. Many of the "new" strategies offered are familiar ground in nursing curricula. Like so much else of nursing, we have not defined to our body of knowledge, thus allowing other disciplines to "discover" it. As one health literacy expert puts it, nurses "get it." And now it is time that we use this long history of an emphasis on patient education to lay claim to this important area of study. Nurses, especially NPs, need to be at the forefront of this movement toward building a health care environment that optimizes the experience for patients. |
| **87** | Gazmararian JA, Curran JW, Parker RM, Bernhardt JM & DeBuono BA 2005, 'Public health literacy in America: An ethical imperative', *American Journal of Preventive Medicine*, vol. 28, no. 3, pp. 317-322. | *American Journal of Preventive Medicine* | Opinion | | Health Literacy | English | Consumers, government, healthcare professionals, patient advocacy groups, healthcare organizations, media, industry, policymakers, and community-based organizations | Progress in public health literacy will yield an informed, motivated public with the skills and resources to make positive choices that enhance individual and community health. A skilled professional workforce in health care and public health will communicate with the public in ways that they understand.<br>We must build a society where people can understand and act on health information. A public health-literate society will be a prized addition to the long list of public health's greatest achievements. |
| **88** | Rootman I 2004a, 'Health promotion and literacy: implications for nursing', *Canadian Journal of Nursing Research*, vol. 36, no. 1, pp. 13-21. | The Canadian Journal of Nursing Research | Discourse | | Health Promotion and Literacy | English | Nurses | This discourse has discussed the development of one new area of research and practice in health promotion. |
| **89** | Gravier S 2007, '*What is health literacy?*" *Adelaidean*, October 2007, viewed 7 February 2012, http://www.adelaide.edu.au/adelaidean/issues/22001/news22021.html. | *Adelaidean* | Commentary | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public | Health literacy is not a magic wand. It is, however, a powerful tool. It's not about being an expert on health but it's being competent to search for and find (with appropriate help) good, relevant and timely information from a variety of sources within an environment which promotes health and wellbeing. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **90** | Jackson R 2006, 'Parental health literacy and children's dental health: implications for the future', *Pediatric Dentistry*, vol. 28, no. 1, pp. 72-7. | *Paediatric Dentistry* | Opinion | | Health Literacy | English | Paediatric dentists | Paediatric dentists must be aware that many of the written materials commonly provided to parents may surpass the capabilities of their readers, and they should make all efforts to identify and assist those with poor health-literacy skills. |
| **91** | Letoré D 2003, 'Health literacy: the role of the pharmaceutical industry', *The Patient's Network*, vol. June, no. 18, pp. 12-14. | *The Patient's Network* | Opinion | | Health Literacy | English | Pharmaceutical industry, healthcare professionals, academicians, researchers, policymakers and general public | The pharmaceutical industry is not yet uniformly aligned to work together on improving health literacy. Individual companies, while pursuing an overall goal, are still working to their individual agendas.<br>What of developing and least developed countries? What are industry, governments and local organizations doing to promote health literacy in countries where literacy in general is low and cultural references vary greatly?<br>If the knowledge, clout and reach of the pharmaceutical industry as a whole are put into assisting the process of educating populations, with the combined efforts of patients, patients' groups, healthcare professionals, regulators and governments, there will be significant gains in health literacy. |
| **92** | Kempner N 2003, 'Health literacy in a changing world', *The Patient's Network*, vol. June, no. 18, pp. 4-8. | *The Patient's Network* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public | Health literacy is climbing up the healthcare agenda. Improving health literacy is essential to the work of patients' organizations, which must now embrace the issue and highlight how it affects their members. |
| **93** | Chang M & Kelly AE 2007, 'Patient education: addressing cultural diversity and health literacy issues', *Urologic Nursing*, vol. 27, no. 5, pp. 411-417. | *Urologic Nursing* | Opinion | | Patient Education and Health Literacy | English | Nurses | Nurses are teachers and have an obligation to facilitate learning for patients and families. Accurate assessment of learning needs and readiness includes assessment of cultural values and health practices as well as literacy issues. Every effort should be made to ensure that teaching plans incorporate patients' cultural values and beliefs. By addressing cultural and literacy issues, nurses can facilitate successful learning outcomes for patients and families enhancing their ability to cope with illness and improve overall health. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **94** | Foulk D, Carroll P & Wood SN 2001, 'Addressing health literacy: a description of the intersection of functional literacy and health care', *American Journal of Health Studies*, vol. 17, no. 1, pp. 7. | *American Journal of Health Studies* | Opinion | | Health Literacy | English | Health educators, healthcare professionals, academicians, researchers, policymakers and general public | Adult illiteracy is a serious problem that undermines both the individual's and the community's health and quality of life. The most common causes of illiteracy include poverty, low parental educational attainment, and home environments in which parents are unable to instil basic literacy skills, especially reading, in their children.<br>Since the National Adult Literacy Survey (NALS) was conducted, the definition of literacy has shifted from a basic description of reading and writing skills to a concern for whether a person's educational level is adequate to function in a modern society and a more comprehensive understanding of functional literacy. Improved literacy provides individuals with the fundamental skills they need to improve their health and their lifestyles.<br>Do health educators have reasons to work with literacy professionals, if one goal of health educators is to improve the quality of health care provided to the children of adults who have not achieved literacy? Should literacy experts consider the basic human needs of safety, shelter, and food when planning to work with adult illiterates, if one of their goals is to improve the quality of life among adults who cannot read, write, or use quantitative information? The answer to both questions should be an enthusiastic "Yes!" |
| **95** | Parker RM & Gazmararian JA 2003, 'Health literacy: essential for health communication', *Journal of Health Communication,* vol. 8, no. Supplement 1, pp. 116-118. | *Journal of Health Communication* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public | Adequate health literacy is critical ingredient of quality health in America. If health communication is not understood, is it truly communicated? |
| **96** | Edmunds M 2005, 'Health literacy a barrier to patient education', *Nurse Practitioner*, vol. 30, no. 3, pp. 54-54. | *Nurse Practitioner* | Opinion | | Health Literacy and Patient Education | English | Nurse practitioners | Difficulty reading also leads to low health literacy—the ability to understand and use information that is important to stay healthy. This may mean a patient cannot read a prescription to learn how many pills to take, cannot figure out when his next appointment is, or read a map to help him get where he needs to go. Patients may not be able to read the information sent home with them that describes their disease, the medicines they are taking, and important facts they need to know. Thus, they often will not have the information to help them get well or stay well.<br>Unfortunately, it makes sense that those individuals who have low literacy often have poor health outcomes. Their inability to read and write places them at higher risk for disease and disability. This is called health disparity. But it does not seem fair that an elderly minority person might die from a disease 6 years before someone else simply because of this difference in ability to read and write. These findings suggest that we all need to review the handouts we give patients. We can help patients be more compliant by giving them materials they can really understand. |

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| **97** | Zarcadoolas C, Pleasant A & Greer DS 2003, 'Elaborating a definition of health literacy: a commentary', *Journal of Health Communication*, vol. 8, no. Supplement 1, pp. 119-120. | *Journal of Health Communication* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public | The ultimate goal of public health communication and education is to advance the public's health literacy. Investigating how health communication and education, individual capabilities, and social processes interact to create health literate citizens is exciting and important. Broadening the lens through which we investigate these complex abilities is the next step in learning how health literacy develops and can be fostered. |
| **98** | The Lancet 2005, 'Taking health literacy seriously', *The Lancet*, Vol. 366 Issue 9480, p95-95. | *The Lancet* | Editorial | | Health Literacy | English | Healthcare professionals | Patients will need better information if they are going to improve their lifestyle, manage their disease, and participate in complex decisions about treatment. Better health-literacy education in schools will help, as will better-written health materials and well-trained educators for patients. But a great deal could be accomplished if doctors and other health professionals took time, at the end of each consultation, to make sure that patient had understood the key points discussed, and that they felt free to ask questions. |
| **99** | Kripalani S & Weiss BD 2006, 'Teaching about health literacy and clear communication', *Journal of General Internal Medicine*, vol. 21, no. 8, pp. 888-890. | *Journal of General Internal Medicine* | Opinion | | Health Literacy | English | Physicians | While some progress has been made, greater attention to health literacy is still needed in medical education. Many opportunities exist to educate medical students and residents about health literacy and the communication skills recommended for clear communication. We encourage clinician educators to implement health literacy workshops and other curricula, and clinical faculty to role model and reinforce techniques to foster clear patient communication. |
| **100** | Wood MR, Kettinger CA & Lessick M 2007, 'Knowledge is power: How nurses can promote health literacy', *Nursing for Women's Health*, vol. 11, no. 2, pp. 180-188. | *Nursing for Women's Health* | Opinion | | Health Literacy | English | Nurses | Nurses must be alert to the widespread epidemic of low literacy and need to consider ways to convey health information in methods that do not require advanced reading skills. Nurses should have access to effective tools for patient education, such as videotapes, computer programs and group education curricula. Nurses can use the "teach-back" method to assess if the woman understands health information. Understanding health information is every woman's right, and improving health literacy is ever nurse's responsibility. |
| **101** | Carmona RH 2005, Improving health literacy: Preventing obesity with education, American Dietetic Association, May, Suppl. 1, vol. 105, no. 5, pp. S9-S10. | *Journal of The American Dietetic Association* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public | By improving health literacy, we can save lives through obesity prevention. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **102** | American Health Consultants 2005, 'Use proven strategist to meet the health literacy challenge: assess the situation and implement policies that include training staff', *Patient Education Management*, vol. 12, iss. 3, pp. 25-28. | *Thomson American Health Consultants* | Opinion | | Health Literacy | English | Nurse managers, education directors, care managers and discharge planners | Research indicates that people with low literacy make more medication or treatment errors, are less able to comply with treatments, lack the skills needed to successfully negotiate the health care system, and are at higher risk for hospitalization than people with adequate literacy skills, according to Pfizer Clear Health Communication Initiative. Health care information often is difficult for many patients to understand, regardless of their reading skills, when they are unfamiliar with the medical terms and issues of their diagnosis. In this issue, *Patient Education Management* discusses ways to meet this health literacy challenge so communication between health care providers and patients can be improved for better health outcomes system wide. |
| **103** | Owens L & Walden D 2007, 'Health literacy: The new essential in nursing education', *Nurse Educator*, vol. 32, no. 6, pp. 238-239. | *Nurse Educator* | Opinion | | Health Literacy | English | Nurses | Nurses are becoming more aware of the problems and issues that affect those with poor health literacy. Statistics regarding the crisis are becoming more available, and more research-based findings are contributing to our knowledge. However, in nursing clinical practice, improvement is needed in assessment of patients with low literacy and developing appropriate interventions for patients with low health literacy. It is imperative that today's nursing educators prepare students to integrate health literacy awareness into professional nursing practice. |
| **104** | Diehl S 2004, 'Life skills to life saving: Health literacy in adult education, *Adult Learning*, vol. 15, no. 1-2, pp. 26-29. | *Adult Learning* | Opinion | | Health Literacy | English | Adult educators | Health literacy skills are important tools that prepare learners to access, understand, and use information to make informed health decisions and to meet personal health goals. This is particularly salient as we shift to a more collaborative decisions-making model between health providers and patients, and patients are asked more frequently to participate in their health care decisions. It is also important for well-managed self-care. The adult education system is a strong, experienced, wide-reaching resource with knowledge and skills to make a difference in adult learners' lives, and to work in tandem with efforts from health and communication professionals to share information, bulked skills, and distil information. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **105** | Ochillo M & Auflick PA 2005, 'Health literacy and consumers: empowering patients', *Journal of Hospital Librarianship*, vol. 5, no. 2, pp. 5765-65. | *Journal of hospital Librarianship* | Opinion | | Health Literacy | English | Librarians | Millions of Americans with low-literacy skills are challenged each day to discern the meaning of written and spoken words. These individuals, already vulnerable when presented a diagnosis, are expected to interpret instructions for prescription medications, perform self-care procedures related to their illnesses, and understand follow-up procedures. Their low-literacy skills place them at risk for negative health outcomes. The complexities of this issue are extensive, and a collaborative system-wide approach involving government institutions, health professionals, community-based organizations, educators, researchers, and libraries is needed to address them. For librarians, health information literacy is one of the major challenges of the immediate future. With library budgets declining, journal costs soaring, and the demand for more and/or electronic resources further eating up budgets, supplying accurate, timely, and appropriate reading-level materials is difficult. Since librarians serve a population of nearly 50% of all adult Americans who fall into the lower two literacy levels as defined by NALS, it is incumbent upon the profession to address the health information needs of these constitutes with proper materials. Every challenge represents an opportunity. To meet this challenge, librarians must develop materials that serve low-literate individuals, conduct health information outreach to consumers, and educate health professionals about health literacy and its implications for their patients. |
| **106** | Shohet L 2004, 'Health and literacy: Perspectives', *Literacy and Numeracy Studies*, vol. 13, no. 1, pp. 65-83. | *Literacy and Numeracy Studies* | Opinion | | Health Literacy | English | Healthcare professionals | This paper, discusses links between literacy and health as currently represented in the discourse communities of the medicine and of adult basic education in several countries. It examines definitions of the terms 'literacy' and 'health literacy' and compares the positions that underpin the research, policy and practices. Looking at selected international policies and professional initiatives, it concludes with an overview of possible future directions.<br><br>Current practice and policy are developing rapidly within the bounds of what is already known or believed. Some of these responses are too simplistic. The hypotheses and assumptions on which they are based will have to be monitored and studied as part of the continuing research agenda. International exchange has to increase, and the role of community and systematic culture in health and literacy has to be fore grounded. |

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| **107** | Davis TC & Wolf MS 2004, 'Health literacy: implications for family medicine', *Family Medicine*, vol. 36, no. 8, pp. 595-598. | *Family Medicine* | Opinion | | Health Literacy | English | Physicians | Health literacy research must move beyond describing the problem to designing potential solutions. The instruments currently used are beginning steps that have allowed for the estimation of overall prevalence of limited literacy among various patient populations, increasing the awareness of the problem and advancing further study. Now is the time to develop tailored intervention strategies and refine screening methods for clinical use. Guidelines are also needed that detail quality standards for patient materials and staff training. Such measures will allow us to more effectively address the epidemic of low health literacy and improve the quality health and health care for all Americans. |
| **108** | Hochhauser M 2003, 'The continuing critical issues is health literacy', *Managed Care Interface*, vol. 16, no. 8, pp. 23-24 & 29. | *Managed Care Interface* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public. | Much health information is written in high level legal language that is designed to protect health care organisations from lawsuits. The information is not written in plain language with the goal of helping patients make better health decisions. If health plans, employers, hospitals and clinics, and doctors intend for patients to change their behaviours, then they should scrutinize the information they provide to patients and the health-literacy skills patient need to understand that information. For example, patients or health plan members should be brought together to evaluate the company's summary plan description, the benefits described by the health plan, sample bills and explanations of benefits, and communications sent to consumers by the organization. Can patient easily read or understand all (or any) of this information? If not, standards should be developed for communicating health information to patients in ways they can both understand and use. One should not assume that patients can actually use this more understandable information. Major differences exist between that capacity to understand information (psychological principles) and the ability to act on that information (behavioural principles). Two choices remain for health plans: (1) Develop a "plain English" strategy for communicating health information to patients or (2) give up on the idea that health information will lead to better health care decisions. The health care system cannot expect to lower costs without educating consumers about their benefits, choices, and rights as patients. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **109** | Kaelin MA & Huebner WW 2002, 'Epidemiology, health literacy, and health education', *American Journal of Health Education*, vol. 33, no. 6, pp. 362-362. | *American Journal of Health Education* | Opinion | | Epidemiology, Health Literacy and Health Education | English | Epidemiologists | By learning the science of epidemiology, middle school students can acquire the knowledge and skills described in the national Health education Standards and acquire health literacy. "Knowledge" includes the most important and enduring ideas, issues, and concepts related to achieving good health. "Skills" include the ways of communicating, reasoning, and investigating that characterize a health-literate person. By understanding how to answer the five essential questions, students develop the knowledge identified in the enduring understandings. By applying this knowledge to contemporary health issues that are relevant to them, middle school students develop their health literacy skills and experience how these skills empower them to make personal and collective, evidence-based, health related decisions. |
| **110** | Hammond PA 2004, 'Developing a health literacy action plan, *Medical Library Association*, vol. 364, no. 8, pp. 10-10. | *Medical Library Association* | Opinion | | Health Literacy | English | Librarians | Hospitals and health departments are assessing forms and patient education materials distributed by their organizations and rewriting or developing more effective written or developing more effective written materials for low literacy readers. Librarians familiar with assessing or producing written health information for low literacy clients can be part of this process. One way to help diminish the barriers is to include the use of instruments in determining readability and grade level. When Microsoft Word completes a prompt to check the spelling and grammar for a document, it can display readability statistics about the document, which include the grade level. The Flesch-Kincaid Readability tool in Ward, which rate text on a US grade-school level, scores this article as 12$^{th}$ grade reading level. To enable the Flesch-Kincaid Readability tool, search for "display readability statistics" in the instructions of the Help Index. |
| **111** | Health literacy rated low in one third of Medicare managed care enrollees 1999, 'American Journal of Health-System Pharmacy, vol. 56, pp. 709-710. | *American Journal of Health-System Pharmacy* | Opinion | | Health Literacy | English | Physicians | In response to the committee's report, AMA adopted policies in 1998 calling for recognition of limited patient literacy as a barrier to effective medical care, efforts to make the community aware of the prevalence of literacy problems, development of training programs to help physicians communicate with patients with limited literacy, inclusion of health-related questions in the next National Adult Literacy Survey, and funding for research on health literacy. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **112** | Featheringham M 2004, 'Health literacy remains a problem for almost half of Americans', *Journal of American Health Information Management Association*, vol. 75, no. 6, pp. 12. | *Journal of American Health Information Management Association* | Opinion | | Low Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public. | The IOM report calls on public healthcare systems, academia, the media, and consumers to do more to improve the U.S.A's health literacy, suggesting health information education be incorporated into school systems and health literacy programs be developed. |
| **113** | Gershenson TA 2004, 'Language of health literacy, *Nursing Spectrum*, vol. 16, no. 8, pp. 1-4. | *Nursing Spectrum* | Opinion | | Health Literacy | English | Nurses | Key concepts in promoting health literacy must include identifying illiterate patients, developing appropriate heath information materials for them, and educating health professionals regarding health literacy, since it's most often impractical to perform individual literacy evaluations, the easiest solution is to communicate with patients and create patient education materials than can be used by the majority of your patient population. The patient education material should be written at the appropriate grade level with suitable visuals and layout. Type size, use of an active voice, amount and arrangement of text and white space, and captions are some of the details that make a difference. The style and language should be geared toward the reader. It should be gender-free references whenever possible. The use of culturally appropriately examples can help to explain difficult topics. The most effective way to ensure the suitability of the educational materials is to pilot or field-test it on the intended patient population. It's up to every nurse to be certain patients understand the medical information they receive well enough to implement it. After all, the health of your patient depends upon it. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **114** | Hill LH 2004, 'Health literacy is a social justice issue that affects us all', *Adult Learning*, vol. 15, no. 1, pp. 4-6. | *Adult learning* | Opinion | | Health Literacy | English | Health educators and healthcare professionals | Health literacy is an area in which there is a lot to learn, and it can be approached from a number of perspectives. Given the complexity of health information, which involves adult learning and decisions about health practices, health information, and health options, this issue affects us all. The articles presented in this article address the need for an approach in which people's knowledge and life experiences are taken into account, and how materials developed need to be written in clear language and be culturally appropriate. Materials must also be tested with their intended audiences. Above all, a deficiency approach with an emphasis on patient compliance should be avoided. People should be treated with respect, and their knowledge and life experiences taken into account. It is matter of social justice, and in more instances than we know a matter of life and death. |
| **115** | Faguy K 2004, 'Health Literacy', *Radiologic Technology*, *vol.* 76, iss. 2, pp. 139-46. | *Radiologic Technology* | Opinion | | Health Literacy | English | Healthcare professionals | Considering U.S.A's resources, functional literacy for virtually all Americans should be an attainable goal. But until they achieve that goal, health care professionals need to be aware that many patients struggle with reading, often with grave consequences. Those patients have a right to information provided in a format they can understand, and they deserve compassionate treatment of both their medical and literacy problems. |
| **116** | Anton B & Nelson R 2006, 'Literacy, consumer informatics, and health care outcomes: Interrelations and implications', *Studies in Health Technology and Informatics*, vol. 122, pp. 49-53. | *Studies in Health Technology and Informatics* | Opinion | | Health Literacy | English | Consumer informatics specialists | Consumer informatics specialists need tools for assessing levels of computer, information, health, health information and basic literacy as well as tools for teaching clients skills related to each type of literacy. Tools for assessing health consumers must be sensitive to each of these literacies as well as to the areas of overlap and interrelations. In addition these tolls must be easily adapted to a variety of settings and clients. The assessment tools presented in this paper can be used as a beginning to develop an integrated assessment approach. In addition they also provide guidance in identifying knowledge and skills needed by all health care consumers. This is the challenge now facing consumer informatics. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **117** | Nutbeam D 1999a, 'Health literacy in a multi-cultural context', *Integration*, vol. 15, pp. 58-60. | *Integration* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public. | Concluding remarks<br>Firstly, improving health literacy in a population involves more than the translation and transmission of health information, although that remains a fundamental task.<br>Second we are in the business of trying to help people develop confidence to act on that knowledge and the ability to work with and support others. This will best be achieved through more personal forms of communication, and through community based educational outreach.<br>Thirdly, if we are to achieve the ultimate goal that is reflected in that definition of health literacy, we are in the business of trying to promote greater independence and empowerment among the individuals and communities we work with and this requires us to acknowledge and understand the political aspect to education, focussed on overcoming structural barriers to health. |
| **118** | Wolf MS, Davis TC & Parker RM 2007, 'Editorial: the emerging field of health literacy research', *American Journal of Health Behavior*, vol. 31, no. Supplement 1, pp. S3-S5. | *American Journal of Health Behavior* | Editorial | | Health Literacy | English | Healthcare professionals | This research is indicative of some of the cutting-edge current and future directions for health literacy field. As a deeper understanding of health literacy and the barriers patients face when accessing and using the health care system is attainted. |
| **119** | Krueger-Parkinson R 2005, 'Speaking the right language: The challenge to improve health literacy: what RTs need to know to communicate effectively with patients', *AARC Times*, vol. 29, no. 5, pp. 40-44. | *AARC Times* | Opinion | | Health Literacy | English | Respiratory therapists | Patients may lack health literacy skills, but they usually don't lack intelligence. Most patients can learn what they need to know with regards to their health care if they are taught clearly, slowly, and completely. By improving our methods of communication, respiratory therapists, can help improve their understanding and that will lead to the kind of patient outcomes we all striving to achieve. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **120** | Kearsey K 2002, 'Nurses lift the lid on illiteracy', *Registered Nurse Journal*, vol. 14, no. 5, pp. 14-16. | *Registered Nurse Journal* | Opinion | | Health Literacy | English | Nurses | Although there are no hard and fast rules or guidelines for communicating with patients with low health literacy, understanding and addressing their needs, and promoting a health-care environment that advocates for patient learning, provides a voice for that 26 per cent of the population that is rarely heard. Altering the daily interactions RNs have with patients to more effectively identify those with limited literacy skills is not difficult. What is perhaps more challenging, however, is ensuring those patients with limited literacy skills alter their interactions with the health-care system so they don't conceal their situation. "Doing" for patients may not be enough to effectively deal with health literacy issues. Nurses and other health-care professionals have a responsibility to also teach patients and their families how to advocate for themselves, and to assume greater responsibility for their health care. If they need convincing, just remind them what some advocates say: health literacy is not just a determinant of health, it's also human right. |
| **121** | Green J 2007, 'Health literacy: socially situating community-based research', *Fine Print*, vol. 30, no. 1, pp. 3-7. | *Fine Print* | Opinion | | Health Literacy | English | Healthcare professionals | Adults need, and use, a variety of literacies to function in society and in a health-related environment.<br>The indications are that literacy-and-health is receiving heightened attention, particularly the sub-field of health literacy. New knowledge is needed to meet the challenges of satisfying health-related knowledge needs, particularly for people experiencing the poorest health.<br>Notions of contextualised and multiple literacies continue to inform and invigorate this research. They represent a lens with which to understand adult literacy concepts and constructs in the context of health and wellbeing. In combination with paradigm grounded in bringing participants' experiences and views to the fore, the study represents a critical step forward to building a larger and stronger foundation of evidence to inform the health literacy field and to support practice and policy decisions in new and informed ways. |
| **122** | Bass L 2005, 'Health literacy: Implications for teaching the adult patient', *Journal of Infusion Nursing*, vol. 28, no. 1, pp. 15. | *Journal of Infusion Nursing* | Opinion | | Health Literacy | English | Nurses | Health literacy is a problem that has been identified across all areas of healthcare. More research is needed not only on health literacy, but also on patient education. Understanding the impact of health literacy on patient outcomes will assist healthcare professionals in the development of effective patient educational materials. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **123** | Evans T 2003, 'Why health literacy matters', *Iowa Medicine*, vol. November/December, p. 6. | *Iowa Medicine* | Opinion | | Health Literacy | English | Physicians and office managers | Health literacy matters for patient care and patient safety. With just a little attention, physician and their office staff could work wonders for their patients. |
| **124** | Wallace L 2006, 'Patients' health literacy skills: The missing demographic variable in primary care Research', *Annals of Family Medicine*, vol. 4, no. 1, pp. 85-86. | *Annals of Family Medicine* | Opinion | | Health Literacy | English | Healthcare professionals | Although the field of health literacy is a relatively new area of inquiry, it is gaining momentum among investigators. We know that patients with limited health literacy skills face enormous obstacles navigating the health care system and struggle with tasks that many of us take for granted (e.g., reading prescription bottles, calculating the amount of cough syrup to give to your child). The implication for adherence to treatment regimens and the threat to health outcomes are obvious and compelling. The time is now for primary care investigators to consider patients' health literacy skills as a key variable in their research studies. |
| **125** | Nichols-English G 2000, 'Improving health literacy: a key to better patient outcomes', *Journal of the American Pharmaceutical Association*, vol. 40, no. 6, pp. 835-836. | *Journal of the American Pharmaceutical Association* | Opinion | | Health Literacy | English | Pharmacists | A caring relationship between pharmacists and patients is the key to patients' willingness to share and receive advice about their medications, regardless of their ability to read. |
| **126** | Morris, AW 2007, 'Health literacy: More than reading a prescription', *Ebony*, vol. 62, no. 9, pp. 121. | *Ebony* | Opinion | | Health Literacy | English | African-American community and healthcare providers | Health literacy means more than being able to read a prescription and follow it, though that is critical it means playing an active role in improving one's health, and incorporating effective practices of healthy living. Doing so could dramatically lessen the chance of even needing a prescription in the first place. |
| **127** | Sorrell JM 2006, 'Health literacy in older adults', *Journal of Psychosocial Nursing & Mental Health Services*, vol. 44, no. 3, pp. 17-20. | *Journal of Psychological Nursing& Mental Health Services* | Opinion | | Health Literacy | English | Nurses | Health literacy is a critical goal for nurses to address.<br>Many older adults struggle daily to manage their health care problems; compounding these difficulties with low literacy skills can be devastating. They need our help. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **128** | Cassey MZ 2007, 'Building a case for using technology: Health literacy and patient education', *Nursing economic$*, vol. 25, no. 3, pp. 186-188. | *Nursing Economic$* | Opinion | | Health Literacy and Patient Education | English | Healthcare professionals | Helping patients with LEP understand the basics of self-care for optimal health will continue to be a challenge in the delivery of the highest quality nursing care. As access to information via the Internet becomes ubiquitous, it is critical that health care providers assist patients to find a way through the glut of health information available online. Becoming familiar with high-quality, peer-reviewed, and reliable health education Web sites is the responsibility of every health care provider so that the 'Carmens' in our clinics receive culturally and linguistically appropriate resources to support healthy lifestyles and choices. |
| **129** | Fitzgerald N 2005, 'Health literacy and your practice', *Michigan Medicine*, vol. 104, no. 1, pp. 22. | *Michigan Medicine* | Opinion | | Health Literacy | English | Physicians | This article provides physicians with strategies for identifying and working with patients who have low health literacy. Using these strategies will help all patients but, most importantly, it will help assure quality care for those with low health literacy. |
| **130** | Rootman I 2006, 'Health literacy: Where are the Canadian doctors?' *Canadian Medical Association Journal*, vol. 175, no. 6, pp. 606. | *Canadian Medical Association Journal* | Commentary | | Health Literacy | English | Physicians | Canadian physicians and medical organizations have as much reason to be concerned about health literacy as their American counterparts. Fortunately, there are things that both individual physicians and their organizations can do to address these issues.<br>Individual physicians could, for example, become more aware of the magnitude of the issue of low literacy and health literacy in the population and in their own practices. They also might become more sensitive to the signs of low literacy and health literacy among their patients and adjust their oral and written communication accordingly.<br>As for physician organizations, they might either initiate new efforts or renew previous ones to advocate for policies and programs related to health literacy. They might also support current promising initiatives to address health literacy in Canada. Two such initiatives are sponsored by the Health and Learning Knowledge Centre of the Canadian Council on Learning: the Expert Committee on Health Literacy, organized by the Canadian Public Health Association, and a project to strengthen the education of health professionals in patient self-management and health literacy organized by the BC Academic Health Council.<br>Whatever is decided by individual physicians or their organizations, their more active involvement in the field of health literacy would be welcome and timely, especially given the fact that the issue of health literacy is gaining momentum in the United States and Europe. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **131** | Parker R 2000, 'Health literacy: a challenge for American patients and their health care providers, *Health Promotion International,* vol. 15, no. 4, pp. 277-283. | *Health Promotion International* | Opinion | | Health Literacy | English | Healthcare professionals | This paper gives an overview of the prevalence of poor health literacy skills in America and describes how poor health literacy affects their health care experience.<br>To promote and provide the best possible care for our patients requires real communication, not just 'words'. Providing high-quality care to patients with health literacy problems does require spending time on patient education. The 'information giving' time that patients value so much is shrinking in practice settings that increasingly seem to equate time with money. Adequately addressing the health literacy needs of all our patients is a virtuous task, and one that will indeed require partnerships with patients (the real experts on health literacy) and all of those concerned with health. |
| **132** | Davidson DA 2004, 'Health literacy: Adverse implications for patients and physicians', *The Journal of Medical Practice Management,* vol. 19, no. 4, pp. 207-210. | *The Journal of Medical Practice Management* | Opinion | | Health Literacy | English | Healthcare professionals | With almost half of adult Americans found to have in adequate literacy skills, it is imperative that clinicians make a concentrated effort to ensure that all their patients are empowered to understand and act on health-care information. Patient-friendly office practices and effective communication are critical in achieving that goal. |
| **133** | Schneider JM 2006, 'Health literacy: Matching patrons to the right materials', *Journal of Hospital Librarianship*, vol. 6, no. 2, pp. 99-105. | *Journal of Hospital Librarianship* | Opinion | | Health Literacy | English | Librarians | Librarians should first become educated in health literacy issues, including how to recognize the low-literate patron. Most people who have difficulty reading are adept at masking their limitations, and use a number of coping mechanisms to hide their abilities. By understanding the issues and using unobtrusive evaluation methods, librarians can increases their own efficacy and effectiveness in matching patrons to materials. |
| **134** | Nutbeam D 1999b, 'Literacies across the lifespan: Health Literacy', *Literacy and Numeracy Studies*, vol. 9, no. 2, pp. 47-55. | *Literacy & Numeracy Studies* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public. | Improving health literacy in a population involves more than the transmission of health information, although that remains a fundamental task. Helping people to develop confidence to act on that knowledge and the ability to work with and support others will best be achieved through more personal forms of communication, and through community based educational outreach. If we are to achieve the ultimate goal that is reflected in that definition of health literacy – trying to promote greater independence and empowerment among the individuals and communities we work with- we will need to acknowledge and understand the political aspects to education, focussed on overcoming structural barriers to health. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **135** | Shohet L & Renaud l 2006, 'Critical analysis on best practices in health literacy', *Canadian Journal of Public Health*, vol. 97, supplement 2, pp. S10-S13. | *Canadian Journal of Public Health* | Opinion | | Health Literacy | English | Healthcare professionals | From a holistic perspective, health literacy is a requirement for the well-being of entire populations. It moves beyond the focus on individuals to consider the role of organizations and systems. This perspective offers a context for discussing best practices in health literacy, and implications for research and policy development. This paper offers an overview of the best practices that were presented at the Second Canadian Conference on Literacy and Health. It discusses clear writing in some detail because it was emphasized at the conference. It also considers practices that were addressed less emphatically, such as oral communication between patients and health care professional, training for health care professionals, non-written means of communication(such as video), and building capacity through action-research. The paper critiques some practices. It also notes the lack of research on the links between health literacy and oral understanding, on the impact of verbal and non-written interventions, and on the effectiveness of these practices on the health outcomes of the population. It briefly discusses policy issues and suggests some future directions. |
| **136** | Lurie N & Parker R 2007, 'Editorial: Moving health literacy from the individual to the community', *American Journal of Health Behavior*, vol. 31, supplement 1, pp. S6-S7. | *American Journal of Health Behavior* | Editorial | | Health Literacy | English | Policy makers, industry, workers, schools, and community organizations | The 2003 NAAL (National Assessment of Adult Literacy) is the first national literacy assessment containing measures of health literacy, and its results will be used to provide a baseline for the healthy People 2010 health literacy objective. The researcher is hopeful that collaborations between researchers at the National Centre for Education Statistics will not only allow people to build a much needed health literacy map of America, but also further the development of interventions for communities whose health literacy needs are better defined by such a tool. Such a resource can then guide efforts by policy makers, industry, workers, schools, and community organizations across the country as they work within neighbourhoods to improve health. Given the magnitude of the problems of health literacy, it is time to embark on target damn meaningful paths to improvement. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **137** | Osborne H 2006, 'Health literacy: how visuals can help tell the healthcare story', *Journal of Visual Communication in Medicine*, vol. 29, no. 1, pp. 28-32. | *Journal of Visual Communication in Medicine* | Opinion | | Health Literacy | English | Healthcare professionals | Patients and their family members often receive an overwhelming amount of health information. The content may be unfamiliar, complicated, confusing, or perhaps even frightening. The format can include numerous multi-syllabic words, dense text, unreadably small fonts, and numbers presented as fractions or decimals or percentages. Adding to these problems, patients and their families often receive health information at times when they feel sick, distracted, and are not at their learning best. Healthcare providers may not always recognize these problems. They know the content is important, but problems arise when there are mismatches between the difficulty of the information and patients' interests or learning skills. This is where health literacy comes in. |
| **138** | Paasche-Orlow MK & Wolf MS 2007, 'The causal pathways linking health literacy to health outcomes', *American Journal of Health Behavior*, vol. 31, supplement 1, pp. S19-S26. | *American Journal of Health Behavior* | Opinion | | Health Literacy | English | Healthcare professionals | Health literacy should be viewed as both patient and a system phenomenon. Three distinct points along a continuum of health are suggested to be influenced by health literacy: (1) access and utilization of health care, (2) patient-provider relationship, and (3) self-care. The conceptual model in this study organizes what has been learned to date and underscores promising areas of future inquiry and intervention. |
| **139** | Tones K 2002, 'Health literacy: New wine in old bottles?' *Health Education Research*, vol. 17, no. 3, pp. 287-290. | *Health education Research* | Editorial | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public. | There seems little if any justification for extending the original formulation of health literacy and incorporating in it re-packaged versions of existing theoretical formulations. Regrettably, however, this process of territorial encroachment seems to be maintaining its impetus. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **140** | Zarcadoolas C, Pleasant A & Greer DS 2005, 'Understanding health literacy: An expanded model', *Health Promotion International*, vol. 20, no. 2, pp. 195-203. | *Health Promotion International* | Opinion | | Health Literacy | English | Healthcare professionals, academicians, researchers, policymakers and general public. | The researchers used an expanded model of health literacy and the constituent domains of fundamental literacy, science literacy, civic literacy and cultural literacy to analyse selected communications during the anthrax threat. We demonstrated that difficult language without definition and explanation, complex sentence structure and assumed knowledge are among the significant issues that must be addressed in terms of fundamental literacy. In terms of science literacy, we examined the successful and less successful attempts to explain the scientific process and the ramifications of that to the anthrax threat. In terms of civic literacy, we demonstrated the role civic literacy skills play in aligning individual decisions with the interests of public health goals. In regard to cultural literacy, we show that cultural differences can lead to different interpretations and reactions to the same message. We have demonstrated the utility of our expanded model of health literacy.<br><br>Much of the time, a central challenge to public health is gaining the attention of a distracted, slow to be motivated public. During the anthrax threat, Americans were actively seeking information about anthrax. That presented a great opportunity to introduce understandable language about the anthrax threat, to advance understanding of science and scientific uncertainty, to promote discriminating evaluation of sources and of information received, and to align individual decisions with the collective good. The anthrax threat presented a great opportunity to advance public health literacy.<br><br>Efforts to improve health literacy should be high among the list of priorities as the country responds to the possibility of terrorism and bioterrorism. An effective policy would include addressing the import and impact of a complex understanding of the multiple domains of health literacy. That understanding will help to create successful health communication efforts, provide an analytical framework from which to analyse health communication as it is encountered, and ultimately lead to development of a fuller measure of health literacy. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **141** | Baker DW 2006, 'The meaning and the measure of health literacy', *Journal of General Internal Medicine*, vol. 21, no. 8, pp. 878-883. | *Journal of General Internal Medicine* | Opinion | | Health Literacy | English | Healthcare professionals | Health literacy is a complicated construct that depends on individual capacity to communicate and the demands posed by society and the health care system. More comprehensive tests are needed to understand the gap between capacities and current demands to help guide efforts to educate children and adults about health issues and to develop health-related information that more of the general public can understand. For research, new instruments are needed that will measure individuals' reading fluency more precisely without posing an undue response burden. Computer-assisted testing, which selects items from a bank of possible items according to a baseline-predicted reading ability and responses to previous questions, should allow more accurate measurement of individual capacity without increasing the time required to complete testing. It remains unclear whether it is possible to develop an accurate, practical "screening" test to identify individuals with limited health literacy. Even if this goal is achieved, it remains unclear whether it is better to screen patients or to adopt "universal precautions" to avoid miscommunication by using plain language in all oral and written communication and confirming understanding with all patients by having them repeat back their understanding of their diagnosis and treatment plan. George Bernard Shaw said, "the main problem with communication is the assumption that it has occurred." This is a universal truth that transcends reading ability. |
| **142** | Agre P, Stieglitz E & Milstein G 2006, 'The case for development of a new test of health literacy', *Oncology Nursing Forum*, vol. 33, no. 2, pp. 283-289. | *Oncology Nursing Forum* | Opinion | | Health Literacy | English | Nurses and health educators | Cancer requires informed, consistent self-care on the part of patients, which is possible only if they understand the instructions they are given. The goal of the research using the SIRACT is to develop a tool that is cancer specific and, thus, feels more like a test of the writing and less like a test of patients'' reading abilities. Nurses and health educators who work in hospitals that serve patients with low socioeconomic levels have led the way in establishing literacy assessments as part of their efforts to educate their patients. The goal of this article, in addition to describing the SIRACT, is to move the discussion of the need for assessments into the mainstream of oncology nursing rather than limiting it to professionals interested in literacy issues and to institutions that serve predominantly minority, immigrant, or low socioeconomic patients. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
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| **143** | McCray AT 2005, 'Promoting health literacy', *Journal of the American Medical Informatics Association*, vol. 12, no. 2, pp. 152-163. | *Journal of the American Medical Informatics Association* | Opinion | | Health Literacy | English | Health informaticians, developers of health information, health educators, and healthcare professionals | There has been substantial research in identifying the significant aspects of health literacy; however, there remain many opportunities for conducting further research to gain a better understanding of the complex interactions between general literacy, health literacy, information technologies, and the existing health care infrastructure. A good deal of the literacy literature has concentrated on one aspect of print literacy, namely readability, and occasionally numeracy. Some of the literature in the investigational area known as "doctor/patient communication" has addressed the oral aspects of literacy. Some attention has been given to other types of knowledge, but this is often done in the context of health care disparities.<br>The role of the Internet and other communication technologies in the health care system is just beginning to be understood. Still needed are better tools to assess and modify the comprehensibility of health materials, methods for improving access to information, and the development of evaluation metrics for assessing usability and impact of information interventions. Health informaticians, developers of health information, health educators, and health care providers all need to work together to ensure that everyone has an equal opportunity to access, understand, and use health information. |
| **144** | Sihota S & Lennard L 2004, *Health literacy: being able to make the most of health*, National Consumer Council, London, UK. | *National Consumer Council* | Report | | Health Literacy | English | Health practitioners, academicians, researchers, policymakers and general public. | To have the capacity to exercise greater control over their health, people need information, knowledge and understanding. This gives confidence and a will to assert control. People also need to have the skills to be able to identify their information needs, know possible sources or avenues for finding out information, be able to read and understand relevant information, and evaluate their options. The issue is complex, in that other factors have to be taken into account. These include people's psychological and emotional states, especially in terms of the seriousness and stage of their illness and their level of preparedness, which can understandably affect the ability to absorb information.<br>However, it is clear that information alone is not sufficient, as much depends on the attitudes of health professional. They are often perceived as significant barriers to people to obtaining information. Patients are less likely to seek information if attempts to do so, or to engage in discussion with health professionals, have been rejected or dismissed.<br>Studies demonstrate that confidence and trust are particularly undermined among disadvantaged groups by negative experiences of using services. This creates the cycle of a reduced capacity to negotiate systems and achieve quality care, and reduced access to healthcare. It also known that poor literacy, as well as poor health literacy is linked to deprivation. Therefore to benefit from choice and engage with better self-care, appropriate measures are needed to build people's capacity to do so. |

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| **145** | Skott D 2006, 'Health literacy: Empowering children to make health choices', *Virtually Healthy,* vol. no. 41, term 3, viewed 7 February 2012, http://www.healthpromotion.cywhs.sa.gov.au/library/vh41.pdf. | *Centre for Health Promotion, CYWHS: Virtually Healthy Newsletter* | Opinion | | Health Literacy | English | School teachers | Developing health literacy will empower children and students to make informed choices and decisions about their health and wellbeing. It will also assist them to clarify and understand the health, social, ethical and environmental issues that exist within their communities. Furthermore, it will prepare them for effective participation in their local, national and global environments and enable them seek appropriate pathways and, support for their own and others' health and wellbeing. |
| **146** | Kilker K 2000, 'Considering health literacy', *Center for Medicare Education,* vol. 1, no. 6, pp. 1-8. | *Center for Medicare Education* | Brief | | Health Literacy | English | Healthcare professionals | Older adults face many decisions as they navigate the complex health-care system. For people with low health literacy skills, making such decisions can be daunting. This brief discusses health literacy and describes techniques organisations or program can use to teach out to those with low levels of health literacy. |
| **147** | Stableford S & Mettger W 2007, 'Plain language: A strategic response to the health literacy challenge', *Journal of Public Health Policy,* vol. 28, no. 1, pp. 71-93. | *Journal of Public Health Policy* | Opinion | | Health Literacy | English | | More research is needed to establish the most effective interventions for reducing the impact of low health literacy. Without a doubt, inaccessible or ineffective communication is only one piece of the puzzle. And, without a doubt, text is not the only way to communicate. Reading is just one way to learn, and understanding is just one step in decision-making. But both are critical skills linked to better health. And, everyone will benefit from halting the burdensome struggle to understand. |
| **148** | Slavkin HC 1998, 'Science, technology and health literacy for the 21st century: A future for dentistry: Percy T. Phillips Memorial Lecture', *New York State Dental Journal,* vol. 64, no. 10, pp. 25-8. | *New York State Dental Journal* | Opinion | | Health Literacy | English | Dentists | American nation's dental and medical schools are in the process of responding to these challenges and opportunities. A future for dentistry can be anticipated by strategically considering where we are today, how we got here, and the linkages between science, technology and health literacy, health care and economics in a changing social context. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **149** | Rudd R & Horowitz AM 2005, 'The role of health literacy in achieving oral health for elders', *Journal of Dental Education*, vol. 69, no. 9, pp. 1018-1021. | *Journal of Dental Education* | Opinion | | Health Literacy | English | Oral health practitioners, academicians, researchers, and policymakers | It remains with oral health practitioners, academicians, researchers, and policymakers to set a research and action agenda and to explore and evaluate efficacious actions that will improve that oral health of elders. This research agenda will be strengthened by attention to health literacy. |
| **150** | Kobylarz FA, Pomidor A & Heath JM 2006, 'SPEAK: A mnemonic tool for addressing health literacy concerns in geriatric clinical encounters', *Geriatrics*, vol. 61, no. 7, pp. 20-2. | *Geriatrics* | Opinion | | Health Literacy | English | Physicians | Clear communication facilitates positive health outcomes. Understanding the component of health literacy I essential to providing clear communication to all patients, but particularly older patients. The SPEAK mnemonic provides a framework that can be used by all healthcare professionals in the clinical encounter. All components do not have to be utilised in every clinical encounter. Although SPEAK can be helpful in awareness with health literacy challenges, it does not address critical non-verbal communication (e.g. body language, eye and physical contact). Additional identified challenges may be difficult to address due to time restraints, lack of interpreters, systematic issues, and unfamiliarity with health literacy assessment tools. However, improving physicians' awareness of health literacy as a component of effective healthcare is the first step toward improving health outcomes in all settings of care for alder adults. |
| **151** | Chiarelli L & Edwards P 2006, 'Building Healthy Public Policy', *Canadian Journal of Public Health*, vol. 97, no. 2, pp. S37-S42. | *Canadian Journal of Public Health* | Opinion | | Health Literacy | English | Healthcare professionals and policy makers | Policy approaches that respect the distinct needs of special population groups and build on their strengths to improve literacy and health literacy have the potential to make greatest contribution to reducing health disparities. |
| **152** | Davis TC, Gazmararian J & Kennen EM 2006, 'Approaches to improving health literacy: Lessons from the field', *Journal of Health Communication*, vol. 11, no. 6, pp. 551-554. | *Journal of Health Communication* | Non-experimental descriptive study (Web-based survey) | Participant completed the survey were from a wide variety of privet and public sector health-related organisations | Health Literacy | English | | The survey results indicate that there is currently not a clear strategy to engage federal health agencies and other health organisations in systematically addressing health literacy issues. Development of policies for the diffusion of health literacy issues within organisations may be helpful. Guidelines are also needed for quality standards in material development and training of staff to make communication more patient/consumer cantered. Collaboration between agencies should be encouraged, particularly in the development and testing of fresh approaches to inform the public. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **153** | DeBuono B 2004, 'Health literacy: a hidden and critical challenge to effective health care', *AHIP Coverage*, vol. 45, no. 6, pp. 38-40. | *AHIP Coverage* | Opinion | | Health Literacy | English | Healthcare professionals, payers and policy makers | Health literacy—known in simplest terms as the ability to read, understand and act on health information—is one of the least recognised yet most widespread challenges to achieving better health outcomes and lowering health care costs in the united states. By some accounts, low health literacy is estimated to cost the U.S. health care system more than $58 billion annually—yet many health care providers, payers and policy makers remain largely unaware of the extent of the problem.<br>Health literacy involves more than a measurement of reading skills—it relates to writing, listening, speaking and conceptual knowledge. Low health literacy can affect any population segment, regardless of age, race, education or income, and cannot be detected by physical symptoms or examinations. Because health literacy is a "hidden crisis" arising from varying educational, social and cultural factors, it requires that diverse fields within the health care system work together to fully penetrate and improve upon the issue. |
| **154** | Feifer, R. 2003, *How a few simple words improve patients' health*, Managed Care Quarterly, vol. 11, iss. 2, pp. 29-31. | *Managed Care Quarterly* | Opinion | | Health Literacy | English | Physicians | With healthcare costs continuing to rise, it is no longer acceptable to ignore the problems of health literacy. It's time Physicians learn that the words they use are as valuable to patient's health as the medicine they take. |
| **155** | Robbins, A. 2003, 'Public health literacy for lawyers: Teaching population-based legal analysis', Environmental Health Perspectives, vol. 111, iss. 14, pp. A744-A745. | *Environmental Health Perspective* | Editorial | | Health Literacy | English | Lawyers | Legal scholars are moving toward conscious development of population-based legal analysis, but they in public health, environmental health, and epidemiology can contribute our support and talents to the effort. They must provide the public health background, critical evidence, methodological analysis, and epidemiologic details to engage lawyers in the public health issues that underline dozens of classic law school teaching cases. Progress in our own fields may depend on well-educated legal allies. Work on population-based legal analysis has started, and there are precedents for bringing new scholarly domains into law. |
| **156** | Burnham E 2003, 'Libraries as partners in health literacy', *Journal of Consumer Health on the Internet*, vol. 7, no. 4, pp. 7-15. | *Journal of Consumer Health on the Internet* | Opinion | | Health Literacy | English | Librarians | This paper overviewed the key issue surrounding health literacy, outlined several initiatives and the methodologies used to evaluate levels of health literacy. Strategies for developing easy-to-read health materials have been explored. Finally, possible roles for libraries and librarians in health literacy have been examined, along with suggestions for further reading. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **157** | Parmet WE & Robbins A 2003, 'Public health literacy for lawyers', *Journal of Law, Medicine and Ethics*, vol. 31, no. 4, pp. 701-713. | *The Journal of Law, Medicine & Ethics* | Opinion | | Health Literacy | English | Lawyers | In this article the authors build upon the intense discussions of the 25 conference participants. They make the case for introducing public health into the core law school curriculum and suggest the content that would be needed to achieve public health literacy among law students. They also argue that public health's focus on populations, aided by the tools of epidemiology, provide a valuable prism for understanding the relationship of individuals and groups and the ways that laws can and ought to affect them. They conclude by urging the development of a body of scholarship and analysis that brings the insights of public health to bear on legal questions. |
| **158** | Nelson JC, Schwartzberg JG & Vergara KC 2005, 'The public's and the patient's right to know: AMA commentary on "Public health literacy in America: an ethical imperative"', *American Journal of Preventive Medicine*, vol. 28, no. 3, pp. 317-322. | *American Journal of Preventive Medicine* | Opinion | | Health Literacy | English | Healthcare professionals | In the American tradition, our population continues to diversity and grow in complexity. However, the responsibility of the medical and public health community to inform the public on how to maintain health and prevent and treat disease remains unchanged. This demands that the message to the public be clear and understood by all. Fortunately, making our practices more sensitive to health literacy will benefit our entire patient population. Additionally, any steps to engage the public in conversation about health promotion and disease prevention will draw the healthcare community closer to the very people we aim to help.<br>As a community of health care professionals, they expect medicine to change. To keep abreast of new techniques and therapies, they constantly study and reform our practices. Now they must begin looking at our patients in the same light. They must renounce the view that all patients are comfortable with receiving information in the same way. As a nation, they will not see improvements in health outcomes without some modifications to our own behaviours and how we communicate, effectively, with both individual patients and the public at large. By improving health literacy and their methods of communication, they will draw their communities closer, empower patients with a deeper ownership of their own health, and ready themselves for whatever changes, be they medical or population based, that undoubtedly lie ahead. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **159** | Bealesa DL 2005, 'Health literacy: The medical librarian's role', *Journal of Hospital Librarianship*, vol. 5, no. 3, pp. 17-27. | *Journal of Hospital Librarianship* | Opinion | | Health Illiteracy | English | Medical librarians | This paper focuses on "health illiteracy" rather than "health literacy," and suggests roles medical librarians can play in addressing the problem of low-literacy, which is associated with poorer health outcomes and an increased bottom line. Multiple patient literacy assessment tools are discussed, as well as formulate for determining "reading level" scores for written materials. Medical librarians can effect institutional change by better understanding the salient issues surrounding health illiteracy, and then applying their knowledge within the organisational structure of their individual medical facilities in order to foster personnel awareness, and ultimately drive policy. |
| **160** | Dray S & Papen U 2004, 'Literacy and health: towards a methodology for investigating patients' participation in healthcare', *Journal of Applied Linguistics*, vol. 1, no. 3, pp. 311-332. | *Journal of Applied linguistics* | Opinion | | Health Literacy | English | Physicians | This paper outlined a concept of health literacy and suggested an approach to studying written texts and the healthcare practices of which they are a part, through drawing on both ethnography and linguistic analysis. The purpose of this approach is to reveal the meanings which are reproduced in healthcare texts and to develop an understanding of the practices of using texts inside and outside healthcare settings. Focusing on patients' own practices here is a deliberate choice that is justified by the current lack of understandings of patients' perspectives. The aim is to challenge the deficit discourse that shapes current policy and highlight some of the barriers to the effective 'empowerment' of patients.<br><br>The research methodology that has been illustrated in this paper provides a means of exploring these tensions and the effects of the new policies more broadly. This supported by the combined strategies of ethnography and textual analysis, which converge in their shared interest in the contextual and situated nature of language and offer complementary data sets. |
| **161** | Mayer GG & Villaire M 2003, 'Health literacy: An ethical responsibility. Mitigating the negative impact of low health literacy is an ethical imperative', *Healthcare Executive*, vol. 18, no. 4, pp. 50-51. | *Healthcare Executive* | Opinion | | Health Literacy | English | Healthcare professionals | The healthcare organisation's function is to diagnose, explain, and treat. The patient's responsibility is to listen, ask question, choose treatment options, follow a prescription regimen, and make appropriate lifestyle choices. When it works properly, a partnership between the patient and provider is a powerful alliance. But if communication breaks down in the partnership, then the outcome is poor and the burden upon the patient and the health care system is only increased. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **162** | DePoy E 2004, 'Universal health literacy: An idea whose time should have come?' *SCI Psychosocial Process*, vol. 17, no. 1, pp. 49-50. | *SCI Psychosocial Process* | Opinion | | Health Literacy | English | Healthcare professionals and social workers | Given the serous negative consequences resulting from health illiteracy, the limited access to critical preventive information, the national priority for universal health literacy by 2010 (Healthy People 2010), and the availability of current state-of-the-art solutions, universal health literacy is a feasible goal that should be implemented by progressive communities, where all people, regardless of personal characteristics, have equivalent access to actual and virtual community resources, including critically needed health information. |
| **163** | Peota C 2004, 'Health literacy and patient safety ', *Minnesota Medicine,* vol. 87, April, pp. 32-35. | *Minnesota Medical Association* | Opinion | | Health Literacy | English | Healthcare professionals | Raising the health literacy bar is more beneficent act for healthcare providers. |
| **164** | Rao PR 2007, 'Health literacy: The cornerstone of patient safety', *ASHA Leader,* vol. 12, no. 6, pp. 8-21. | *The ASHA Leader* | Opinion | | Health Literacy | English | Healthcare professionals | Health care illiteracy cannot be eliminated with one measure. Start with only one initiative, obtain baseline data, and then begin the odyssey of enhancing patient safety by enhancing health care literacy. |
| **165** | 'Health literacy solutions stated plainly', 2003, *CAM Today,* vol. 36, no. 6, pp. 18-22. | *CAM Today* | Opinion | | Health Literacy | English | Healthcare professionals | There are many patient education resources available. By using the many tools and guidelines available and by keeping the message clear, clinicians can improve communication with patients for whom communication is often a special challenge. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **166** | Roberts K 2004, 'Profiles: Simplify, simplify', *The American Journal of Nursing*, vol. 104, no. 3, pp. 118-119. | *The American Journal of Nursing* | A report on Gloria Mayer, EdD, RN, speech at the Institute for Healthcare Advancement's 2003 Conference. | | Health Literacy | English | Nursers | Many so-called medical errors are the result of the inadequate "health literacy", which is a client's understanding of health-related concepts terms.<br>Mayer has some advice for nurses. "A general guideline is that a person will usually read three to five grade levels below the last year of school completed. If he dropped out in eighth grade, he probably reads at about the fourth- or fifth-grade level", she says. "Watching the patient fill out a form may reveal something of a patient's abilities, but that takes more time than most nurses have. Never ask the patient or use a literacy test, as this may undermine trust and lead to embarrassment".<br>Instead, Mayer advises nurses to use common since. "Slow your speech down. Decide what is most important and focus on that. Take a little extra time to assess language skills of patient s who are immigrants", she advises. "Avoid using children as interpreters. If you are providing printed material, it should have large type, lots of white space, and only one picture per page".<br>Mayer adds, "The Prudential Centre for Health Care Research now the Emory Centre on Health Outcomes and Quality found that one out of three U.S. Medicare recipients lacks the literacy skills needed to understand and follow their health care provider's instructions. One of every five Americans reads below the fifth-grade level. Health care is complicated, but we have to remember who we're trying to reach. It's important for health care providers to use simple ways to explain things". |
| **167** | Singleton K 2001, *Picture stories for adult ESL health literacy*, Fairfax County (Virginia) Public Schools, viewed 7th February 2012 http://www.cal.org/caela/esl_resources/Health/healthindex.html . | Fairfax County (Virginia) Public Schools | Tool description | | Health Literacy | English | English for Speakers of Other Languages (ESOL) instructors | This tool uses picture stories to help English as a Second Language teachers address topics affecting their students' health and wellbeing. It is useful are for beginner and low-literacy students, offering a safe , impromptu way to discuss difficult topics, ask questions, and obtain information. |
| **168** | 'Health literacy: a public health issue', 2007, *Migrant Health Newsline*, vol. 24, no. 1, pp. 1-2. | *Migrant Health Newline* | Opinion | | Health Literacy | English | Healthcare professionals | Health literacy, the issue facing patients and providers and possible solutions to help improve patient-provider communication and health outcomes. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **169** | Schwartzberg JG 2006, 'Health literacy and a patient's right to understand', *Aging Today*, vol. 27, no. 2, pp. 8-10. | *Aging Today* | Opinion | | Health Literacy | English | The U.S. Congress<br>The Centres for Medicare and Medicaid Services<br>The Food and Drug Administration and other agencies<br>Health and social service Professionals | Recommendations of the White House Conference on Aging (WHCOA) Mini-Conference on Health Literacy and Health Disparities:<br>Training in communication strategies (to include giving clear instructions and assessing patient understanding) should be implemented for all professionals and administrative staff to ensure that all patients or clients can accurately summarize the information they need in their own words and demonstrate how the information can be applied in their daily life.<br>Public health messages and community outreach should use simple, clear, plain language. Messages should be field-tested with consumers for accuracy and understanding. Special attention should be paid to multicultural media such as radio, local newspapers, and community and faith-based organizations. In addition, health literacy efforts should include working with social service agencies, libraries, adult education and local literacy programs.<br>Simplify and standardize written and oral communication to improve understanding, increase patient safety and reduce medication misuse. |
| **170** | Australian Bureau of Statistics 2009, *Health Literacy: A B S Australian social trends 4102.0, ABS*, Australian Bureau of Statistics, Canberra. | *ABS Australian Social Trends* | Report | | Health Literacy | English | Healthcare researcher, healthcare professionals and health clients | This article uses data form the 2006 Adult Literacy and Life Skills Survey (ALLS). The ALLS provides information on the knowledge and skills of 15-74 years olds Australians in a number of literacy domains including health literacy. |
| **171** | Quigley BA 2004, 'Knowledge is not enough: advancing health literacy through lessons from history', *Adult Learning*, vol. 15, no. 1-2, pp. 10-12. | *Adult Learning* | Opinion | | Health Literacy | English | Adult literacy practitioners | Examined from an historical perspective, the starting point for this paper was not an assumption that adults with low health literacy skills needed to be "educated", so they might make better use of existing systems. The starting place was the need to see the world through the eyes of those whose lives were to be affected. Like the Hull House workers, we came to the decision that our study was not to be based on what *we perceived* about adults with low literacy skills, but what they articulated *out of their own lived experiences*. Like so many historically successful movements in adult education, we began with partnerships. And, through ongoing partnerships, today's changes hold promise for further systematic change and improved health across our region for further systematic change and improved health across our region as a result. We have the experience of two established literacy models and two centuries of history. Today, many adult literacy practitioners insist on having learners as partners. Why not build on his history for advancing health literacy? |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **172** | Rootman I 2004b, 'Literacy and health: prescription for progress. Critical issues in literacy and health', Literacy Across the Curriculumedia Focus, vol. 17, iss. 2, pp. 8-10. | *Literacy Across the Curriculumedia Focus* | Opinion | | Health Literacy | English | Healthcare professionals, researcher and policy makers | This is a somewhat biased view of the issues in the field of literacy and health. Nevertheless I hope that it will help participants at the Institute identify an express their own biases so that we can have a productive discussion leading to better understanding, if not consensus, on the issues that prevent us from us from moving forward in the field of literacy and health. |
| **173** | Stockton PL 2004, 'Improving health literacy', *AMWA Journal*, vol. 19, no. 3, pp. 101-104. | *AMWA Journal* | Opinion | | Health Literacy | English | Health educators | This article introduces the problem of low health literacy and provides a few examples of what the Centres for Disease Control and Prevention (CDC) is doing about it. |
| **174** | Amaya H & Petersen J 2004, 'Introduction: Breast cancer and the perils of health literacy', *International Journal of Qualitative Studies in Education*, vol. 17, no. 4, pp. 467-471. | *International Journal of Qualitative Studies in Education* | Critical discourse | | Health Literacy | English | Healthcare professionals, researcher and policy makers | Critical discourses (which offer a critical pedagogy) have a harder time finding a public home. These discourses, when they find a way to circulate, educate researchers and policymakers to look at structural inequities in living conditions and the role of environmental and/or industrial practices in food manufacture that may lead women to develop breast cancer in the first place, and inequities in access to health insurance and doctors as barriers to women seeking screening, prevention and treatment. This approach focuses attention on prevention rather than treatment and on improving structural and social factors rather than individual attitudes in attempting to expand screening and treatment programs. On the individual level, it also offers a more robust way of understanding the disease, and its trauma, for those who live with it.<br>The authors hope that this collection will further the understanding of breast cancer as a social and as an educational phenomenon. Though studies of only two nations are included in the collection, the authors hope that the international community will profit from our localized experiences and contingent theorizations. |
| **175** | Irwin R 1998, 'Questions of health literacy and the national literacy policy for schools', *The ACHPER Australia Healthy Lifestyles Journal*, vol. 45, no. 1, pp. 24-25. | *The ACHPER Healthy Lifestyles Journal* | Opinion | | Health Literacy | English | Healthcare professionals, school educators, researcher and policy makers | As an important part of Australian Council of Health, Physical Education and Recreation's (ACHPER) work, the Board resolved to consider the development of background papers and position papers on the health literacy dimension. At the same time, consideration will be given to the use of this documentation within the strategic dimension of ACHPER. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **176** | Wilson KK 2001, *Promoting health literacy*, The Institute on Family and Neighborhood Life at Clemson University and of the J. Marion Sims Foundation, Inc., Lancaster SC. | *A Report of the Institute on Family and Neighborhood Life at Clemson University and of the J. Marion Sims Foundation, Inc.* | Report | | Health Literacy | English | Adult literacy practitioners,<br>Health care professional, academicians, researchers, policymakers and general public. | Promoting health literacy by increasing literacy skills related to maintaining individual, family and friend's health care is an important task for both counties given the current population statistics and costs associated with low literacy rates. Literally millions of dollars per year could be applied elsewhere if health literacy rates were increased in both counties. And more importantly the quality of life of more adults in both counties and across South Carolina would be significantly enhanced. |
| **177** | Kantor A 2006, 'A new level of understanding: Health insurers are developing health literacy initiatives and taking steps to help consumers get clear information', *AHIP Coverage*, vol. 47, no. 6, pp. 18-22. | *AHIP Coverage* | Opinion | | Health Literacy | English | Health insurers | Our future progress depends on educating the health care community about health literacy, making the industry aware of how it impacts medical outcomes and then achieving complete buy-in from the medical and research communities. |
| **178** | Norton L 1998, 'Health promotion and health education: What role should the nurse adopt in practice?' *Journal of Advanced Nursing*, vol. 28, no. 6, pp. 1269-1275. | *Journal of Advanced Nursing* | Opinion | | Health promotion and health education | English | Nurses | Health promotion and health education: what role should the nurse adopt in practice? Health promotion is widely accepted as part of the role of the nurse, midwife and health visitor. Theoretical definitions of health promotion and health education are presented. The author suggests that a variety of different approaches to health promotion can be adopted by nurses in practice, including education, persuasion, manipulation and attempts to promote an environment where healthy decisions about lifestyle can be made. Each strategy is examined and the advantages and the ethical limitations are explored. It is suggested that nurses may theoretically accept the notion of being a health promoter, but that in the reality of practice, their role may be primarily that of the health educator. The importance of recognizing that there are a variety of determinants of health, including social and environmental factors, as well as individual lifestyle, is emphasized throughout the paper |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **179** | Kickbusch I, Wait S & Maag D 2005, *Navigating health: the role of health literacy*, Alliance for Health and the Future, International Longevity Centre-UK. | *Navigating health:* *the role of health literacy* | Opinion | | Health Literacy | English | Health care professional, academicians, researchers, policymakers and general public. | • Health literacy is a right of citizenship<br>• Create a voice for health literacy in the political process<br>• Politicians, professionals and the public all must take responsibility for health literacy<br>• Governments must commit to long-term investment in health<br>• Build partnerships to promote heath literacy<br>• Adopt a multilevel approach in health literacy building<br>• Invest in new types of professionals<br>• Health literacy should be put on the school curriculum<br>• Enabling health literacy in health settings<br>• Building health literacy to reduce health inequalities<br>• Develop more simple and practical information<br>• Create a European Centre of Excellence on Health Literacy<br>• Develop a research a network agenda on health literacy in the European Union |
| **180** | Brey RA, Clark SE & Wantz MS 2007, 'Enhancing health literacy through accessing health information, products and services: An exercise for children and adolescents', *Journal of School Health*, vol. 77, no. 9, pp. 640-644. | *Journal of School Health*, | Report on a project | | Health Literacy | English | Physiologists, health scientists and school teachers working with children and adolescents | After completing the lesson/project, the student will be able to:<br>1. Identify and describe the 4 health education settings where health information, services, or products can be found.<br>2. Explain how to use at least 2 examples of health information, services, or products from each of the 4 health education settings.<br>3. Acquire contact information for at least 3 agencies, organizations, or institutions under 1 of the 4 health education settings and determine if they are sources of valid health information.<br>4. Identify at least 3 reasons a health agency, organization, or institution would be considered a credible source of health information, services, or products.<br>5. Call, e-mail, or write to at least 3 agencies under 1 of the 4 health education settings to determine the provided health information, products, and services.<br>6. Prepare and present an oral report of health information, products, and services provided by the assigned agencies, organizations, or institutions.<br>7. Compose a summary of health information, products, and services provided by the assigned agencies, organizations, or institutions for inclusion in a class computer data file.<br>8. Explain at least 3 examples of personal, family, or community health advocacy activities in a reflective paper. |

| # | Author(s) and year | Journal/Book/ Report | Types of article | Types of participants | Focus | Language | Target Audience | Specific outcomes |
|---|---|---|---|---|---|---|---|---|
| **181** | Renkert S & Nutbeam D 2001, 'Opportunities to improve maternal health literacy through antenatal education: An exploratory study', *Health Promotion International*, vol. 16, no. 4, pp. 381-388. | *Health Promotion International* | Non-experimental descriptive study (focus groups and interviews) | A range of health care providers<br>Pregnant women<br>New mothers | Health Literacy | English | Antenatal educators | This paper examines the concept of maternal health literacy, defined as the cognitive and social skills that determine the motivation and ability of women to gain access to, understand, and use information in ways that promote and maintain their health and that of their children. Specifically, it investigates the feasibility of using the concept of health literacy to guide the content and process of antenatal classes. The paper reports on the results of focus groups and interviews conducted with a range of health care providers, pregnant women and new mothers to obtain different perspectives on the issues surrounding antenatal education and parenting. The results give us a realistic look at what women are learning from existing antenatal education and how it can be improved. Comparing the results from the educators and the women, the same basic issues surface. Both recognize that there are serious time limitations in antenatal classes. These limitations, combined with natural anxiety and curiosity about childbirth, generally ensure that the content of classes is confined to pregnancy and childbirth. The limitations of time are also cited as a reason for the teaching methods being heavily weighted towards the transfer of factual information, as distinct from the development of decision-making skills, and practical skills for childbirth and parenting The results indicate clearly that antenatal classes cannot possibly cover all there is to know about pregnancy, childbirth and parenting. If the purpose of antenatal classes is to improve maternal health literacy, then women need to leave a class with the skills and confidence to take a range of actions that contribute to a successful pregnancy, childbirth and early parenting. This includes knowing where to go for further information, and the ability to analyse information critically. The authors conclude that this would represent a very challenging change in orientation for both the educators and pregnant women included in this study. Work continues on the development of the tools that will be needed to support this change. |
| **182** | Harper W, Cook S & Makoul G 2007, 'Teaching medical students about health literacy: Two Chicago initiatives ', *American Journal of Health Behavior*, vol. 31, supplement 1, pp. S111-S114 | *American Journal of Health Behavior* | Non-experimental descriptive study | | Health Literacy | English | Healthcare practitioners and health institutions | The 2 initiatives presented in this article offer examples of approaches that integrate literacy into clearly relevant components of the curriculum. The ultimate goal of these curricula is for students to develop the core skills necessary for effective communication with all patients. |

# Appendix H Delphi Questionnaires

- Direct quotes extracted from the literature to form the Delphi survey round 1 statements
- Pilot questionnaire
- First Delphi questionnaire
- Second Delphi questionnaire including letter to participants pertaining the summary of results from the first Delphi questionnaire
- First Delphi questionnaire participants' comments
- Second Delphi questionnaire participants' comments
- Follow-up letter to participating staff (Delphi Survey Round 1)
- Follow-up letter to participating staff (Delphi Survey Round 2)

## Direct Quotes from the Literature to Form the Delphi Survey Round 1 Statements

| # | Statements | Original Statements | References |
|---|---|---|---|
| 1 | **Being health literate means more than being able to read pamphlets and successfully make appointments.** | 'Health literacy means more than being able to read pamphlets and successfully make appointments.' | Nutbeam D 2000, 'Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century', *Health Promotion International*, vol. 15, no. 3, pp. 259-267. |
| 2 | **Improving health literacy amongst children and young people is important for their health and wellbeing.** | 'Improving health literacy will first result in patients who are more discerning about the medical advice they receive.' | Logan RA 2007, 'Clinical, classroom, or personal education: attitudes about health literacy', *Journal of the Medical Library Association,* vol. 95, iss. 2, pp. 127-137. |
| 3 | **Health literacy is part of lifelong learning.** | 'Health literacy is not simply health knowledge. The goal is a change in social norm of developing health literacy at a level commensurate with age, mental capacity, gender and environment.' | Ratzan SC 2001, 'Health literacy: communication for the public good', *Health Promotion International,* vol. 16, no. 2, pp. 207-214. |
| 4 | **Health literacy is a priority focus in health policy.** | 'Health literacy is an emerging public priority.' | Stockton PL 2004, 'Improving health literacy', *The American Medical Writers Association Journal*, pp. vol. 19, no. 3, 101-104. |
| 5 | **Promoting health literacy should be an essential element of child and youth nurse practice.** | 'Government agencies, health care professionals, privet industries, patient advocacy groups, community-based organizations, academia, and the health care system must work together to improve the nation's health literacy. | Stockton PL 2004, 'Improving health literacy', *The American Medical Writers Association Journal*, pp. vol. 19, no. 3, 101-104. |
| 6 | **Being health literate may enable people to better manage their own health.** | '[The WHO definition of health literacy] significantly broadens the scope of the content of health education and communication, indicates that health literacy may have both personal and social benefits, and has profound implications for education and communication methods. In terms of 'content', efforts to improve people's knowledge, understanding and capacity to act, should not only be directed to changing personal lifestyle or the way in which people use the health services.' | Nutbeam D 2000, 'Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century', *Health Promotion International*, vol. 15, no. 3, pp. 259-267. |
| 7 | **A child or young person who is health literate may access, understand, and interpret basic health information.** | 'A person possessing health literacy can access, interpret, and understand basic health information and services and has the skills to use the information, services, and products to promote health.' | Brey RA , Clark SE & Wantz MS 2007, 'Enhancing health literacy through accessing health information, products and services: an exercise for children and adolescents', *Journal of School Health,* vol. 77 no. 9, pp. 640-644. |
| 8 | **A parent/guardian of a child or young person who is health literate has the skills to use health services to promote their child's health and well-being.** | 'A health advocate is a person who speaks on behalf of others. As health advocates, we use a set of skills to create a shift in opinion or mobilize people, resources, and forces to support an issue or policy.' | Brey RA , Clark SE & Wantz MS 2007, 'Enhancing health literacy through accessing health information, products and services: an exercise for children and adolescents', *Journal of School Health,* vol. 77 no. 9, pp. 640-644. |
| 9 | **Being health literate should help more children and young people understand their needs.** | 'Health literacy initiatives should help more people of all ages understand how the human body functions rather than focusing on lay translations of medical terms and vocabulary.' | Logan RA 2007, 'Clinical, classroom, or personal education: attitudes about health literacy', *Journal of the Medical Library Association,* vol. 95, iss. 2, pp. 127-137. |

| # | Statements | Original Statements | References |
|---|---|---|---|
| 10 | **A low level of functional health literacy can affect anyone.** | 'Low health literacy can affect virtually anyone of any age, ethnicity, background, or education level.' | Stephenson L 2006, 'Health literacy: are you doing enough to communicate with your patients?' *Iowa Medicine,* vol. 96, iss. 4, pp. 16-17. |
| 11 | **Low health literacy increases health care costs at an individual level.** | 'The consequences of inadequate health literacy include:<br>Poorer health status;<br>Lack of medical care knowledge;<br>Impaired comprehension of medical information;<br>Lack of knowledge about medical conditions;<br>Lack of understanding and use of preventive services;<br>Poorer self-reported health, poorer compliance rates with treatment modalities;<br>Increased hospitalisations and increased health care costs.' | Andrus MR & Roth MT 2002, 'Health literacy: a review', *Pharmacotherapy*, vol. 22, iss. 3, pp. 282-302. |
| 12 | **Being health literate will enable children and young people to make informed health care decisions.** | 'Poor health literacy may also affect the patient's and ability to make informed health care decisions when therapeutic care is required.' | Jackson R 2005-2006, 'Health literacy: an introduction of the literature', *Journal of Indiana Dental Association,* vol. 84, iss. 4, pp. 10-13 |
| 13 | **Being health literate will enable parents/guardians of children and young people to make informed health care decisions.** | 'Poor health literacy may also affect the patient's and ability to make informed health care decisions when therapeutic care is required.' | Jackson R 2005-2006, 'Health literacy: an introduction of the literature', *Journal of Indiana Dental Association,* vol. 84, iss. 4, pp. 10-13 |
| 14 | **Children and young people with low health literacy are unlikely to seek preventive health care.** | 'People with low health literacy:<br>Fail to seek preventive care and are at higher (more than double) risk for hospitalisation.' | Stephenson L 2006, 'Health literacy: are you doing enough to communicate with your patients?' *Iowa Medicine,* vol. 96, iss. 4, pp. 16-17. |
| 15 | **Parents/Guardians of children and young people with low health literacy skills are unlikely to facilitate preventive care for their children.** | 'People with low health literacy:<br>Fail to seek preventive care and are at higher (more than double) risk for hospitalisation;' | Stephenson L 2006, 'Health literacy: are you doing enough to communicate with your patients?' *Iowa Medicine,* vol. 96, iss. 4, pp. 16-17. |
| 16 | **It is important for child and youth health nurses to recognize health literacy problems experienced by children and young people.** | 'Functional health illiteracy needs to be recognized as a problem that can negatively affect patients' health outcomes. Because of the silent nature of this problem, healthcare providers may not know that their patients do not understand what has been said. The result is that patients may not adhere to treatment protocols, thereby reducing the effectiveness of the prescribed regimen. There is a potential for harm that needs to be recognized so that maximum health benefits are realized.' | Erlen, JA 2004,'Functional health illiteracy', *Orthopaedic Nursing,* vol. 23, no. 2, pp. 150-153. |

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|---|---|---|---|
| 17 | **It is important for child and youth health nurses to recognize health literacy problems experienced by parents/guardians of children and young people.** | 'Functional health illiteracy needs to be recognized as a problem that can negatively affect patients' health outcomes. Because of the silent nature of this problem, healthcare providers may not know that their patients do not understand what has been said. The result is that patients may not adhere to treatment protocols, thereby reducing the effectiveness of the prescribed regimen. There is a potential for harm that needs to be recognized so that maximum health benefits are realized.' | Erlen 2004, 'Functional health illiteracy: ethical concerns', *Orthopaedic Nursing*, vol 23, iss. 2, pp. 150-3. |
| 18 | **Improving an individual's health literacy will help overcome health inequalities.** | 'Improvements in health literacy will help overcome health inequalities.' | Kickbusch I, Wait S, Maag D 2006, *Navigating health. The role of health literacy,* The International Longevity Centre-UK, Alliance for Health and the Future, London. |
| 19 | **Health literacy development should be an integral component of health promotion for children and young people.** | 'The practice of public health embodies advancement of the quality of life, prevention and treatment of disease, and promotion of health of health and human rights for all. Promulgating the concept and advancing such an outcome of health literacy can serve as an organising principle for 21st century public health activities.' | Ratzan SC 2001, 'Health literacy: communication for the public good', *Health Promotion International,* vol. 16, no. 2, pp. 207-214. |
| 20 | **Health education which includes health literacy should be provided by child and youth health nurses.** | 'Practitioners should then modify their educational programs to meet the needs of individual patients based on their literacy skills.' | Jackson R 2005-2006, 'Health literacy: an introduction of the literature', *Journal of Indiana Dental Association,* vol. 84, iss. 4, pp. 10-13 |
| 21 | **Providing health education to children and young people will not always result in adopting good health habits/behaviors.** | 'Health education will not necessarily result in people changing their behavior.' | Norton L, 1998, 'Health promotion and health education: what role should the nurse adopt in practice?' *Journal of Advanced Nursing,* vol. 28, iss. 6, pp. 1269-1275. |
| 22 | **Health education alone will not be useful to people who do not feel that they have the capacity to change their personal circumstances.** | 'Health education will not necessarily result in people changing their behavior.' | Norton L, 1998, 'Health promotion and health education: what role should the nurse adopt in practice?' *Journal of Advanced Nursing,* vol. 28, iss. 6, pp. 1269-1275. |
| 23 | **Educating children and young people about their health should be an essential part of nursing.** | 'As nurses, we are mandated to provide healthcare and information that all patients and families can understand.' | Cutilli CC 2005, 'Do your patients understand? Determining your patients' health literacy skills', *Orthopaedic Nursing,* vol. 24, iss. 5, pp. 378-379. |
| 24 | **Clarifying the concept of health literacy to child and youth health nurses is essential.** | 'Clarifying the concept is essential.' | Speros C 2005, 'Health literacy: concept analysis', *Journal of Advanced Nursing,* vol. 50, iss. 6, pp. 633-640. |
| 25 | **Nursing and midwifery curricula and/or staff development should address health literacy.** | 'Too few resources exist for clinicians seeking specific guidance on how to address the issues of health literacy in their own work, and organizationally how to integrate this cross-cutting issue into the operating philosophy, polices, and procedures of their clinics to improve communication and help patients achieve better self-management of a chronic condition.' | Barrett SE & Puryear JS 2006, Health literacy: improving quality of care in primary care settings, *Journal of Health Care for the Poor and Underserved*, vol. 17, no. 4, pp. 690-7. |
| 26 | **Healthcare professionals generally assume health consumers to be functionally health literate.** | 'Healthcare professionals generally expect health consumers to have adequate health literacy.' | Cole MR 2000, 'The high risk of low health literacy', *Nursing Spectrum,* vol. 9, pp. 1-6. |

| # | Statements | Original Statements | References |
|---|---|---|---|
| 27 | **There is little or no time for health education in current health settings.** | 'Perceived barriers to implementing formal health literacy programs by health care providers in community health centers:<br>• Lack of time to screen patients.' | Schlichting JA, Quinn MT, Heuer LJ, Schaefer CT, Drum ML & Chin MH 2007, 'Provider perceptions of limited health literacy in community health centers', *Patient Education and Counseling,* vol. 69, iss. 1-3, pp. 114–120. |
| 28 | **Child and youth health nurses may have deficits about the concept of health literacy.** | 'Perceived barriers to implementing formal health literacy programs by health care providers in community health centers:<br>• Health literacy is lower priority<br>• Lack of knowledge about health literacy<br>• Belief that health literacy would not improve outcomes or quality of patient care' | Schlichting JA, Quinn MT, Heuer LJ, Schaefer CT, Drum ML & Chin MH 2007, 'Provider perceptions of limited health literacy in community health centers', *Patient Education and Counseling,* vol. 69, iss. 1-3, pp. 114–120. |

## Pilot Questionnaire

**A critical analysis of the construction of health literacy**

**by paediatric and child and youth health RNs**

**Delphi Survey**

**Questionnaire One**

**Researcher – Ola Kutah**

Phone – (8)83021158

Mobile –0422742537

**PLEASE ANSWER ALL QUESTIONS AND RETURN YOUR COMPLETED SURVEY VIA EMAIL TO ola.kutah@postgrads.unisa.edu.au OR AS A HARD COPY TO THE SCHOOL OF NURSING & MIDWIFERY RECEPTION DESK ON LEVEL 6, CENTENARY BUILDING BY THE 8th OF DECEMBER**

THANK YOU FOR PARTICIPATING

1

## SECTION ONE

**Please mark the appropriate box**

**Socio-demographic data**

**1. What is your current position or its equivalent in your state?**

- ☐ Director of Nursing
- ☐ Clinical Nurse Consultant
- ☐ Staff Development Coordinator
- ☐ Nurse Practitioner
- ☐ Nurse Specialist
- ☐ Head of School
- ☐ Course Coordinator
- ☐ Senior Lecturer/Lecturer
- ☐ Other (please specify)

_____

_____

_____

**2. Please mark the age bracket that includes your age**

- ☐ 20-29 years
- ☐ 30-39 years
- ☐ 40-49 years
- ☐ 50-59 years
- ☐ 60-69 years

**3. Gender**

- ☐ Male
- ☐ Female

**4. What is your highest educational qualification?**

- ☐ PhD
- ☐ Masters degree
- ☐ Bachelor degree
- ☐ Diploma
- ☐ Certificate
- ☐ Other (please specify)

_____

_____

_____

**5. Please indicate the number of years you have been working within the area of child and youth health**

_____

_____

_____

## SECTION TWO

**Many definitions of health literacy & health education exist. To assist in providing a context for the statements in Section 3, some definitions are provided below.**

**Health literacy:**

'The ability to access, understand, and communicate information to engage with demands of different health contexts to promote good health across the life-course'. (Rootman, El-Bihbety, Kaszap, Frankish & Hemming 2005)

'Represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use the information in ways which promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment' (WHO 1998, p. 10)

'Health literacy entails the ability to make sound health decisions in the context of everyday life – at home, in the community, at school, at the workplace, in the health care system, in the market place and in the political arena. It is a critical empowerment strategy to increase people's control over their health, their ability to seek out information and to take responsibility.' (Kickbusch 2007, p. 2)

Three levels of health literacy that reflect increasing degrees of autonomy and personal empowerment have been identified by Nutbeam (1999): functional health literacy, interactive health literacy, and critical health literacy.

**Functional Health literacy**:

'The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.' Institute of Medicine and Healthy People 2010 (Ratzan & Parker 2000, p. vi)

'...constellation of skills, including the ability to perform basic reading and numerical tasks required to function in the health care environment' (The Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs of the American Medical Association 1999).

**Health education is:**

'Any combination of learning opportunities designed to facilitate voluntary adaption of behaviour which will improve or maintain health' (Green 1987, p.4).

'The process of providing learning opportunities for patients and their families to increase knowledge of the disease improve skills in assisting with treatment-related tasks, and aid in the development of coping mechanisms' (Wingard 2005, p.212).

**References:**


American Medical Association, 1999, 'Health Literacy: Report of the council on scientific Affairs', *JAMA*, vol. 281, no. 6, pp. 552-557.
Green, L 1987, 'Letter to the editor', *Health Education Quarterly*, vol. 14, no. 1, p. 4.
Kickbusch, I 2007, *Health literacy: skilling students for better health*, Centre for Health Promotion, CYWHS: Virtually Healthy newsletter no.41, viewed 14 February 2008, < http://www.chdf.org.au/i-cms_file?page=81/vh41.pdf>.
Nutbeam, D 1999, 'Lateriacies across the lifespan: health literacy', *Literacy & Numeracy Studies*, vol. 9, no. 2, pp. 47-56
Ratzan, SC & Parker, R 2000, 'Introduction', in *National Academics of Medicine Current Bibliographies in Medicine: Health Literacy*, eds. CR Selden, M Zorn, SC Ratzan & RM Parker, Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services, 2000.
Rootman, I, El-Bihbety, D, Kaszap, M, Frankish, J, Hemming, H 2005, *Canadian literacy and health research program: what should its future be?*, viewed 14 June 2008, < http://www.cpha.ca/literacyandhealth/october17.html>.
Wingard, R 2005, 'Patient education and the nursing process: meeting the patient's needs', *Nephrology Nursing Journal*, vol. 32, no. 2, pp. 212-214.
World Health Organization [WHO] 1998, Health promotion Glossary, *Health Promotion International*, p.10.

## SECTION THREE

**In this section you are asked to respond to a series of statements that have been collated from a review of related literature. Please indicate your opinion from five possible choices: strongly agree, agree, neutral, disagree and strongly disagree. Please mark the box which most closely represents how you feel and in the space provided write any comments about the statement.**

1. **Being health literate means more than being able to read pamphlets and successfully make appointments.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

2. **Improving health literacy amongst children and young people is important for their health and wellbeing.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

3. **Health literacy is part of lifelong learning.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

4. **Health literacy is a priority focus in health.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

5. **Promotion of health literacy by child and youth nurses is essential.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

6. **Being health literate enables people to better manage their own health.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

7. **A child or young person who is health literate can access, interpret, and understand basic health information.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

8. **A parent/guardian of a child or young person who is health literate has the skills to use health services to promote their child's health and well-being.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

9. **Being health literate should help more children and young people understand their needs.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

10. A low level of functional health literacy can affect anyone. (See definitions of functional health literacy)

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

11. Low health literacy increases health care costs at an individual level.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments –

12. Being health literate will enable children and young people to make informed health care decisions.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

13. Being health literate will enable parents/guardians of children and young people to make informed health care decisions.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

14. Children and young people with low health literacy are unlikely to seek preventive health care.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

15. Parents/Guardians of children and young people with low health literacy skills are unlikely to facilitate preventive care for their children.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

16. It is important for child and youth health nurses to recognize health literacy problems in children and young people.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

17. It is important for child and youth health nurses to recognize health literacy problems in parents/guardians of children and young people.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

18. Improving an individual's health literacy will help overcome health inequalities.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

19. Health literacy development should be an integral component of health promotion for children and young people.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

**20. Health education provided by child and youth health nurses is necessary.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

**21. Providing health education to children and young people will not always result in adopting good health habits/behaviors.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

**22. Health education alone will not be useful to people who do not feel that they have the capacity to change their personal circumstances.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

**23. Educating children and young people about their health should be an essential part of nursing.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

**24. Clarifying the concept of health literacy to child and youth health nurses is essential.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

**25. Nursing and midwifery curricula and/or staff development should address health literacy.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

_____

_____

_____

_____

**26. Healthcare professionals generally assume health consumers to be functionally health literate. (See definitions of functional health literacy)**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments –**

_____

_____

_____

_____

**27. There is little or no time for health education in current health settings.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

_____

_____

_____

_____

**28. Child and youth health nurses may have deficits about health literacy.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

_____

_____

_____

_____

**THANK YOU FOR TAKING THE TIME TO**

**COMPLETE THIS QUESTIONNAIRE**

## First Delphi Questionnaire

A critical analysis of the construction of health literacy

by paediatric and child and youth health RNs

**Delphi Survey**

**Questionnaire One**

**Researcher – Ola Kutah**

Phone – (8)83021158

Mobile –0422742537

**PLEASE ANSWER ALL QUESTIONS AND RETURN YOUR COMPLETED SURVEY VIA EMAIL TO ola.kutah@postgrads.unisa.edu.au OR AS A HARD COPY TO THE SCHOOL OF NURSING & MIDWIFERY RECEPTION DESK ON LEVEL 6, CENTENARY BUILDING BY THE 8th OF DECEMBER**

THANK YOU FOR PARTICIPATING

**SECTION ONE**

**Please mark the appropriate box**

**Socio-demographic data**

1. **What is your current position or its equivalent in your state?**

☐ Director of Nursing

☐ Clinical Nurse Consultant

☐ Staff Development Coordinator

☐ Nurse Practitioner

☐ Nurse Specialist

☐ Head of School

☐ Course Coordinator

☐ Senior Lecturer/Lecturer

☐ Other (please specify)

_____

_____

_____

2. **Please mark the age bracket that includes your age**

☐ 20-29 years

☐ 30-39 years

☐ 40-49 years

☐ 50-59 years

☐ 60-69 years

3. **Gender**

☐ Male

☐ Female

4. **What is your highest educational qualification?**

☐ PhD

☐ Masters degree

☐ Bachelor degree

☐ Diploma

☐ Certificate

☐ Other (please specify)

_____

_____

_____

5. **Please indicate the number of years you have been working within the area of child and youth health**

_____

_____

_____

**SECTION TWO**

**Many definitions of health literacy & health education exist. To assist in providing a context for the statements in Section 3, some definitions are provided below.**

**Health literacy:**

'The ability to access, understand, and communicate information to engage with demands of different health contexts to promote good health across the life-course'. (Rootman, El-Bihbety, Kaszap, Frankish & Hemming 2005)

'Represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use the information in ways which promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment' (WHO 1998, p. 10)

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'...constellation of skills, including the ability to perform basic reading and numerical tasks required to function in the health care environment' (The Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs of the American Medical Association 1999).

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**References:**

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Rootman, I, El-Bihbety, D, Kaszap, M, Frankish, J, Hemming, H 2005, *Canadian literacy and health research program: what should its future be?,* viewed 14 June 2008, < http://www.cpha.ca/literacyandhealth/october17.html>.
Wingard, R 2005, 'Patient education and the nursing process: meeting the patient's needs', *Nephrology Nursing Journal,* vol. 32, no. 2, pp. 212-214.
World Health Organization [WHO] 1998, Health promotion Glossary, *Health Promotion International*, p.10.

**SECTION THREE**

**In this section you are asked to respond to a series of statements that have been collated from a review of related literature. Please indicate your opinion from five possible choices: strongly agree, agree, neutral, disagree and strongly disagree. Please mark the box which most closely represents how you feel and in the space provided write any comments about the statement.**

1. **Being health literate means more than being able to read pamphlets and successfully make appointments.**

**Strongly disagree** ☐ **Disagree** ☐ **Unsure** ☐ **Agree** ☐ **Strongly agree** ☐

**Comments -**

_____

_____

_____

_____

2. **Improving health literacy amongst children and young people is important for their health and wellbeing.**

**Strongly disagree** ☐ **Disagree** ☐ **Unsure** ☐ **Agree** ☐ **Strongly agree** ☐

**Comments -** _____

3. Health literacy is part of lifelong learning.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

4. Health literacy is a priority focus in health.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

5. Promotion of health literacy by child and youth nurses is essential.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

6. Being health literate enables people to better manage their own health.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

7. A child or young person who is health literate can access, interpret, and understand basic health information.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

8. A parent/guardian of a child or young person who is health literate has the skills to use health services to promote their child's health and well-being.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

9. Being health literate should help more children and young people understand their needs.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

10. A low level of functional health literacy can affect anyone. (See definitions of functional health literacy)

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

11. Low health literacy increases health care costs at an individual level.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments –

12. Being health literate will enable children and young people to make informed health care decisions.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

13. Being health literate will enable parents/guardians of children and young people to make informed health care decisions.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

14. Children and young people with low health literacy are unlikely to seek preventive health care.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|

☐ ☐ ☐ ☐ ☐

Comments -

15. Parents/Guardians of children and young people with low health literacy skills are unlikely to facilitate preventive care for their children.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

16. It is important for child and youth health nurses to recognize health literacy problems in children and young people.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

17. It is important for child and youth health nurses to recognize health literacy problems in parents/guardians of children and young people.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

18. Improving an individual's health literacy will help overcome health inequalities.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

19. Health literacy development should be an integral component of health promotion for children and young people.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

20. Health education provided by child and youth health nurses is necessary.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

21. Providing health education to children and young people will not always result in adopting good health habits/behaviors.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

22. Health education alone will not be useful to people who do not feel that they have the capacity to change their personal circumstances.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

23. Educating children and young people about their health should be an essential part of nursing.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

24. Clarifying the concept of health literacy to child and youth health nurses is essential.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

25. Nursing and midwifery curricula and/or staff development should address health literacy.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

26. Healthcare professionals generally assume health consumers to be functionally health literate. (See definitions of functional health literacy)

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments –

27. There is little or no time for health education in current health settings.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

28. Child and youth health nurses may have deficits about health literacy.

Strongly disagree Disagree Unsure Agree Strongly agree

☐ ☐ ☐ ☐ ☐

Comments -

THANK YOU FOR TAKING THE TIME TO

COMPLETE THIS QUESTIONNAIRE

**Second Delphi Questionnaire including letter to participants pertaining the summary of results from the first Delphi questionnaire**

**A critical analysis of the construction of health literacy**

**by paediatric and child and youth health RNs**

**Delphi Survey**

**2nd Round Questionnaire**

**Researcher – Ola Kutah**

Phone – (8)83021158

Mobile –0422742537

Dear .....

Thank you again for participating in my doctoral research project. Please find enclosed the 2nd Round Delphi survey questionnaire as well as a statistical summary of the responses from the 1st Round. This is only for information to provide you with some idea of where your responses may have been in relation to other participants. The statistic used for reporting the responses is the mode; this statistic reflects the response chosen most frequently by you and other participants for each question.

Please note that there are no correct or incorrect responses. Most statements had a mode of 5 indicating agreement. The only statements where this differed were:

Question 4 - Health literacy is a priority focus in health policy.
Question 10 - A low level of functional health literacy can affect anyone.
Question 11 - Low health literacy increases health care costs at an individual level.
Question 14 - Children and young people with low health literacy are unlikely to seek preventive health care.
Question 15 - Parents/Guardians of children and young people with low health literacy skills are unlikely to facilitate preventive care for their children.
Question 18 - Improving an individual's health literacy will help overcome health inequalities.
Question 26 - Healthcare professionals generally assume health consumers to be functionally health literate.
Question 27 - There is little or no time for health education in current health settings, and;
Question 28 - Child and youth health nurses may have deficits about the concept of health literacy, where participants indicated they were either unsure or did not agree with theses statements.

I am forwarding you the 2nd Round Delphi Survey electronically via email and as a hard copy. Please answer all questions and return your completed survey via email to ola.kutah@postgrads.unisa.edu.au or by post in the stamped addressed envelope I will also forward for your convenience. Please return your completed questionnaire by the 5th of June 2009.

Again, I appreciate your participation and look forward to receiving your completed 2nd Round questionnaire. My supervisors (Dr. Kay Price and Professor Helen McCutcheon) and I are very happy to answer any questions or queries you may have.

Yours sincerely

Ola Kutah, PhD Candidate
School of Nursing and Midwifery
University of South Australia
GOP Box 2471
Adelaide SA 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

**Descriptive Analysis of the responses to statements 1-28**

The mode is the score with greatest frequency.

**Statement 1 - Being health literate means more than being able to read pamphlets and successfully make appointments.** The mode was 5. 96.9% of participants selected agree or strongly agree on the Likert scale

**Statement 2 - Improving health literacy amongst children and young people is important for their health and wellbeing.** The mode was 5. 96.9% of participants selected agree or strongly agree on the Likert scale.

**Statement 3 - Health literacy is part of lifelong learning.** The mode was 5. 93.7% of participants selected agree or strongly agree on the Likert scale.

**Statement 4 - Health literacy is a priority focus in health policy.** The mode was 4. 31.3% of participants either disagreed or strongly disagreed, 15.6% were unsure and 53.1% agreed or strongly agreed on the Likert scale.

**Statement 5 - Promoting health literacy should be an essential element of child and youth nurse practice.** The mode was 5. 100% of participants selected agree or strongly agree on the Likert scale.

**Statement 6 - Being health literate may enable people to better manage their own health.** The mode was 5. 96.9% of participants selected agree or strongly agree on the Likert scale.

**Statement 7 - A child or young person who is health literate may access, understand, and interpret basic health information.** The mode was 5. 96.9% of participants selected agree or strongly agree on the Likert scale.

**Statement 8 - A parent/guardian of a child or young person who is health literate has the skills to use health services to promote their child's health and well-being.** The mode was 5. 87.1% of participants selected agree or strongly agree on the Likert scale.

**Statement 9 - Being health literate should help more children and young people understand their needs.** The mode was 4. 93.8% of participants selected agree or strongly agree on the Likert scale.

**Statement 10 - A low level of functional health literacy can affect anyone.** The mode was 4. 6.3% of participants either disagreed or strongly disagreed, 15.6% were unsure and 78.1% of participants selected agree or strongly agree on the Likert scale.

**Statement 11 - Low health literacy increases health care costs at an individual level.** The mode was 4. 6.2% of participants either disagreed or strongly disagreed, 21.9% were unsure and 71.9% of participants selected agree or strongly agree on the Likert scale.

**Statement 12 - Being health literate will enable children and young people to make informed health care decisions.** The mode was 5. 93.5% of participants selected agree or strongly agree on the Likert scale.

**Statement 13 - Being health literate will enable parents/guardians of children and young people to make informed health care decisions.** The mode was 5. 93.3% of participants selected agree or strongly agree on the Likert scale.

**Statement 14 - Children and young people with low health literacy are unlikely to seek preventive health care.** The mode was 4. 12.5% of participants either disagreed or strongly disagreed, 9.4% were unsure and 78.2% of participants selected agree or strongly agree on the Likert scale.

**Statement 15 - Parents/Guardians of children and young people with low health literacy skills are unlikely to facilitate preventive care for their children.** The mode was 4. 15.6% of participants either disagreed or strongly disagreed, 6.3% were unsure and 78.1% of participants selected agree or strongly agree on the Likert scale.

**Statement 16 - It is important for child and youth health nurses to recognize health literacy problems experienced by children and young people.** The mode was 5. 100% of participants selected agree or strongly agree on the Likert scale.

**Statement 17 - It is important for child and youth health nurses to recognize health literacy problems experienced by parents/guardians of children and young people.** The mode was 5. 100% of participants selected agree or strongly agree on the Likert scale.

**Statement 18 - Improving an individual's health literacy will help overcome health inequalities.** The mode was 4. 12.5% of participants either disagreed or strongly disagreed, 15.6% were unsure and 71.9% of participants selected agree or strongly agree on the Likert scale.

**Statement 19 - Health literacy development should be an integral component of health promotion for children and young people.** The mode was 5. 100% of participants selected agree or strongly agree on the Likert scale.

**Statement 20 - Health education which includes health literacy should be provided by child and youth health nurses.**The mode was 5. 84.4% of participants selected agree or strongly agree on the Likert scale.

**Statement 21 - Providing health education to children and young people will not always result in adopting good health habits/behaviors.**The mode was 4. 93.8% of participants selected agree or strongly agree on the Likert scale.

**Statement 22 - Health education alone will not be useful to people who do not feel that they have the capacity to change their personal circumstances.**The mode was 4. 84.4% of participants selected agree or strongly agree on the Likert scale.

**Statement 23 - Educating children and young people about their health should be an essential part of nursing.**The mode was 5. 100% of participants selected agree or strongly agree on the Likert scale.

**Statement 24 - Clarifying the concept of health literacy to child and youth health nurses is essential.** The mode was 4. 93.8% of participants selected agree or strongly agree on the Likert scale

**Statement 25 - Nursing and midwifery curricula and/or staff development should address health literacy.**The mode was 5. 96.9% of participants selected agree or strongly agree on the Likert scale.

**Statement 26 - Healthcare professionals generally assume health consumers to be functionally health literate.** The mode was 4. 31.3% of participants either disagreed or strongly disagreed, 12.5% were unsure and 56.3% of participants selected agree or strongly agree on the Likert scale.

**Statement 27 - There is little or no time for health education in current health settings.** The mode was 4. 31.3% of participants either disagreed or strongly disagreed, 21.9% were unsure and 46.9% of participants selected agree or strongly agree on the Likert scale.

**Statement 28 - Child and youth health nurses may have deficits about the concept of health literacy.** The mode was 4. 21.9% were unsure and 78.1% of participants selected agree or strongly agree on the Likert scale.

## SECTION ONE

**In this section you are asked to respond to a series of statements that have been collated from review of related literature. Please indicate your opinion from five possible choices: strongl agree, agree, neutral, disagree and strongly disagree. Please mark the box which most closel represents how you feel about the statement.**

1. **Child, youth and paediatric nurses have a professional responsibility to improve children and young people's access to evidenced based information.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

2. **Child, youth and paediatric nurses have a professional responsibility to improve how children and young people learn to navigate the health care system.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

3. **Child, youth and paediatric nurses have a professional responsibility to improve how children and young people learn to know what is good advice related to their health.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

4. **A child, youth and paediatric nurse can create the appropriate opportunities for children and young people to learn about being health literate.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

5. **A child, youth and paediatric nurse can create the appropriate opportunities for children and young people and their parents/ guardians to learn about being health literate.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

6. **Child, youth and paediatric nurses have a professional responsibility to take a long term view to educating children and young people about their health during any professional encounter.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

7. **Child, youth and paediatric nurses have a professional responsibility to explore ideas on how to improve a child's or young person's health literacy.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

8. **A child, youth and paediatric nurse can create the appropriate opportunities for children and young people and their parents/ guardians to understand how to make healthy choices in their everyday lives.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

9. **It is possible for children and young people to learn how to say no to unhealthy activities.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

10. **Children and young people learn about how to be healthy from their parents not child, youth and paediatric nurses.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

11. **Child, youth and paediatric nurses' ability to provide effective health advice to children and young people is influenced by their own health literacy.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments –**

12. **Child, youth and paediatric nurses have a professional responsibility to evaluate children and young people's health literacy skills.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

13. **The provision of health education is an instrument of change.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

14. **Child, youth and paediatric nurses have a professional responsibility to advocate for a focus on health literacy for children and young people.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

15. **Child, youth and paediatric nurses have a professional responsibility to be aware of how health policy related to children and young people is informed, developed and in turn enacted.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

16. **Child, youth and paediatric nurses have a professional responsibility to communicate the importance of health literacy to children, young people and their parents/guardians.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

17. **Child, youth and paediatric nurses are important role-models for children and young people.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

18. **Child, youth and paediatric nurses have a professional responsibility to undertake research on health literacy.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

19. **There is a lack of opportunities for child, youth and paediatric nurses to promote health literacy for children and young people.**

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**Comments -**

20. Child, youth and paediatric nurses have a professional responsibility to recognise that low health literacy can be a problem effecting children and young people's health outcomes.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

21. Child, youth and paediatric nurses have a professional responsibility to focus on assisting children and young people to realise that prevention of non-communicable diseases is a possibility.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

22. Child, youth and paediatric nurses have a professional responsibility to evaluate whether parents/guardians of children or young people with whom they interact are health literate.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

23. Child, youth and paediatric nurses have a professional responsibility to influence the health literacy levels of children and young people.

| Strongly disagree | Disagree | Unsure | Agree | Strongly agree |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Comments -

**THANK YOU FOR TAKING THE TIME TO**

**COMPLETE THIS QUESTIONNAIRE**

## First Delphi Questionnaire Participants' Comments

| Statements | Comments |
|---|---|
| **1. Being health literate means more than being able to read pamphlets and successfully make appointments.** | **Participant #12**<br>'Reading pamphlets is a GOOD START. – Considering many Australian have literacy difficulties (i.e. 30% of Australian population has only "functional literacy levels or less") – the pamphlets provide a good pictorially based introduction to healthy issues and starts to 'get the message out there.'<br>**Participant #14**<br>'Although which contributes to improving health is important and one doesn't have to be an expert or read to degree level to distribute health lit/promotion.'<br>**Participant #15**<br>'Families need to know about what is normal health so that they know when something is not right. They need to be educated about illness and how to maintain optimum health.'<br>**Participant #16**<br>'It is keeping up-to-date with current trends in your own specialty for health care professionals. It is knowing what is best for your own health for a lay person (the general public).'<br>**Participant #17**<br>'It's what you do or don't do in your life. I prefer the Kickbusch definition.'<br>**Participant #26**<br>'Children and families need to understand their health needs and the services available to meet these needs. Only then will people be more involved in optimizing their health and wellbeing.'<br>**Participant #31**<br>'Literacy includes understanding the content well enough to appreciate its significance.'<br>**Participant #34**<br>'Understanding of disease and risk factors and health promotion is critical to this.' |
| **2. Improving health literacy amongst children and young people is important for their health and wellbeing.** | **Participant #12**<br>'This is the BEST place to start – building a foundation of basic health literacy skills on which a more detailed picture can be evolved over time.'<br>**Participant #15**<br>'Education about their bodies and what is normal and what is not is very important for the well being of young people. Parents need to be educated during the antenatal period about how to best care for their new baby.'<br>**Participant #17**<br>'To take control of something you have to be able to understand it and talk about it and in the case of children convince others that you understand why you are doing something (unlike adults who are permitted to be as dumb as they like)'' |

| Statements | Comments |
|---|---|
| **(2 – continued)**<br>**Improving health literacy amongst children and young people is important for their health and wellbeing.** | **Participant #26**<br>'Compliance becomes an issue as children grow older as they oppose "expert" ideas of healthcare. It's important for them to understand their health needs and the services to avoid adverse health outcomes – to optimize their full potential in health and wellbeing as well as social and psychological aspects of life in the future.'<br>**Participant #31**<br>'Yes, to learn lifelong good health habits.'<br>**Participant #34**<br>'Foundational building blocks of a healthy society.' |
| **3. Health literacy is part of lifelong learning.** | **Participant #12**<br>'Yes – fun, simple and pictorial at first – changing approaches as cognitive skills develop and understanding increases.'<br>**Participant #16**<br>'But it should be.'<br>**Participant #17**<br>'Health is a journey and you have to be able to respond/ adapt to changes in your situation, to make it part of your way of being.'<br>**Participant #26**<br>'Childhood/adolescence is a window of opportunity for healthy behaviours to be established. Even at an older age adapting behaviours to promote one's health and wellbeing is vital for health to health in later years.'<br>**Participant #34**<br>'One critical fact.' |
| **4. Health literacy is a priority focus in health policy.** | **Participant #12**<br>'While health literacy is a focus, I would disagree that it is a strong focus. While public health campaigns aim to raise awareness of one or two major health issues i.e. Smoking and Sunsafe, there is a lack of a wide ranging awareness campaigns that would raise literacy in many highly relevant health areas.'<br>**Participant #13**<br>'Particularly mental health and primary health care.'<br>**Participant #16**<br>'But it should be.'<br>**Participant #17**<br>'Health is becoming an even bigger issue in Australia – some would say it's the new morality but I don't know that the politicians in particular understand that it's something that requires education not just reading. Although the health policy people are much more aware of its importance, however, I cannot think off the top of my head of a policy outside school.'<br>**Participant #19**<br>'I am not sure that it is a priority but if it isn't, it should be.' |

| Statements | Comments |
|---|---|
| **(No 4 - continued)**<br>**Health literacy is a priority focus in health policy.** | **Participant #22**<br>'Am not convinced it is included in health policy as highly prioritised as it could be.'<br>**Participant #26**<br>'It needs to be more of a priority with more Government funding and initiatives directed towards it. Engaging people in making decisions about their own health promotes responsibility and ownership.'<br>**Participant #28**<br>'I know of only one country in the world that is actively seeking to incorporate health literacy in young people- Cuba.'<br>**Participant #31**<br>'Health policy is more about health care and health service than literacy issues.'<br>**Participant #34**<br>'Not as positive/priority as it should be.' |
| **5. Promoting health literacy should be an essential element of child and youth nurse practice.** | **Participant #12**<br>'Knowing that children are quick learns and that what they learn in their early years plays an important role in their decision making in later years is a key to improving health outcomes. Start early to get those key messages across...'<br>**Participant #17**<br>'Yes the idea is to facilitate children's control and independence, to seek information and support independently, as part of one's interactions with them.'<br>**Participant #26**<br>'The course that I'm doing at the moment emphasizes working in partnership with parents. By doing so, health professionals can empower families to aim for the best- with optimal outcomes for their child's physical, mental and social wellbeing.'<br>**Participant #31**<br>'As part of promoting self efficacy.'<br>**Participant #34**<br>'So many times children and families bounce back to a facility, increasing health literacy for this group is critical to their self-reliant wellbeing' |
| **6. Being health literate may enable people to better manage their own health.** | **Participant #12**<br>'While it would be fantastic if people managed their health better on the basis of improved health literacy it is not, on its own a panacea for all ills. It must be supported by additional strategies that reinforce primary health literacy messages. For example, even though there has been a concerted effort to reduce alcohol drinking and driving there are still many people who, even though they would be considered 'health literate' in this matters, still continue to drink and drive...many of them well would be considered highly literate and well educated. I the same vein, many people still smoke regardless of the massive health literacy campaign.'<br>**Participant #14**<br>'Although managing health doesn't mean improving their health.' |

| Statements | Comments |
|---|---|
| **(No 6 – continued)**<br>**Being health literate may enable people to better manage their own health.** | **Participant #17**<br>'It's essential to begin with but it won't help if you cannot do anything to manage your health, e.g. buy fresh food'<br>**Participant #26**<br>'Increasing people's control over their health increases their ability to take responsibility – and engages them more in their health care.'<br>**Participant #34**<br>'So many times children and families bounce back to a facility, increasing health literacy for this group is critical to their self-reliant wellbeing' |
| **7. A child or young person who is health literate may access, understand, and interpret basic health information.** | **Participant #12**<br>'I think perhaps you need to include the word 'may BETTER access, understand, and interpret basic health information, in comparison to those who are not health literate - just because they know a little more does not mean that they WILL access, understand or interpret basic health information.'<br>**Participant #17**<br>'Isn't this a tautology?'<br>**Participant #22**<br>'Depends on context and if information is appropriate for context, developmentally and age appropriate.'<br>**Participant #26**<br>'It's an ongoing process. There is no time–line to health literacy. As new research and findings are being published so new measures for improving health will be found'<br>**Participant #34**<br>'This is the hope.' |
| **8. A parent/guardian of a child or young person who is health literate has the skills to use health services to promote their child's health and well-being.** | **Participant #12**<br>'This may not be necessarily so, as a child who has been educated in health matters may have families that have never been so and will not understand health issues as much as their child does. I am thinking here of migrant families where parents do not speak English as well as the child and are unaware of health matters and health services available to them.'<br>**Participant #14**<br>'If this is the case, we surely wouldn't have the level of obesity etc. or ADHD.'<br>**Participant #16**<br>'Not necessarily. Depends on the literacy of the parent.'<br>**Participant #17**<br>'It also depends on the sensitivity of the service to listen to the carer- maybe we should teach 'assertiveness training'.'<br>**Participant #22**<br>'This is assuming the parent has enough or all the information required to make an informed decision and has a measure of understanding. There are factors that can influence the parent/guardian in decision making.' |

| Statements | Comments |
|---|---|
| **(No 8 – continued)**<br>**A parent/guardian of a child or young person who is health literate has the skills to use health services to promote their child's health and well-being** | **Participant #26**<br>'The health services still need to be available and accessible to those in need. There are still areas of disadvantage amongst certain communities in Australia.'<br>**Participant #28**<br>'It would be interesting to investigate the health literacy of children born to health professionals.' |
| **9. Being health literate should help more children and young people understand their needs.** | **Participant #12**<br>'One would think that being health literate SHOULD help more children understand their health needs, but it will not always be so. I think here of the example of teenage pregnancies. Even though there has been a concerted campaign over the years (in schools) to raise awareness of sex health issues, teenage pregnancy is still a major occurrence in some communities. Just being health 'literate' does not mean that you will follow advice....there are many other factors/forces operating in a child's world that will affect decision making. i.e. family values and beliefs, culture, social norms, peer group pressure etc'<br>**Participant #20**<br>'Not sure what needs refers to here.'<br>**Participant #26**<br>'There is so much information out there, accessible on the net. As health professionals, we need to guide young people in the direction of age-appropriate and need-appropriate information for them to be able to use it for their best outcome.'<br>**Participant #28**<br>'It depends upon the child – but in theory yes this should be so. Too many variables to state so conclusively.'<br>**Participant #34**<br>'We need to not rely so much on 3rd party health practitioners and use health literacy as a means of improving self-reliance. .' |
| **10. A low level of functional health literacy can affect anyone.** | **Participant #12**<br>'No doubt about it.'<br>**Participant #26**<br>'There can be times of low level health literacy in anyone when people are bombarded by conflicting information. Stress, anxiety, depression and fatigue can also affect a person's ability and cognitive functioning – making it difficult to understand health concepts and relate them to self'<br>**Participant #31**<br>'There are other avenues of gaining health knowledge.'<br>**Participant #34**<br>'We have great access to health care in this country.' |

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| **11. Low health literacy increases health care costs at an individual level.** | **Participant #12**<br>'Perhaps not initially in life, but as the child grows and makes choices that affect health in a negative way (i.e. smoke, drink, drive fast, don't exercise regularly etc) then health care costs increase as disease processes take place. Although, there was once a study done in Czechoslovakia that came to the conclusion that it was a lot cheaper for the government to not stop people smoking - if they smoked, they may have expensive health costs for a short time while dying of cancer, but then it was cheaper for the government to have them die young than to look after a lot of elderly people who lived long lives!! (And they got the taxes from the cigarettes in the meantime...)'<br>**Participant #14**<br>'I think this is too complex an issue for a Likert question.'<br>**Participant #17**<br>'Initially, we are told that health prevention is cheaper for the state than treatment but it is not necessarily so, as they may not know what to ask for or for what they are eligible'<br>**Participant #20**<br>'The individual who does not access health care or engage in preventative health measures has low costs. i.e. the individuals have ↓ costs community ↑ costs '<br>**Participant #22**<br>'Not sure, this statement assumes that low health literacy is accompanied by ill health? Is that the intent or assumption?'<br>**Participant #26**<br>'Low health literacy increases health care costs on an individual, national and global level. 'Prevention is better than cure' when viewed in the context of physical, mental and social aspects of self as well as the burden on health services for people with preventable ill health'<br>**Participant #28**<br>'It is possible – but again too many variables to consider.'<br>**Participant #34**<br>'To a degree. Congenital defects are difficult to account for.' |
| **12. Being health literate will enable children and young people to make informed health care decisions.** | **Participant #12**<br>'It will certainly improve the chances that they will make more informed choices...but is no guarantee that they will.'<br>**Participant #14**<br>'It should but it probably isn't important enough to them.'<br>**Participant #16**<br>'Sometimes.'<br>**Participant #17**<br>'While this is the idea again, not necessarily because adults often have to help children develop and make their case, although of course it is vital.'<br>**Participant #22**<br>'Ideally yes, but this assumes that individuals have the capacity and means to act on the basis of being informed, again context is important.' |

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| **(No 12 – continued)**<br>**Being health literate will enable children and young people to make informed health care decisions** | **Participant #26**<br>'Children and young people, despite having the information and understanding, will need the support of family, friends and their community to make appropriate health care decisions'<br>**Participant #28**<br>'I believe this would be the optimum situation.<br>**Participant #29**<br>'This is one dimension only. There are many factors which affect health care decisions.'<br>**Participant #34**<br>'Knowledge is power.' |
| **13. Being health literate will enable parents/guardians of children and young people to make informed health care decisions.** | **Participant #12**<br>'I am not sure what this question is asking me - I assume you mean if the parents are health literate - rather than the child...I certainly believe that if parents have the opportunity to learn more about important health issues in regard to their children then they will make more informed health care decisions. This, of course, may not mean that their decisions match those of mainstream medicine discourses – I am thinking here of families (usually highly educated parents) who chose NOT to have their children vaccinated.... they would consider their decision to be very well informed... while mainstream medicine would not.'<br>**Participant #17**<br>'Well of course it will help but someone has to be listening and facilitating.'<br>**Participant #22**<br>'Ideally, yes, but again assumes parents have the capacity and means and will act on the basis of being well informed. Other influences may need to be considered.'<br>**Participant #26**<br>'Parents/guardians too need support and understanding of their community to make important decisions about their child's health, especially if there are cultural or religious conflicts.'<br>**Participant #28**<br>'If you accept the evidence.' |
| **14. Children and young people with low health literacy are unlikely to seek preventive health care.** | **Participant #12**<br>'Definitely less likely - but often not just a result of low health literacy - if services in the area are not easily accessible and visible , then seeking preventative health care is often not possible.'<br>**Participant #14**<br>'Parents bring children in to clinics to get vaccinations.'<br>**Participant #17**<br>'Yes you are unlikely to realise that prevention is a possibility, or have a sense of control'<br>**Participant #22**<br>'May be unlikely to seek preventative care, other influences in their lives may also influence.' |

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| **(No 14 – continued)**<br>**Children and young people with low health literacy are unlikely to seek preventive health care** | **Participant #26**<br>'Children and young people with low health literacy are unlikely to seek preventive as well as GP health care. It will also depend greatly on the health literacy of their parents who may access health services on their behalf. As health literacy is viewed as lifelong learning, these young people with low health literacy still have the capacity to become adults involved in maintain their own health and wellbeing. Some of the issues in adulthood (smoke, heart disease, diabetes) however could have been avoided'<br>**Participant #28**<br>'This was clearly the case when I worked in the field of sexual health.'<br>**Participant #34**<br>'How would they know?' |
| **15. Parents/Guardians of children and young people with low health literacy skills are unlikely to facilitate preventive care for their children.** | **Participant #12**<br>'How can you expect to engage in preventative care when you do not have a foundational understanding of health issues?'<br>**Participant #17**<br>'See 14--Yes you are unlikely to realise that prevention is a possibility, or have a sense of control'<br>**Participant #26**<br>'Parents/guardians with low health literacy often see health professionals as 'experts' and diminishes their control over their health and that of their children. By supporting, guiding and working closely with these families, more optimal outcomes for children can be achieved'<br>**Participant #34**<br>'I presume so but can't be sure.' |
| **16. It is important for child and youth health nurses to recognize health literacy problems experienced by children and young people.** | **Participant #12**<br>'As a well trained professional it is often difficult to understand how other people cannot possibly have a more comprehensive knowledge of their own health. I feel many health professionals fail to recognise their own biases in this regard.'<br>**Participant #17**<br>'It is a fundamental part of practice to elicit the child/parents understanding in order to treat ethically, in terms of consent and simply to make a thorough assessment<br>One must consider though, e.g. Is the individual literate; how do they understand their body, do they have an internal or an external locus of control?'<br>**Participant #20**<br>'They should assume so unless assessment proves otherwise'<br>**Participant #26**<br>'It is important to address deficits in knowledge of children and young people and their parents about their health and wellbeing. Attitudes of health professionals and time constraints in health care settings all have an impact on the level of appropriate intervention/ education/ knowledge of these children and families' |

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| **(No 16 – continued)**<br>**It is important for child and youth health nurses to recognize health literacy problems experienced by children and young people** | **Participant #28**<br>'All nurses should be - in the laws of health not just the law of pathology. Fundamental change to the curricula is required.'<br>**Participant #34**<br>'Should be as incorporated component of discharge planning.' |
| **17. It is important for child and youth health nurses to recognize health literacy problems experienced by parents/guardians of children and young people.** | **Participant #17**<br>'See Q 16--It is a fundamental part of practice to elicit the child/parents understanding in order to treat ethically, in terms of consent and simply to make a thorough assessment.<br>One must consider though, e.g. Is the individual literate; how do they understand their body, do they have an internal or an external locus of control?'<br>**Participant #26**<br>'Same as above - It is important to address deficits in knowledge of children and young people and their parents about their health and wellbeing. Attitudes of health professionals and time constraints in health care settings all have an impact on the level of appropriate intervention/ education/ knowledge of these children and families'<br>**Participant #34**<br>'Difficult but necessary.' |
| **18. Improving an individual's health literacy will help overcome health inequalities.** | **Participant #11**<br>'It may assist individuals' awareness of services but not necessarily assist their ability to access services. There are multiple contributors to health inequality; health literacy may only assist in the process of overcoming.'<br>**Participant #13**<br>'There are many structural barriers beyond individual control that maintain health inequalities.'<br>**Participant #17**<br>'Yes knowledge is power but it has to be thought through; health is multiply determined.'<br>**Participant #19**<br>'To some extent.'<br>**Participant #22**<br>'Health literacy is but one part of what can contribute to the influences and determinants of health.'<br>**Participant #26**<br>'An individual's increased knowledge of health and understanding of their needs are important but they but they may still not have the accessibility of health services. Governments and NGOs can all help in improving provision and accessibility to health services for <u>all</u>'<br>**Participant #28**<br>'I would like to believe no.'<br>**Participant #29**<br>'Health equality needs to be addressed from a number of perspectives. This would be only one way. Policy, staffing etc all contribute to ensuring all people have access to relevant health care.'<br>**Participant #31**<br>'Inequality is a complex notion and involves more than literacy.' |

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| **19. Health literacy development should be an integral component of health promotion for children and young people.** | **Participant #11**<br>'Health promotion concepts cannot be understood without a level of health literacy.'<br>**Participant #16**<br>'Should be in schools.'<br>**Participant #17**<br>'Health in western medicine is a complex, massive issue, it requires the development of a conceptual understanding – there is more to it (if it meaningful) than learning to wash your hands. What do glycaemic index levels mean?'<br>**Participant #21**<br>'Health education can be provided by all nurses and midwives.'<br>**Participant #26**<br>'The health and wellbeing of children should be the priority of all communities and nations. To do that, there should be policies in place at international, national and local level based on health literacy being an integral part of health care.'<br>**Participant #28**<br>'Refer to question 4. This topic should be a mandatory part of the school curricula and School Nurses/ Public health Nurses should support School Teachers, who have had health literacy training in the delivering of the topic.' |
| **20. Health education which includes health literacy should be provided by child and youth health nurses.** | **Participant #11**<br>'Education about health can be provided by any discipline who has opportunity, accurate and relevant information.'<br>**Participant #12**<br>'While child and youth nurses are more than capable of promoting health literacy – to isolate health education to this group alone limits many possibilities.... extent of reach (are their child and youth health nurses in ALL communities? – no)... types of promotion - most child and youth workers have limitations on how they operate - other community workers may not be so limited...<br>It is VERY possible to employ other educated people to assist in promoting health literacy - for example,<br>teenagers with melanoma, or those who have survived cancer, car accidents, drug overdoses etc have been enormously successful in encouraging others to consider the health risks they are taking – this is an EXCELLENT peer education technique - and reaches an age group that would not normally take a minute to listen to a nurse.<br>The options about who can engage in health literacy is enormous... please don't limit it to one small group that struggles to fulfil the many roles demanded of it already!!'<br>**Participant #16**<br>'Someone within right information and an ability to present the information and educate the children and young people not just show them.' |

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| **(No 20 – continued)**<br>**Health education which includes health literacy should be provided by child and youth health nurses** | **Participant #17**<br>'It's not just a question of health literacy it's a question of rights and consent (or assent if the child is under 12 yrs) if the child is your patient. If it's for a healthy population then you would look at specific groups of nurses e.g. school nurses.'<br>**Participant #18**<br>'Depends upon nurse's role, time restraints. May not be most qualified to do this'<br>**Participant #22**<br>'In addition to other forums and provider settings.'<br>**Participant #26**<br>'Health education/ promotion should be a priority for health professional. It is also the domain of education and sporting groups to engage and challenge young people in changing/improving their behaviours – to optimise health and wellbeing.'<br>**Participant #34**<br>'And others – schools, sporting groups, kindergartens.' |
| **21. Providing health education to children and young people will not always result in adopting good health habits/behaviours.** | **Participant #11**<br>'The effectiveness of health education should always be evaluated to continually attempt to optimum result.'<br>**Participant #12**<br>'There is little doubt that health education does not always work – you just need to look at the number of nurses who STILL smoke to realise that health education is not always successful!!'<br>**Participant #17**<br>'For about a million reasons, almost all of which are outside the nurses control, e.g. junk food advertising'<br>**Participant #18**<br>'May not be receptive to info – Not what they want to hear'<br>**Participant #26**<br>'Adapting health education to oneself is still a voluntary process. 'You can lead a horse to water but you can't make it drink' is a phrase often used. Health education must involve an understanding of the issues related to self and the motivational need to change.'<br>**Participant #28**<br>'Depends on so many variables.'<br>**Participant #34**<br>'Learning theory – Although I teach does not mean you learn.' |
| **22. Health education alone will not be useful to people who do not feel that they have the capacity to change their personal circumstances.** | **Participant #11**<br>'Support services are integral service to health education.'<br>**Participant #12**<br>'ON its own it is not enough, but in conjunction with other health programs, services etc...'<br>**Participant #16**<br>'There needs to be a passion for change.' |

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| **(No 22 – continued)**<br>**Health education alone will not be useful to people who do not feel that they have the capacity to change their personal circumstances.** | **Participant #17**<br>'If you believe in the idea of a locus of control this would be true but there is more to people than psychological constructs – it takes imagination'<br>**Participant #22**<br>'People may also need to see how change is possible and assisted in that also.'<br>**Participant #26**<br>'Capacity to change one's personal circumstances can change over a life-time so health education is important – but needs to be in conjunction with positive partnership, support and commitment of health care professionals.'<br>**Participant #28**<br>'Government needs to take action in the areas of life style, i.e. alcohol smoking housing subsidizing healthy food-diet, environmental concerns.'<br>**Participant #34**<br>'Access issue – they feel - sociologically - excluded from access.' |
| **23. Educating children and young people about their health should be an essential part of nursing.** | **Participant #12**<br>'Yes, start young - get the positive messages in early and you provide a good foundation for later.'<br>**Participant #17**<br>'To the extent of those nurses who work with children in any capacity'<br>**Participant #22**<br>'Opportunities to influence health outcomes and behaviours is fundamental to the role of nurses.'<br>**Participant #26**<br>'Health promotion concepts/strategies need to be integral to the nursing care delivered to children and young people and their families.'<br>**Participant #28**<br>'See question 16. All nurses should be --- in the laws of health not just the law of pathology. Fundamental change to the curricula is required.'<br>**Participant #34**<br>'I thought it was.' |
| **24. Clarifying the concept of health literacy to child and youth health nurses is essential.** | **Participant #12**<br>'We must remember that health literacy will take different forms and be multi faceted and multi levelled. Health literacy must consider the many various discourse on health and nurses must be literate in these themselves.'<br>**Participant #26**<br>'Health literacy is so much more than health education. It is the concept of understanding that knowledge and seeing how it applies to self. Then having the motivation to adapt one's own behaviours for optional health outcomes.'<br>**Participant #28**<br>'I believe all nurses should be schooled in the laws of health- specialized education should be provided to nurses who wish to specialize further.' |

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| **25. Nursing and midwifery curricula and/or staff development should address health literacy.** | **Participant #17**<br>'The Trouble is that out curricula are over –crowded and everything is important and everything vies for attention. And there is little to be gained from surface learning.<br>I have used the work of Anne Johnson to ask my students to examine parent information, both online and as handouts in order to ascertain how useful the sheet is and whether people with limited reading ability understand it.'<br>**Participant #26**<br>'There is definitely a place for health literacy in current nursing and midwifery curricula – targeting children, young people and parents at this time of contact could have a lasting impact on their health behaviours in adulthood.'<br>**Participant #34**<br>'We have some - not enough on client And family education.' |
| **26. Healthcare professionals generally assume health consumers to be functionally health literate. (See definitions of functional health literacy)** | **Participant #12**<br>'... and get upset when parents profess to not knowing... or knowing 'To much'... many well educated parents question the healthcare professionals these days and it is a challenge that health care professionals must meet - without accusing parents of undermining their professionalism - having well educated parents must be seen as a bonus to the child's welfare and not as a criticism of the nurse or the 'system'.'<br>**Participant #17**<br>'We do forget how much we know and understand and assume others do too.'<br>**Participant #20**<br>'I am not familiar with literature on this topic of HC professionals assumptions'<br>**Participant #26**<br>'To a certain extent, it's easier for health professionals to assume health literacy. There is however a broad spectrum of health and social advantage and disadvantage. Health professionals have a duty of care to assess a person's health literacy and adapt their care accordingly.'<br>**Participant #28**<br>'I'm not sure all health problems are health literate. We all work support a medically based and control sickness service not a health service. The service it not designed to maximize ones health it is there and organized to deal with ---who is sick injured.'<br>**Participant #30**<br>'I'm not sure that we think much about it.' |
| **27. There is little or no time for health education in current health settings.** | **Participant #12**<br>'As I do not work in a health setting outside of the university I can only report from anecdotal evidence that staff are very busy and have little time to engage in health education sessions.'<br>**Participant #15**<br>'I think that education could take place during care and that it can be done without bit appearing to be specifically education.'' |

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| **(No 27 – continued)**<br>**There is little or no time for health education in current health settings** | **Participant #17**<br>'It depends on whether it is seen as important.'<br>**Participant #20**<br>'Not working in health setting so not sure.'<br>**Participant #26**<br>'I work in a tertiary children's hospital where there are many time constraints to health education and advice. Parents are often anxious and stressed doing their child's admission and are not able to process information given, especially if it doesn't relate directly to their child's immediate health needs.'<br>**Participant #27**<br>'Limited time. Use the time to the best of your ability.'<br>**Participant #28**<br>'It will require a change to current care practice. A move to RNs being case manager rather than task completers is the central change'<br>**Participant #31**<br>'Health 'education' can be a 5 minute chat at the bedside at the 'teachable moment'.'<br>**Participant #34**<br>'Not with current trainings and practice. Medium selection is important for enabling these people - DVD, CD, reading – poor outcomes.' |
| **28. Child and youth health nurses may have deficits about the concept of health literacy.** | **Participant #11**<br>'Nurses may also not feel empowered to advocate the issues of health literacy.'<br>**Participant #12**<br>'I think we need to look very closely at the question 'What is health for infants and children?' especially when it comes to early childhood. The focus is so often on physical manifestations of health i.e. eyesight, height, weight etc - but many nurses miss key influences on healthy child well being...,psychological health, behavioural health, healthy brains and healthy bodies, ... the list goes on... Health literacy is limited to basic physiological well being without links to later well being in areas outside of health that affect a child's ability to have a happy and successful life - i.e. Education, relationships, etc.'<br>**Participant #17**<br>'We all have deficits'<br>**Participant #26**<br>'The benefits of health literacy and engaging consumers in their own health care are becoming more widely studied and acknowledged. Nursing curriculum needs to adapt accordingly to the benefit of newly – qualified nurses. Child and youth health nurses already qualified will need to be made aware of the benefits of newly – qualified nurses. Child and youth health nurses already qualified will need to be made aware of the benefits of health literacy – through seminars, in services and workshops on a local level.'<br>**Participant #28**<br>'Once again we come from a sickness paradigm not a health paradigm. What are the laws of health? We do not research such.' |

## Second Delphi Questionnaire Participants' Comments

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| **1. Child, youth and paediatric nurses have a professional responsibility to improve children and young people's access to evidenced based information.** | **Participant #24**<br>'This is not just their role – it is up to schools and families. Child health nurses are primarily responsible for health, not improving access to information, but they can provide information in their work.'<br>**Participant #26**<br>'Much information is accessible these days via internet & web without being necessarily correct, appropriate or evidence based. Nurses have a role in guiding children, young people & their families to accurate & up to date information & resources.'<br>**Participant #31**<br>'In child and family health nursing health promotion is considered the dominant feature of the nursing practice. Health promotion should be evidence based.'<br>**Participant #32**<br>'Partly role of the parent/carer. So therefore the nurse is also responsible in this regard.' |
| **2. Child, youth and paediatric nurses have a professional responsibility to improve how children and young people learn to navigate the health care system.** | **Participant #14**<br>'The potential problem with this is there are so many other groups which can interfere or contradict guidance given by paediatric nurses so it is difficult to categorically state we have a responsibility.'<br>**Participant #24**<br>'Again, this is not just their role – it is up to all health professionals and families. Child health nurses are primarily responsible for health, but will advise on this or make referrals during the course of their work.'<br>**Participant #26**<br>'Young people, especially those with a chronic illness, need to be supported in gaining independence as they learn self-management of their condition and of themselves-especially in the transition from a paediatric to an adult service.'<br>**Participant #31**<br>'Child and family health nursing is grounded in the principles of primary health care. One of those principles is to enable citizens to access health care, beginning at the primary level of health care services. The primary health care practitioner has a responsibility to assist and guide clients through the labyrinthine health care service and its many levels.'<br>**Participant #32**<br>'Partly role of the parent/carer. So therefore the nurse is also responsible in this regard.' |
| **3. Child, youth and paediatric nurses have a professional responsibility to improve how children and young people learn to know what is good advice related to their health.** | **Participant #14**<br>'One would hope that any information we give will be seen as good but for us to dictate what young people should and shouldn't access is problematic, especially if I don't agree with certain things. For example, don't needle share is good advice but I might not want to give any advice about needle sharing because I may vehemently disagree with IV drug use thus any information relating to this would be contra to my beliefs.' |

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| **(No 3 – continued)**<br>**Child, youth and paediatric nurses have a professional responsibility to improve how children and young people learn to know what is good advice related to their health** | **Participant #17**<br>'I'm not a teacher per se.'<br>**Participant #24**<br>'It is important for child, youth and paediatric nurses to provide accurate information and alert their clients to appropriate well informed resources to improve their health.'<br>**Participant #26**<br>'Need to assist children & young people to filter good & bad advice. Especially as advice is related to peer groups-need to find ways of engaging young people in forums to access good advice.'<br>**Participant #31**<br>'This is about educating the public (in this case children and young people) how to use judgement to make good health choices to encourage healthy living.'<br>**Participant #32**<br>'Partly role of the parent/carer. So therefore the nurse is also responsible in this regard.' |
| **4. A child, youth and paediatric nurse can create the appropriate opportunities for children and young people to learn about being health literate.** | **Participant #24**<br>'It depends on the setting in which the child, youth and paediatric nurse operates. They cannot teach literacy skills or be responsible for the education level of their clients, but they can help them to access appropriate information and help them to interpret that information. But some settings do not provide time or access to environments in which the nurse can create these learning opportunities.'<br>**Participant #26**<br>'If appropriate support (practical), time and resources are directed to their learning as a priority. Health literacy will ease the burden of ill health in adult hood as healthy choices will be more likely followed.'<br>**Participant #28**<br>'As I am somewhat unsure of the roles and regulations pertaining to practice in Australia I am unsure whether such nurses can negotiate their role and activity or whether a health department dictated it for them.'<br>**Participant #31**<br>'This should be an integral part of the nurses' practice. I believe it is not appropriate to just tell people about healthy living. The outcomes will be better if people are encouraged to be actively involved in making healthy choices.'<br>**Participant #32**<br>'Partly role of the parent/carer. So therefore the nurse is also responsible in this regard.' |
| **5. A child, youth and paediatric nurse can create the appropriate opportunities for children and young people and their parents/ guardians to learn about being health literate.** | **Participant #24**<br>'It depends on the setting in which the child, youth and paediatric nurse operates. They cannot teach literacy skills or be responsible for the education level of their clients, but they can help them to access appropriate information and help them to interpret that information. But some settings do not provide time or access to environments in which the nurse can create these learning opportunities.' |

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| **(No 5 – continued)**<br>**A child, youth and paediatric nurse can create the appropriate opportunities for children and young people and their parents/ guardians to learn about being health literate** | **Participant #26**<br>'If given adequate time and resources to support these opportunities.'<br>**Participant #28**<br>'Same issue as No 4. If I was back in the UK I would say strongly agree.' |
| **6. Child, youth and paediatric nurses have a professional responsibility to take a long term view to educating children and young people about their health during any professional encounter.** | **Participant #7**<br>''Any'? Some will be time limited.'<br>**Participant #17**<br>'Again, this is not my primary role.'<br>**Participant #18**<br>'Not sure about 'long term' usually more like 'seize the moment'.'<br>**Participant #24**<br>'It depends on the type of service. It is best to work on a long term view in any encounter, but it depends if the child/young person accesses a service on a long term or regular basis. Establishing relationships and encouraging long term relationships is best, but it is best not to crowd a one off encounter with everything about the future – very off putting for the clients.'<br>**Participant #26**<br>'At times may not be appropriate to address, i.e. in time of crisis, stress, bereavement where long term view is not priority. But need to be mindful to address when more appropriate as soon as crisis has passed.'<br>**Participant #31**<br>'I presume by 'long term view' you mean lifelong learning.' |
| **7. Child, youth and paediatric nurses have a professional responsibility to explore ideas on how to improve a child's or young person's health literacy.** | **Participant #12**<br>'Self education is really important in this area. If a CHN is not well educated in the 'What, why, how, when and where' of health education then they will find it challenging to educate their clients.'<br>**Participant #24**<br>'If they are working in a school setting, they can explore how to improve health literacy for the school cohort in innovative sessions. If they work in a clinic that is accessed on an ad hoc basis, they can provide innovative type information sessions as well as written literature.'<br>**Participant #26**<br>'Promoting health and understanding health is one of fundamental roles in child & family health nursing.' |
| **8. A child, youth and paediatric nurse can create the appropriate opportunities for children and young people and their parents/ guardians to understand how to make healthy choices in their everyday lives.** | **Participant #12**<br>'They are certainly part of the system that can assist - but needs to be done in combination with responsible media, school education, parent education and government schemes.'<br>**Participant #17**<br>'My problem is the number of overweight/obese/smoking nurses – not helpful.' |

| Statements | Comments |
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| **(No 8 – continued)**<br>**A child, youth and paediatric nurse can create the appropriate opportunities for children and young people and their parents/ guardians to understand how to make healthy choices in their everyday lives.** | **Participant #24**<br>'This is well within the scope of practice of this nurse, as they discuss the treatment or solutions to the current health problem.'<br>**Participant #26**<br>'If given the time and resources to support these opportunities. Children, young person & family need to be receptive to be able to value information on board & understand. Need to find ways to engage all stakeholders.' |
| **9. It is possible for children and young people to learn how to say no to unhealthy activities.** | **Participant #12**<br>'Children are of course faced with many pressures from peer groups, media etc - but well educated children are less likely to make choices that are unhealthy – education has been shown to have a powerful influence on decision making.'<br>**Participant #14**<br>'This is an easy thing to answer as it is possible for anyone to do this. The hard part is the doing.'<br>**Participant #26**<br>'It is possible for children & young people to say 'no' but they may still be in forced by their peers or by role leaders in society (celebrities, sports people, etc) into making wrong choices.'<br>**Participant #31**<br>'I agree that they have the right to choose. This doesn't mean they always choose wisely.' |
| **10. Children and young people learn about how to be healthy from their parents not child, youth and paediatric nurses.** | **Participant #7**<br>'This depends on the age of the child and the nature of their parenting.'<br>**Participant #12**<br>'While parents and peer groups will influence a child's health choices, child, youth nurses can provide alternative viewpoints and information. Children who recognise that there are other choices may just follow the road of others, but may also chose otherwise.'<br>**Participant #14**<br>'The reason I'm unsure is there are so many variables to this. Parents who are not clear or have no idea about being healthy will not do this but parents who do know are more likely to be influential than any of the above professionals.'<br>**Participant #16**<br>'Children and young people learn from everyone; their parents, nurses, school teachers, peers & the media. Therefore it is important to clarify what is truth.'<br>**Participant #18**<br>'Peers mostly.'<br>**Participant #19**<br>'I think this is how it is at the moment. I would also include peers in this mix.'' |

| Statements | Comments |
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| **(No 10 – continued)**<br>**Children and young people learn about how to be healthy from their parents not child, youth and paediatric nurses** | **Participant #22**<br>'Combination of all influence/exposures including people generally, media, family, peers, & health professionals.'<br>**Participant #24**<br>'They learn from both but parents have the biggest influence from birth throughout their childhood.'<br>**Participant #26**<br>'Some parents do not act as good role models for their children, as seen by the high levels of obesity (poor dietary intake & lack of exercise). Young people often do not listen to their parents or will do the opposite of what their parents say risk-taking behaviour.'<br>**Participant #31**<br>'In the first instance health habits are learnt within the family. That does not absolve child and family health nurses from the responsibilities discussed above.'<br>**Participant #32**<br>However by educating the family necessary change can be effected' |
| **11. Child, youth and paediatric nurses' ability to provide effective health advice to children and young people is influenced by their own health literacy.** | **Participant #17**<br>'See previous comment. From my perspective as an educator, very little opportunity in curriculum to learn about health.'<br>**Participant #26**<br>'How can a nurse provide health advice if she is unaware of the healthy choices to make or ignores these choices herself (i.e. Smoking/ alcohol/drug-taking).' |
| **12. Child, youth and paediatric nurses have a professional responsibility to evaluate children and young people's health literacy skills.** | **Participant #12**<br>'While I agree with this I also feel that the way in which this is undertaken is not something that is done be 'tests' of measures, but rather through engaging with the children in discussion and exploring their knowledge by opening up topics for their consideration and feedback.'<br>**Participant #14**<br>'Too broad a statement. The responsibility can only be to those children and young people we encounter not all young people.'<br>**Participant #17**<br>'It is intrinsic to teaching.'<br>**Participant #26**<br>'Nurses are in a prime position of assessing children both physically and developmentally – to be able to direct appropriate information & intervention.'<br>**Participant #31**<br>'Depends what you mean by 'evaluate'. Nurses will certainly have to make judgements about their client's level of literacy in order to provide suitable services to them.' |

| Statements | Comments |
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| **13. The provision of health education is an instrument of change.** | **Participant #12**<br>'Yes, but we need to acknowledge that this is not an 'overnight fix'. Change and education takes time. Often generational. It also needs to be done alongside other measures (as discussed above).'<br>**Participant #17**<br>'But not the only thing – people have to believe change is possible.'<br>**Participant #20**<br>'Change requires a more complex intervention.'<br>**Participant #26**<br>'Health education & promotion is a vital tool in changing individuals, families & communities.'<br>**Participant #31**<br>'I agree, but it is not the only instrument and may not be a strong motivator for change.' |
| **14. Child, youth and paediatric nurses have a professional responsibility to advocate for a focus on health literacy for children and young people.** | **Participant #12**<br>'Current government spending has reduced primary health care and education spending. CHN must advocate for a stronger focus on health literacy and health education.'<br>**Participant #26**<br>'Nurses need to stand united as advocates for children & young people with regards to all concepts of their health & well-being.'<br>**Participant #28**<br>'If such nurses – working from within a primary care paradigm are not health educators first and foremost then they have no real role.'<br>**Participant #31**<br>'This is a bit vague.' |
| **15. Child, youth and paediatric nurses have a professional responsibility to be aware of how health policy related to children and young people is informed, developed and in turn enacted.** | **Participant #26**<br>'By being aware of international, national & local health policies, nurses are able to direct recourses to areas of need & increase their role as advocates for the rights of children & young people to equal access to appropriate health care – 'health for all' .'<br>**Participant #31**<br>'I believe that child and family health nurses should be actively engaged in the policy process. Otherwise they are merely carrying out policies devised by others, who may have less understanding of the situation than the nurses.' |
| **16. Child, youth and paediatric nurses have a professional responsibility to communicate the importance of health literacy to children, young people and their parents/guardians.** | **Participant #17**<br>'As part of empowerment.'<br>**Participant #26**<br>'It can be challenging at times to engage children & their families, especially if they are seen in an acute care setting.' |

| Statements | Comments |
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| **17. Child, youth and paediatric nurses are important role-models for children and young people.** | **Participant #12**<br>'CHN nurses tend not to see themselves as role models. I suspect that young people do not see them as role models either. I also suspect that this is related often to the age gap between the nurses and the children they are working with, along with the fact that they are in irregular contact and do not feature prominently in the young person's life. I think we need to ensure that child health nurses working with teenagers need to be young, vibrant and be able to relate to the youth with whom they work - so the young people can relate back. Older CHN may be more appropriately working with parents and younger children.'<br>**Participant #17**<br>'See above comments about state of N's health/lifestyle.'<br>**Participant #26**<br>'It is never enough to say 'do as I say, not as I do'. Children & young people are more likely to respond to and respect someone who is honest and has a core of integrity.'<br>**Participant #28**<br>'I am not sure that such nurses can be role -- models as such – they can role model some healthy behaviours but they are human beings too!' |
| **18. Child, youth and paediatric nurses have a professional responsibility to undertake research on health literacy.** | **Participant #12**<br>'Knowledge is the only way we can improve our own skills.'<br>**Participant #13**<br>'They don't all need to understand research but they do need to access, critique & apply research evidence.'<br>**Participant #18**<br>'Responsible for research in some area not always literacy.'<br>**Participant #26**<br>'Health literacy is not just the domain of physicians. Children & young people respond well to nurses who take an interest in them. Nurses are in an ideal position to engage children & families in improving many aspects of health care & delivery.'<br>**Participant #31**<br>'I agree that research is part of the professional role, but acknowledge that for many nurses participation in research is not a priority.' |
| **19. There is a lack of opportunities for child, youth and paediatric nurses to promote health literacy for children and young people.** | **Participant #12**<br>'Busy schedules. Too many clients. Not enough time. Limited opportunities.'<br>**Participant #18**<br>'Opportunity there, not the time.'<br>**Participant #22**<br>'Limited opportunities to conduct research or be involved depending on practice setting etc.'<br>**Participant #26**<br>'Lack of peer support, time and financial resources place constraints on nurses through all aspects of health care. These negative impacts would affect the opportunities to promote health literacy.' |

| Statements | Comments |
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| **(No 19 – continued)**<br>**There is a lack of opportunities for child, youth and paediatric nurses to promote health literacy for children and young people.** | **Participant #28**<br>'I'm unsure in the Australian context. I would assume school, youth centres, sport clubs, etc would be the facilities used by such nurses whether they take it up I don't know.'<br>**Participant #31**<br>'An opportunity exists in every encounter with a client.' |
| **20. Child, youth and paediatric nurses have a professional responsibility to recognise that low health literacy can be a problem effecting children and young people's health outcomes.** | **Participant #12**<br>'You need to recognise a problem to be able to do something about it.'<br>**Participant #17**<br>'I don't understand this question.'<br>**Participant #26**<br>'Not just immediate outcomes but health outcomes in adulthood – which have significant impact on the individual, family & health care setting.' |
| **21. Child, youth and paediatric nurses have a professional responsibility to focus on assisting children and young people to realise that prevention of non-communicable diseases is a possibility.** | **Participant #12**<br>'Why limit the scope of a CHN role? Communicable diseases are also important to limit.'<br>**Participant #26**<br>'Prevention is always better than cure, wherever possible.' |
| **22. Child, youth and paediatric nurses have a professional responsibility to evaluate whether parents/guardians of children or young people with whom they interact are health literate.** | **Participant #7**<br>'Role blurring; pt-nurse confidentiality an issue here.'<br>**Participant #12**<br>'Not an easy thing to do but one that CHN should realise is part of her/his role. One needs to evaluate whether what you are doing is working on some level or not – so evaluation is an important part of this.'<br>**Participant #13**<br>'Whenever possible but some nurses e.g. school-based nurses may never come in contact with the parents.'<br>**Participant #17**<br>'Part of teaching – you begin where they begin.'<br>**Participant #24**<br>'Depends on the age of the child / young person – definitely for children, but once young people are closer to the age of consent, it is more a responsibility to interact with the young person, not parents.'<br>**Participant #26**<br>'Needs to be in conjunction of assessment of child's/ young person's health literacy. Important to know where to direct recourses/ information to parents to assist in supporting child/ young person.'<br>**Participant #32**<br>'But the emphasis is on wailing with them.' |

| Statements | Comments |
|---|---|
| **23. Child, youth and paediatric nurses have a professional responsibility to influence the health literacy levels of children and young people.** | **Participant #12**<br>'Prevention is far more important than cure. Young people who are alert to health issues are more likely to make appropriate health choices. If they do not understand that there are choices to be had - how can they make something other than the only one they know?'<br>**Participant #24**<br>'Maybe only within their sphere of influence – they need to focus on their clients, not changing the world. Academics and nurse leaders should be influencing this.'<br>**Participant #26**<br>'It's central to the nurse's role – and if not then why not?'<br>**Participant #31**<br>'Not sure what you mean by 'influence'. I agree they have a professional responsibility to improve health literacy levels.' |

## Follow-up Letter to Participating Staff (Delphi Survey Round 1)

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Dear,

My name is Ola Kutah, and I am a PhD candidate in the School of Nursing and Midwifery at the University of South Australia. My research project is entitled **'Exploring how health literacy is understood by registered nurses'.** I am focusing specifically on the role of paediatric and child and youth nurses.

I recently sent you an email inviting you to participate in my research. If communications between us have crossed and you have agreed to participate and received the questionnaire, please continue to complete it and send it back to me as soon as possible. I greatly appreciate your support. If you have not responded I would be very grateful if you would reconsider my offer to participate. You do not need to have any prior experience with health literacy; I seek your views about this topic. As this is my second email to you, no further emails will be forwarded.

As a potential respondent in my Delphi survey (a structured, indirect interaction method which uses a series of rounds to collect data), you may be asked to participate in a minimum of 2 but not more than four rounds. Please find attached to this email the following documents:

- Information Sheet
- Consent Form
- Project Flyer

Please note that a hard copy of these documents plus the Delphi survey will be sent to you by post.

Should you agree to participate in the research project your identity and the identity of your organisation will be kept confidential, and all identifying features will be removed from any publications and reports that emerge from the study. I am hoping that you will be happy to support my doctoral research. For more information about the project, please refer to the attached Information Sheet. If you agree to participate, please inform me as such by return email and/or sign the Consent Form attached. I can forward you the Delphi Survey as a hard copy or electronically via email: please indicate your preference in your email reply.

To ensure my findings take into account as wider views as possible of paediatric nursing and child and youth health RNs, I would be very grateful if you could distribute the attached Project Flyer and Information Sheet via email to your registered nursing staff so that they may be given an opportunity to volunteer to participate.

Thank you for your attention and support. My supervisors (Dr. Kay Price and Professor Helen McCutcheon) and I are very happy to answer any questions or queries you may have.

Yours Sincerely

Ola Kutah, PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide SA 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

**Follow-up Letter to Participating Staff (Delphi Survey Round 2)**

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

Dear,

I recently sent you the 2nd Round Delphi survey questionnaire. If communications between us have crossed and you received the questionnaire, please continue to complete it and send it back to me as soon as possible. However, if you have not received or misplaced it please find attached to this email the following document:

- Copy of the 2nd Round Delphi Survey

If you have completed the questionnaire could you please give me an estimation of when you sent it.

I understand that there are many demands on your time, and I really do appreciate the consideration that you have given to my request for your participation. My supervisors (Dr. Kay Price and Professor Helen McCutcheon) and I are very happy to answer any questions or queries you may have.

Yours Sincerely

Ola Kutah, PhD Candidate
School of Nursing and Midwifery
University of South Australia
Adelaide SA 5001
Phone: 08 8302 1158
Mobile: 0422742537
Email: ola.kutah@postgrads.unisa.edu.au

# Appendix I Confidentiality Declaration

- Confidentiality declaration for transcriber

## Confidentiality Declaration for Transcriber

**UNIVERSITY OF SOUTH AUSTRALIA**
**School of Nursing and Midwifery**

**Declaration of confidentiality**

**A critical analysis of the construction of health literacy by paediatric and child and youth health RNs**

**Researcher: Ola Kutah**

**School of Nursing & Midwifery, University of South Australia**

*Declaration of Confidentiality for Transcribers*

I Barbara Ryan hereby declare that I agree to maintain the confidentiality of participants in the study entitled "A critical analysis of the construction of health literacy by paediatric and child and youth health RNs".

Signed: B Ryan (Transcriber)

Dated: 12th October 2009

Signed: Ola (Researcher)

Dated: 12th October 2009