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Potential and Challenges of School-Parent Collaboration in Developing Parental Health Literacy

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Abstract. The aim of this study is to use the experience of two Latvian schools to outline the potential of school-parent collaboration in promoting parental health literacy by answering the following questions: 1) How is the concept of health literacy understood by parents, teachers, and school administration? 2) What factors limit or hinder school-parent collaboration in promoting health literacy? 3) What are the recommendations of the actors involved to improve school-parent collaboration in promoting parental health literacy? This study adopts a qualitative case study approach and explores two cases of schools in Latvia. The data are obtained from 4 focus group discussions and 2 interviews with 26 respondents, including teachers, parents, and school principals, as well as from school records. The data are processed using content analysis.
Keywords: parental health literacy, health education, health care, collaboration, parents, school

Mokyklos ir tėvų bendradarbiavimo galimybės ir iššūkiai ugdant tėvų sveikatos raštingumą

Santrauka. Šio tyrimo tikslas – apibūdinti mokyklos ir tėvų bendradarbiavimo potencialą ugdyti tėvų sveikatos raštingumą remiantis dviejų Latvijos mokyklų patirtimi ir atsakant į šiuos klausimus: 1) Kaip tėvai, mokytojai ir mokyklos administracija supranta sveikatos raštingumo sąvoką? 2) Kokie veiksniai riboja arba trukdo mokyklos ir tėvų bendradarbiavimui skatinant tėvų sveikatos raštingumą? 3) Kaip dalyviai rekomenduotų pagerinti mokyklos ir tėvų bendradarbiavimą skatinant tėvų sveikatos raštingumą? Tyrime naudojamas kokybinis atvejo studijos metodas ir nagrinėjami du Latvijos mokyklų atvejai. Duomenys surinkti iš keturių fokusuotų grupių diskusijų ir dviejų interviu su 26 informantais, įskaitant mokytojus, tėvus ir mokyklų direktorius, taip pat iš mokyklų dokumentų. Duomenys analizuoti taikant turinio analizę.
Pagrindiniai žodžiai: tėvų sveikatos raštingumas, sveikatos ugdymas, sveikatos priežiūra, bendradarbiavimas, tėvai, mokykla.

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Introduction

Health literacy is a concept widely used in the healthcare system, but still not sufficiently explained and understood in daily family and school life. Based on research and health policy documentation, we define health literacy as: 1) knowledge about human health, the health care system, and health-promoting interventions; 2) ability to use health information and services to maintain health and prevent disease; 3) ability to make responsible decisions that are important for one's own health and the health of others (Likumi. LV…, 2022; Kickbusch, Pelikan, Apfel and Tsouros, 2013).

Health literacy monitoring in European countries indicates that the overall level of health literacy varies across countries and social groups (Sørensen, Pelikan, Röthlin, Ganahl, Slonska, Doyle, Fullam, Kondilis, Agrafiotis, Uiyers, Falcon, Mensing, Tchamov, Broucke and Brand, 2015). The disparities have been exacerbated by the Covid-19 pandemic. Therefore, when improving health equity in Europe, social factors should be considered (Sørensen et al., 2015), which, in turn, is closely linked to the family environment where the health literacy of parents and children is shaped and developed. The studies demonstrate that economic conditions and parental literacy affect the health status of parents and children, which, in turn, affects the quality of life of both actors (Koffijberg, Adami, Buskens and Palme, 2012; Torvik, Eilertsen, McAdams, Gustavson, Zachrisson, Brandlistuen, Gjerde, Havdahl, Stoltenberg, Ask and Ystrom, 2020), including the educational process of a child. If a child does not feel physically, emotionally, and mentally healthy, their learning ability is impaired: concentration declines, attention shifts from learning to solving health issues, and the energy resources are not sufficient to manage the cognitive functions needed for communication and education. Children and adolescents with health issues demonstrate lower academic achievement (Mikonnen, Remes, Moustgaard and Martikainen, 2020). Parents recognise that their children's illness also affects their emotional well-being (Stars, Smane, Pucuka, Roge and Pavare, 2021).

The research findings indicate that the following factors are relevant for parental health literacy today, but are not always fully taken into account and thus pose a problem: 1) the control measures and restrictions imposed during COVID-19 pandemic have shown that parents are not always able to respond appropriately to their children's needs when in permanent contact with their children, especially as regards younger children. Children, being dependent on parental care, may suffer in situations where parents' health literacy is insufficient (Sanders, Federico, Klass, Abrams and Dreyer, 2009; De Buhr and Tannen, 2020); 2) there is a link between health and a child's performance in learning, so parental competence in monitoring a child's health status is imperative; 3) changes in the healthcare system due to digitalisation are increasing the individual responsibility of each person for their own and their family's health (Kickbusch, 2019).

Health literacy research also spotlights the need for tools to promote parental health literacy, i.e. organizations that manage and disseminate reliable information and can therefore be called health literate. Schools as learning organizations can become these helpful institutions (Kools and Stoll, 2016). School health literacy is part of the health-

care and education process for children, adolescents, and young adults (Centres for Disease Control and Prevention, 2022). The acquisition of health literacy in an organised educational space is considered to be the foundation of health promotion: from an early age, alongside literacy, schools have the opportunity to promote pupils' health literacy by stimulating critical thinking and educating them about the risks of health-harming behaviours (World Health Organization, 2022). Schools should play a mediating role in disseminating quality health information not only to pupils but also to teachers and parents. Coleman, Hudson and Pederson (2017) emphasise that the information people receive about health issues should be sufficiently comprehensible, for example, without complex linguistic constructions. This raises the question of how all actors involved can better understand the concept of health literacy.

A large body of research on the role of parental involvement in children's learning has shown that parental involvement is effective in raising children's academic achievements (Edwards and Warin, 1999; Hoover-Demspsey and Sandler, 2005; Cook, Dearing and Zachrisson, 2018; Fan and Chen, 2001). Teachers consider successful collaborations to be those where parents and families are perceived as an important support resource, with both parties - school and parents - equally involved in the pupil's education (Lazar and Slostad, 1999). Parental involvement is, thus, also an important factor in promoting health education in schools. However, for parents to be able to participate competently in their children's health education, they themselves have to be knowledgeable in this area, which, in turn, can be facilitated by the school as a health literate organisation. Systemic collaboration, health literate teachers, parents, and children are essential for improving health literacy in the public domain in general (Bruselius-Jensen, Bonde and Christensen, 2016).

There is much to be done in health literacy in Latvia. Health literacy as a component of health education has been studied worldwide since the 20th century. However, in Latvia, this area of research has been developing only in recent years. The same is true for health literacy practice. Unlike in Australia, Canada, Finland and Germany, where health education is integrated into the school curriculum (Okan, Paakkari and Dadaczynski, 2020), health literacy is not specifically taught in Latvian schools; there are no specially trained health literacy educators, and there is no systematically organised collaboration between schools and health experts. The Latvian case can, thus, serve as an example for the countries where the development of health literacy is still at an early stage.

The aim of our study is to highlight the potential of school-parent collaboration in promoting parental health literacy considering the experience of two Latvian schools. The research questions are: 1) How is the concept of health literacy understood by parents, teachers, and school leaders? 2) What factors limit or hinder school-parent collaboration in promoting parental health literacy? 3) What are the recommendations of the actors involved to improve school-parent collaboration in promoting parental health literacy?

Research methodology

Our study adopted a case study design, which aimed to analyse a phenomenon, in this case an organisation – a school – in its natural environment, using several data mining techniques (Yin, 1994). The sample was selected using purposive sampling, convenience sampling and actors representative of the educational environment. This study explored two cases of two schools at the same time: one located in Riga, the capital of Latvia, and the other in the suburbs of Riga or Pierīga. The data on the schools were obtained from school self-assessment reports. The school in Riga lists 290 pupils and 136 teachers. The school in Pierīga area has 602 pupils and 56 teachers. Both schools have a school psychologist and a social pedagogue. Both schools are high-performing in terms of academic achievement, as evidenced by pupils' regular awards in school subject Olympiads. Both schools have fragmented activities that could be linked to health literacy: for example, the Riga school organises lectures for pupils, parents, and teachers on mental health, voice health, and emotional intelligence. The Pierīga school is involved in an eco-school project, an anti-mobbing project, and organises joint sports activities for parents, pupils, and teachers. Both schools are involved in a project to prevent early school dropouts. These brief profiles show that both schools have the potential to become health-literate organizations, which also means being involved in developing health literacy for parents.

Two methods were used to collect the data, namely, focus group interviews and individual interviews. The study analysed six sub-cases or three groups from each school, including six teachers, six parents, and the school administration. The number of respondents – 6 in each group – was selected based on the recommendations for sampling in qualitative research designs (Creswell, 1998). The participants' eligibility was determined by their affiliation with one of the two schools, and their voluntary consent to participate in the study. The following selection criteria were also considered: age, gender, place of residence; age of children growing up in the family or in the teacher's class. Individual and focus group interviews were held with 26 respondents. Prior to the interviews, participants received an information letter outlining the research topic, aim, and procedure, so that all respondents had the opportunity to prepare for the discussion on health literacy and school-parent collaboration. All respondents' data were pseudonymised for the study.

The focus group discussions were organised remotely on Zoom platform and lasted 2x40 minutes. The sample respondents were 25 women aged 37–43 and one man aged 45. The respondent-parent group consisted of 12 mothers whose children were enrolled in the respective schools from the 1st to the 12th grade. Five of the mothers are teachers by profession, so they also responded as teachers during the interview. The respondent-teacher group consisted of 12 teachers who teach the Latvian language, literature, German and geography in their respective schools. Nine teachers are also mothers of children aged 5–18. Thus, in all focus group interviews, the participants responded both as teachers and as parents, i.e. their social identities or roles overlapped, allowing for a broader view of both sides. The parent group was made up exclusively of mothers, which

is one of the limitations of this study. Another limitation to note is the age of the children whose parents participated in the focus groups, i.e. the age of the children ranging between 6 and 15 years. The interviews with school leaders were conducted separately in order to obtain the most authentic view of health literacy in the organization, while respecting their confidentiality. The interview with the Riga school principal was conducted remotely on Zoom platform – 2x40 minutes. The interview was recorded and transcribed. The interview with the principal of the Pierīga school was conducted in person; it lasted 60 minutes and was recorded in audio format and transcribed. The school principals received a letter of informed consent and verbally agreed to participate in the study. During the interviews, the school leaders were not anxious, they had not made special preparations, but were actively engaged in the conversation and demonstrated willingness to understand the current situation in health literacy.

The data were analysed using thematic analysis, since Howitt (2010) maintains that thematic analysis data and conclusions are easier to understand and more useful for the public and policymakers. The thematic analysis was performed when analysing the main themes in each of the cases, including 1) homogeneous group analysis or case grouping: parents and teachers from both schools and school administration; 2) cross-sectional breakdown by contrasting homogeneous groups: teachers – teachers; parents – parents, school administration – school administration. In line with the research questions, the key themes of discussion reflected the awareness of health literacy and aspects of collaboration, forming a platform for further analysis. The themes included health and health education, educational environment, determinants or influencing factors, collaboration mechanisms, and the concept of health literacy.

The six steps of Braun and Clarke's (2006) thematic analysis model – data familiarisation, primary coding, generating themes in the primary codes, reviewing themes, defining and naming themes, and report production – were followed in the analysis of the research data. The data familiarisation was performed by converting video and audio material into text, and preparing the transcription or textual data. The primary coding was carried out as line-by-line coding, highlighting keywords. The data analysis was performed primarily by searching for the subject of this study 'parental health literacy' and concepts describing health literacy and health, such as health education, health foundation, healthy lifestyle, etc. The secondary searches identified concepts or passages of text that related to school-parent collaboration, e.g. the passage where a teacher talked about an individual lesson with a pupil and hygiene issues was coded as 'collaboration'. The coding was developed based on the data analysis and theory, for example, by searching for and tagging words and passages in the text that addressed factors influencing parental health literacy – parental education, socio-economic status, or the COVID-19 pandemic.

The respondents' use of many different health literacy-related concepts, as well as the use of concepts that do not seem to fit into any of the themes, such as 'domestic violence', which refers to family relationships, posed a challenge. Given the focus on the two big thematic threads, namely, 'health literacy' and 'collaboration', a separate

theme 'health' was created with sub-themes 'health education' and 'health in the family'. The theme annotation also included separate themes such as 'educational environment', which outlined the educational context, and 'influencing factors', which referred not only to the factors influencing parents' health literacy but also to the factors influencing collaboration with schools. This can be considered the most difficult part of the data analysis as the references to influencing factors were rather implicit, i.e. the respondents described their feelings, e.g. '*I don't know how much and in what form I can communicate this to parents'*, which could be interpreted as 'teacher's uncertainty in communicating with parents', coded as a category and listed with the theme 'influencing factors', subtheme 'collaboration', coded as 'communication difficulties'.

To answer the research questions and achieve the research aim, a theory-based set of health literacy parameters was developed, identifying six themes characterised based on the units of analysis 'health literacy' and 'collaboration'. The thematic analysis resulted in 276 concepts, which were clustered into 18 sub-themes, forming the six themes introduced above, according to which the focus group discussions and interviews were analysed.

Due to the article volume constraints, we will only present what we consider to be the most important findings of the empirical study and rather focus on shared trends and commonalities in the respondents' answers than on the differences in their opinions.

Understanding the concept of health literacy

Although the term 'health literacy' was new to the parent respondents, at the level of practical skills, parental knowledge about health existed since childhood. Baiba, a mother of four, offered a rather typical insight: '*I have been thinking about health literacy for years without knowing it was called health literacy'*.

Among teachers, only two respondents had not heard of health literacy. Some participants had looked up what health literacy was on the internet, while others relied on logic and reason, and their own life experience. The school principals responded as responsible officials, viewing health literacy mainly in terms of their school experience.

All participants agreed that health literacy is rooted in a healthy lifestyle and taking care of oneself, however, each respondent assigned a subjective meaning to this concept. For example, for one teacher, taking care of oneself meant finding time for a good night's sleep, while for another teacher it meant shopping, and yet another teacher believed in spending time outdoors. Teacher Dita sensibly characterised the concept of health literacy, accentuating the subjectivity of this understanding '*Health literacy means the ability to take care of one's health, to follow a healthy lifestyle, it is a holistic concept that includes the whole person – his mental and physical health as well as the social aspect. (...) The only issue is that the understanding of what is healthy varies greatly. And especially when these different opinions clash somewhere between parents and teachers, it is not very easy (...)'*. Scepticism was also expressed about the term 'health literacy' itself, for example, teacher Renāte admitted: '*my personal opinion about all this literacy (...)*

is that it's probably a recent "hit/buzz word". (...) These things have always been there anyway, but under a different name...(...)'.

As observed by the respondents, knowledge about health is brought into focus when a family starts preparing for the birth of a child. From then on, the family is the first institution where the child learns elementary skills such as brushing his/her teeth, washing his/her hands, going to bed on time, and eating healthy food. These are the health habits that have been nurtured over generations, coming from parents and grandparents. Mothers feel that their child's health is definitely a family responsibility. Lelde, a mother of three, said that it is important to *'teach your child how to behave in crisis situations, to recognise (...) the symptoms of unhealthiness in themselves. Health literacy is about being able to make your own decisions, (...) being able to understand what is best for your child, to lay the foundations.'*

It is important to note that our study was conducted during the COVID-19 pandemic, and as such, the pandemic was a prevalent topic in all discussions. The quarantine imposed during the pandemic not only rekindled the concern for children's health, but also underscored the need to think about the well-being and especially mental health of their parents and teachers. Parents and teachers alike felt burnt out. This led to the realisation that health literacy can only be considered when adults themselves are healthy. Mother Santa said: '*I meditate, I do everything I can so that only my family can rely on my emotional health because a healthy mum means a happy family*.' The role of the father, not only the mother, was highlighted in the discussions, both in joint sports activities and in creating a family value system, but especially in critical moments: '*In crisis situations, decisions are made by the husband, who is calmer and more rational in these moments (...)'*, as mother Lelde told us.

It turned out that health literacy in the family is not just a one-way process, with parents educating their children. Several mothers admitted that their children were already smarter about health literacy than their parents. Mother Vita said of her teenage daughter: '*She knows a lot, I myself sometimes treat my health a bit carelessly, but my daughter says: "now it's time to make an appointment with the doctor." I don't know if it's a gut feeling or acquired knowledge, but she tells me when she needs to do something for her health*.' These findings show that parents can be encouraged to consider their health by a child who has been educated in this particular field.

During the discussions, the research participants confirmed the findings obtained in previous studies, namely that health literacy is closely linked to education: the respondents recognised the importance of staying up to date on health issues, reflecting on them, and choosing reliable sources of information. The teachers argued that health literacy should also be viewed in a cultural context, i.e. what knowledge we have inherited, what beliefs we integrate into our current attitudes towards health. As teacher Anna explained, religious beliefs also play a role here: '*there are families who believe that there will be as many children as God decides , but only within the marriage, of course. (...) Different faiths and beliefs should definitely be discussed, [there are] different people, different perceptions*.'

Another premise that parents took away from the discussion was health prevention. Currently, parents and teachers are more focused on disease literacy, reacting only in times of crisis when symptoms are already visible and behaviour becomes problematic, e.g. parents have to be called to school because a pupil is sleeping during lessons. Teacher Anna pointed out that a special study subject called 'Health' should be introduced so that pupils learn '*to anticipate what will happen if I do this or that (...) I mean that I know what to do when I am sick, I understand why it happened, I can analyse what to do differently next time. It's like making my own medical history/archive, which I can intelligently create based on my knowledge.'* Both school principals emphasised the importance of age-appropriate physical exercise as a prevention factor: '*We must not leave [pupils] without a gym and without intensive sports. I think that one thing that needs to be improved is that the formative stage of children should be taken into account and different physical activities, infrastructure, and qualified professionals should be ensured*.'

The parents and teachers alike expressed the view that health literacy awareness and knowledge alone do not guarantee that pupils, parents, and teachers will remain healthy. It is one thing to know that people need good quality sleep, food, and exercise, but it is quite another to put this knowledge into practice. Ilze, a mother of three, said: *'I can have any skills I want, but if I don't put it into practice, it doesn't work. The groundwork of health literacy has to start with my own example, taking care of what I eat, how I sleep, what my regime is, how I take care of my emotional state. How can I pass this on to my children? Only through what I do myself.'*

The parents also pointed to positive changes in the perception of health literacy in Latvian society. Mother Vita acknowledged: '*I think there is a change in society in general, if we are talking about mental health, which is an achievement. We used to have this attitude" don't whine, don't complain, just move on. Now we notice that a child perhaps might have depressive traits. I think this is an indication that health literacy is increasing*.' The parents mentioned that the change in the attitudes towards health is finally opening up the possibility to talk about issues that were previously silenced and this, in turn, is promoting communication on health literacy at different levels of society.

School-parent collaboration: obstacles and constraints

Parents and teachers are convinced of the importance of collaboration, but, as it turns out, this is not so easy to achieve in practice. The collected responses showcased the lack of communication skills as a serious problem. Several teachers indicated that they were 'afraid to communicate' with parents or felt uncomfortable doing so. The reason for this is probably the specific situation in Latvia, where teachers feel undervalued in their profession, the teaching profession lacks prestige in society (Priževoite, 2022, p. 44), and therefore teachers lack self-confidence. This is one of the reasons why teachers are not ready to take on the 'mission' of parent educators in health literacy.

The parents also seemed unenthusiastic about 'being educated'. The focus groups on collaboration revealed that there were parents for whom teachers or school support

staff were not 'the authority' and who did not want to be 'educated' in this environment. While only a few parents expressed a categorical position, the presence of such a stance within a small sample suggests an emerging trend that should be addressed.

The parents expressed a preference for centralised public education programs staffed by health professionals. As mother Kate pointed out, '*It is not the school's responsibility to educate parents, but the school can be an excellent vehicle through which health literacy information reaches parents'*. The parents emphasised that they want to be informed about their child's health status, including new educational trends in health literacy, but as Inese said, 'nothing should be imposed', i.e. the communication process between school and parents should be relaxed and free. Formal forms of health literacy, such as lectures and seminars, are therefore not popular among parents. This attitude of parents was also addressed from 'the other side of the curtain'. The school principal, speaking about the health literacy activities run at the school by external experts, said: '*The response from parents is very, very low'*.

As other studies have shown, parents' collaboration with schools is influenced by the economic situation in the family and the level of education of the parents. The teachers told us that there are parents who do not recognise that their child has health issues. Then again, others are over-sensitive about the teacher's remarks, as teacher Dita revealed: *'one is to talk, the other is how many parents really accept and understand it, some adopt "we-are-fine attitude" and see teacher's observations as a "swipe", because it is very difficult to admit a problem and even more difficult to admit a mistake.'* The school principal admitted*: 'If everything is fine in the family, if the parents are sensible and educated, then whatever the problem is, it can be solved'.*

The lack of communication skills and specialised teacher education was particularly spotlighted by the 'awkward' topics related to health literacy. For example, sexual issues, mental health, and hygiene, which are still a taboo for some part of Latvian society. As class teachers revealed, there are still situations where girls think they are going to die when they start their menstrual cycle.

Mental health issues have worsened during the COVID-19 pandemic. Several respondents said that they felt uncomfortable talking about the subject and did not know what to do when faced with a real case of depression in the family or the classroom. In addition, the value of dealing with any problem on one's own is still held, which means that help is not sought even when it is really needed – teachers and parents prefer to confront challenges independently. Teacher Dita said: *'For example, I have a girl in Year 5 who is depressed at the moment. I try to help, but it's quite difficult for me as a teacher because I haven't encountered these issues often, so I don't know how to help.'*

One of the most sensitive topics during the study was the hygiene of schoolchildren. Several teachers pointed to problems in this area, asking rhetorically how to be discreet enough to talk to both children and parents about the need for personal hygiene. Conducting lessons remotely exposed the situation in students' homes to the eyes of both teachers and classmates. This made teacher Renāte weigh in: *'It's pretty crazy. In distance learning, for example, I saw children who have untidy rooms all the time, and*

I wasn't ready to bring that up either, because you have to think very, very hard about how to talk about it. Because maybe it's my understanding of order that is very different from their parents' understanding of order.' This again confirms the above-mentioned: teachers are afraid of parents and do not know how to talk about health literacy matters because parents' and teachers' understanding of the matter might be different. As a result, just like parents, teachers choose to remain silent. Teacher Anna observed, *'The problem is that many parents are shy to talk about these issues or consider it the school's duty to educate their children about hygiene.'*

Opportunities for school-parent collaboration

We could not but agree with the school principal who said: '*The main thing would be to define what we want to emphasize in this topic (...) I think the basis is to have a clear idea of what we want to achieve*.' Hence, school-parent collaboration in promoting parental health literacy has to be targeted. In addition, the objectives of the collaboration must be defined jointly and cannot be imposed 'from above'. Teacher Zanda noted: '*If you listen to the children, the class team, and the parents, then you get a pretty good idea of the path you need to take with parents and children. You have to try to find the right direction of collaboration that parents would respond to,–- if you miss the point, you can't go in the same direction with them. And if the parent trusts you, the conversation will flow naturally – the key is to listen to both parents and children and create a safe environment for conversation*.' Hence, anyone can be a facilitator including parents, teachers and/or school leaders; there is no need to wait for orders from education policymakers on how schools and parents should work together. However, according to the respondents, it is important to make a clear division of responsibilities, i.e. what is expected rom the teacher in health literacy at school and what is the responsibility of parents in this area, keeping the focus on pupils, their health, and education.

Here we have to return to the parent–school communication barriers mentioned above and ways to overcome those. All respondents agreed that openness and mutual trust are key to the cooperation, to wit, a quote from the discussion with the principal: '*Since we have improvements in the Parents Council, this communication with the school has become much better, at least on the part of the school administration the fear of talking to parents has decreased (...) the school has realised that parents no longer come with 'daggers' saying that everything is bad'*. More empathy towards teachers was revealed by those parent-respondents, who work as teachers themselves; for example, teacher Solvita admitted that '*(...) what I expect from a teacher [as a mum] and what I don't get as a teacher [from parents] (...) I try to do that, I do my best to make sure that we have that cooperation*.'

The desire to communicate effectively with parents is reflected in the principal's remark that '*there are some small things that we can do by communicating with parents directly, for example, in my class there is a parent with a fairly low level of education, but we regularly communicate by phone, which allowed us to draw a plan to help his child regulate his mobile device use.'* This passage is also significant in that it points to the

need for an individual approach with parents, as each one is different, with their own life experience and beliefs. Hence, the teacher must be professionally trained to work with parents in general, not just on health literacy issues.

This brings us to teacher education, which the respondents believed to be one of the cornerstones in promoting health literacy among parents. The teachers said they wanted to work with health professionals, to be supported, and to have the opportunity to learn. Likewise, they wanted to get training in the areas related to media and digital literacy. As teacher Anna noted, health topics become particularly relevant when students reach the age of 11–12, and adolescents undergo rapid physiological changes. Not all teachers are competent in understanding these different processes, especially in the area of mental health. Teacher Dita acknowledged: '*Health is such a special field because if we can still find information about puberty, it is impossible to know everything about depression and we definitely need more education*.'

The school principals echoed the teachers' sentiments, pointing out that the complexity of health literacy calls for further education within schools. Not only parents need to be trained in health literacy, but also teachers, school support staff, and school leaders. This, in turn, underlined the need for a well-thought-out health literacy policy at the national level, which should be developed by health policy professionals.

However, in all educational processes, a supportive environment at school was considered a priority, i.e. it is important that teachers and school administration, pupils and teachers, as well as teachers and school support personnel, which in Latvian schools consists of a speech therapist, psychologist, social pedagogue, and special education teacher, cooperate with each other. It should be noted that not all schools have all this support staff, for example, one of the schools in our study lacks a speech therapist and a special education teacher.

As one of the principals indicated, it is important that the school, as an organisation, has a shared understanding of the importance of health literacy in a child's psycho-emotional development, that there is a balance between physical activity and positive emotions, and also that there is a common health literacy algorithm. This is all facilitated by the cooperation of the school's support staff, which is sometimes a problem: '*We used to have a psychologist, but somehow the cooperation didn't work, and now, thanks also to our proactive teachers, it seems that this support mechanism algorithm will start to take hold*,' said the school principal.

When it came to the involvement of school support staff, there were conflicting views among the respondents, even within the same school. As teacher Anna said, '*In co-vision, the main idea is that you see others, you hear others, that you are not left alone with your problem, that others can talk about it, that it makes it easier for you if you have a leader who is skilled in leading the conversation. Our school psychologist is really good, I really like the way he works*.' However, teacher Dita was more sceptical: '*(...) I'm probably one of those thick-skinned people. I'll be honest, I get very little support from the school*.' This showcased the importance of harmonising the communication on health issues within the school.

The key figure for the harmonisation is the school leader. This theme came to the fore in the respondents' answers – namely, the support of the school administration to the teachers or the lack of it. Two teachers felt that the school administration was supportive, and understanding: 'does even more than asked'; three teachers, on the other hand, admitted that they had to manage everything themselves at school, including health literacy issues, that there was no exchange of ideas between teachers. One teacher remained neutral, stating that the initiative should come from both sides – teachers and school administration. In general, the teacher-respondents said that they expected support from the school administration in planning a set of activities that would 1) help in organising discussions with parents on sensitive health issues; 2) include separate classes and courses for teachers on health literacy; 3) include dissemination of information about the school support staff and possible involvement of other health professionals.

When asked about opportunities to work with parents to promote health literacy, the respondents most frequently mentioned joint events for school, children, and parents, which can be divided into three groups: 1) events that are educationally targeted; 2) activities that are health promotion-related; 3) permanently accessible, up-to-date information in a digital environment.

Traditional, frequently practiced educational activities mentioned by the respondents include thematic parent meetings with a school psychologist or social pedagogue, lectures and seminars, which were discontinued during the COVID-19 distance learning mode. One of the principals said: '*We have truly thematic parent meetings – not to talk about reports or achievements, but to fill them with meaningful content that has a continuing education context and added value*.' However, according to the parent respondents, educational events are hardly the most effective form, as parents are not always ready to be 'educated'. The exceptions can be made if, for example, the school has enthusiasts who offer to listen to attractive, even sometimes famous, speakers. Two teachers from among the respondents were singled out as examples of good practice, as they were able to justify with their enthusiasm why students, teachers, and parents need to be lectured by a famous and attractive adolescent psychologist, trained at the University of Manchester.

However, practical, health-enhancing activities such as sports and outdoor excursions involving children, teachers, and parents are the most popular among the respondents. For example, one school organises a sports event called 'Run the Winter!' and 'Colour the Spring!' The other school regularly organises a performance event where parents and teachers perform together.

Another suggestion communicated by the respondents was to taking advantage of digital technologies. The parent respondents suggested creating a single digital health literacy information space for parents. Mother Inese suggested: '*(...) so that I don't have to look for these Zoom lectures and seminars myself, that when I log into [the digital platform] 'E-Classroom', I can see this list (...) of everything related to my children and also connect to the relevant link instead of searching Facebook for the topics I'm*

interested in.' The need for health literacy information available to parents in a digital environment was also highlighted by both school principals.

Discussion and conclusions

We believe that the most important outcome of our research is the identification of the themes and issues that should be further addressed in school-parent collaboration on health literacy.

Although the term 'health literacy' is new in Latvia and many people, including teachers, have not even heard of it, health knowledge and skills are present in practice. Our respondents revealed how subjective health literacy can be as it is influenced by individual experience, education, and family environment, but above all, by currently-faced health issues that are very personal to each person and family. The COVID-19 pandemic has brought mental health issues to the forefront, and these were mentioned in all the respondents' interviews. The respondents, parents and teachers alike, recognised that their own health, including mental health, is an important prerequisite for being able to take care of the health of their children and pupils, including the development of health literacy. The respondents considered all the components of health literacy that we already know to be important, namely, the knowledge about health, the ability to use reliable information and to make responsible decisions, but they particularly emphasised two components: prevention and the importance of personal example in health literacy.

We believe that the attitudes towards health literacy were largely determined by the social role of the respondents includingthat of a parent, teacher or school principal. The teacher interacts with a large number of pupils and colleagues in the educational environment, whereas parental health literacy refers to the family space, thus, the parents' perspective is narrower and more subjective. The school principals, on the other hand, reflected as responsible officials, and leaders. At the same time, the teacher and the principal live in their families on a daily basis and, thus, the health literacy of the educator as a parent overlaps with their professional experience. The observations from the discussions show that parents who are teachers are more sensitive to their children's teachers in matters of collaboration.

The lack of mutual understanding and trust is one of the factors that create barriers to communication between school and parents. This is not only a problem in Latvia, as research shows, – other countries have also recognised the inadequate professional training of teachers concerning cooperation with parents (Gartmeier, Gebhard and Dotger, 2016).

Our research shows that on one side, there are teachers who do not know how to communicate with parents, especially on sensitive health issues such as mental health, sexuality, and hygiene. Teachers feel uncomfortable in their communication, realising that they are expected to have a higher level of health literacy than they currently have. This breaks down their self-confidence. Teachers are also afraid of parents' differing perceptions of health, which, in turn, leads to conflict situations. Indeed, as our research

and others have shown, health is a very personal territory, hence, parents tend to be highlyemotional about the school's reprimands and may reject them because they have different ideas about their child's health status and prevention measures.

On the other hand, there are parents whose differing perceptions of health hinder the trust in school, which is reinforced by the lack of prestige of teachers in Latvian society. Some parents also do not want to be specifically 'educated' in health literacy at school, because they (rightly) doubt the school's competence in this area. Health literacy education is also associated with formal and boring events – lectures. This is compounded by the suspicion that health literacy is just another campaign that will soon be swept away again by other educational issues.

Parental attitudes are, of course, felt at school. The school does not want to be the 'bad guy', so it opts for voluntary parental involvement and individual communication. The school expects the initiative 'from below', for example, through parents' committees. The school's own activities are fragmented and mainly initiated by individual enthusiastic teachers. There is a lack of consensus on the responsibility of both parties – parents and school – and on collaboration to improve the situation. The school is currently not an institution where parents can seek reliable support for their health literacy; parents' health literacy remains mainly their personal responsibility.

Although the current situation in the two observed schools may seem rather confrontational, the discussions reveal that all the parties involved are seemingly open to receiving new knowledge and also to collaboration. The main takeaway is that the process has to be purposeful, orderly, and systematic. This insight is in line with what other researchers have written about the need for strategic goals in health education, starting with the family and the school and on to reviewing health policies and attracting funding (Vamos, Okan, Sentell and Rootman, 2020). In the respondents' view, health education is closely linked to the development of communication skills and media literacy. It is hoped that a collaborative educational process could also enhance understanding and trust between schools and parents, a problem highlighted by the respondents. These findings are also relevant for teacher educators and are in line with other researchers' findings that, in recent years, it has become increasingly important to introduce family and community engagement themes into teacher education curricula to prepare teachers more effectively to work with families (Epstein, 2018).

The forms of parent education already practised in schools are fragmented but varied. The respondents mainly supported joint events for parents, teachers, and children, questioning the effectiveness of thematic lectures aimed at 'educating'. However, lectures and seminars are not a form to be completely discarded if the professionalism of the lecturer and the attractiveness of the speaker are seriously considered. The respondents agreed that a digital platform, accessible to parents and educators, could provide systematic information on health issues.

For a school to become a centre for health literacy promotion or at least a support point for parents, it is important that all actors – school administration, teachers, and support staff – work together. The school principals acknowledged the need to create a health literacy algorithm within the school, to foster cooperation between teachers and

support staff. The teachers, on the other hand, emphasised the importance of support from the school administration.

Last but definitely not least, our study shows that the pupil can become a key figure in parents' health literacy, taking home what he/she learns at school and educating the family, becoming a mediator of health education between the school and parents. This is yet another confirmation of the importance of health literacy at school. Besides, today's pupils are tomorrow's parents, hence, health literacy for tomorrow's parents starts in today's school.

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