Health literacy development for the prevention and control of noncommunicable diseases

Volume 3

Recommended actions
Health literacy development for the prevention and control of noncommunicable diseases

Volume 3  Recommended actions
Recommended actions

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The burden caused by the epidemic of noncommunicable diseases (NCDs) and mental health conditions and their modifiable risk factors on people, communities and economies is a major challenge to health, well-being and sustainable and equitable development. Governments need to address the urgency of investing in healthy populations and resilient health systems, with increased investments in prevention, screening, early diagnosis and appropriate treatment for NCDs. They must do so through inclusive, contextual and equity-driven strategies that are fit for local purposes and with a commitment to leaving no one behind.

A key enabler to accelerating progress towards the NCD targets in the Sustainable Development Goals is health literacy, to support people, communities and organizations to understand, recognize and take effective actions to protect and promote their own health.

This report provides practical recommendations for developing health literacy interventions to support countries to systematize the co-design of health literacy actions to enhance the impact of policies, programmes and services for the prevention and control of NCDs and mental health conditions, and their modifiable risk factors and determinants.

These recommendations draw from the findings of 16 case studies from low- to high-income countries, which have generated data supporting the development of locally owned and fit-for-purpose NCD strategies that are more likely to be embraced, implemented and sustained, especially among disadvantaged and poor communities.

The imperative is for rapid development and systematic implementation of country-relevant, context-specific solutions. The wide-scale implementation of the guidance contained in this report by World Health Organization (WHO) Member States will generate implementable and sustainable NCD health literacy development actions that respond to local contexts and demand. This will help to drive progress towards the WHO Triple Billion targets and improve health and well-being for current and future generations.
Acknowledgements

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<td>eHLQ</td>
<td>eHealth Literacy Questionnaire</td>
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<tr>
<td>GCM/NCD</td>
<td>World Health Organization Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases</td>
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<td>HICs</td>
<td>high-income countries</td>
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<td>HLQ</td>
<td>Health Literacy Questionnaire</td>
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<td>LMICs</td>
<td>low- and middle-income countries</td>
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<td>NCD</td>
<td>noncommunicable disease</td>
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<td>NHLDP</td>
<td>National Health Literacy Demonstration Project</td>
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<td>Ophelia process</td>
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<td>Org-HLR</td>
<td>Organisational Health Literacy Responsiveness</td>
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<td>SDGs</td>
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**Being left behind**

Being left behind relates to the motto of the Sustainable Development Goals – “Leave no one behind”. This refers to groups or communities that are not included in services or do not have equitable access to health information and services for the prevention and control of NCDs. It indicates a gap in society where groups or communities are missing out on opportunities to prevent and control NCDs or to maintain, manage or improve their health, which leads to poorer health status compared with other groups in the society.

**Co-design**

This is the active and meaningful engagement and participation of relevant stakeholders (e.g. people with lived experiences, community members, health workers, clinicians and other professionals, managers, policy-makers) throughout the process of designing health-care services and health-promotion activities, drawing on their experience and in-practice wisdom.

**Determinants of health**

These are the range of personal, social, economic and environmental factors that determine the healthy life expectancy of individuals and populations. Health determinants vary for countries, regions, communities, villages, families and individuals.

**Globally relevant perspective of health literacy**

A globally relevant perspective of health literacy recognizes the diverse ways in which knowledge is produced, transferred, exchanged and used in different countries, cultures and settings around the world, especially how knowledge accumulates in families, communities and societies through daily, often communal, activities and social interactions within these diverse settings. This perspective recognizes that different strategies will almost certainly be required in different cultures and settings, and that deep engagement with local communities is needed to develop the most appropriate strategies.

**Health literacy**

This represents the personal knowledge and competencies that accumulate through daily activities and social interactions and across generations. Personal knowledge and competencies are mediated by the organizational structures and availability of resources that enable people to access, understand, appraise and use information and services in ways that promote and maintain good health and well-being for themselves and those around them.
Key terms and concepts

In this report, four different facets of health literacy are explored: community health literacy, health literacy development, health literacy of an individual, and health literacy responsiveness. Distinguishing these is important when taking a globally relevant perspective on health literacy for the purpose of improving health and equity in diverse settings.

**Community health literacy**

This refers to health literacy-related assets (knowledge, resources, abilities), including:

- knowledge held by people in the community;
- the extent to which knowledge is trusted, circulated and adapted freely in a community;
- health-promoting customs embedded in cultural beliefs and norms, and in traditional or emerging practices of daily life;
- relationships between the community and outside sources of information.

Family, peer and community conversations and interactions are central to determining community health literacy, behaviours and outcomes.

**Health literacy development**

This refers to the ways in which health workers, services, systems, organizations and policy-makers (across government sectors and through cross-sectoral public policies) build the knowledge, confidence and comfort of individuals, families, groups and communities through enabling environments. Enabling environments support people to access, understand, appraise, remember and use information about health and health care, through verbal, written, digital and other communication channels and social resources, for the health and well-being of themselves and those around them, within the circumstances and demands of their daily lives.

**Health literacy of an individual**

As viewed from a globally relevant perspective, this is people’s knowledge, confidence and comfort – which accumulate through daily activities and social interactions and across generations – to access, understand, appraise, remember and use information about health and health care, for the health and well-being of themselves and those around them.

**Health literacy responsiveness**

This refers to the extent to which health workers, services, systems, organizations and policy-makers (across government sectors and through cross-sectoral public policies) recognize and accommodate diverse traditions and health literacy strengths, needs and preferences to create enabling environments that optimize equitable access to and engagement with health information and services, and support for the health and well-being of individuals, families, groups and communities.
National Health Literacy Demonstration Projects (NHLDPs)

NHLDPs were designed and supported by the WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases Global Expert Working Group on Health Education and Health Literacy for NCDs. NHLDPs implement the Optimising Health Literacy and Access (Ophelia) process in various forms, depending on the needs and resources of each project context.

NHLDP teams develop, refine, test and evaluate health literacy actions that develop and respond to health literacy strengths, needs and preferences. These actions can range from low- or no-cost actions that are easy to implement through to complex multilevel health literacy actions. Each project collects evidence about health literacy actions that prove effective for the prevention and control of NCDs and, importantly, the context in which the actions proved effective and why. The long-term purpose of a programme of NHLDPs is to promote and support sustainable and scalable health literacy development and responsiveness actions in communities, organizations, health systems, and local, regional and national policies to accelerate the prevention and control of NCDs.

Optimising Health Literacy and Access (Ophelia) process

This is a co-design approach used frequently in health literacy development. It generally uses multidimensional health literacy or digital health literacy questionnaires such as the Health Literacy Questionnaire (HLQ) and the eHealth Literacy Questionnaire (eHLQ), which specifically investigate the diverse health literacy strengths, needs and preferences of individuals and groups of people. In this way, the process uncovers who is being left behind and why services are not effective for them, and provides information about what to do next. The Ophelia process uses meaningful engagement to understand and build on local knowledge and wisdom and international evidence to co-design, develop and implement health literacy actions that are accessible, sustainable and useful for the people who need them. The Ophelia Manual (1) provides a detailed step-by-step method to undertake health literacy development projects, including the NHLDPs.

People

In this document, the term “people” refers not only to individuals but also to collectives such as families, communities and groups associated by kinship or land, and nations.

Settings

Health literacy development is undertaken across all settings where people’s knowledge, understanding and behaviour about health can be influenced. This includes prenatal environments, people’s homes, villages and cities, schools and workplaces – that is, all the places where people are exposed to health-related information and where their health behaviours may be influenced.
The report is a designated WHO Global Public Health Good and, as such, is in line with the primary function of WHO to ensure access to authoritative and strategic information about matters that affect human health. Effectively delivering on this function involves influencing the actions of others in ways that can be shown to improve health outcomes and equity. To accelerate efforts to prevent and control NCDs and mental health conditions, Member States are encouraged to explore and implement a wide range of health literacy development and responsive actions.
Volume 2. A globally relevant perspective described health literacy development and responsiveness and why it is necessary to use health literacy to improve the prevention and control of NCDs and mental health conditions. Using this health literacy approach, Volume 3 provides guidance to WHO Member States about practical actions that can be taken.

Given that Member States have different contexts and diverse communities and cultures, the recommendations for action are general. To assist Member States to accelerate the application of health literacy development to prevent and control NCDs, five action areas are suggested and these should be adapted to local needs and opportunities.
3.1

Volume 2 described the two main foci for health literacy actions:

**Health literacy development refers to:**

The ways in which health workers, services, systems, organizations, and policy-makers (across government sectors and through cross-sectoral public policies) build the knowledge, confidence and comfort of individuals, families, groups and communities through enabling environments. Enabling environments support people to *access, understand, appraise, remember and use* information about health and health care, through verbal, written, digital, and other communication channels and social resources, for the health and well-being of themselves and those around them, within the circumstances and demands of their daily lives.

**Health literacy responsiveness refers to:**

The extent to which health workers, services, systems, organizations, and policy-makers (across government sectors and through cross-sectoral public policies) recognize and accommodate diverse traditions and health literacy strengths, needs and preferences to create enabling environments that optimize equitable access to and engagement with health information and services, and support for the health and well-being of individuals, families, groups and communities.

The two health literacy action foci aim to develop the health literacy of people in the population and improve access and outcomes for people by responding to their health literacy needs. With these foci as a background, this document considers practical activities that can be applied to develop health literacy in populations, organizations and communities, and to effectively deliver health services and health-promotion activities to people with varying health literacy profiles in different contexts.

**Use of "actions" rather than "interventions", for health literacy development**

In this report, we talk about *"actions" rather than "interventions"* for health literacy development. This is because the range of activities necessary for health literacy development and responsiveness often require small changes or integration into the daily practices of health workers at all levels, changes in education practices and health policy, and the formalized programmes that would normally be referred to as interventions.

When thinking about health literacy development and responsiveness, there is an important distinction between:

- actions that seek to **build capacity** of workers, organizations and health systems to undertake health literacy development and to be responsive; and
- projects and programmes that seek to **directly engage** people and communities for the purpose of health literacy development.
This distinction is important because health literacy profiles in communities vary widely. If workers and organizations assume the health literacy development needs of a community, without directly engaging and consulting with people and the community, then important needs may be missed, and inequities widened. Responsive health literacy development requires careful engagement with local communities in all their diversity.

A final point of clarification is that in this report we often talk about people being left behind, or missing out, usually because of specific limitations or failures of health literacy responsiveness. People are left behind in many ways, including:

- not accessing health services that they are entitled to and could benefit from;
- not having financial resources to access health services;
- not receiving information that would help them care for their health in ways they can understand and apply;
- not being able to express their needs or explain their problems;
- not being able to participate in important discussions and advocacy about issues affecting the health of the community.

These ways of being left behind can and often do lead to worse health outcomes for individuals and communities.

The action areas proposed in this volume are not meant to displace activities that may already be under way in countries. Rather, these are suggestions for commencing activities or for supplementing what is already occurring. It should be emphasized that there is no one-size-fits-all approach – activities should be undertaken within each Member State’s societal, cultural and community context. The proposed action areas are designed as a framework that can be taken into different Member State settings to be adapted and contextualized as needed. The framework has a starting point action area; three core action areas for building responsive health systems, building community health literacy, and targeting priority groups; and a fifth action area for integrating health literacy in country-wide implementation. (Fig. 3.1).

**Fig. 3.1.** The five action areas for health literacy development and responsiveness
Activities include developing an appropriate understanding of health literacy, measuring health literacy to understand needs, integrating health literacy into existing NCD policies and programmes, enhancing the reach and acceptability of WHO Best Buys and other recommended interventions, and overcoming barriers to health literacy development and responsiveness.

In recent years, an increasing number of WHO Member States have included a health literacy focus on domestic policies and research. Many Member States have programmes or policies that already align closely with health literacy, but they may not refer to these as health literacy programmes or policies. Health literacy-related processes and techniques are common to many public health approaches, and all countries have health and health-promotion workers who promote health literacy, even if they do not call it that. This section will assist Member States to consider the programmes and policies already in place, and the skills of their workers, and to decide what new actions, or integrations of actions, need to be taken.

Preparing for systematic and integrated health literacy development and responsiveness at a national level first requires an understanding of what health literacy (and, consequently, health literacy development and responsiveness) means within cultural and country contexts. Countries also need to assess their current situations and focus not on national averages but on who has health literacy needs and who is missing out on access to effective health services and health promotion. This is done by assessing and understanding the differences in health literacy strengths, needs and preferences in communities. With this information, countries can prioritize action areas, including where and how to implement WHO Best Buys and other recommended interventions for NCDs. Barriers to health literacy development and responsiveness can then be identified and addressed.

There are five components to action area 1 to prepare for NCD health literacy development and responsiveness:

- 1.1 Develop an understanding of health literacy that is contextually appropriate;
- 1.2 Measure health literacy to identify and understand differences about who is being left behind;
- 1.3 Integrate health literacy into existing NCD policies and programmes;
- 1.4 Enhance the reach and acceptability of “WHO Best Buys and other recommended interventions for the prevention and control of NCDs”;
- 1.5 Overcome barriers to health literacy development and responsiveness.

The first task, however, is to establish a unit to coordinate the national health literacy development actions.
Establish a health literacy coordination unit

Establish a health literacy coordination unit in the ministry of health or across ministries responsible for health to support the development of specific health literacy policy and health literacy-informed NCD policy, and for the implementation of health literacy programmes. The unit could:

- inform or enhance an existing national multisectoral or multistakeholder NCD coordination mechanism, such as a high-level commission, agency or task force for engagement, policy coherence and mutual accountability of different spheres of policy-making that have a bearing on NCDs, to ensure effective implementation of responsive health literacy development in national priority areas;
- promote where and how health literacy development and responsiveness actions can be used to develop and improve NCD policy;
- coordinate and implement health literacy capacity-building;
- undertake or facilitate a situational analysis and health literacy survey (see Practical activity 3.2C);
- fund and promote National Health Literacy Demonstration Projects (NHLDPs);
- develop locally relevant strategies for surveillance, evaluation and impact assessment.
The term "health literacy" can be difficult to translate because it is a complex idiomatic expression in English. It was coined and is used mainly in individualistic cultures (Australia, North America, western Europe) for testing patients in clinical settings and conducting surveys to suggest the percentage of people experiencing health information difficulties. As mentioned previously (e.g. see sections 2.2.1 and 2.3.2 in Volume 2), people develop their health literacy over many years through interactions with their families, communities, and health services. Conversations between people within their social networks are often the main way they interpret and make decisions about health throughout life (2, 3).

To develop an understanding of health literacy within the context of a particular country, Member States will need to consider:

- the range of ways (formal and informal) that people develop their health literacy in their daily contexts – each of these is an opportunity to develop health literacy support actions (consider Fig. 2.3. in Volume 2);
- the most appropriate language and phrases for talking about health literacy diversity (see below);
- the wide range of health literacy strengths, needs and preferences that exist across the country.
3.2.1 Language for discussing health literacy diversity

Health literacy diversity in a community is often presented as high and low or adequate and inadequate. These categories are based on averages, however, and ignore the different strengths, needs and preferences in and among people and communities. For planning action, it is more helpful to use descriptive phrases about:

How people are able to or prefer to acquire knowledge such as based on traditional wisdom, acting by following instruction of those with authority in their family or community, preferring to use technology, high trust in health professionals, or being influenced by their peer group.

The types of knowledge where people are strong or have limitations such as traditional survival knowledge, understanding of chronic disease that exists even without symptoms, understanding of health related to religious concepts such as "sin" or "fate", knowing and understanding modern health services, or understanding lifestyle risk factors.

In thinking about how to describe the health literacy differences that exist in the country, officials will develop a specific understanding of health literacy that fits the country’s uniqueness and context.

To use health literacy to plan effective actions for people with a wide range of health literacy needs, including building on strengths and supporting people’s preferences, the strength-based approaches applied in the WHO NHLDPs will be needed (see Volume 4).
Translate the concept of health literacy and co-design to a nationally acceptable name

Direct translations of the term "health literacy" vary greatly across the world depending on how "health" and "literacy" are translated. For example, the term is translated on health literacy questionnaires as "health knowledge, skills and attitude" in China, "competencies about health and health care" in Spain, and "information and support for health actions" in Thailand.

With a national team, develop a linguistically and culturally acceptable translation of the concepts of health literacy, health literacy development, health literacy responsiveness, and community health literacy (see Key terms and concepts). This process can sensitize key stakeholders and stimulate interest.

With a national team, document expected local linkages between health literacy and risk factors for NCDs and how health literacy may determine NCD management. Also explore access to information and services using Fig. 2.6 in Volume 2.

Audit national activities across 10 fields of health literacy policy development and implementation

Table 3.1 presents 10 fields for health literacy policy development and implementation. This is not an exhaustive list, but it covers many of the key fields for health literacy development. Establish a working group to survey and review current national activities across the 10 fields (i.e. conduct a situational analysis) to identify health literacy capacity, opportunities to build on what is already good, and fields to strengthen.
### 3.2.1

<table>
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<th>Field</th>
<th>Policy development and implementation</th>
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<tr>
<td>1</td>
<td>Health literacy surveys to compare across regions or population groups</td>
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<td>Surveys that enable comparison of health literacy profiles within regions and countries can be useful to help incentivize authorities and organizations (including governments) to invest in health literacy (see section 2.3.8.3 in Volume 2 and section 3.2.2 below).</td>
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<td>2</td>
<td>Health literacy of leaders and policy-makers, including across sectors</td>
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<td>Leaders, policy-makers and other stakeholders in different sectors need to be aware of health issues, particularly relevant to NCDs and their risk factors and determinants, and the impacts of the activities, policy-making processes, programmes and planning in their sectors on these issues to facilitate cross-sectoral coherent action and integrated healthy public policy approaches. This field includes the idea of public health literacy, which considers the extent to which government sectors and policy-makers are aware of public health principles and approaches and the impact of their sectoral agenda on health outcomes. Development of this field will create enabling environments and assist in the understanding and, therefore, the application of health literacy development by leaders across sectors in useful and effective ways.</td>
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<td>3</td>
<td>Health literacy for mass communication</td>
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<td>This field includes setting guidelines relating to content, presentation, sustainability and delivery systems for information, including mass media, information websites and hubs, and literature for mass dissemination. These guidelines should be informed by the experience and expertise of health and behavioural science, social marketing, linguistics and digital communication. This is a particularly important field for application of digital health platforms. Development of this field will assist authorities to understand the range of learning mechanisms of diverse communities, how best to present mainstream messages and how this may need to be adapted to minority groups to ensure no one is left behind. Health literacy development also helps to ensure an understanding of who has access to particular communication channels (e.g. television, radio, social media, print media) and how these channels affect behavioural changes. While communication through mass media is useful to sensitize populations (communities, community leaders, local and regional authorities), minority groups or groups in low-resource settings may have different preferences, and care needs to be taken to identify the appropriate channels to avoid inequitable access.</td>
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3.2.1 Table 3.1. continued

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<th>Field</th>
<th>Policy development and implementation</th>
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<td>4. Child and adolescent health literacy</td>
<td>Actions in this field seek to develop knowledge, motivation and competencies of children, parents, school principals and teachers concerning health (e.g. nutrition, oral health, basic hygiene, anatomy, vaccination, healthy behaviours, health services) to promote, access and maintain health throughout life. Health promoting schools are a major contributor for health literacy development among children. Development of this field will assist in supporting children to make daily health-related decisions and empowering them to demand the enabling environment that will lead to good long-term health and avoid NCD risk factors (especially resisting and managing commercial determinants of health). Health literacy development within, and outside of, the school environment also leads to distributed health literacy, whereby the health literacy skills of children are passed on to their families and communities. A range of school-based programmes are available, including the WHO Health Promoting Schools initiative.</td>
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<tr>
<td>5. Digital health literacy</td>
<td>This field seeks to ensure people have the information, knowledge and skills to engage timely and appropriately in all forms of health services on digital platforms (e.g. use of information technology and digital health, navigation and access to services and insurance systems). It can also include advocating for the role of service providers in ensuring people have access to accurate information instead of misinformation or disinformation. Development of this field will assist in reducing the chances of increasing inequity between people with and without access to and skills in using digital technologies. It is also essential in mitigating the infodemic (i.e. the overwhelming amount of information, especially misinformation and disinformation, on the internet).</td>
</tr>
<tr>
<td>6. Health literacy and behaviour change competencies of health-care staff</td>
<td>Actions in this field ensure health-care staff can interact with a diverse range of individuals and provide information and stimulate motivation in ways that are contextual, acceptable, understandable and useable. This includes routine use of good practices (e.g. plain language, pictures, action planning, checking understanding and confidence), awareness of diversity and ability to adapt to individual needs (e.g. understanding differences in health literacy, life status and how people access, interpret and process information, and having a repertoire of communication methods). This includes cultural competence and non-stigmatizing attitudes, especially when engaging with minority groups and groups that may experience marginalization (see section 2.2 in Volume 2). Digital health literacy competency of health-care staff is also increasingly important in this field. Development of this field will assist to refine health literacy of health workers and their role in health literacy development and responsiveness. Incorporate health literacy in the educational curricula of health workers to build the organizational capacity needed to cover health literacy needs in Member States.</td>
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3.2.1

<table>
<thead>
<tr>
<th>Field</th>
<th>Policy development and implementation</th>
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<tbody>
<tr>
<td>7 Health literacy-related problem-solving for targeting “gap” groups, i.e. those not benefiting from current strategies.</td>
<td>The aim is to identify individuals who are not, or who are insufficiently, interacting with health services or preventive activities. These individuals are often being left behind from the health benefits of policies and programmes. Understanding health literacy issues that limit people’s ability to benefit from current services and approaches will enable new, more suitable approaches to be identified. Possible health literacy barriers to engagement in health care and self-care include trust and rapport, stigmatization, false beliefs, fear of health services, conflicting priorities, conflicting social influences, and trail-and-error decision-making (see section 2.2 in Volume 2). The purpose is to develop more equitable approaches to health care and service provision. While the number of people within these gap groups may be small, they are often experiencing the highest levels of vulnerability and marginalization. Therefore, it is likely that they experience worse health outcomes (not engaging in preventive health care, seeking help too late). Identifying new inclusive approaches will reduce health inequities and support access.</td>
</tr>
<tr>
<td>8 Health literacy as a means of enabling consumer choice and self-direction</td>
<td>Many services seek to engage health consumers by allowing them to make choices about their health care (demand-side strategies). These include, care packages (voucher systems) in disability services, maternal and child health services, and many chronic disease self-management programmes. These programmes place particular demands on people’s health literacy to be enabled or empowered to ask questions or request specific treatment options. This also includes digital systems that support people’s involvement in their own health (e.g. booking systems to choose a consultation time or time for a blood test). The aim is to strengthen programmes that focus on self-management and people-centred approaches. These approaches typically rely on the health consumer having the necessary health literacy skills and agency to take the required actions, but they may (inadvertently) leave behind those who do not have the necessary health literacy skills, or “build them up for failure” when they do not have access to healthy options. Developing programmes in accordance with health literacy principles will ensure the programmes are responsive to diversity among different population groups.</td>
</tr>
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### 3.2.1 Table 3.1. continued

<table>
<thead>
<tr>
<th>Field</th>
<th>Policy development and implementation</th>
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<tbody>
<tr>
<td>9. Promoting community action on health</td>
<td>This field has a focus on the extent to which people have the critical health literacy needed to actively engage in their communities and wider society through talking about their concerns, participating in public debates and decision-making processes about health, and demanding policy and programme changes necessary to improve health and equity for people around them. This includes formal processes (e.g. community juries, health impact assessment) and less formal community action processes (e.g. industrial and agricultural developments) at local, regional and national levels. It includes the ability to resist, and demand necessary changes in, unhealthy choices and environments. Development of this field will assist in collective action for health literacy and strengthening of community resources, including strengthening the role and impact of community health advocates.</td>
</tr>
<tr>
<td>10. Building community health literacy: working with community networks and formal and informal conversations about health</td>
<td>In many communities, people form their health beliefs and health actions largely through conversations with their friends, family and peers. Influencing health beliefs and behaviours as part of health literacy development and responsiveness often requires engaging in community processes, such as women’s health networks, men’s sporting clubs or religious networks. Development of this field will assist in strengthening the resources people have to gain health knowledge and act on it within their own social and cultural contexts — for example, the development of community-based approaches that facilitate exchange and co-creation of health knowledge in group settings, led by community members.</td>
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</table>
Measure health literacy to identify and understand differences about who is being left behind

Measuring health literacy can be important if it helps to assess the current situation and focus on which groups have health literacy-related problems and which groups are missing out on accessing effective health services and health promotion opportunities within national contexts. Measurement can also help to understand differences in health literacy strengths, needs, preferences and contextual factors, (e.g. traditions in communities).

3.2.2.1 Measure health literacy responsiveness

Measurement of health literacy responsiveness can be approached in five ways, and each makes an important contribution. The first two approaches focus on the perspective of people in the general population. The other three approaches focus on the characteristics of health services, including the skills of the staff.

1. Overall indicators of who is left behind
   Ultimately, health literacy responsiveness is about leaving no one behind, no matter what their health literacy strengths, needs and preferences. At some point, efforts to increase health literacy responsiveness must show that fewer people are being left behind. Indicators of nonparticipation (groups identified as receiving insufficient services, e.g. migrant, language minority or ethnic minority groups) and the presence of outreach services (authorities actively taking services to community groups not receiving adequate information and care) are important indicators of health literacy responsiveness.

2. Surveys of perceived responsiveness and satisfaction among users of a service
   Several measures have been developed to assess the perceived health literacy responsiveness of the health system. Similarly, patient satisfaction surveys often include questions related to health literacy responsiveness, such as the perceived skill and friendliness of staff, how clearly they explained health and treatments, how they respond to questions, or whether they encourage clients to ask questions (4, 5).
3. Organizational audits, self-assessment tools and checklists to analyse the responsiveness of health services or programmes

Checklists and self-assessment tools have been developed to assist organizations assess their health literacy responsiveness. The earliest and most well-known is the Universal Precautions Toolkit (5). More recent tools have been based on models such as the Health Literate Hospital model (7, 8) or have been developed and tested within diverse healthcare settings (9–11). The assessment is often linked to quality-improvement activities, accreditation and standards programmes for health services, such as the National Safety and Quality Health Service Standards in Australia (12) and the Agency for Healthcare Research and Quality Indicators in the United States (13). Indicators for the effectiveness of health-promoting schools highlight the importance of health literacy in children’s knowledge and skills building (14).

4. Organizational audits and self-assessment with a focus on service user feedback

This approach combines the previous two and involves service users in an audit of health literacy responsiveness. This can occur through a physical inspection of the environment, such as, by auditors (including service users and external staff) walking around the facility with the staff and giving their feedback; or it may occur by stepping through some of the processes of care (the service user’s journey) and giving feedback on the user-friendliness of these processes (15).

5. Health literacy-responsive practice skills of workers

This approach to assessing health literacy responsiveness involves assessing the skills, confidence and behaviour of staff in health literacy-responsive consultation skills such as teach-back. There is also ongoing work towards the development of health literacy competencies for health workers to guide and assess practice and education, including the development of curricula (16, 17).

Practical activity 3.2D

Measure health literacy responsiveness

Establish an inclusive working group and identify the most relevant of the five ways to measure health literacy responsiveness in your context to address health and equity priorities. Seek local data and expert local opinion (from community members, people living with or affected by NCDs, and clinical leaders) on whether there are specific groups who are not accessing services or are being excluded. Meaningful engagement with diverse community groups will help to ensure in-depth information is obtained to make informed decisions about service improvements.
3.2.2 Measure health literacy of individuals

The measurement of health literacy among individuals in the general population and specific groups with NCDs is another way to assist Member States to identify who is missing out on services and, importantly, why this is happening. Understanding why certain groups are being left behind is important for informing health literacy development. Health literacy surveys can help evaluate the impact of development activities and identify and share good practices. There is a consistent pattern in many countries about which groups have low health-related literacy and numeracy (the most common way health literacy is estimated, often referred to as functional health literacy). These groups include people living in the most deprived areas, people with a complex health conditions or disabilities, people with low socio-economic status, elderly people, people from ethnic minorities (18–24) and people affected by the factors influencing health literacy (see Fig. 2.5 in Volume 2).

Given that most health literacy work has been undertaken using individualistic approaches, most measurement tools reflect such approaches rather than the diverse health literacy strengths and challenges that people from communal cultures may have. Measurement needs to consider that people with health literacy challenges may be illiterate in the majority language or their native language (e.g. they may be migrants, be from a minority language community, or have had limited formal schooling), but they may have other health literacy strengths. These challenges and strengths influence participation in services (and research surveys) among people living with or at greatest risk of NCDs and with substantial barriers to accessing information and health services.

Multidimensional health literacy assessments produce a range of scores that show dimensions of strengths, needs and preferences for managing health (25–28), including in communities with high illiteracy rates (29). Social structures may lead to observed weakness in one dimension of health literacy (e.g. they find it difficult to access information) to be mitigated by strengths in another (e.g. they are helped by a supportive family member, or they have a helpful service provider). Health literacy assessments that produce only a single average health literacy score can be misleading because the data do not distinguish health literacy strengths and needs of individuals and communities (3, 30).
Surveys that measure health literacy strengths, needs and preferences of individuals and communities provide rich data about how to build or improve NCD interventions using WHO NHLDPs (see Volume 4).

Many communities in LMICs have oral communication traditions and text-based survey assessments of health literacy that are not woven into local community narratives may not be appropriate. A mixed-methods design is recommended to capture local nuances and perspectives.

In cultures with oral communication traditions, people will have habitual ways to find and understand health information through family and social networks. Consequently, it is important to consider contemporary strengths-based approaches to measurement that account for local contexts and respect cultural practices.

It is helpful to understand several fundamental health literacy elements at the community level. For example:

- What knowledge do people have (and not have) about locally relevant NCD issues (e.g. risk, protective factors, treatment and care)?
- How do they obtain knowledge, including the sources of information they rely on (e.g. government sources, local peer community sources, social media)?
- What are people’s practices for managing NCDs and avoiding risk factors?

Answers to these questions can efficiently inform the development of actions that prevent and control NCDs and are responsive to health literacy needs.

Many health literacy questionnaires are available (Table 3.2). They range from testing an individual’s health-related literacy and numeracy (e.g. Test of Functional Health Literacy in Adults) (31) to surveys seeking to classify the proportion of people in a country as having adequate or inadequate overall health literacy and comparing this with other countries (e.g. European Health Literacy Survey in the European Action Network on Measuring Population and Organizational Health Literacy) (32).

For health literacy development, it is important to take a strengths-based approach, collecting unbiased data on diverse people’s health literacy strengths, needs and preferences. The measurement approach developed for the NHLDPs enables the identification of as many strengths as possible in diverse subgroups. It is important to recognize that individuals and sub-groups may have several severe health literacy needs – that is, comparably lower scores in one or more health literacy dimensions e.g. reading, navigating services, finding information– and yet they may not be regarded as having low health literacy because they may have some very strong health literacy strengths (e.g. social support, excellent relationship with a health-care provider).

An important part of health literacy development is active identification of any strengths and preferences and building on these – that is, taking a strengths-based approach.
3.2.2  

**Undertake targeted or national surveys of health literacy**

Different types of health literacy tools are used for different measurement purposes (Table 3.2) and may have different target groups (from regions to individuals Table 3.3). The measurement purpose needs to be matched with the corresponding type of measurement tool. Because health literacy is linked strongly to determinants of health, there will be a higher proportion of people with health literacy needs in regions with low education, poor access to good quality health care, and people with more than one NCD. The use of inclusive survey methods (e.g. household surveys), and appropriate personnel training to ensure biases and stigmatizing behaviours do not influence face-to-face data collection, will allow representative participation of people with varying health literacy. It is also important, in health literacy development to take a strengths-based approach – therefore, select a measure that identifies people’s strengths, needs and preferences.

The combined use of quantitative and qualitative methods provides rich information about health literacy strengths, needs and preferences to assist the co-design of appropriate health literacy actions. The WHO NHLDPs provide examples of co-design of health literacy actions. The NHLDPs mostly use the nine-dimension Health Literacy Questionnaire (HLQ) (33), which was designed specifically to support development of interventions or actions. The Boston University Health Literacy Tool Shed (https://healthliteracy.bu.edu/) is a database with many quantitative tools to measure health literacy.
### Table 3.2. Examples of health literacy assessments and their purposes

<table>
<thead>
<tr>
<th>Type of measure</th>
<th>Purpose</th>
<th>Example</th>
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</thead>
<tbody>
<tr>
<td>Knowledge tests</td>
<td>Measures general education / health education knowledge</td>
<td>Chinese Resident Health Literacy Scale</td>
</tr>
<tr>
<td>Health-related literacy and numeracy tests</td>
<td>Focuses on ability to read e.g. medicine labels</td>
<td>Test of Functional Health Literacy in Adults</td>
</tr>
<tr>
<td>Disease specific and specialty assessments</td>
<td>Usually used to test specific knowledge or behaviour</td>
<td>Nutrition literacy or digital literacy tools</td>
</tr>
<tr>
<td>Multi-dimensional generic assessments that estimate overall health literacy at population and group level</td>
<td>Often used for benchmarking and estimated classification of health literacy levels as adequate or inadequate</td>
<td>HLQ, European Health Literacy Survey</td>
</tr>
<tr>
<td>Multi-dimensional generic assessments that provide profiles of health literacy for surveys, needs assessment, and intervention planning</td>
<td>Identifies specific areas of health literacy strengths, needs and preferences, and supports health literacy development.</td>
<td>HLQ</td>
</tr>
</tbody>
</table>
### Table 3.3. Purpose for health literacy measurement and target groups

<table>
<thead>
<tr>
<th>Target group</th>
<th>Purpose for health literacy measurement</th>
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</table>
| **Regions**                         | • For governments in countries with health literacy needs to advocate for health literacy development  
  • Identify regions with advanced health literacy development and responsiveness practices  
  • Develop region-relevant recommendations about enhancement of health literacy, to be implemented at regional or country level |
| **National surveys (comparing regions and groups)** | • Identify relationships between health literacy and access, participation and outcomes  
  • Planning health education campaigns  
  • Assess regional health literacy burden for planning and funding purposes (assuming that it often takes more intensive input and therefore more resources to achieve the same result with people with health literacy needs) |
| **Local areas**                     | • Plan service marketing and education strategies  
  • Assess people’s ability to participate in community-based health-planning activities |
| **Individual services**             | • Diagnose health literacy strengths, needs and preferences and assess their contribution to known inequities of access, participation and outcomes |
| **Groups of people living with or affected by NCDs** | • Identify factors contributing to poor outcomes  
  • Plan services to respond to identified health literacy needs |
| **Individuals living with or affected by NCDs** | • Problem solving for people with complex issues  
  • Staff training for responding to different health literacy needs |
All Member States have specific NCD policies and programmes. With responsive health literacy development, the reach and effectiveness of such policies may be improved. The following high-level guidance from the 2016 Shanghai Declaration (34) may help Member States strengthen their NCD policies and assist with prioritizing policy initiatives. The Declaration calls for:

- recognition of health literacy as a critical determinant of health and the need to invest in its development;
- development, implementation and monitoring of intersectoral national and local strategies for strengthening health literacy in all populations and in all educational settings;
- increasing individuals’ and communities’ control of their own health and its determinants, through harnessing the potential of digital technology (digital health literacy);
- ensuring consumer environments support healthy choices through pricing policies, transparent information and clear labelling.

Governments, at all levels, are encouraged to develop and implement local, regional and national policies to prevent and control NCDs and their risk factors. This should, however, be informed by local health literacy needs. Commissioning health literacy development projects, collating local and international evidence, and building capacity among leaders across sectors will help to contextualize and embed strong health literacy development approaches into current and future NCD programmes and policy. Interestingly, a ripple effect of health literacy policy integration has been detected within NCD policies such as national cancer control plans in countries that have also adopted national health literacy strategies or are otherwise engaged in health literacy development and advocacy. Investing in health literacy in one policy area is thus likely to amplify health literacy in other policy areas (35).

To strengthen the reach, acceptability and impact of NCD programmes, leaders and operational staff may benefit from practical training and the availability of toolkits in health literacy development. Health literacy leadership is also important among mayors, provincial leaders, cultural leaders and village leaders, which is also a recommendation of the Shanghai Declaration (34).
3.2.3  Practical activity

Review and strengthen NCD policy using health literacy development and responsiveness approaches

As outlined in the Shanghai Declaration, local leadership (e.g. city mayors, provincial leaders, cultural leaders, village leaders) is important to advance practical health literacy development and responsiveness programmes that recognize and meet the needs of community members.

Develop a multisector working group to review NCD-related policy for prevention or management of NCDs. Use health literacy thinking to improve the policy or develop new policies and programmes to prevent and control NCDs and their risk factors. Establish partnerships between central government, local leaders and community organizations, including patient groups, to increase the effectiveness, reach and implementation of the programmes.

The consultation and coordination processes could be organized as part of the needs assessment of a WHO NHLDP, see the Ophelia Manual (1).
It is critical that Member States develop and implement policies and programmes to rapidly reduce the prevalence of risk factors for NCDs and to improve the treatment of people living with or affected by NCDs. Legislation and associated resources provided directly by central and regional governments are urgently required to create healthier environments. WHO Best Buys and other recommended interventions are a menu of policy options and intervention, and their cost-effectiveness, to assist WHO Member States, as appropriate for their national context, in implementing measures towards achieving the SDG Target 3.4 on NCDs. The Best Buys are a list of effective interventions presented for four key risk factors for NCDs (tobacco, harmful use of alcohol, unhealthy diet, physical inactivity) and for four disease areas (cardiovascular disease, diabetes, cancer, chronic respiratory disease). There are 16 Best Buys that are considered most cost-effective and feasible, and other recommended effective interventions that are above the cost-effectiveness threshold of the Best Buys or for which cost-effectiveness analyses are not available (36).

Standardized interventions tend to be designed for individuals and groups who speak and read the majority language and belong to the majority culture. It is important to apply health literacy principles to ensure language, cultural and religious minority groups are included. Using a health literacy approach will help to tailor and improve reach and uptake of NCD interventions.

Member States are encouraged to explore if WHO Best Buys and other recommended interventions they select can be strengthened through applying a health literacy approach to maximize the reach of the interventions to minority groups and groups who are frequently left behind. In this way, there is the potential for health literacy-improved Best Buys to also reduce health inequities. For example, one of the recommended overarching enabling actions that should support the Best Buys that address harmful use of alcohol is to “Increase awareness and strengthen the knowledge base on the magnitude and nature of problems caused by harmful use of alcohol by awareness programmes, operational research, improved monitoring and surveillance systems” (36). This strategy calls for better health literacy of policy-makers (“Increase awareness and strengthen the knowledge base on the magnitude and nature of problems”), and needs to apply the health literacy approach to ensure broad reach and uptake (“by awareness programmes, operational research, improved monitoring and surveillance systems”).
3.2.4

Table 3.4 displays exemplars of common programme activities and potential barriers to effective and equitable uptake by population groups. Where relevant, the programme activities are related to specific WHO Best Buys and recommended interventions. As each Member State, province, district and local community have a wide range of potential health literacy needs to respond to, only broad examples are outlined and are provided to demonstrate the nature of the health literacy approach.

Table 3.4. Common NCD programme areas and health literacy-related barriers and considerations

<table>
<thead>
<tr>
<th>NCD programme area</th>
<th>Health literacy barriers and considerations to optimize reach and impact</th>
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<tbody>
<tr>
<td>Mass media education campaigns, including specific education to alert the community (included in WHO Best Buys for smoking, unhealthy diet and physical activity)</td>
<td><strong>Barrier:</strong> for people who do not read, who use a minority language or have oral communication traditions, it can take time and multiple exposures to messages from trusted sources before messages are trusted and used. <strong>Health literacy consideration:</strong> use multiple formats (oral, written, traditional media, social media, arts) in multiple languages and design or formats, promoted over time (one-off interventions are weak in terms of uptake of the message by target populations).</td>
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<tr>
<td>Lifestyle changes, self-management support, complying with treatment regimes, participation in rehabilitation services (included in WHO effective interventions for smoking, alcohol, physical activity and diabetes)</td>
<td><strong>Barrier:</strong> health-care workers with limited skills or traditions to communicate with and support clients to adopt healthy behaviours. <strong>Health literacy consideration:</strong> improve health-care workers’ skills in teach-back and supportive media (e.g. written, pictorial, video) to improve communication; community health workers, lay workers and peers assist with training (knowledge, motivational strategies, confidence-building, skills, routines).</td>
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<tr>
<td>Perinatal interventions among women living with diabetes (WHO recommended intervention for diabetes)</td>
<td><strong>Barrier:</strong> cultural and religious practices, inadequate access to health services, inadequate social support, poor mental health, illiteracy, feelings of shame and awkwardness can prevent women from seeking or continuing this care. <strong>Health literacy consideration:</strong> local religious leaders and village elders may have strong influences and be able to promote and endorse young women learning through regular groups using narrative and storytelling.</td>
</tr>
<tr>
<td>Vaccination against human papillomavirus to prevent cervical cancer (WHO Best Buys for diabetes)</td>
<td><strong>Barrier:</strong> there is no obvious link between the infection and cancer, also vaccine hesitancy and fear of potential harm may cause people to not get vaccinated. <strong>Health literacy consideration:</strong> to overcome fears, develop a series of educational radio, television or print media presentations by local or celebrity figures (influencers) that appeal to young mothers and daughters.</td>
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### 3.2.4 Table 3.4. continued

<table>
<thead>
<tr>
<th>NCD programme area</th>
<th>Health literacy barriers and considerations to optimize reach and impact</th>
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</table>
| Use of diet, exercise, medicines and blood glucose tests by people living with diabetes (WHO Best Buys for diabetes) | **Barrier:** an appropriate diet may be difficult to follow (e.g. people may believe it doesn’t provide them enough energy to do their work; access barriers to healthy choices), lack of understanding about what medicines do, or traditional medicines displace evidence-based medicines.  

**Health literacy consideration:** people with limited biomedical knowledge need complex information in chunks (i.e. series of short segments of information) and explanations in non-medical terms; careful explanation of the long-term implications of high blood sugar and benefits of treatment explained by both a doctor and a well-trained lay health worker; respected local community member informed and supported to take on the role of village diabetes champion and to promote availability of and access to healthy environments; diet advice must be culturally appropriate. |

| People do not engage in prevention, especially those with lived experiences of mental health issues (this issue affects all the WHO Best Buys and recommended interventions related to prevention) | **Barrier:** people with lived experiences of mental health issues may have difficulty communicating what is wrong and may feel stigmatized; they may have more than one NCD and be exposed to a range of risk factors so treatment regimens are complex to follow and maintain.  

**Health literacy consideration:** health workers could focus initially on simple, direct information about the important health concerns while building trust and confidence; build understanding, deal with fears and support self-management into daily routines; empower people to take action for their health. |
Overcome barriers to health literacy development and responsiveness

Policy is required to assist the development of programmes that specifically seek to enable equitable access and equitable effectiveness across groups with diverse health literacy strengths, needs and preferences. To achieve this, it is first necessary to consider the things that can block health literacy development and thus prevent programmes from reaching diverse communities.

The displacement of traditional lifestyles by unhealthy lifestyles and environments, including, tobacco products, poor air quality in the home, unsafe places for work and cheap socially desirable but unhealthy foods mean that for many people, NCDs develop unnoticed and unchecked. Socially desirable components of community life and lifestyle, including local hazardous businesses and industries providing valued employment, may not be viewed as public health problems and authorities may regard attempts to change them as politically undesirable (37-39).

Conflict, and fear of conflict (including feuds and rivalries within a community and between religious groups and families), adversely affect mental health and physical health. Racism and gender discrimination and family violence may not only lead directly to poor health, but also prevent or discourage health-promoting environments, and they must be dealt with in parallel with health literacy development actions (40-42). See section 2.3.7 in Volume 2 for a list of several possible blocks to health literacy development and responsiveness.
Health literacy responsiveness is the extent to which health workers, services, systems, organizations and policy-makers (across government sectors and through cross-sectoral public policies) recognize and accommodate diverse traditions and health literacy strengths, needs and preferences to create enabling environments that optimize equitable access to and engagement with health information and services, and support for the health and well-being of individuals, families, groups and communities.

There are many benefits that result from building a health literacy-responsive health system:

- reducing the risk of harm to people engaging in care, such as preventing faster progression of a condition, a medication error or poorer health outcome (43);
- increasing the appropriate and timely use of health and social services and therefore lowering health and social care costs (44, 45);
- reducing the demand on services through more appropriate and timely referrals to the right level of services, including reduced rates of avoidable hospitalization and use of emergency departments, shorter periods of treatment and less frequent readmissions (46, 47);
- increasing people’s active involvement and decision-making in relation to their health and well-being (48);
- increasing coordination between services for more holistic services (11, 49–52);
- gaining a deeper understanding of beliefs, traditions and culture to improve communication with people from minority groups (48).

It is critical that information and services are made as user-friendly and as inclusive as possible for people with all profiles of health literacy because developing health literacy in individuals and communities can be a slow process. Many people, especially those who may be experiencing vulnerability (e.g. elderly people, people who are unwell, people with lived experiences of mental health issues, migrants, people living with disabilities) and their carers, may have limited and inequitable access to information and services. In other words, information and services need to be developed or refined to be as responsive as possible to the community to maximize utility for diverse community groups and individuals.
The term health literacy responsiveness was first introduced in the WHO Health literacy toolkit for low- and middle-income countries (53). It reflects the inherent dual responsibility embedded in the health literacy concept (54) with a focus on:

- health systems actively supporting community members to understand available services and their rights to access;
- ensuring an adequate range and quality of services are available that are inclusive and accessible.

Being responsive also includes recognizing and addressing the determinants of health and understanding how local cultures and religious beliefs affect access and use of services (see Fig. 2.3 in Volume 2). Therefore, health literacy responsiveness means incorporating access, availability and inclusiveness of services, and the determinants of health into the design of health systems. Consequently, health literacy thinking is necessary for the design and implementation of universal health coverage.

### Health literacy and universal health coverage

Under their universal health coverage provisions, most Member States are making new packages of services available to their populations. Every time new services are developed, a new burden of understanding is created for the population. People must come to understand something about the purpose and rationale for the new services, when and for whom they are appropriate, and how to access them. This is a major health literacy challenge.

The fact that this is not easy can be seen from the decades of efforts in helping women and communities understand, accept and use two services – antenatal care and professionally attended childbirth. It is critical to use health literacy development to help individuals across diverse contexts understand, access and appropriately use new service packages.

As health care systems are strengthened, ensuring those systems are health literacy-responsive will increase the quality, reach and equity of services provided. Ultimately, health literacy responsiveness could be incorporated into the set of indicators used for monitoring, evaluation and quality improvement of health services and systems.
There are two main objectives when seeking to develop health literacy responsiveness:

- ensure services are as user-friendly and accessible as possible for all people who access the services;
- address health literacy barriers that lead to some people not using or under-using services.

Strategies for the first objective focus on health literacy quality improvement within health services, as demonstrated by the United States Agency for Healthcare Research and Quality Health Literacy Universal Precautions Toolkit (6). In recent years, a great deal of emphasis has been placed on meaningful engagement of individuals with lived experiences of diseases and representatives of consumer organizations in all aspects of developing health services and programmes.

Strategies for addressing barriers for people who are not using, are under-using, or are simply not aware of health services include:

- community engagement and mobilization, including raising community awareness about the services through dissemination of information in diverse formats, peer-to-peer education and community champions;
- identifying and addressing issues that may have led people to lose trust in health services;
- identifying and addressing practical barriers such as cost, transport and time;
- constructive engagement with traditional health practitioners;
- using whole-of-community approaches to education about services so that individuals with lived experience and with leading roles in communities and families are involved in deciding how they can engage with services;
- implementation of co-design strategies.

Critical for building the health literacy responsiveness of services is the development of meaningful, ongoing interaction and participation of service users (i.e. people living with NCDs), potential users, their families and communities.
3.3.1

The first and most important step in developing health literacy responsiveness is for organizations to recognize the need and to adopt it as a priority. Recognizing the need involves identifying the areas where systems and practices that are not health literacy-responsive might be affecting who uses their services and the health outcomes that might be achieved or inhibited. Identifying areas where responsiveness is not optimal might include considering the problems that are already indicated by available data. This can help, for example, to identify groups of people who are missing out on services, such as those who:

- do not use services;
- frequently drop out of services or attend erratically;
- do not act on advice given;
- use services inappropriately;
- use treatments and services that are known to be ineffective.

Responsibility for adopting health literacy responsiveness as a priority is not up to health providers alone. Leadership needs to come from government authorities and key policy bodies that can authorize health services to undertake health literacy development activities in communities, and performance monitoring systems must give recognition to achievements in this area.

Community co-design and collaborative capacity-building approaches to health literacy development are ways in which health services and governments can identify and respond to the health literacy needs of individuals, groups of people who are missing out, and whole communities and populations. Recognition of health literacy as a measurable multidimensional concept opens the way to identifying which strategies work for whom, in what circumstances and why. When the people who most need support are kept central to the process of health system and policy improvement, then the implemented solutions are likely to specifically address their needs for accessing, understanding and using information and services and, importantly, will support equitable health outcomes.
Co-design health literacy-responsive actions using the Ophelia process

Like other collaborative co-design models, the Ophelia process (55) undertakes meaningful engagement with community members, health workers, service managers and decision-makers to uncover local wisdom and ensure fit-for-purpose, needed and wanted health literacy-informed actions are developed. Using a strengths-based approach, the Ophelia process draws on three methods: intervention mapping (56–58), quality-improvement collaboratives (59–61), and realist synthesis (62–64). It incorporates processes similar to assets based community development (ABCD) (65, 66) and lean manufacturing (67, 68).

Ophelia was specifically designed to build health literacy actions that respond to local needs, are effective and implementable. The process starts with a needs assessment using a multidimensional health literacy questionnaire that reveals key mechanisms that determine people’s ability to access, understand, appraise, remember and use health information and health services. These data are often collected in partnership with community organizations and service providers to generate deep local ownership of the processes and data and what the data mean. These data inform the development of vignettes (short narratives about types of community members) to uncover different health literacy strengths, needs and preferences. The vignettes are then the foci of deeply engaging workshops with a wide range of people with lived experiences of the target condition or service engagement challenges and who live in diverse contexts in which the health literacy actions are to be implemented. Other stakeholders, such as health service providers, community workers and municipal staff who have grounded insights into the daily lives of target groups are engaged in the same type of workshop.

The outputs of the workshops are reviewed, and potential actions are prioritized and tested using quality improvement cycles in a way that is responsive to contexts and changes (health literacy or other relevant changes) that might occur over time for individuals, groups, communities and organizations.

Health literacy varies greatly across populations, so Member State contexts, community health literacy assets and potential barriers to health literacy also vary. The Ophelia process was designed to be flexible to meet the needs of local implementation teams. This is achieved through the application of eight core principles (Fig. 3.2). Implementation teams are strongly encouraged to adhere to these principles, but to adapt the Ophelia protocol where needed.
Fig. 3.2. The eight principles of the Ophelia process

1. **Focus on outcomes**
   Focus on improving health and well-being outcomes

2. **Driven by equity**
   Focus on increasing equity in health outcomes and access to services for people with varying health literacy needs

3. **Driven by local wisdom**
   Prioritize local wisdom, culture and systems

4. **Diagnosis of local needs**
   Respond to locally identified health literacy needs

5. **Co-design approach**
   Engage all relevant stakeholders in the co-design and implementation of actions

6. **Responsiveness**
   Respond to the varying and changing health literacy needs of individuals and communities

7. **Applied across systems**
   Focus on improvement at and across all levels of health systems

8. **Sustainable**
   Focus on achieving sustained improvements through changes to environments, practices, cultures, and policies

The Ophelia process is further described in the Ophelia Manual (1).
Organizations need policies, systems, processes, infrastructure and environments that make it easy for people to access, understand, appraise, remember and use information and services to promote and maintain good health. Focus on the concept of organizational health literacy has led to the development of frameworks, tools and processes to put this into action (Table 3.5). To date, most work has focused on hospitals and health-care facilities, but interest is also growing beyond the health sector (48).

**Table 3.5. Approaches to organizational health literacy responsiveness**

- Health Literacy Universal Precautions Toolkit by the Agency for Healthcare Research and Quality
- Health Literacy Environment of Hospitals and Health Centers
- Ten Attributes of Health Literate Organizations by the Institute of Medicine
- Organisational Health Literacy Responsiveness self-assessment tool and process
- Vienna Health Literate Organisation
Choosing a framework

There are many factors that need to be considered when choosing an organizational health literacy framework, especially given the range of frameworks and tools available and the diverse health-care settings around the world. Consider the following issues when choosing a framework suitable for a particular setting:

- **Relevant to the organization**: close attention needs to be paid to the translation and implementation of these frameworks, tools and processes into practice to better understand what is required to support organizations across different sectors. The actions to develop organizational health literacy responsiveness need to match the operational context – that is, the actions need to be relevant to the way the organization functions, including its clinical and financial context. Developing organizational health literacy responsiveness requires a systems approach, meaning multiple changes will be needed at many levels, and changes made to one part of the system will impact on other parts of the system.

- **Systems approach**: embarking on this kind of transformative change journey can lead to many unforeseen but connected actions. This highlights the need to ensure the frameworks used take into account the existing systems and the interconnection between them. For example, the Organizational Health Literacy Responsiveness self-assessment tool and process highlights the interconnection between leadership and culture, systems, processes and policies, access to services and programmes, community engagement and partnership, communication practices and standards, and workforce (49).

- **Focus on both quality improvement and equity**: quality improvement and accreditation standards are often a driver for the development of organizational health literacy responsiveness. Care should be taken, however, not to engage with these activities as a standalone endeavour – that is, not to improve health-care delivery only for the purpose of achieving accreditation. The benefits of building a health literacy-responsive health system clearly demonstrate that organizational health literacy is also a population health issue. Therefore, specific strategies to improve access, understanding and use of health information are needed together with strategies to ensure equity for all.

- **Assessment, tools and resources**: choose a framework that includes a process for self-assessment to highlight the areas of good practice and strengths, and areas for improvement. Noting what the organization is doing well can support the process for collecting evidence for quality accreditation standards, particularly those relating to patient outcomes, consumer rights, and community development. The findings from the self-assessment process can be used to develop a health literacy action plan to guide the ongoing cycle of action, evaluation and improvement.
Explore organizational health literacy responsiveness

With a team or working group, comprehensively discuss what your idea of a health literacy-responsive organization would:

- look like (e.g. physical environment, signs, waiting areas);
- feel like (the experience of being in the physical environment and interacting with people);
- do (e.g. routine activities, reception, intake, ways of providing information).

Compare your responses with the dimensions of organizational health literacy responsiveness.

Develop what you learned from the activity into your own vision of a health literacy-responsive organization.

See Case study 4.6 in Volume 4 for an example of how a cardiac rehabilitation organization applied this approach to improve its health literacy responsiveness (9) and Case study 4.17 for an example of a community co-design process to develop a state-wide approach to mental health literacy responsiveness.
3.3.4 Improve the health literacy responsiveness of health workers

Education and training programmes for health workers are critical components of organizational health literacy responsiveness. This workforce includes medical professionals, nursing, allied health and community health workers and peer workers. Health workers are well placed to identify and respond to the health literacy needs of people and communities. It is important that all health workers understand and respond to the health literacy diversity in their communities. Irrespective of the health literacy competency of any community member seeking care, health workers should be able to maximize all opportunities for providing health information, treatment and services that their community understands and needs.

Health workers are a primary source of health information and can support the development of health literacy in people and communities. Many health workers, however, have significant gaps in their own health literacy knowledge and practices. There are three main categories of health literacy skills and competencies required for health workers:

- their own health literacy and knowledge of the health system;
- general health literacy skills appropriate to everyone such as communication skills and teach-back;
- skills that involve assessing people’s health literacy diversity and then responding appropriately.

A range of professional development and training options have been developed in response to these identified needs, including communication skills, disease-specific content knowledge, client self-management and motivation, and generalized health literacy knowledge and skill development. These approaches seek to ensure that health workers can interact with a diverse range of people and provide information in ways that are understandable and useable. Health workers should be trained to be health advocates for the community.
3.3.4

Health workers need to understand health literacy diversity; the factors that influence individual and community health literacy (including risk factors and determinants of health); and how people access, interpret and process information. Health literacy skills and practices include:

- routine use of plain language;
- use of a variety of teaching options such as relevant pictures and diagrams;
- action planning in ways that puts the condition, treatment and relevant risk factors within the context of the person’s daily life;
- checking understanding and confidence;
- awareness of diversity and the ability to adapt to individual needs;
- digital health literacy;
- cultural competency.

“Ask, tell, ask” is a collaborative communication method that can help to build trust, rapport and effective communication between health worker and community member (69). This framework for communication contrasts with a method of directly telling people what to do, or “tell, tell, tell”. The “ask, tell, ask” method increases the likelihood that the health information or advice will be received by the person.

Ask – determine the agenda for the conversation by first understanding what the person hopes to accomplish:

- Ask open-ended questions and listen and respond to emotion.
- Ask permission to give information or advice (respect the person’s autonomy).
- Ask what the person already knows or understands or what they want to know so that you can tailor your response.

Tell – use health literacy skills and practices to deliver information tailored to the person’s needs and health literacy strengths and preferences:

- Tell using plain language and use pictures or diagrams if relevant.
- Tell in small chunks or pieces of information.
- Tell things that are focused, personal or specific to the person and their situation.

Ask – check understanding using teach-back (70, 71):

- Ask the person to teach-back key messages or topics covered in the conversation.
- Ask in a way that is respectful, caring and non-shaming and places responsibility for the messaging on the health worker – for example, “We have covered a lot of information today, can I please check that I have explained things clearly? Can you please explain to me...”.
- Ask the person to explain or demonstrate what they have learned.

With the increasing digitalization of health services and the expansion of telehealth during the COVID-19 pandemic, health workers need to be mindful of the digital health literacy skills of community members to help them access and engage with digital services. The development of digital health actions will be more responsive to people’s needs if digital health literacy concepts are included in how they are designed, although, to date this has not been widely adopted (72). Tools such as the eHealth Literacy Questionnaire are being increasingly used (73), including in the Ophelia process, to inform digital health programmes and to ensure these actions account for people’s preferences, challenges and readiness in engaging with digital health and telehealth.
Health literacy-responsive health systems require a suitably skilled workforce. Education and training institutions have a vital role in developing this workforce, but health literacy skills are not yet included in most teaching institutions. The skills required are to undertake health literacy development across the life course, and to work with people with particular health literacy limitations, preferably within a universal precautions approach (i.e., an approach that seeks to be simple, invitational and health literacy friendly for all users of the service). The skills should be specifically taught as part of undergraduate or postgraduate curricula, as many health workers are unaware of the significance of the problems and the roles they can play.

Curricula for educating health personnel are often already crowded, so an approach that incorporates health literacy principles and skills into existing content in ways that are opportunistic and emphasize integration with all aspects of practice may be beneficial. Incorporating health literacy into curricula can occur in a subtle way that seeks to establish health literacy responsiveness into the norms and values of practice. These norms, values and practices may include advocacy, health equity, and carefully considering the social circumstances of the person.

Health literacy is also a cross-cutting subject, meaning it is important curriculum content that can be covered across subjects, rather than learned in one particular subject. In this way, health literacy can enrich the curriculum without overloading it. For example, health literacy can be taught as part of health communication, social determinants of health, human rights, primary health care and working with diverse communities.

Health care service providers often have limited time available to attend training courses. One way of overcoming this obstacle is low-dose high-frequency training, which is a competence-building approach that promotes maximum retention of information and skills. Low-dose high-frequency training involves short, targeted, in-service simulation-based learning activities spaced over time and reinforced with structured, ongoing practice sessions in or out of the workplace. Low-dose high-frequency training is effective not only for skills-building, but also for continuous improvement of performance, and it helps to maintain competence over time. Other strategies for improving ease of access for service providers include on-the-job training and the option of online training and learning resources.
Training of health-care workers

Develop and implement programmes to improve the health literacy responsiveness of health-care organizations through enhancing the skills of health service providers, including medical professionals and undergraduates, nursing, allied health and community health workers, and peer workers. Managers and policy-makers also need specific training and education about ways to develop and support organizational health literacy responsiveness.
This section describes strategies for WHO Member States to strengthen community health literacy, including the community’s knowledge and actions towards the prevention and control of NCDs and their risk factors and determinants. In most settings, health-related decisions are not made only by individuals. On a daily basis, people are influenced by other people in the immediate vicinity such as family members, carers, peers and local community leaders, including health professionals and traditional healers. It is important to understand these communication channels and ensure accurate and needed health information is continuously built within and across communities when developing health literacy at the community level.

Community health literacy includes the total health literacy-related assets in a community. These assets may include community members with strong health knowledge, who are good communicators, and to whom people frequently go for information. These individuals influence what the community believes and how they behave. They may strongly influence how people in the community perceive the quality and trustworthiness of information (oral, written, broadcasts) and health-promoting customs and behaviours such as embedded cultural beliefs, religious practices or social norms.

In the same way that an individual can believe in misinformation or disinformation, which can have a negative effect on their health literacy and health behaviour, there can also be entrenched community-wide misunderstandings about health that put the whole community at risk. Supporting an individual to move to healthy and safe beliefs involves openness to discussion with others and access to good information. Equally, positive community health literacy requires openness and constructive discussion with health authorities and sources of correct information. These assets need to be understood if NCDs and their risk factors are to be reduced in a community.

Activities include strengthening community health worker programmes, implementing the Action for Healthier Families Toolkit, and strengthening the competencies of trusted community influencers, leaders and connectors to facilitate discussion and adaption of health information and services to local contexts.
Strong community networks can be very powerful in spreading health information and in helping people work out how to put it into practice in their context and daily lives. The same networks, however, can also spread and reinforce misinformation that is misleading and harmful. For this reason, it is necessary to consider two aspects of community health literacy:

- the people, traditions and community networks that share information and help people through the process of understanding what information might mean for them and how they can apply it;
- the knowledge content and whether it is accurate and beneficial or inaccurate, misleading and potentially harmful.

It is possible for a community to be strong in some aspects of health and weak in others. For example, there may be strong knowledge and acceptance of the benefits of breastfeeding but poor understanding of the negative health effects of excess sugar and salt in products.

One of the best safeguards against inaccurate information being spread and consolidated in communities is to ensure communities have ongoing trusting relationships with health and other authorities in their context. This also requires that local and regional health and other authorities take the time not only to distribute information but also to participate in an active dialogue with communities, including people living with NCDs, to fully understand how communities are thinking, talking about, and acting on the health issues of concern.

Actions related to community health literacy should be built on the understanding that people form their health beliefs and health actions largely through conversations with their friends, family and peers. Influencing health beliefs and behaviour often requires engaging in community processes such as women’s health networks in cities, towns or villages, men’s sporting or activity clubs, support groups for people living with NCDs, and close knit working environments such as garment factories, farming communities and fishing unions. These existing community structures are key venues to develop health literacy.

In many countries, there are formal networks of village or community health workers, perinatal women’s groups, networking groups of people living with NCDs, Men’s Sheds, and religious groups, which can be readily mobilized and strengthened with useful NCD preventions and control messages to support the development of health literacy. In many LMICs, peer-support programmes, such as village health volunteers and women’s health networks are widespread in every village (74). The Thai village health volunteer programme was particularly successful at having community health workers acting as agents of health promotion during the avian influenza epidemic and the COVID-19 pandemic (75, 76). In HICs, several community health literacy models have been identified (77), other examples can be found in the case studies in Volume 4.
Communities can be important sources of support and inspiration to each other. For example, Myanmar and Thailand have networks of “smoke-free communities” that share experiences and strategies for maximizing smoke-free spaces in the community. It is important to note, however, that attempts by one community to simply copy what has occurred in another are usually unsuccessful, and that each community needs its own strong dynamics of health communication and creative adaptation.

Leaders, including village leaders and city mayors, play a critical role in bringing innovations to their people and facilitating their implementation.

A review of the role and potential contribution of community health workers indicated that they can help people navigate a fragmented health-care system and support universal health coverage (74). The review argues that community health workers:

- recruited from the communities they serve are less likely to go elsewhere because of difficult living conditions;
- who speak the local language and identify with the local community can convey health messages more effectively;
- who are properly trained, equipped and supported can take on a range of tasks that otherwise depend on mid-level health workers;
- contribute to training and service capacity for community leadership;
- extend care to underserved communities, where they enhance access to health services and promote people’s trust, demand and use of such services;
- can help service users avoid trips to health facilities, which translates into saved transportation costs and time;
- can meet some of the needs of people who cannot leave their homes (74).

Develop and support the introduction and continuous development of community health workers

Strengthen or establish a community health worker programme whereby volunteers receive basic training in health and assist communities with getting good health information in words they understand and navigating access to the right level of health services.

There are many examples of community health worker development around the world, including in India (ASHA workers) (78), Thailand (village health worker) (76, 79), Afghanistan (Afghani community health workers) (80) and Slovakia (Roma Health Navigators) (81).

Community health workers can function as health literacy translators, especially if they are recruited from local communities and they understand local dialects and customs (74).
Implement the Action for Healthier Families Toolkit

The Action for Healthier Families Toolkit is a resource developed, tested and evaluated by the WHO Regional Office for the Western Pacific (82). It has visually based tools to assist families to have deep conversations about the health problems and risks affecting people in the family and to identify actions that families can take to help address these problems and risks. In addition, the toolkit has tools and a process to draw together the needs identified by families, and insights of community members and leaders, to determine:

- problems that can best be addressed at a whole-of-community level;
- the resources available to the community to tackle these problems;
- the prioritized actions to be taken at the community level.
Activities include identifying and prioritizing groups that are being left behind, implementing NHLDPs to allow for meaningful engagement with priority groups, and applying health literacy and co-design principles when implementing digital services.

In every country, there are groups of people who are missing out on accessing health care and groups whose needs are not met by the current approaches to health service delivery. In these situations, there are likely to be health literacy mechanisms causing the disparity, and therefore the assessment and use of such causal mechanisms in the development of actions to improve services and outcomes is warranted.

Fig. 3.3 outlines some of the reasons why many mainstream programmes fail to be effective for everyone, including after initial periods of early success and substantial investment of resources. Many programmes designed to prevent and control NCDs and other conditions and their risk factors and determinants are developed using top-down approaches, developed in isolation from the end-users, and are designed for the average person or people who are easiest to reach. Efforts for wide implementation of such programmes tend to return marginal gains. Many interventions have structural elements that simply make them inaccessible or ineffective for some groups of people because their particular health literacy needs were not considered during the development and implementation of the intervention.
The role of health literacy diversity in explaining why one-size-fits-all programmes are effective for some, but not all, members of society.

NHLDPs are advancing international health literacy practice and aim to accelerate progress towards realizing high-level commitments for the prevention and control of NCDs and mental health conditions. The projects are being implemented in HICs and in some LMICs. The WHO NHLDPs are designed to draw on best practices in co-design with key target groups, and processes to support Member States to implement and embed programmes.

There are groups in societies who tend to miss out or are left behind. Table 3.6 shows some examples with links to NHLDP case studies.
3.5

**Groups that may experience vulnerability or are left behind by mainstream services**

<table>
<thead>
<tr>
<th>Language and cultural minority groups, including migrants and refugees</th>
<th>NHLDP case studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with disabilities</td>
<td>• Portugal (migrants) – Case study 4.12</td>
</tr>
<tr>
<td>People with mental health problems</td>
<td>• The Netherlands (musculoskeletal) – Case study 4.9</td>
</tr>
<tr>
<td>People with low education or low socioeconomic status</td>
<td>• Canada (mental health) – Case study 4.5</td>
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<tr>
<td></td>
<td>• Australia (mental health) – Case study 4.17</td>
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<tr>
<td>Young people</td>
<td>All case studies, especially:</td>
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<td></td>
<td>• Mali (diabetes) – Case study 4.3</td>
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<td></td>
<td>• France, Réunion Island – Case study 4.7</td>
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<td></td>
<td>• Portugal (diabetes) – Case study 4.11</td>
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<td></td>
<td>• Portugal (migrants) – Case study 4.12</td>
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<td></td>
<td>• Egypt (fishing villages) – Case study 4.14</td>
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<tr>
<td>Older people</td>
<td>• Ireland (school children) – Case study 4.8</td>
</tr>
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<td></td>
<td>• Australia (school children) – Case study 4.16</td>
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<td></td>
<td>• Canada (heart disease, lung disease) – Case study 4.4</td>
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<td></td>
<td>• Norway (lung disease) – Case study 4.10</td>
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**Practical activity 3.5A**

**Identify and prioritize groups that are being left behind and implement NHLDPs**

Engage with people living with NCDs and gather key stakeholders concerned with NCDs, mental health, risk factors, health systems development, behavioural science, education, health promotion and other relevant areas, to identify groups being left behind. Ask the following questions about groups that are at risk of or are living with NCDs:

1. Which groups are you failing to engage or be effective with in your service or setting? (see Fig. 3.3)
2. Which groups are falling out of your service along the pathway? (see Fig. 2.6 in Volume 2)

Establish a programme of work to prioritize the identified groups and implement NHLDPs to improve outcomes for these NCD groups. See the case studies in Volume 4 and the Ophelia Manual (1).
Digital health has the potential to increase timely and appropriate access to health information and services. The COVID-19 pandemic has demonstrated the essential role of telehealth in supporting consultations, treatments and healthy behaviours during lockdown, prompting further acceptance and usage of technology for health in the wider community (83). Studies of digital interventions for NCD management generally reported positive health outcomes (84–87). WHO is urging Member States to accelerate digital health adoption to strengthen health systems and improve public health capacity (88, 89).

People with limited access or skills to use the internet and digital technologies are at risk of missing out. A systematic review exploring the development of digital health interventions specifically targeted at socially disadvantaged populations found that digital health literacy principles, such as those outlined in the eHealth Literacy Framework (90), or co-design principles, such as user involvement, were rarely considered. Strategies to help users to engage with digital health systems or accessibility features were also limited (72). As such, certain groups in the community are at risk of being left behind in the digital age. Overlooking digital health literacy needs may widen the digital divide and increase health inequities.

Digital health literacy indicates whether people have access to the internet and digital devices and if they can use the information and knowledge obtained to assist them in dealing with health issues, in addition to basic understanding of health, risks and health services (91, 92). Issues such as privacy concerns and motivation should also be considered when seeking to understand digital health literacy needs (90). Digital health literacy is an emerging area where the five actions of health literacy (access, understand, appraise, remember, use) are undertaken using digital resources. There is growing research in some countries (Australia, Canada, China, some European countries (especially Denmark), the United States), but digital health literacy has not yet been incorporated into mainstream initiatives. Digital technologies are, however, becoming part of everyday day life in many Member States, and the area will continue to grow.
Advancing digital health literacy is one of the strategic objectives proposed in the WHO Global Strategy on Digital Health 2020–2025 (89). The development of digital health literacy can be through strengthening the development and implementation of digital services using digital health literacy principles and co-design, so that actions are inclusive for people with health literacy needs (90, 93). Digital health literacy should also be part of the curriculum at all institutions that educate health professionals to provide an understanding of the needs of receivers of digital services and how providers can be responsive to these needs (94, 95).

Countries need to commit to developing national digital health strategies and building person-centred digital health systems (89). These systems need to be responsive to the diverse digital health literacy needs of existing and potential users of their services. Digital health systems need to maximize participation to ensure digital products and processes are optimized for reach and access, particularly for people with low literacy, people with disabilities and people living in low-resource settings. Access includes physical access (e.g. mobile phone, computer, internet, user interface design incorporating accessibility features) and the skills to access, understand, retrieve, appraise and apply digital health information. Governments should also ensure that infrastructure is in place, especially in rural or remote areas, to allow for efficient internet access. Non-digital services need to be considered when digital access is not forthcoming (96).
Integrate health literacy at the national level through to local levels

A health literacy coordination unit, as described in Practical activity 3.2A, would be ideally placed to undertake national integration of health literacy policy and programmes across jurisdictions. Governmental, nongovernmental, academic and civil society organizations, such as people living with NCDs who have experiences, responsibilities and roles for NCD prevention and control, including for risk factors, should be involved in national efforts of integration.

The purpose of national integration of health literacy is to strengthen the reach and effectiveness of NCD prevention and control programmes through:

- developing a **national action plan** to guide the improvement of current programmes and policy using health literacy approaches, ensuring new programmes and policies are as effective and inclusive as possible;
- improving and sharing **health literacy expertise** through, for example, capacity building, a knowledge sharing facility, and communities of practice.

Activities include integrating Action areas 1 – 4 into a new or existing national NCD plan, establishing a series of NHLDPs involving sectors within and outside health, establishing a health literacy knowledge repository and communities of practice, and scaling up actions that work.
3.6.1 Develop a national action plan that integrates Action areas 1–4

Health literacy development needs to prioritize context-appropriate, locally co-designed initiatives, services, environments and, importantly, national health literacy policies to leave no one behind. Inputs for the development of a national action plan could include many of the practical activities listed in the sections above, from an audit of what a country is already doing in the area of health literacy (to build on what is already good), capacity-building activities that have been found to be effective, and analyses of groups that tend to be left behind and why this is the case. Each country will have processes for developing national action plans. It is particularly important in the area of health literacy that there is extensive consultation with people with lived experience of NCDs, and their carers and family (kinship groups), and diverse frontline practitioners. Case study 4.17 in Volume 4 outlines a state-wide approach to building a roadmap for mental health literacy responsiveness. Further inspiration for the development of a national health literacy action plan can be obtained from key WHO policy documents (34, 53, 97).

Establish WHO NHLDPs

As shown in the case studies in Volume 4 and the Ophelia Manual (1), the NHLDPs use a health literacy approach, including co-design, to focus on a range of NCDs, mental health conditions and their risk factors. A country’s national NCD priorities can be used to guide implementation of NHLDPs with a view to scaling up effective practices.

A well-selected and coordinated series of NHLDPs will complement implementation of the WHO Best Buys and other recommended interventions for NCDs to help ensure no one is left behind.
Establish a health literacy knowledge repository and community of practice

Actions for health literacy development and responsiveness are being generated on a weekly basis across the world. It will be helpful for local and regional stakeholders to be able to access an online and living repository of effective tools and processes. This repository could house internationally tested tools, and tools and processes developed and tested locally. Evaluations of health literacy actions, such as outcomes from NHLDPs, should be systematically uploaded to the repository.

Set up a local or regional, or join the global, NHLDP community of practice to share lessons learned and to get insights from other settings or countries.
The most widely used formal method to develop health literacy-informed actions is the Ophelia process (see section 3.3.2 and the Ophelia Manual (1)), which is used in various forms in most of the NHLDPs. It is difficult or impossible to recommend a set of general health literacy actions because the contexts of communities in each Member State are so varied. The presence or absence of comprehensive NCD and mental health policies and programmes, universal health coverage, the health literacy-related mechanisms behind why particular groups are being left behind, and the prevalence of NCDs and their particular (combination of) NCD risk factors can all vary greatly, which makes it inappropriate to recommend universal health literacy actions. Fig. 2.3 in Volume 2 outlines the various determinants of health and other factors that make tailored (national through to sub district level) health literacy actions necessary.

WHO NHLDPs seek to systematize and scale up the development of informed health literacy actions. Evidence is being collected locally and globally about the NHLDP actions that are effective for NCD prevention and control for whom, in which contexts and why. NHLDPs develop, refine, test and evaluate multiple actions that may range from local low- or no-cost and easy-to-apply actions through to more complex health literacy actions. The WHO Best Buys and other recommended interventions for the prevention and control of NCDs will help to develop and respond to health literacy in communities when health literacy development concepts are included and they are implemented at scale. The health literacy development approach will assist Member States to tailor the WHO Best Buys to assist with implementation such that non-majority population groups are included, and to assist with the development of novel local actions on NCDs for groups and communities unable to access, understand, appraise, remember and use health information or services.
Many WHO Member States are struggling under the immense burden of NCDs and their modifiable risk factors. The burden relates to raising health care costs, compromised productivity and economic growth, which in turn, exacerbate health inequities within and across countries. Governments must invest in the development of healthy populations and resilient health systems by putting in place pathways for prevention, screening, early diagnosis, and appropriate treatment of NCDs and mental health conditions. Such investment must be through inclusive, contextual and equity-driven strategies that are fit for local purposes and that ensure no one is left behind.

Health literacy development brings much-needed discipline and method to understanding the diverse needs and opportunities of local communities, which directly feeds the co-design of contextual and equitable policies, programmes and health services that are responsive to a community’s capacity to access, understand, appraise, remember and use health information and services.

This report, which includes evidence and case studies from NHLDPs, will build capacity of Member States to systematize the co-design of health literacy actions to augment policies, programmes and services for the prevention and control of NCDs and mental health conditions, and their risk factors and determinants. This report will enable Member States to generate country-specific solutions through contemporary bottom-up and top-down programme development techniques, using a health literacy-informed process.

The purpose of NHLDPs is to improve health and health equity and accelerate global NCD progress on the achievement of SDG 3.4. NHLDPs complement and support the implementation and scale up of the WHO Best Buys and other recommended interventions for the prevention and control of NCDs.
The wide-scale implementation of a structured literacy-informed approach – the Ophelia process – used within NHLDPs in diverse settings can support a broader programme that builds a coherent evidence base of what works, for whom, under what circumstances and why. Data will accumulate within Member States about how actions are built, what causal mechanisms are targeted, how actions are implemented, and the effects that the actions have on the prevention and control of NCDs and mental health conditions. NHLDPs generate actions that are embraced locally, are implementable, respect and use local wisdom and resources, and are therefore likely to be sustained.

The data generated through networks of NHLDPs are designed to be a public health knowledge asset for Member States. *Volume 4* presents 16 NHLDPs as case studies. Each case study demonstrates the usefulness and local impact of the project. The projects are in diverse settings and carried out by teams of people with different skills and professions, including teams working in high- and low-resource settings.

**Conclusion**

Investments are needed by and for Member States for scaling NHLDPs through a capacity-building programme, project operational costs, establishment of regional training centres, and a global knowledge coordination platform underpinned by ongoing monitoring and evaluation. The wide-scale implementation of NHLDPs by Member States will generate NCD health literacy development actions that are implementable, are sustainable, and respond to local contexts and demands – especially by the billions of people who are already being left behind – and will generate good health and health equity outcomes for current populations and their future generations.

2. Papen U. Literacy, learning and health: a social practices view of health literacy. Lit Numeracy Stud. 2008;16(2)17(1). doi: 10.5130/lns.v0i0.1275.


Health literacy development for the prevention and control of noncommunicable diseases

Volume 1
Overview

Volume 2
A globally relevant perspective

Volume 3
Recommended actions

Volume 4
Case studies from WHO National Health Literacy Demonstration Projects

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