Using health literacy approaches to ensure no one is left behind: An update on World Health Organisation (WHO) initiatives and other programs

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How does **health literacy** relate to **health education**

Health education is largely about health providers and policy makers and the messages that we think that it is important to convey

Health literacy is about understanding people (the nature of the soil)
Health literacy is a **bottom-up** perspective focused on understanding people as lifelong learners and their differences. It relates to all health decisions they make in their life, not just the one's we are focusing on.

Health literacy =

The characteristics of the person + the things and supports they need

Skills	Knowledge	Motivation	Beliefs	Confidence	Resources	Supports

To

Access	Understand	Appraise	Retrieve	Use

Information and services to make decisions about their health and the health of their family and community

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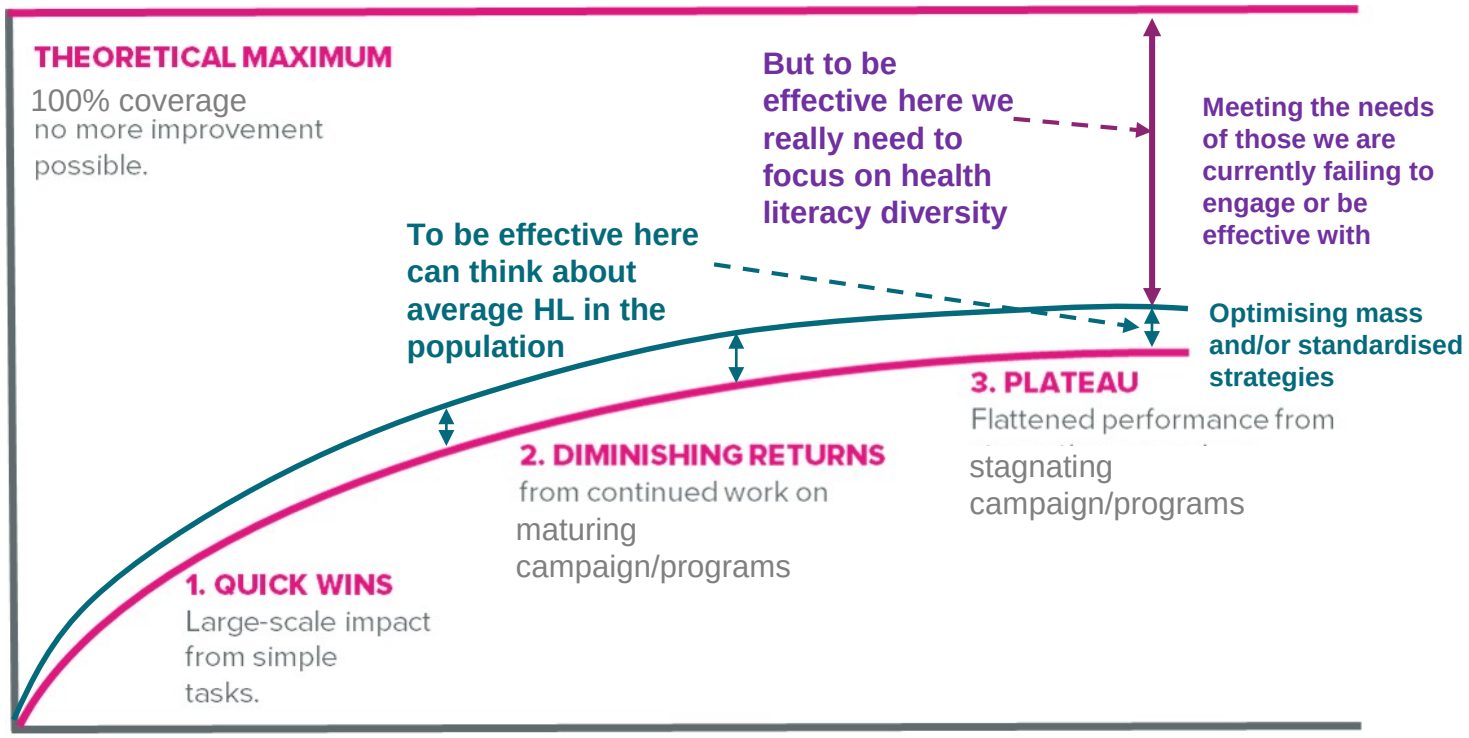
Effectiveness of services for everyone in our community: Why do we fail?



How can a fisherman and his family in a poor region of Egypt engage in co-design to generate local solutions?

مصري، صياد، 39 سنة، لا يقرا و لا يكتب، دخله الشهري لا يزيد عن 2000 جنيه، متزوج و له ثلاث ابناء يساعده اكبرهم في مهنة الصيد بعد اليوم الدراسي في الشتاء و في الاجازات الصيفية. مصري يعاني من السمنة و عدم ممارسة الرياضة. كذلك مع الأسف هو مريض بالفشل الكلوي و يتبع برنامج للغسيل الكلوي. يشعر مصري ان مشكلة الكلى عنده بسبب المياه البنية اللون التي يضطر لشربها على حد قوله. تعرض مصري لحادث اثناء الصيد نتج عنه عدة اصابات و الآم مزمنة اسفل الظهركما انه و للاسف لم يجد اي هيئة تأمين صحي لتغطي نفقاته و تعوضه. يشعر مصري بأنه لا يمتلك المعلومات الكافية لادارة حياته و الاهتمام بصحته و لكنه يمتلك الاصدقاء و المعارف الذين يمكن ان يمنحوه الدعم الاجتماعي و يحاولون توجيهه لاهمية دور الاطباء و الرعاية الصحية في المجتمع.

How can a fisherman and his family in a poor region of Egypt engage in co-design to generate local solutions?

Ahmed, is a 39 years old fisherman. He is obese, smokes, and was diagnosed with hypertension in 2000. He is married with no children. Although he has been told he has several risk factors for heart disease, he doesn't seek medical advice on regular basis. He has never used the Internet. He only sometimes looks at health information but finds it is really hard to find, and work out if it useful or not.

He is on tablets to lower his blood pressure, but sometimes he forgets to take it. Sometimes he stops getting his medication when he runs out of money. He doesn't visit his physician much. Lately, after encouragement from his wife to take care of his health, he passes by a nearby pharmacy to measure his blood pressure. If he finds that he has high blood pressure, he resumes his medications.

What is Health Literacy: Real-world experience

Thinking about your experiences in trying to look after your health (or that of your family), what does a person need to be able to get and use all of the information they need?

Best practice in concept development / questionnaire development

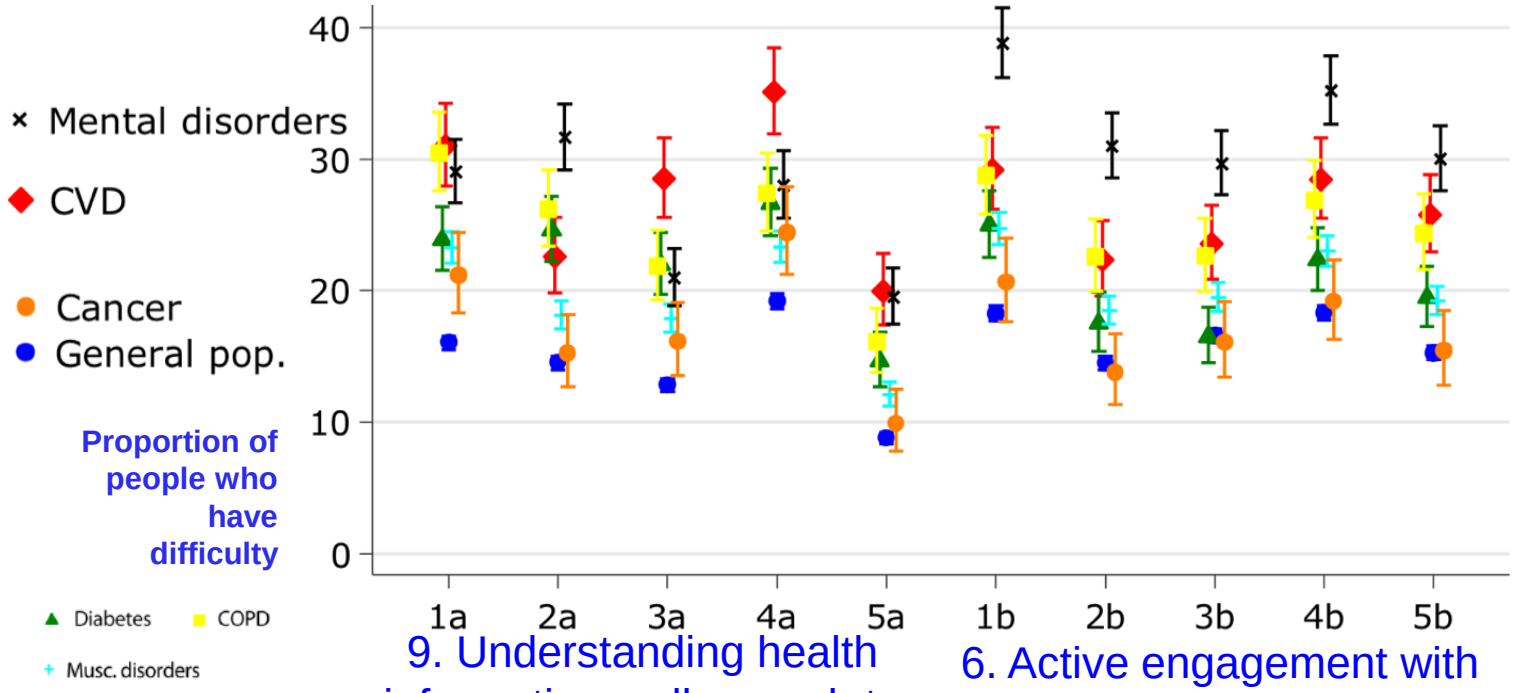
1. Brainstorming session
2. Sorting and rating of statemen
3. Multivariate analysis
4. Interpretation of maps

HLQ: Health Literacy Questionnaire (dimensions)

1. Feeling understood and supported by healthcare providers	**6. Ability to actively engage with healthcare providers**
2. Having sufficient information to manage my health	**7. Navigating the healthcare system**
3. Actively managing my health	**8. Ability to find good health information**
4. Social support for health	**9. Understand health information well enough to know what to do**
5. Appraisal of health information	

Health Literacy measurement (HLQ) the midlands Denmark National Health Survey (N=29,473)

Gaps in understanding health and engagement with healthcare providers across common long-term conditions: a population survey of health literacy in 29,473 Danish citizens. Friss, Lasgaard, Osborne, Maindal BMJ Open, 14th January, 2016



9. Understanding health information well enough to know what to do

6. Active engagement with healthcare providers

Comparison between CALD groups and general population in Melbourne
Somali, Indian, Chinese, Australian residents

Dr Rhonda Garard, Deakin University

Overall, CALD groups have lower Health Literacy,

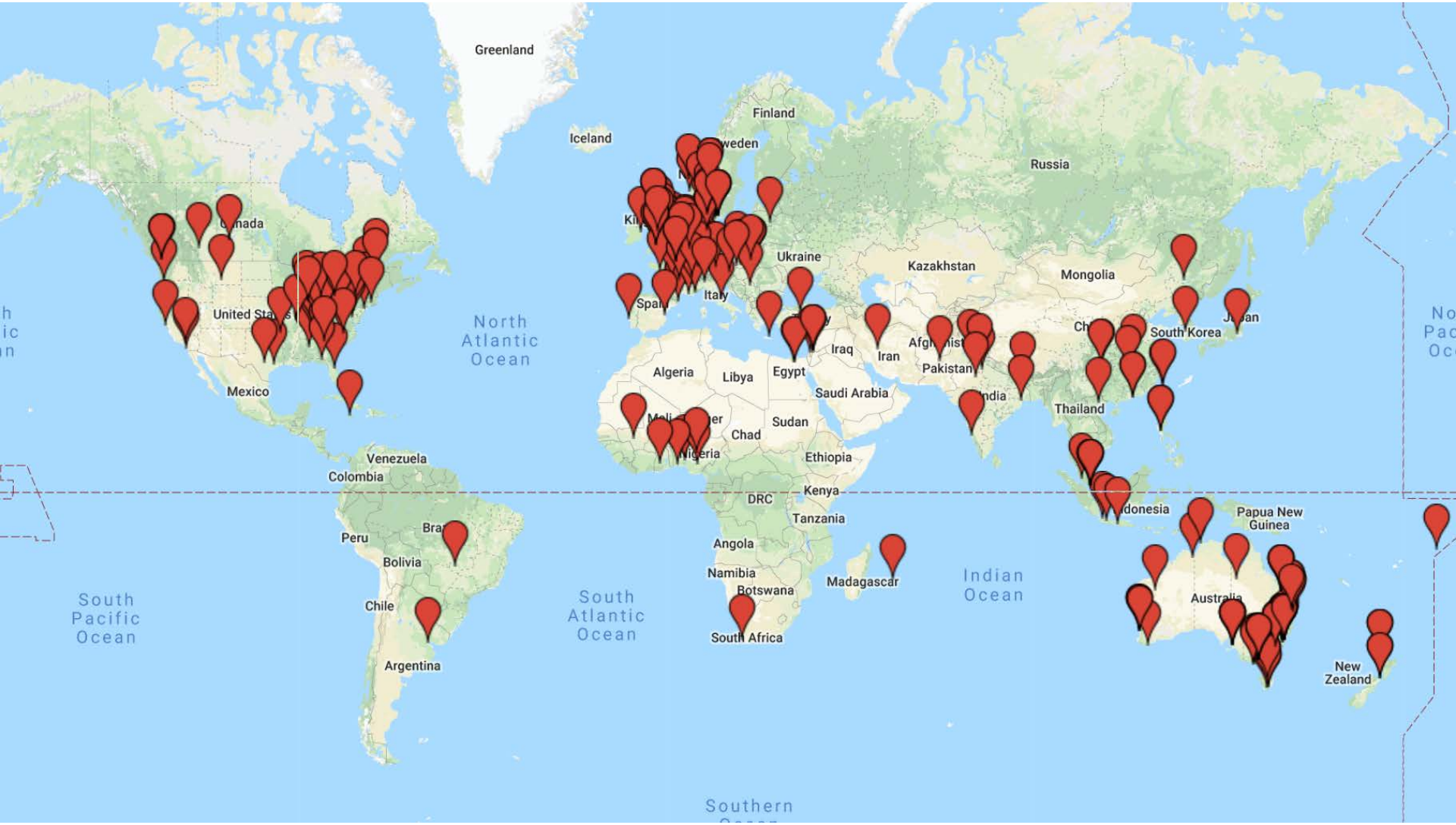
Surprisingly, Somali have highest health literacy

Why?

Scale	Group	Mean (SD) [95% CI] *		Effect size (95%CI) compared with Ophelia
1. Feeling understood and supported by health care providers	Somali	3.44 (0.58)	[3.31, 3.57]	0.43 (0.38,0.44)
	Indian	3.02 (0.51)	[2.91, 3.14]	-0.35 (-0.39,-0.34
	Chinese	2.58 (0.60)	[2.45, 2.72]	-1.17 (-1.22,-1.15)
	Ophelia	3.21 (0.54)	[3.18, 3.25]	
2. Having sufficient information to manage my health	Somali	3.40 (0.59)	[3.26, 3.53]	0.78 (0.73, 0.79)
	Indian	2.80 (0.58)	[2.67, 2.93]	-0.33 (-0.38,-0.32)
	Chinese	2.78 (0.44)	[2.68, 2.88]	-0.37 (-0.41,-0.36)
	Ophelia	2.98 (0.54)	[2.94, 3.01]	
3. Actively managing my health	Somali	3.34 (0.59)	[3.21, 3.47]	0.59 (0.54, 0.61)
	Indian	3.01 (0.53)	[2.89, 3.13]	-0.02 (-0.06,-0.01)
	Chinese	2.61 (0.58)	[2.48, 2.74]	-0.76 (-0.81,-0.75)
	Ophelia	3.02 (0.50)	[2.98, 3.06]	
4. Social support for health	Somali	3.60 (0.46)	[3.49, 3.70]	1.06 (1.02, 1.07)
	Indian	3.12 (0.53)	[3.00, 3.24]	0.17 (0.12, 0.18)
	Chinese	2.94 (0.41)	[2.85, 3.03]	-0.17 (-0.20,-0.15)
	Ophelia	3.03 (0.47)	[2.99, 3.07]	
5. Appraisal of health information	Somali	3.29 (0.65)	[3.14, 3.43]	0.94 (0.89, 0.96)
	Indian	2.68 (0.58)	[2.55, 2.81]	-0.19 (-0.23, -0.17)
	Chinese	2.77 (0.66)	[2.67, 2.87]	-0.02 (-0.07,0.00)
	Ophelia	2.78 (0.54)	[2.70, 2.82]	
6. Ability to actively engage with health care providers	Somali	4.34 (0.66)	[4.19, 4.48]	0.69 (0.63, 0.70)
	Indian	3.85 (0.62)	[3.71, 3.99]	-0.22 (-0.27, -0.20)
	Chinese	3.50 (0.68)	[3.36, 3.65]	-0.87 (-0.93,-0.85)
	Ophelia	3.97 (0.69)	[3.92, 4.01]	
7. Navigating the health care system	Somali	4.30 (0.65)	[4.16, 4.44]	0.91 (0.85, 0.92)
	Indian	3.63 (0.73)	[3.44, 3.76]	-0.33 (-0.39, -0.32)
	Chinese	3.46 (0.69)	[3.31, 3.61]	-0.65 (-0.71,-0.63)
	Ophelia	3.81 (0.67)	[3.76, 3.85]	
8. Ability to find good health information	Somali	4.21 (0.71)	[4.06, 4.37]	1.02 (0.96, 1.04)
	Indian	3.56 (0.78)	[3.39, 3.73]	-0.19 (-0.25, -0.17)
	Chinese	3.66 (0.56)	[3.54, 3.79]	0.00 (-0.05, 0.02)
	Ophelia	3.66 (0.74)	[3.61, 3.71]	
9. Understanding health information well enough to know what to do	Somali	4.14 (0.71)	[3.98, 4.30]	0.54 (0.48, 0.56)
	Indian	4.13 (0.62)	[4.00, 4.27]	0.52 (0.47, 0.54)
	Chinese	3.71 (0.58)	[3.58, 3.84]	-0.26 (-0.31, -0.24)
	Ophelia	3.85 (0.74)	[3.80, 3.91]	

*CI= Confidence interval, scale scores range for 1 to 4 for first 5 scales, then from 1 to 5 for scales 6 to 9.

Application of the HLQ



The concept of health literacy is the important thing….

How people come to…

- **think what they think,**
- **believe what they believe, and**
- **decide what they decide about health**

What information and support do people really need for health actions?

Health literacy in cross-cultural settings

1. Health-related beliefs are often highly variable
2. The insights of modern medicine must compete with traditional beliefs about health
3. Health decision-making is often a communal rather than an individual process

Grounded approach to what Health Literacy is…
Asian / communal societies

Thinking about your experiences in trying to look after your health (or that of your family), what does a person need to be able to get & use all of the information they need?

Best practice in concept development / questionnaire development

1. Brainstorming session
2. Sorting and rating of statements
3. Multivariate analysis
4. Interpretation of maps

Concept mapping
A structured process to capture the knowledge of patients, practitioners, and policy makers

ISHAQ: Information and Support for Health Questionnaire – for LMIC/Communal societies (developed by MoH Thailand, AIHD, Deakin University)

isha-Q

1. Knowledge about service entitlements	**5. Close support people**
2. Awareness of resources that support health in your neighbourhood	**6. Ability to find suitable health information**
3. Ability to access health services	**7. Accepting responsibility for health**
4. Ability to get the information and advice you want from health professionals	**8. Evaluating the trustworthiness of health information**

Ophelia (OPtimise HEalth LIteracy and Access): building on current good practices

Communities of practice, quality improvement collaboratives

Realist program design and evaluation

Intervention mapping

Health service settings : participatory service development and quality improvement (e.g. LEAN)

Local stakeholders **identify local priorities**

Document **local needs** (HLQ, ISHAQ)

Uncover local wisdom (practice excellence)

Intervention design and sharing
1. Co-develop framework
2. Community of practice

Implement intervention
Test, evaluate, feedback, compare

Community settings : participatory community development/ participatory research (e.g. ABCD)

Whole of community perspective and focus on who is 'left behind'

Cycling between bottom-up and top-down planning

Phase 1

- Local data about health, health behavior, service engagement, organizational responsiveness, and health literacy are systematically collected.
- These data are analyzed and presented to stakeholders for discussion and interpretation.
- Effective local practices and innovative intervention ideas are then identified.

Phase 2

- Local stakeholders make decisions about local priorities for action.
- Interventions with potential to respond to local health literacy challenges, or to improve information and service access and availability, are designed and implementation is planned.

Phase 3

- Health literacy interventions are applied within quality improvement cycles.
- Organizations develop and implement trials, and actively evaluate and improve the effectiveness, local uptake and sustainability of the interventions.

How can a fisherman and his family in a poor region of [illegible]erate

1. Do you recognise this person in your community?

2. What is being done, or could be done, to improve outcomes for this **person**?

3. If there were lots of people like this…
What could services/ community organisations etc do to improve outcomes for these people?

A[illegible]is obe[illegible]
diag[illegible]d with hyper[illegible]n in 2000. He is m[illegible]en. Altho[illegible]n he has been t[illegible]he has several risk [illegible]ease, he does[illegible]n't seek medical [illegible]vice on regular bas[illegible]d the Internet. He only sometim[illegible]s looks at health infor[illegible]on but finds it is really hard to find, and wor[illegible]k out if it useful or not

He is on tablets to lower his blood pressure, but sometimes he forgets to take it. Sometimes he stops getting his medication when he runs out of money. He doesn't visit his physician much. Lately, after encouragement from his wife to take care of his health, he passes by a nearby pharmacy to measure his blood pressure. If he finds that he has high blood pressure, he resumes his medications.

Integrated Ophelia framework for HL interventions

Changes in organization

- Prioritization of responding to diversity (including outreach and intake procedures)
- Systematic processes to support access
- Systematic processes to respond to diversity (and to enable staff to do so)

Changes in staff

- Knowledge about health literacy
- Knowledge of HL diversity in their community
- Skills and knowledge of good practice

Changes in community engagement

- Activate and equip change leaders
- Sustainable mutual support
- Activating diverse groups

Changes in individuals

- Increased health literacy
- Increased mutual support in accessing and using health information
- Improved access- and health-related behaviours

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Project objectives

The project objectives were:

1. Identify breast screening barriers experienced by ATSI, Italian and Arabic women aged 50-74 in north west Melbourne.
2. Design, plan, implement and evaluate interventions to meet these needs to improve the screening experience and participation of women in the target populations.

VICTORIA State Government

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BreastScreen Victoria

Caring about Women

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TABLE 1. Number of people consulted per activity during Phase 1			
Group	HLQ/Survey	Interviews	Workshops/ Yarning Circles
Aboriginal	52	9	17
Arabic	71	3	30
Italian	173	4	12
Control	133	5	23
NW clinic staff	-	-	21
TOTAL	**429**	**21**	**103**

Five key barriers were identified for women in the target groups:

1. **Lack of knowledge** about breast screening, e.g. importance of screening, eligibility, and what to expect at an appointment.
2. **Fear** at being unable to communicate with clinic staff, anticipation of pain, fear of being touched by a stranger, and fear of being diagnosed.
3. **Having other priorities** that conflict with screening, such as taking care of family or having chronic diseases that required ongoing care.
4. **Having health beliefs** that negate the benefit of screening, for example, some women believe cancer cannot be cured.
5. **Facing access/logistical issues** e.g. not being able to read invitation letters, being unable to get to an appointment due to a lack of appropriate transport, or being unfamiliar with public transport.

The impact of translated reminder letters and phone calls on mammography screening booking rates: two randomised controlled trials

Table 6: Comparison of screening appointment booking rates according to language group in the phone call trial: Cochran-Mantel-Haenszel (CMH) test and sub-group analysis

	Relative risk[1]	95% CI	p-value
Arabic women	11.6	2.9, 46.5	<0.0001[2]
Italian women	10.0	3.9, 26.3	<0.0001[2]
C-M-H combined	10.6	4.8, 23.23	0.8679[3]

[1] Risk ratio; Control group as reference category; [2] Fisher's exact test for sub-group analysis; [3] Cochran-Mantel-Haenszel combined RR; [3] Test of homogeneity (interaction between language group and intervention

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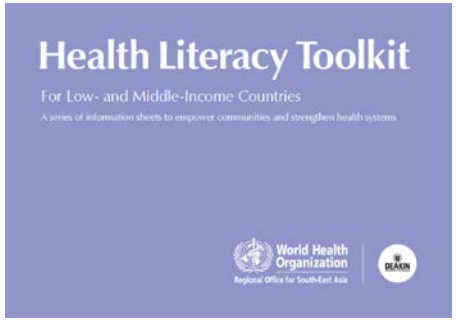
Considerations for setting up a National Health Literacy Demonstration Project (NHLDP)

World Health Organization Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases

WHO GLOBAL COORDINATION MECHANISM ON NCDs

#beatNCDs #gcmncd



Flagship WHO Projects:
China, Egypt, Myanmar
Also underway:
Philippines (x3), Thailand, Mali, Benin, French Reunion, Portugal, Slovakia, Denmark, Norway, Netherlands, France, Australia (x2), Brunei Darussalam

WHO NHLDP European Implementation Action Network
- To be launched by Portuguese Government and Russian Federation in January 2019

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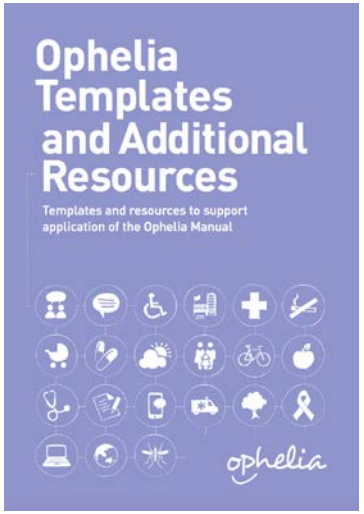
http://www.who.int/global-coordination-mechanism/activities/working-groups/wg-february-2018/en/

GCM/NCD National Health Literacy Demonstration Projects (NHLDP)

- **Concept Note**
  - Background
  - Overview of setting up a WHO NHLDP
  - Phases of the Ophelia approach
  - Specific activities
  - Evaluation
  - Resources and materials
  - Time Frames for running an Ophelia project



WHO GCM/NCD
National Health Literacy Demonstration Projects (NHLDP)

Projects may focus on:

- using health literacy to **improve current programs or to develop new programs** to reduce the gap between those with and without the resources needed to access, understand, appraise and use information and services;
- using health literacy to **inform and empower communities and/or individuals** (considering the continuum from highly communal societies to more individualistic societies) to make decisions and engage in healthy behaviors and access appropriate services;
- **optimizing health education and service provision** including stakeholder outreach, engagement and commitment; and
- **scaling up best practices and strategies in organizations** so that organizations are responsive to the health literacy needs of the communities they serve, including through sustained improvements to practice, culture and policy.

Some new thinking in Health Literacy…

Health Literacy Impact Matrix: General observations on the roles of different modalities for the tasks in health knowledge work to impact on disease prevention and control

Consider people with low health literacy	1. Accessing	2. Understanding	3. Appraising	4. Retrieving / remembering	5. Applying
1. Printed materials (pamphlets, posters, written health resources)					
2. Talk with health staff					
3. Media, TV, radio					
4. Community conversations (friends, neighbours, family, colleagues)					
5. ICT, Internet, social media, Apps					
6. Arts (songs, plays, paintings, drawings)					

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Health literacy responsiveness is….

the way in which healthcare services **make**

information	resources	supports	environments

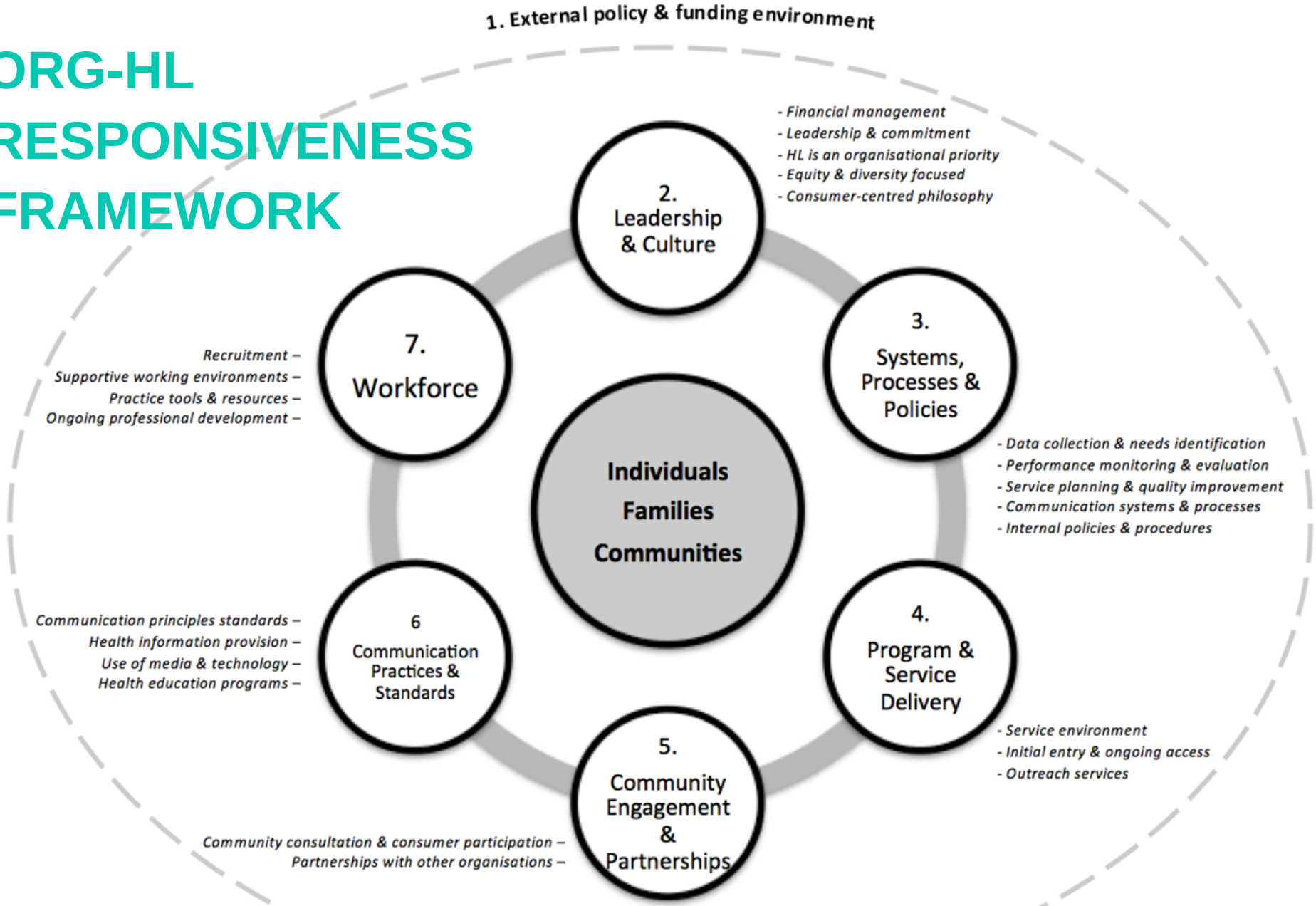
accessible

to people with **varying** health literacy strengths and limitations

(accessible = **approachable, acceptable**, available, affordable, **appropriate** and **aware**)*

*Levesque J, Harris M, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health* 2013; 12:18

ORG-HL RESPONSIVENESS FRAMEWORK



Further information: Anita Trezona, Richard Osborne.

Org-HLR tool components

Reflection Tool

- Encourages reflection and open-ended discussion among staff about health literacy concepts, the specific health literacy needs of the clients and communities, and the role of organisations in responding to these health literacy needs.

Self-Rating Tool

- Assesses the organisation's health literacy responsiveness against a set of criteria and performance indicators.

Priority Setting Tool

- Supports identification of the system, process and practice improvements required, and determine priorities for implementing health literacy improvement activities.

https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2465-z

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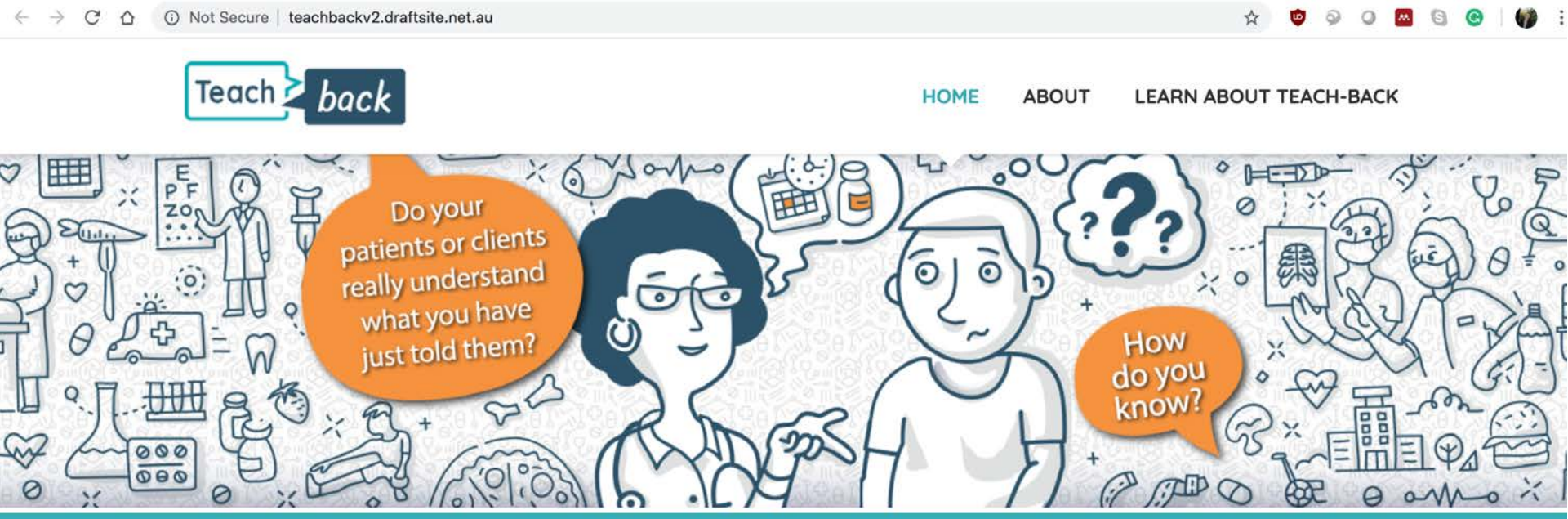
Teach-back

http://teachbackv2.draftsite.net.au/



What is teach-back?

Teach-back is a simple yet effective communication tool used to check understanding.

The Australian Bureau of Statistics (ABS) National Health Survey HLQ included in telephone follow-up survey

- Population-based, N~6,000
- Linked to all other health data collected
- Will be able to take a strengths and action orientated approach
- Inform population health planning, quality and safety, patient experience
- We need these data to be widely utilised by policy, academic and health services sectors
- [New Zealand Govt – N=14,000, 6 HLQ scales, household survey]

HLQ: Health Literacy Questionnaire (dimensions)	
1. Feeling understood and supported by healthcare providers	**6. Ability to actively engage with healthcare providers**
2. Having sufficient information to manage my health	**7. Navigating the healthcare system**
3. Actively managing my health	**8. Ability to find good health information**
4. Social support for health	**9. Understand health information well enough to know what to do**
5. Appraisal of health information	

Summary

Four key disciplines – that needs to be applied to generate effective & scalable interventions

1. Systematically consider **how people actually do the tasks** of accessing, understanding, appraising, retrieving/remembering and using health information in an ongoing way in their life context

2. Recognize that types of health literacy are all strongly **interconnected** and that communication aspects are central

3. Focus on **health literacy diversity** and in particular the health literacy needs of those who are at highest risk of being left behind.

4. Recognize the **role of traditional and local wisdom** and knowledge and the potential to activate this to develop locally and contextually relevant solutions

WHO Demonstration Projects are operationalizing these disciplines

plementation of programs

Problems with Top-down:
- Implementation guidelines often disconnected with real world,
- Performance indictors not connected with meaningful impacts
- Limited responsiveness

Top-down

vs

Bottom-up

+

Top-d

An idea!

Policy

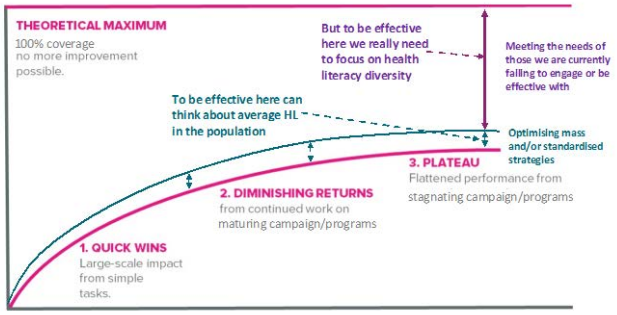
Program

Commissioned

Why we do co-design:
- Develop local capacity to respond to local needs
- Deep understanding of who is missing out (gaps)
- Use local wisdom to generate fit-for-purpose interventions (gaps)
- **This is our vision for Australia**

An idea based on

Health literacy diversity, policy and system level solutions



Co-desi

Plan-Do-Study-Act (PDSA) cycles

Consolidation

Scaling-up strategy/policy

Agreed outcomes framework

The 9th Global Conference on Health Promotion

9th Global Conference on Health Promotion
Shanghai · 21-24 November, 2016

Key statements:

- We recognize that health and wellbeing are essential to achieving sustainable development;
- We will promote health through action on all the *Sustainable Development Goals* (SDGs)
- We will make bold political choices for health

Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development

3 Focal areas

1. Good governance

2. Healthy cities & communities

3. Health literacy

Building health literacy in support of the SDGs

1. Good governance

Ministry of Health / LHN
with representatives from other government departments (i.e., multisectorial action)…

Education	Finance	Employment	Justice	Transport	etc.

Targeted policy, funding, interventions, regional (or national) health literacy survey (+/- digital ehealth survey)

2. Healthy cities & communities

Provincial leader / Mayoral coalition

Co-ordinated multisectorial co-design & action
[Health, social care, & other services]

3. **Health literacy**

Tailored fit-for-purpose interventions (hypothetical)

1. Put HL into policy, e.g., national health plans	2. Basic health education needed to inform/ empower people. "What is health/ health services" Why engage in health. Mixed media?	3. Capacity building: for policy, program development, HP officers/ volunteers	4. Survey of HL & needs strengths (target regions/ groups)	5. Schools and techers	6. HL responsive health system, practitioner skills	Etc

Improved health and equity… to leave no one behind

13-15th November 2019
Melbourne

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Thank you

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