ECOSOC Annual Ministerial Review

Regional Preparatory Meeting on Promoting Health Literacy
Beijing, China, 29-30 April 2009

Background Note[1]

1. Background

The Annual Ministerial Review (AMR) of the Economic and Social Council (ECOSOC) was established by Heads of State and Government at the 2005 World Summit. It serves as instrument to track progress and step up efforts towards the realization of the internationally agreed development goals (IADGs), including the Millennium Development Goals (MDGs), by the 2015 target date.[2] The theme for the 2009 AMR is "Implementing the internationally agreed goals and commitments in regard to global public health".

The AMR process features three main elements: national voluntary presentations, country-led regional reviews and a global review, based on a comprehensive report by the Secretary-General. These elements are complemented by an innovation fair. Prior to the AMR session a global preparatory meeting in New York and e-forums on the theme of the AMR took place. Effort has also been made to engage the philanthropic foundation communities in support of the global public health agenda.[3]

The first AMR was held in July 2007 and focused on poverty and hunger (MDG1). The 2008 AMR focused on sustainable development (MDG7). Both the 2007 and 2008 AMR sessions were preceded by regional consultations (on the "Key challenges of financing poverty and hunger eradication in Latin America" in Brasilia, Brazil in 2007; and on "Sustainable Urbanization" in Manama, Bahrain in 2008). In 2009, in addition to the regional meeting on health literacy in China, regional consultations were held on "Financing Strategies for Health Care" in Sri Lanka. Two more regional consultations, namely, on "Preventing and Controlling Noncommunicable Diseases" and on "E-health – Use of Information and Communication Technologies for Health" will be held in Qatar and Ghana, respectively.

The overall objective of these regional consultations is to support the global review by focusing, in addition to the progress of the region towards the health–related development goals, on a specific aspect relevant to countries in the region. The outcome of such review will contribute to the Council's deliberations in July 2009, in Geneva. The

1 This background note was prepared by WHO.
2 A/RES/60/1, Para. 155 (c).
3 For more information, see: http://www.un.org/ecosoc/newfunct/amr.shtml

consultations also promote stakeholder engagement early on in the process leading to the AMR session during the ECOSOC high-level segment in July.

2. Introduction

Health literacy is commonly defined as *an individual's "ability to gain access to, understand and use health information"* for promoting and maintaining health.[4] [5] [6] It can be examined by "the degree to which individuals and communities have the capacity to obtain, process, and understand basic health information and services" needed to make appropriate health decisions.[7]

It means more than being able to "read pamphlets", "make appointments" and "understand food labels" or to have "an understanding of a health problem and the ability to comply with prescribed actions to remedy the problem"[8]. It describes "the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community heath by changing personal lifestyles and living conditions". [4] Skills in social organization and advocacy are also an integral component of health literacy. [4] [5]

There is a direct link between health literacy and health education in the way that health literacy is a public health outcome and health education is a public health process. [5] [9] Therefore, health education as a means to promote health literacy will also be discussed at the meeting.

3. Level of health literacy

It appears that regardless of the country's level of development, the level of health literacy is low worldwide. In Australia, for example, 60% of the population has scored below a level regarded as optimal for health maintenance[10]; and in the United States, about 50% of all adults "have difficulties understanding and acting upon health information" [7]. Low health literacy may well be more prevalent in many low and middle income countries. However, the extent to which it is a problem in many low and middle income countries in the Asia and Pacific Region has to be further researched and documented.

4. Health-related Millennium Development Goals and noncommunicable diseases

While the level of health literacy in the Asia and Pacific Region is not known, it is clear that countries in this Region are confronted with a wide range of development and public health priority issues to which health literacy can have an impact. To name a few, these concerns include the achievement of MDGs, the reduction of disease burdens due to

[4] WHO Health Promotion Glossary. 1998,
[5] Nutbeam , D. Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st Century. Health Promotion International 2000, 15 (3), 9-17.
[6] Canadian Council on Learning. Health Literacy in Canada: A Healthy Understanding 2008.
[7] IOM. Health Literacy: A Prescription to End Confusion. 2004.
[8] Wang R. Critical health literacy: a case study from China in schistosomiasis control. HPI 2000, 15 (3), 18-23.
[9] Nutbeam, D. The evolving concept of health literacy. Soc Sci Med 2008; 67, 2072-2078
[10] Australian Bureau of Statistics. Health Literacy, Australia, 2006.

noncommunicable diseases (NCDs), the effective management of public health emergencies such as Avian Flu and SARS, as well as the development of worldwide actions to combat issues that pose a threat to sustainable development, such as climate change. It is desirable to focus at the regional meeting on some of the most pressing issues for the region, such as (1) the achievement of health-related MDGs - the reduction of maternal and child mortality, under-nutrition and HIV transmission in particular; and (2) the reduction of disease burden due to NCDs, through implementation of initiatives such as the Global Strategy on Diet, Physical Activity and Health (DPAS) and the Framework Convention on Tobacco Control (FCTC).

Since 1990s, progress has been made within the Asia and Pacific region to reduce maternal and child mortality, under-nutrition and HIV infection. Results have been uneven however. Many women and children continue to die in an early stage of life. In brief, East Asia has seen a considerable decline in the proportion of children under five who die or are underweight. The proportion of maternal death and adult women living with HIV has also dropped in East Asia. However, these proportions continue to be high in Southern Asia and Oceania, where they are among the worst worldwide.[11] Additionally, inequities arising from gender differences and urban/rural divides are not uncommon.

NDCs have become a major public health threat not only in high income countries, but also in low and middle income countries. NCD death rates are now higher than those from communicable diseases, maternal and perinatal conditions and nutritional deficiencies combined in many countries in Asia and Pacific Region including China, India, Pakistan and Russia Federation.[12] Some 18 million people die every year from cardiovascular diseases, for which diabetes and hypertension are major predisposing factors.[13] [14] Overweight and obesity have increasingly become prevalent even in low and middle income countries, particularly in urban areas. More than 1.1 billion adults worldwide are overweight, and 312 million of them are obese. In addition, at least 155 million children worldwide are overweight or obese. If a broader definition of obesity is used (adjusted for ethnic differences), the number of people classified as overweight reaches 1.7 billion. [14] The Asian continent concentrates the majority of deaths related to tobacco use and the top five countries with the largest number of smokers are all members of Economic and Social Commission for Asia and the Pacific (ESCAP). Actions have already been taken to combat NCDs worldwide, among others and more notably, the implementation of the NCD Action Plan by the WHO.[15] Improving health literacy has been highlighted as a key action area in the European Strategy for the Prevention and Control of NCDs and DPAS. Moreover, countries in the Region have adapted the MDG targets and indicators to include NCDs that are most relevant to their country. As such, heart disease was added by Thailand and tobacco use by Indonesia. [12]

[11] UN, the Millennium Development Goals Report 2008
[12] WHO. Preventing Chronic Diseases: a vital investment. 2005, 44
[13] WHO. The World Health Report 2002: Reducing Risks, Promoting Healthy Life. 2002
[14] Hossain, P. Kawar, B. Nahas, M. Obesity and Diabetes in the Developing World: A Growing Challenge. New England Journal of Medicine 2007; 356: 3, 213-215.
[15] WHO. Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases. WHO, 2008.

Health gains have been made through the actions taken so far, but unless those actions are accelerated and broadened, the chance of meeting the development goals and public health commitments will become increasingly challenging.

5. Links between health, education and development

Improved health literacy is considered critical to the achievement of health and development. Examples of success have been found in patient education in clinical settings and in advocacy and community action in community settings across many health and disease issues, including those targeted by the many IADGs and public health commitments. Issues include improving maternal health, reducing child mortality, eradicating child hunger and combating HIV/AIDS, as well as implementing the FCTC and the Global Strategy on Diet, Physical Activity and Health. [12] [13] [16] [17] [18] [19] [20] [21] [22]

While the link between health literacy and development is not well documented, strong links exist between health literacy and education and also between education and development.[23] [24] It has been found that health literacy increased with the level of formal education attained[25] and that every dollar spent on education could lead to a yield of more than seven dollar in return or a yield of some twelve percent rate of return.[26] [27]

In brief, by helping people navigate the health system, engage in self care and participate in community action for health, improved health literacy can lead to health gains. Taking the use of prenatal and antenatal care to reduce maternal mortality as an example, women without prior knowledge about the usefulness and availability of those services can be informed about the services through health education. Nevertheless, access to information alone may not lead to increase in use and women may also need to be equipped with self management skills that will enable them to use the information and eventually the care. Some people in the community also need to be provided with the skills to effectively disseminate the information and advocate for the care in the community. In this example, increasing community health literacy will help increase use of prenatal and antenatal care

---

[16] UK DOH Health Literacy Available at www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthyliving/DH_080149. Accessed 22 Jan 2009

[17] Coulter, A. & Ellins, J. Effectiveness of strategies for informing, educating, and involving patients. BMJ 2007, 335; 24-27

[18] WHO Commission on the Social Determinants of Health. Achieving health equity: From root causes to fair outcomes. 2007.

[19] Guise, J. Palda, V., Westhoff, C., Chan, B., Helfand, M. & Lieu, T. The effectiveness of primary care based interventions to promote breastfeeding: systematic evidence review and meta-analysis for the US Preventive Services Task Force. Annals of Family Medicine 2003; Vol 1 No 2.

[20] Assai, M., Siddiqi, S. & Watts, S. Tackling social determinants of health through community based initiatives. BMJ 2006; 333, 854-856.

[21] Costello, A., Osrin, D. & Manandhar, D. Reducing maternal and neonatal mortality in the poorest communities. BMJ 2004; 329, 1166-1168,

[22] Ohnishi, M., Nakamura, K: & Takano, T. Improving in maternal health literacy among pregnant women who did not complete compulsory education: policy implications for community care services. Health Policy 2005; 72 (2), 157-164.

[23] Agency for Healthcare Research and Quality. "Literacy and Health Outcomes" Summary of Evidence Report No 87. Available at www.ahrq.gov/clinic/epcsums/litsum.htm. Accessed 22 Jan 2008.

[24] UNESCO. Education for All Global Monitoring Report 2005 - The Quality Imperative, 2005. Available at http://portal.unesco.org/education/en/ev.php-RL_ID=35945&URL_DO=DO_TOPIC&URL_SECTION=201.html

[25] Rootman, I. & Gordon-El-Bihbety, D. A Vision for a health Literate Canada: Report of the Expert Panel on Health Literacy.. Public Health Agency, Canada, 2008

[26] Patrinos H. The Living Conditions of Children. World Bank Policy Research Working; 2007 Paper 4251.

[27] University of Phoenix. Measurement Economic Benefits of Education Investment - An illustration, Private Versus Social Costs, Empirical Findings, Estimation Issues. http://education.stateuniversity.com/pages/1930/Economic-Benefits-Education-Investment-Measurement.html (access on 4 April, 2009)

and reduce maternal mortality. Similarly, the burden of overweight and obesity on health can be more effectively tackled if people in the community know for example how many grams of sugar or fat one should eat in a day, what caloric intake against expenditure means, what and how to cook a healthy meal at home, and what can be done to use up the excess calories. Learning how to advocate and act collectively for an environment that can help promote healthy eating and physical activity may also be helpful in this regard.

6. Objectives of the regional ministerial meeting

Given the general low level of health literacy in the region and worldwide and the urgent need to speed up the progress in meeting the MDGs, and the reported positive impact of health literacy on health and development, there is a need for increased and sustained action.

It is imperative to examine how health literacy can be improved in order to achieve the overall objective of these consultations, which is to accelerate action on achieving health related MDGs and commitments. The means through which improved health literacy can contribute and add value to the achievements of the MDGs, particularly in reducing maternal and child mortality, HIV infection, under-nutrition, tobacco control, unhealthy eating and physical inactivity, should also be discussed. All these development goals and public health commitments have been and still are priorities for action in the Asia and Pacific Region.

Therefore, the regional meeting aims to recommend ways of scaling up effective health literacy interventions in order to accelerate progress towards the achievement of the health related MDGs and public health commitments, including the consideration of developing a regional action plan to promote health literacy.

An evidence based approach must be used to improve health literacy and achieve health. Effort must be made to identify examples of success and lessons learned in the development and implementation of health literacy interventions, including the availability of indicators, baselines and benchmarks for measurement of health literacy and reporting on progress. The use of the evidence based approach is both a target and a process. To facilitate the process, effort is required to examine how joint actions can be undertaken by key stakeholders given that the achievement of the development goals and public health commitments requires resolution of issues and involvement of new and additional stakeholders within and beyond the health sector. Furthermore, how information and communication technologies can be more effectively used should be examined because of the unprecedented and enormous capacity and speed that digital ICT can disseminate information and the extensiveness of population groups that the ICT can cover and reach. While it is important to look at how information can be more readily available, it is of equal importance to look at how the information is used. Empowerment of people, particularly the disadvantaged and new migrants, has a direct bearing on information use. Last but not least, capacity to improve health literacy in countries must be built.

Accordingly the following issues have been selected for discussion at the regional meeting:

- Assess the impact of health literacy on health and development and identify and develop measures for reporting progress;
- Strengthen multisectoral collaboration at the national, regional and international levels to undertake joint actions for increasing health literacy;
- Promote better access and use of information through information and communication technology and empowerment; and
- Build capacity for sustained action to increase health literacy.

Through identifying and sharing examples of success and lessons learned, the objective of these consultations is to accelerate actions to achieve the health related MDGs and combat NCDs, including through the development of a regional action plan.

7. Assess the impact of health literacy on health and development and identify and develop measures for reporting progress

Impact of health literacy on health and development

Over the years, there has been evidence of effective interventions to increase health literacy. The evidence largely comes from the United States however, on patient-focused interventions.[17] [28] [29] It was found that the applicability of such evidence outside of the United States might well be questionable however. [28]

More recently, there has also been evidence of effective interventions in some other countries in and outside the Asia and Pacific Region. Education on breastfeeding for example has been found to be the most effective single intervention for increasing breastfeeding initiation. [19]

Increased health literacy through improved knowledge, adherence and access to anti retroviral treatment has shown to lead to increased prevention and treatment of opportunistic infections among people living with HIV/AIDS in Thailand. [30]

Mandatory health warnings on tobacco packaging have also been found to increase the number of calls to 'quitlines' in Thailand. Well executed social marketing campaigns could also increase public support for key policy changes such as smoke free public places.[31] Health education and media campaign have been found to be effective in reducing tobacco use in India mainly due to the paucity of information among the

[28] Rootman I. Health literacy in other countries. LACMF 17 (2) - 2004 - Literacy & Health: Prescription for Progress. Available at www.centreforliteracy.qc.ca/publications/lacmf/vol17no2/11.htm. Accessed 15 Jan 2009
[29] Pignone, M et al. Interventions to Improve Health Outcomes for Patients with Low Literacy - A Systematic Review. J Gen Intern Med 2005; 20, 185-192.
[30] Aree Kumphitak, Siriras Kasi-Sedapan, David Wilson et al. Involvement of People Living with HIV/AIDS in Treatment Preparedness in Thailand: Case Study. WHO, 2007 http://www.who.int/hiv/pub/prev_care/en/thailand.pdf
[31] TFI Briefing Note on Health Literacy and Tobacco Control

population on the impact of tobacco use.[32] In tobacco control, many of the demand reduction strategies were linked to increased health literacy, whereby individuals, organizations and governments were able to gain better access to information on the full extent of the risks of tobacco and increase their capacity to make fully informed decisions related to tobacco. [31]

Health education through broadcast and print media focusing on body mass index and cholesterol concentrations has been found to be cost-effective in limiting cardiovascular disease by lowering systolic blood pressure and cholesterol.[33] Health education was also a key strategy used to effectively reduce dietary salt intake in the late 1980s in Japan and China.[34] [35]

Increased health literacy has also been reported to be effective in preventing diarrhoeal disease in Bangladesh[36] and in promoting healthy lifestyles in Japan,[37] and in a number of countries in the Eastern Mediterranean States through Community Based Initiatives.

In increasing physical activity, two informational approaches, community-wide campaigns and point of decision prompts (i.e. signs placed by elevators and escalators), have been reported as being effective. However, sufficient evidence has yet not been found to conclude that the other two approaches, mass media campaigns and classroom based health education, are also effective.[38]

Apart from the above mentioned examples from peer reviewed articles, anecdotal reports indicate that there are number of successes in countries of different levels of development, for example in the uptake of immunization to eradicate polio in the Democratic Republic of Congo through media campaign and community mobilization,[39] and in school health and community based health education through modern information and communication technologies (eLearning) in Egypt and Jordan.[40]

Based on available information, the examples of success can be grouped into two board categories: (1) actions targeted to individuals in clinical settings and (2) actions focused on disadvantaged groups in community settings. In the clinical settings, improvements

---

[32] Reddy, S. & Gupta, P. Report on Tobacco Control in India. Ministry of Health & Family Welfare, Government of India, 2004; 219-227

[33] Murray, C. Lauer, J., Hutubessy, R. et al. Effectiveness and costs of interventions to lower systolic blood pressure and cholesterol: a global and regional analysis on reduction of cardiovascular-disease risk. Lancet 2003; 361: 717–25

[34] Iso H, Shimamoto T, Yokota K, Sankai T, Jacobs D R and Komachi Y. Community-based Education Classes for Hypertension Control - A 1.5 year Randomised Controlled Trial. Hypertension 1996; 27, 968-974.

[35] Tian H G, Guo Z Y, Hu G, Yu S J, Sun W, Pietinen, P and Nissinen, A. Changes in sodium intake and blood pressure in a community intervention project in China. Journal of Human Hypertension 1995; 9, 959-68.

[36] Jahan, R. Promoting helath literacy: a case study in the prevention of diarrhoeal disease from Bangladesh. Health Promotion International 2000; 15 (4), 31-38

[37] Yajima, S et al Effectiveness of a community leaders' programme to promote healthy lifestyles in Tokyo, Japan. HPI 2001, 16 (3), 235-243

[38] Zaza, S., Briss, P. & Harris, K. The Guide to Community Preventive Services: What Works to Promote Health? Oxford University Press. 2005.

[39] WHO. SADC Capacity Building Project - Project Completion Report, Health Promotion Unit, WHO 2008

[40] WHO. The Health Academy pilot projects. Available at http://www.who.int/healthacademy/countries/en/. Accessed on 22 Jan 2009.

were made among patients in disease management, medical adherence and service use essentially in high income countries. In community settings, improvements were made in community participation, mobilization of community resources and creation of opportunities for meeting basic development needs in low income countries [20] [21] and promoting healthy life styles essentially in high income countries. [37]

Turning to the lessons learned, the hygiene education component of a project which focused on drinking safe water, the installation and use of latrines and hand washing to prevent and control diarrhoeal diseases in Bangladesh in the early 1990s has shown minimum positive behavioural changes due to the failure to communicate effectively with the targets of intervention and to field test the intervention message prior to dissemination. [36] In Australia in the early 1990s, the quality of antenatal education classes varied as they differed widely in length, focus and content. As a number of concerns were raised, standards of practice and instructor training were included, in addition to standards for course content.[41] More recently, it has also been found that the readability and suitability of the majority of educational print resources related to physical activity were often not adequate, making these resources limited in their effectiveness in affecting behavioural change.[42]

While health education has been found to be an effective intervention for behavioural changes, when used alone, its effectiveness appears to be rather limited. For example, to prevent adolescents from smoking, health education classes alone will not be as effective as a combination of health education, restrictions on sales and ban on advertising. In this case, using health education, together with other intervention strategies, such as policy and environmental changes, as well as strengthening community action is recommended. Likewise, to promote condom use to reduce HIV infections among women, the women must be empowered, for example, to be assertive through provision of skills and support, in addition to giving them access to information about the effectiveness of condom use. Moreover, condoms must also be readily available. Accordingly, it is not uncommon to find health education to be a key component of a combination of interventions that aim to reduce maternal and child mortality, under-nutrition, HIV infections, tobacco use, unhealthy eating and physical inactivity, particularly in population groups with low level of literacy.

To expand the evidence base and inform practice, effort must be made to examine why the examples of success and lessons learned have not been more readily applied: Is it due to the difference in context where the interventions were implemented, the complexities in translating evidence into practice or the limited capacity to translate the evidence? It is therefore necessary to scale up action on documenting and disseminating examples of good practice at the local level and inform policy development and practice through the global health promotion community.

[41] Renkert S. & Nutbeam, D. Opportunities to improve maternal health literacy through antenatal education: an exploratory study. HPI2000, 16 (49, 72-79

[42] Vallance, J., Taylor, L. & Lavallee, C. Suitability and readability assessment of education print resources related to physical activity: Implications and recommendations for practice. Patient Education and Counseling 2008; 72, 342-349.

Key questions that could be discussed by the panelists could include:

- What works to increase health literacy in order to improve health outcomes, health choices and opportunities, particularly in achieving selected health-related MDGs including maternal and child mortality, HIV infection and under-nutrition as well as combating NCDs particularly in reducing tobacco use, unhealthy diet and physical inactivity? (If some of these interventions are pilot projects, how can they be sustained and implemented at a wider scale?)
- How does this evidence of success inform policy development and practice in the region?
- What are the barriers that hinder the improvement of health literacy where it is low?
- How can access to and use of primary health care by people with low levels of health literacy be improved?

Measuring and reporting progress

Turning to the need for measures to report progress, there is no data available to determine the level of health literacy in most countries in the region of Asia and Pacific. To increase health literacy, baselines, indicators and benchmarks at the individual and community levels need to be developed to inform action and report on progress. Though measures for quantifying health literacy such as IALS (International Adult Literacy Survey), TOFHLA (Test of Functional Health Literacy in Adults) and REALM (Rapid Estimate of Adult Literacy in Medicine) are available, their use is mainly confined to developed countries, and effort is still needed to improve the validity and reliability of these measures.[43] [44] The applicability of these measures to countries with different levels of development, different languages, customs, etc, is also unclear. Moreover, as the way people define and manage health and illness varies from one culture to another, the meaning of health literacy may well also differ. Unless the concept of health literacy and the determinants are known, it is difficult to develop a measure which is valid and reliable.

It would be helpful for countries in the region to have a set of recommendations available on the core content areas of health literacy and a set of guidelines for undertaking measurement.

Baselines, targets and benchmarks for achieving the above mentioned international goals and agreements will also be required at the impact level, for example in terms of behavioural change and service use. Examples include increase in breastfeeding and use of antenatal services, universal access to sexual education, increase in availability of school meals, reduction in smoking prevalence among young people and women, increase in quit rates, daily activity levels and levels of consumption of dietary salt and fruit and vegetables. Apparently, the development of baselines, targets and benchmarks requires systematic collection of valid and reliable data over time. Moreover, the data

[43] Nutbeam D. Advancing health literacy: a global challenge for the 21st Century. HPI 2000; 15 (3), 7-8
[44] Kickbusch I. Health literacy: addressing the health and education divide. HPI 2000; 16 (3), 63-71.

collected must be properly used. There are both financial and human resource implications for the collection and use of data, which may be seen as a barrier to data collection and use particularly in low income countries. Yet, the Community Health Audit of Gonoshathaya Kendra, a NGO in Bangladesh, is an example of success that demonstrates how data can be collected and used for reporting progress and achieving accountability, with limited resources.

Key questions that could be discussed by the panelists could include:

- What are the present levels of health literacy throughout Asia-Pacific?
- To what extent can the current measures such as TOFHLA and REALM be used in Asia-Pacific?
- What indicators could be used at the impact level (e.g. behavioural change and service use) for reporting progress and how could baseline data be collected?

8. Strengthen multi-sectoral collaboration

To increase the level of health literacy and reduce maternal and child mortality, HIV infections, under-nutrition as well as tobacco use, unhealthy diet and physical inactivity, actions must be taken by different professional groups in the health, education and other sectors. Key stakeholders within and outside the government sector at the national, regional and global levels must also be involved.

While efforts to improve health literacy and education have mainly been done under the leadership of the health sector, experiences from healthy cities and settings have demonstrated many advantages of involving communities in the process of health education. More recently, the WHO Commission on Social Determinants of Health has made the case and supported such a strategy to tackle inequities. A similar social determinants approach can be argued as being effective in tackling the social factors influencing health literacy. In this regard, the active involvement of the local government and participation of people in the wider community is critical, as reflected in the approach being undertaken by Gonoshasthaya Kendra in Bangladesh, in which mechanisms and processes are set for government officials to work in collaboration with the villagers to examine health issues of grave concern, determine responsibility and suggest improvements. Through village solidarity and self knowledge, this process help to come up with informed answers and avoid repetition of mistakes in the future.[45]

In addition to the health sector, other sectors and actors can make a substantial contribution to developing health literacy, such as (1) the education sector through the curriculum,[46] (2) community based organizations, such as by Gonoshasthaya Kendra in Bangladesh through the provision of a wide range of health and development programmes, the World Alliance for Breastfeeding Action through the promotion of

[45] World Bank. Bangladesh Development Series 14: To the MDGs and Beyond: Accountability and Institutional Innovation in Bangladesh. 2007.
[46] St Leger, L. Schools, health literacy and public health: possibilities and challenges. Health Promotion International 2000; 15 (4), 46-54.

breastfeeding and (3) professional associations, such as the medical and pharmacists associations who takes stances against tobacco use for example.

The business sector has also been playing a role in promoting health literacy through occupational health services. The economic consequences of lost productivity and the shift of the financial burden for medical coverage to employers suggest that the corporate sector will increasingly support these initiatives. Recently, some countries such as Japan have subjected employers with fines and penalties for their overweight employees.

However, the extent to which the business sector can be engaged in health literacy activities with a focus that may run counter to its interests, however - for example, the promotion of food items such as powder milk[47] and medicines[48] - should be further explored. While it is important to look at how to engage the business sector to promote health literacy through responsible marketing for example, it is of equal importance to look at the extent to which the business sector's involvement will potentially lead to any conflicts of interests and more importantly, the measures that can be undertaken to avoid such conflicts. This has been particularly the case of the tobacco industry.

Aid development agencies, together with the United Nations and international organizations have also been increasingly active, in undertaking health literacy activities for combating public health emergencies for example, such as SARS, the Avian Flu and natural disasters through risk communications using ICT.[49] A review of the collaboration among the different partners will shed light on how joint actions should be organized in terms of the need for effective mechanisms (e.g. networks) and processes (e.g. operational procedures) to deal with health and development crises arising from public health emergencies.

To better inform policy and service development, the views of all the actors need to be sought and their respective roles defined, taking the specific country context into consideration. Though there are different approaches to raising health literacy at the country level, the individual approach (immediate focus of interventions is on the individuals' changes in attitude, knowledge and skills) and structural approach (immediate focus of interventions is on infrastructure and policy changes), it is difficult to come up with the right mix and select an approach, unless the views and roles of the relevant actors as well as the country context are known.

Opportunities for and barriers to collaboration among the key actors should also be examined. Effort must also be made to investigate how best to put in place the mechanisms and processes at the country level for a coordinated approach to promote synergy and avoid duplication.

Key questions that could be discussed by the panelists include:

---

[47] The Nestlé boycott & Lal. N. Nestlé - the baby killer. The Lancet Students, 2008 Available at http://www.thelancetstudent.com/2008/12/08/nestle-%E2%80%93-the-baby-killer/

[48] WHO. Essential Drugs Monitor. WHO 2002. Available at http://www.who.int/medicinedocs/en/d/Js4937e/2.html

49 http://www.idrc.ca/fr/ev-127030-201-1-DO_TOPIC.html

- What actions can be taken and/or policies implemented by governments, civil society and the private sector to increase the level of health literacy to achieve health related MDGS including maternal and child mortality, HIV infection and under-nutrition and combat NCDs particularly in reducing tobacco use, unhealthy diet and physical inactivity?
- What mechanisms and processes need to be put in place at the national and regional levels?
- Is there a specific and defined role for the private sector for increased health literacy, particularly the food industry and drug companies? Can its involvement potentially lead to conflict of interests? If so, what measures need to be taken to maximize or optimize the benefits while limiting risks of conflicts?
- What effective models that aim to promote multisectoral action are available and could be replicated within the region with the objective to achieve international development goals and health commitments and specifically reduce maternal and child mortality, HIV infections, malnutrition, physical inactivity and tobacco use?
- What are the roles of traditional media and mass media in increasing and sustaining health literacy? How can these be strengthened?

9. Promote better access to and use of information through information and communication technology and empowerment

The role of information and communication technologies in fostering health literacy

The two central thrusts of increasing health literacy are to **improve access to information** and to **make appropriate use of the information**. While, the use of information and communication technologies (ICTs) is imperative to ensure access to health information, its appropriate use must be ensured through the empowerment of the population, particularly the most disadvantaged.

Folk art and traditional media, such as pantomimes and puppetry, as well as traditional mass media, including newspaper, radio and television broadcasting, have been and will continue to be valuable sources of information to individuals and communities to raise their level of health literacy. This is particularly so because folk arts can reach people in rural and remote areas in developing countries and newspaper, radio and television can provide broad exposure to health messages for communities that have limited access to the internet. There is a need to engage traditional media more actively in spreading the message on health literacy.

With the advancement of ICTs, dissemination and access to information is becoming easier, cheaper, and more creative. More information has been made available on the Internet and other multimedia formats. The Internet, access to health information online, electronic learning (eLearning), the use of text messaging, web 2.0 and online social networks are becoming increasingly common in the daily lives of people even in some developing countries. However, the quality and usability of this information can sometimes be questionable.

Mobile devices such as mobile telephones, Personal Digital Assistants (PDAs), and laptops, as well as wireless and satellite communications are giving remote communities an opportunity to be connected and have access to information. These developments offer exciting opportunities for expanding the availability of health information - one of the building blocks of health literacy.

Public-private partnerships play an increasing role in enhancing health literacy, particularly in developing countries. Partnerships at all levels (government, private sector, civil society, institutions and individuals) are needed to facilitate access, provide information, and introduce innovative and effective methods to reach target population. Special attention has to be given to ensuring high quality information and services on the internet. As such, codes of ethics to enhance the value of information for both consumers and providers should be closely followed. Information should be available in local language(s) and skills training to use ICTs for health literacy should be provided as necessary. The power of ICTs to improve health literacy comes from (1) its ability to support interactivity where the learner is part of the process and (2) its multimedia format, through which sound, video, text and animation support the health message.

Such approaches and programmes should be designed to more strategically use ICTs as a tool for achieving existing health literacy objectives. Actions could therefore be taken to develop and deploy relevant and sustainable national programmes based on the available technologies in the countries. There should also be collaboration among countries in the region to share best practices. Key indicators should be developed to measure and evaluate the benefits of ICTs as a tool for enhancing health literacy in the region.

It appears that ICTs can also play an important role in risk communication in emergency preparedness and response where it relates to health literacy. The extent to which ICTs can be used during public health emergencies, as well as the association between the two requires further scrutiny. Further, ICTs have a major role to play in health literacy among persons with disabilities. ICTs tools have much better capacity and potential to reach out to people with visual impairment, hearing problems and mobility and even mental disabilities.

Empowering people to increase health literacy

However, access to information and knowledge is necessary for making decisions on health, but not sufficient. How the information is used is of critical importance; further, such use is affected by power relations between individuals. Kickbusch argues that it is important to clarify the issue of power in the health literacy debate. According to him, the failure of efforts to promote health literacy, particularly among women in sexuality and reproductive health, was due to the lack of concern for empowerment.[50]

To make decisions on their own health and the health of the wider community, in addition to being informed, individuals must be empowered with increased skills and resources, so that they can "apply their skills and resources in collective efforts to address

[50] Kickbusch I. Health literacy: addressing the health and education divide. HPI 2000; 16 (3), 63-71.

health priorities and meet their respective health needs to meet their health needs[51] and "to make governments and the private sector accountable for the health consequences of their policy and practices".[52]

Communication is not only dissemination of information, but also a means for fostering participation and ownership, facilitating mutual understanding and building trust among key stakeholders[53] and a process of community involvement to "espouse common values of humankind".[54] Participation, ownership, stakeholder management, as well as common values of humankind are all elements of participation. Other critical elements include self esteem, confidence and worth.[55]. Health literacy is a means to empower people to have control over the factors that affect their health through the acquisition of knowledge and skills in self development and influencing others. Vice versa, empowerment can also help to improve health literacy through advocacy and community action for health.[56]

Evidence of interventions that show improved health from empowerment through health literacy is still limited in many countries, particularly in low and middle income countries. However there are some examples of success, such as those adopted by the healthy cities approach and those that promoted mutual aid and collective action among individuals in community groups in the Regional Offices in East Mediterranean, South East Asia, Western Pacific and also Americas, which have made a contribution to meeting development goals and public health commitments.[57] [58] [59] [60] [61]

Key questions that could be discussed by the panellists include:

- What can ICTs (including Internet, Web2.0 and social networking, mobile phones, etc.) bring to health literacy? (Benefits and risks)
- What are the dimensions of health literacy in the information age? (skills, access, content, quality of health information, trust, language, etc)
- How can we improve health literacy through the use of media and ICTs (role of government, private sector, individuals, etc)
- What mechanisms need to be used to improve the quality of health information in the cyberspace?
- How can ICTs be leveraged to safeguard health in emergency situations?

[51] WHO. The Ottawa Charter on Health Promotion. WHO, 1986.
[52] WHO. The Bangkok Charter on Health Promotion in a Globalized World. WHO, 2005.
[53] Mefalopulos, P. (2005) Communication for sustainable development: applications and challenges. In Hemer, O. & Tufte, O. (eds) Media and Glocal Change: Rethinking Communication for Development. Nordicom and CLACSO.
[54] Ratzan, S. Health literacy: communication for the public good. HPI 2000; 16 (3), 55-62.
[55] UNESCO. Literacy: a key to empowering women farmers. UNESCO 2001.
[56] Kickbusch, I. Health literacy: Skilling students for better health. In Children, Youth and Women's Health Service, Government of South Australia. Virtually Health newsletter 2006; 41, 2-3.
[57] Goetz, A. & Gaventa, J. Bringing citizen voice and client focus into service delivery. Institute of Development Studies 2001; Working Paper 138.
[58] Loewenson, R. Annotated Bibliography on Civil Society And Health: Civil society – state interactions in national health care systems. World Health Organization and Training and Research Support Centre, Zimbabwe 2003.
[59] Vega-Romero, R. & Torres-Tovar, M. The role of civil society in building an equitable health system - Paper prepared for the Health Systems Knowledge Network of the World Health Organization's Commission on Social Determinants of Health. 2007.
[60] Health Cities Projects in WPRO and Faces, Voices and Places in PAHO
[61] SEWA in SEARO http://www.searo.who.int/en/Section1174/Section1458/Section2545.htm

- What models of good practice in empowerment are available and could be replicated within the Asia and Pacific Region in interventions that aim to increase health literacy for improved health particularly the achievement of MDGs and other public health commitments such as the Framework Convention on Tobacco Control and Global Strategy on Diet, Physical Activity and Health?

9. Building capacity for sustained action to increase health literacy

As mentioned above, examples of success in increasing health literacy and improving health are available. To increase the level of health literacy and improve health, interventions shown to be effective need to be put into practice within and between countries, in order to have an impact. This requires translating evidence into practice and transplanting these examples of success, taking into consideration the differences in context of each country.

Even when effective interventions are available at low cost, the desired health outcomes will not be achieved if the interventions are not made context specific, successfully delivered and implemented. For example, child mortality and HIV transmission are not reduced by the respective availability of childhood immunization and antiretroviral drugs per se.[62] [63]

One of the most important barriers to delivery and implement effective interventions is the shortage of human resources particularly in low income countries and remote areas. The shortage of health workers has become the most serious obstacle to implementing national treatment plans and is among the most significant constraints to achieving the health related MDGs. To overcome the shortage requires, among other strategies, the expansion of village volunteers and traditional health practitioners such as birth attendants and a shift to community based care.[64] Attempts must be made to examine how these community based and traditional human resources can be used more effectively for health gains. The use of traditional birth attendants has led to an improvement of health including the reduction in perinatal and maternal mortality as well as perinatal transmission of HIV.[65] [66] The evidence of success in using traditional birth attendants can further be enhanced by better training and health strengthening.[67] It is also important to prepare the health workforce to respond more effectively to the "new paradigms of care" [64] to combat NCDs, which have become the major disease burden. This can be done through preventive care for example, by doctors prescribing not only medicines but also lifestyle changes, such as physical activity and healthy eating advice, as well as through community based care by allied health practitioners, such as pharmacists and dentists providing advice on ways to quit smoking.

---

[62] WHO WPRO, Weak health services block progress in Asia and the Pacific
[63] UNAID. Health Systems. Available at http://www.usaid.gov/our_work/global_health/hs. Accessed on 20 March 2009.
[64] WHO. The World Health Report 2006: Working together for health. WHO 2006
[65] Jokhio, A., Winter, H., Cheng, K. An Intervention Involving Traditional Birth Attendants and Perinatal and Maternal Mortality in Pakistan. NEJM 2005; 352:20, 2091-2099.
[66] Bulterys, M. Fowler M., Shaffer, N. et al Role of traditional birth attendants in preventing perinatal transmission of HIV. BMJ 2002, 324, 222-225.
[67] Kruske S & Barclay L Effect of shifting policies on traditional birth attendant training. Journal of Midwifery and Women's Health 2004; 49(4):306-311.

Apart from a skilled workforce and funding for interventions, the support to be given to the workforce system-wide is of equal importance. A system-wide approach targets the capacity of all of the service providing organizations within the system. The term "capacity" refers to a number of key capacity building areas organization-wide, particularly with regard to the workforce, such as information, leadership, funding, supplies and equipments and coordinated actions of the organizations, as reflected in health system strengthening building blocks[68] and the health promotion capacity wheel.[69]

To inform policy development and practice in building capacity so as to be able to develop and implement interventions to enhance health literacy, immediate actions are warranted to examine what capacity building areas are relevant and how the capacity of those areas can be built in countries of different levels of development, given the different social, economic and political context of the countries in the Region, and the different health issues that the countries confront.

Key questions that could be discussed by the panellists include:

- What roles do the different key stakeholders (e.g. health care providers, patients and their family) play in strengthening the skills patients need in order to take appropriate health decisions? What types of organization-wide capacity-building activities should be undertaken by the stakeholders so as to improve health outcomes through increased health literacy among patients?
- What roles do the different key stakeholders (e.g. education and health service providers and community groups) play in strengthening the capacity of the community to take appropriate health decisions? What types of organization-wide capacity-building activities should be undertaken by the stakeholders to increase health literacy community wide so as to improve the above mentioned health outcomes through increased health literacy among people in the wider community?
- What can different levels and types of health practitioners do to help increase and sustain populations' health literacy? What skills and support do they need to do this?

10. Concluding remarks

This paper sets the scene for the deliberation by the participants at the regional consultations by providing a snap shot of a number of key issues that are important for developing and implementing outcome-oriented health literacy interventions. Through the deliberations, it is expected that recommendations will be made as to how effective health literacy interventions can be scaled up so as to accelerate progress towards the achievement of the health related MDGs and public health goals and commitments.

[68] WHO, Everybody's Business, Strengthening Health Systems to Improve Health Outcomes - WHO's Framework for Action. WHO 2007.
[69] Catford, J. The Bangkok Conference: steering countries to build national capacity for health promotion (Editorials). Health Promotion International 2005; 20 (1) , 1-6.