

A close-up photograph of two hands, one larger and one smaller, clasped together in a firm grip. The hands are positioned in the upper half of the frame, with the larger hand on the left and the smaller hand on the right. The background is a lush field of green grass and numerous small, vibrant purple flowers, likely thistles, under bright, natural light. The overall mood is one of support and connection.

Health literacy in the Nordic countries

Not only a determinant of health, but also a
tool for health promotion



Nordic Welfare
Centre

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Foreword

Nordic co-operation envisages a Nordic region that will be the most sustainable and integrated region in the world in 2030. To achieve the vision three strategic key pillars are prioritised: a green Nordic region, a competitive Nordic region, and a socially sustainable Nordic region. In the action plan for Vision 2030, which runs from 2021 to 2024, twelve objectives have been linked to the three strategic key pillars. Objective number nine states that the Nordic Council of Ministers will contribute to a good, equal, and secure health and welfare for all (Nordic Co-operation, n.d.; Nordic Council of Ministers, 2020). In achieving this goal, health literacy can be an important measure to focus on.

Many determinants help to define our health. One of these is health literacy, which also serves as a mediating and moderating factor of health. All in all, health literacy is an important concept to consider in matters of health and, in particular, the health of all people.

With this report, the Nordic Welfare Centre wishes to introduce the concept of health literacy, its trajectory over time, and how the concept fits into the health structure today. The report will also view health literacy in relation to the field of integration, where health literacy can have a significant role. In addition, country profiles for each Nordic country will provide insights into health literacy at a structural level in the five countries as well as examples of projects/initiatives that focus on health literacy among migrants and refugees. International reports and research material have been used in the preparation of this report, but the report itself should not be considered research.

An informal Nordic network on health literacy has also been established among the Nordic health authorities in connection with the preparation of this report. The Nordic Welfare Centre would like to thank the members of the network for their cooperation and for reviewing the texts in the country profiles. Special thanks go to co-author of the report, Josefin Wångdahl (Researcher, PhD, Department of Public Health and Caring Sciences, Uppsala University), and to Kristine Sørensen (Global Health Literacy Academy) for professional sparring and final review of the report.

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Introduction

Health literacy is a part of all our lives, as it affects our ability to make well-informed decisions in everyday life on healthcare, disease prevention, and health promotion. Health literacy is essential to maintaining and improving the quality of life during the life course (Sørensen et al., 2012). According to the World Health Organization, WHO, 'health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health' (WHO, 1998).

However, being a health-literate person in modern societies is a growing challenge. We are bombarded with information and misinformation, which has grown even stronger during the Covid-19 pandemic. We are being challenged to make healthy lifestyle choices and find our way through complex environments and healthcare systems (Kickbusch et al., 2013; Paakkari & Okan, 2020). Furthermore, people do not have the same prerequisites to be equally literate in terms of health, which is why health literacy is also associated with inequity in health. For example, individuals with lower literate and educational skills, the elderly, the chronically ill, and different migrant groups including refugees are at risk of having limited health literacy (Wångdahl & Sørensen, 2020; WHO, 2016).

It is important to start promoting personal health literacy early in life, where the education system can play a focal role in teaching and strengthening the personal skills and competencies related to health literacy (Nutbeam, 2000). Also, health literacy is not fixed and can be improved throughout life with adequate and effective information, communication, and education adapted to the right contextual situation in life. The environments that we inhabit should also be made more responsive to health literacy issues: for example, healthcare organisations should meet the health literacy needs and preferences of the people and communities they serve (Trezona et al., 2017). This approach is also referred to as organisational health literacy.

But most of all, it requires political support, action, and commitment to improve and ensure an adequate level of health literacy in a population. Politicians create the policies and frameworks for the cultural context in which individuals are born, grow up and live, and under which the healthcare system operates. Therefore, politicians have a responsibility to prioritise health literacy as a part of these policies and frameworks to ensure equity in health in a population that is constantly changing, also demographically (Kickbusch et al., 2013).

Immigration has played the central role in demographic change in the Nordic countries in general and in Sweden in particular over the past 30 years (Grunfelder et al., 2020). 'Migrants' is an umbrella term for a heterogeneous group with differing reasons for migration. Some have made a voluntary choice, while others, such as refugees, have acted out of necessity due to war, conflict, or persecution (WHO Europe, 2018; United Nations, n.d.).

Migrants will bring with them different linguistic, cultural, and social experiences, as well as different norms and knowledge. As part of the integration process, the host country and the services need to adapt to meet the individual needs of migrants, their living situation, and their level of skills and competences. This is particularly important in the area of health, as health is also a mediating factor in achieving good integration, and health literacy plays a leading role in reaching this goal.

Health literacy: Concept and definition

Health literacy was first introduced in the 1970s in the United States and Canada and has since evolved globally as a concept and a field of research. The concept has also made its way onto the political agenda in many countries, as can be seen, for example, from the many national health literacy policies (Nutbeam, 2017). In the Nordic region, so far only Norway has a national strategy on health literacy.

Throughout the years, several definitions and conceptual models have been used to explain the concept of health literacy, partly because it has been employed in many different contexts (Sørensen et al., 2012). In the beginning, the focus was mainly on the ability to understand health information related to healthcare. Later the focus has broadened, and a paradigm shift has taken place. Today, health literacy generally focuses on several skills and competencies needed to access, understand, appraise, and apply health information that has to do with healthcare, disease prevention and health promotion.

In the 1998* health promotion glossary, the WHO defines health literacy as

"the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy implies the achievement of a level of knowledge, personal skills, and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions. Thus, health literacy means more than being able to read pamphlets and make appointments. By improving people's access to health information, and their capacity to use it effectively, health literacy is critical to empowerment (WHO, 1998)."

In 2000, Nutbeam operationalised the WHO definition of health literacy and created a conceptual model operating on three levels of health literacy known as basic/functional, communicative/interactive, and critical health literacy. What started out as being a qualification of sufficient reading and writing skills, and with a basic knowledge of health (basic/functional health literacy), health literacy has evolved into a competence in the ability to perform knowledge-based literacy tasks to exert greater control over life events and situations (critical health literacy). A higher level of health literacy also leads to greater autonomy and personal empowerment (Nutbeam, 2000; Nutbeam, 2017).

Furthermore, different approaches and efforts are needed to meet the needs and skills of people at each level of health literacy. This

applies, for example, to adapted information and media use, as there is no one-size model that fits all (Nutbeam, 2017). For many years, Nutbeam's conceptual model was the most used in explaining the concept of health literacy.

*By the final review of this report, it became known that WHO had updated the health promotion glossary from 1998 and modified the definition of health literacy. In the new health promotion glossary of terms, WHO defines health literacy as representing

"the personal knowledge and competencies that accumulate through daily activities, 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 (WHO, 2021)."

An integrated model of health literacy

In 2012, Sørensen and colleagues published a systematic literature review of existing definitions and concepts of health literacy as reported in international literature. The systematic review resulted in several definitions and conceptual models of health literacy, which guided the content analysis and led to an integrated model of health literacy (Figure 1). This model outlines the main dimensions of health literacy (represented in the concentric oval shape in the middle of the figure) together with a logical model showing the proximal and distal factors that impact on health literacy, and the pathway linking health literacy to health outcomes.

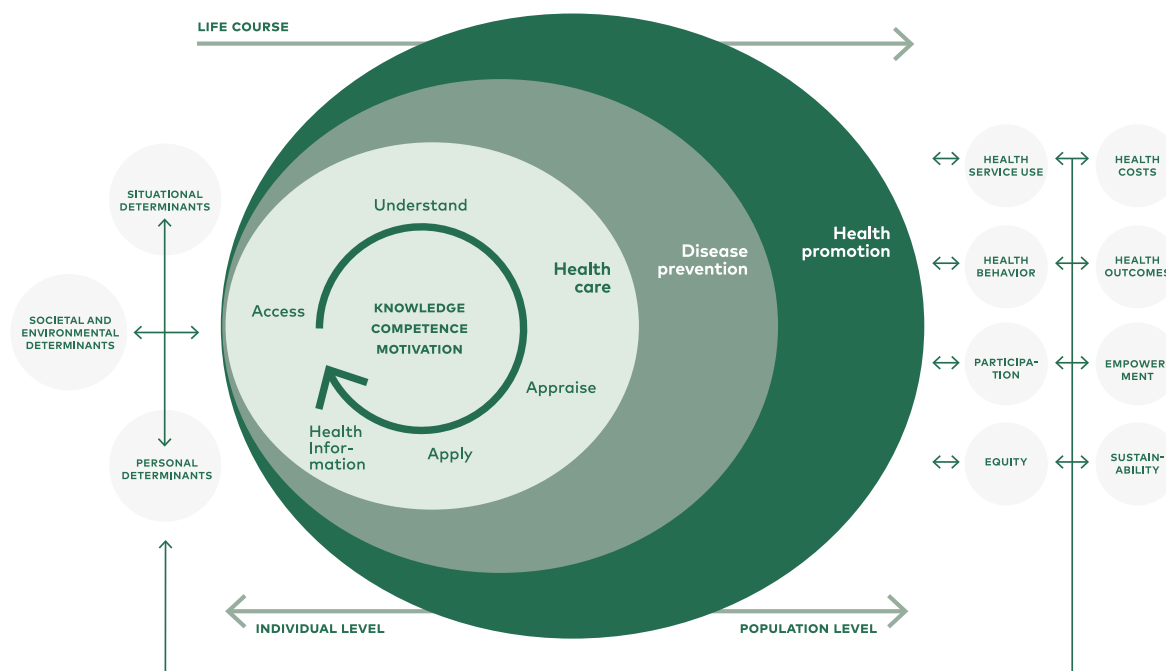


Figure 1: An integrated model of health literacy (Sørensen et al., 2012)

Health literacy is closely linked to literacy and includes people's knowledge, competence, and motivation to access (to seek, find, and obtain health information), understand (to comprehend the health information that is accessed), appraise (to interpret, filter, judge, and evaluate the health information that has been accessed), and apply (to communicate and use) the health information. Each step of the process represents a crucial dimension of health literacy which is related to specific cognitive and psychosocial qualities, but also to the quality of the information provided. The process also incorporates the levels of functional, interactive, and critical health literacy as defined by Nutbeam (2000).

The process of accessing, understanding, appraising, and applying health information generates competencies and skills, which enables a person to navigate, make judgements and decisions in everyday life within the three domains of healthcare, disease prevention, and health promotion. However, as contextual demands change over time, and the capacity to navigate the health system depends on cognitive and psychosocial development as well as previous and current experiences, the competencies and skills of health literacy develop during the life course and are linked to life-long learning. Health literacy is also impacted by other factors such as societal and environmental determinants (for example, demographic situation, culture, language, political forces, societal systems), personal determinants (such as age, gender, race, socioeconomic status, education, employment, income, literacy), and situational determinants (such as social support, family and peer influences, media use, and physical environment).

Health literacy can influence health behaviour and the use of health services, which can affect health outcomes and the health costs in society. Advancing health literacy will progressively allow greater autonomy and personal empowerment, and the process of health literacy can be seen as a part of individual development towards improved quality of life. In the population it may also lead to more equity and sustainability of changes in public health. Limited health literacy can be addressed by educating persons to become more resourceful (for example, increasing their personal health literacy) and by making the task or situation less demanding (for example, improving readability of the system and the information provided) (Sørensen et al., 2012). Today, the integrated model by Sørensen and colleagues (2012) is widely used in international literature and research to explain the concept of health literacy.

Organisational health literacy

Although health literacy has often been defined and portrayed as a personal trait, there is a growing appreciation that health literacy does not depend on the skills of individuals alone. It is the product of individuals' capacities and the health literacy-related demands and complexities of the healthcare system. To align healthcare demands better with the public's skills and abilities calls for systemic and organisational changes (Brach et al., 2012).

"A health-literate organisation can be described as enabling people to navigate, understand, and apply information and services to take care of their health (Farmanova et al., 2018)."

There are different options to choose from in becoming a health-literate organisation, and different healthcare organisations can choose different strategies. What is important is how well the chosen strategies work in relation to the different people in the population that the health organisations serve (Kickbusch et al., 2013).

Brach and colleagues (2012) introduced a list of ten attributes (see below) to exemplify a health-literate healthcare organisation. The list is not exhaustive nor is it adapted to societies globally, but it represents an attempt to synthesise a body of knowledge and practice, supported by the science in health literacy. Therefore, healthcare organisations that embody these attributes create an environment that enables people to access and benefit optimally from the range of healthcare services.

The ten attributes of a health-literate healthcare organisation:

1. Has leadership that makes health literacy integral to its mission, structure, and operations.
2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement.
3. Prepares the workforce to be health-literate and monitors progress.
4. Includes populations served in the design, implementation, and evaluation of health information and services.
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatisation.

6. Uses health literacy strategies in interpersonal communication and confirms understanding at all points of contact.
7. Provides easy access to health information and services and navigation assistance.
8. Designs and distributes print, audio-visual, and social media content that is easy to understand and act on.
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines.
10. Communicates clearly what health plans cover and what individuals will have to pay for services.

The ten attributes thus relate to the structure and work within the organisation, the design and implementation of information, communication and services, and what knowledge the staff in the organisation have. The attributes also demonstrate that healthcare organisations can immediately take concrete, practical action to close the gap between individuals' health literacy skills and the demands of complex healthcare systems. Healthcare organisations that adopt and invest in these attributes, even in a modest way, will create an environment that enables people to access and benefit optimally from the range of healthcare services, which will contribute to improved population health (Brach et al., 2012).

Health literacy affects health in many ways

Health literacy is a broad concept that can be used in several contexts and can affect health in many ways. Besides being a determinant of health, health literacy is also a mediating and moderating factor for health (Pelikan et al., 2018).

Some people are more vulnerable to the risk of limited health literacy, and therefore health literacy is also associated with inequity in health (Nutbeam & Lloyd, 2021). For example, limited health literacy is more prevalent among people with lower literacy and educational skills, the chronically ill, the elderly, and various groups of migrants, including refugees (Kickbusch et al., 2013). In the absence of a one-size-fits-all model, it is therefore important to focus on the issue of inequity when working on health literacy in order not to leave anyone behind.

At the international level, the WHO has highlighted health literacy as a significant factor in achieving the Sustainable Development Goal, SDG on health (Goal 3). Health literacy is also a mediating factor in promoting a wide range of other SDGs (WHO Europe, 2021a; WHO, 2016).

Population-based surveys of health literacy in Europe

To know how health-literate a population is, it is relevant to measure and monitor health literacy in surveys. Implemented in 2009–2012, the European Health Literacy Project, HLS-EU produced a survey which provided, for the first time, a status of general health literacy at population level in the European Union, EU. Eight countries across the EU (although none from the Nordic region) participated in the project, in which the European health literacy survey questionnaire, HLS-EU-Q47, was developed and used to collect data on general health literacy. The HLS-EU-Q47 questionnaire operates on four levels of health literacy: inadequate, problematic, sufficient, and excellent. The study showed that almost half of the respondents (47.6 percent) in the total sample had limited (inadequate or problematic) general health literacy, with a prevalence range of 29–62 percent between the countries (Sørensen et al., 2015).

In 2018, the World Health Organization Regional Office for Europe, WHO/Europe, launched the Measuring Population and Organizational Health Literacy Action Network, M-POHL to gauge and generate data on population and organisational health literacy. This was to support evidence-based policy-making, decisions, and

interventions. The M-POHL was initiated based on the recommendations of the report *Health literacy: The solid facts*, published by WHO/Europe and drawing also on the findings of HLS-EU (Gesundheit Österreich GmbH, n.d.a). The Health Literacy Population Survey Project 2019–2021, HLS₁₉, is the first M-POHL project to collect comparative data on population health literacy across member states in the European region of WHO. The survey is intended to be conducted at regular intervals to report comparative trends over time. The HLS₁₉ participants are 17 countries in the European region of WHO, including Denmark and Norway from the Nordic region (Gesundheit Österreich GmbH, n.d.b).

The International Report on the Methodology, Results, and Recommendations of the European Health Literacy Population Survey 2019–2021 (HLS₁₉) of M-POHL shows the participating countries' results in different types of health literacy they have chosen to study, such as digital health literacy, vaccination health literacy, etc. What all countries have measured is general health literacy, which they surveyed with the help of the HLS₁₉-Q12 instrument, a short form of the HLS-EU-Q47 that was developed and used in the HLS-EU project.

The international report shows that across all participating countries, around 40 percent of respondents have a sufficient level of health literacy, while around 15 percent have an excellent level. On the other hand, about 33 percent have a problematic level of health literacy and 13 percent an inadequate level. In line with the HLS-EU project, when the categorical levels of inadequate and problematic health literacy are combined as limited health literacy, the resulting variation ranges at 25–72 percent between the countries. Compared to the HLS-EU, the variation between countries in this report is even more pronounced, which could be the result of a different methodology and different countries being included in the two studies.

The results from the Danish survey, in the international report, show that 36 percent have a problematic level and 11 percent an inadequate level of health literacy: as a whole, 47 percent of the Danish respondents had a limited level of general health literacy. Similarly, the Norwegian results in the international report show that 38 percent have a problematic level of health literacy, and 8 percent have an inadequate level, resulting in 46 percent having a limited level of general health literacy (The HLS₁₉ Consortium of the WHO Action Network M-POHL, 2021).

Norway has published two national reports based on its own data from the HLS₁₉ survey. These reports give deeper and slightly different insights into the health literacy situation in Norway than is shown in the international report. The report *Befolkningens*

helsekompetanse, part I is based on a representative sample of the Norwegian population (including a total of 6,000 respondents from the age of 16 years). The study operates with three levels of general health literacy as measured by HLS₁₉-Q12-NO. According to the findings, one out of three Norwegian respondents (33 percent) scored at or below level 1, which indicates a limited level of general health literacy (Le et al., 2021a). The report *Befolkningens helsekompetanse, part II* is built on data from five immigrant groups in Norway – Pakistan, Poland, Somalia, Turkey, and Vietnam (a total of 1733 respondents). Compared to the population's level of general health literacy, a higher proportion of people with a background in Turkey and Vietnam are at or below level 1 for general health literacy. Somewhat unexpectedly, the study shows that a lower proportion of people with a background in Pakistan, Poland, or Somalia are at the same level. However, there is considerable uncertainty associated with the results of this study, and the findings should be read and interpreted with caution (Le et al., 2021b).

Health literacy in times of Covid-19

The outbreak of the 2019 coronavirus disease, Covid-19, not only started a health pandemic, but also caused an infodemic, a pandemic of misinformation. It spread rapidly through various social media platforms, posing a serious public health problem (Zarocostas, 2020). Correct and important information is mixed up with misinformation and fake news, and much of the information is not communicated in plain and understandable language (Dib et al., 2021; Stern et al., 2021). Understandable and plain information is important if people are to be able to interpret and act on it in an appropriate, health-promoting, and disease-preventing way. It requires health literacy, which is an underestimated problem in the context of Covid-19 (Paakkari & Okan, 2020).

Research indicates that people with limited health literacy to a higher degree than those with higher health literacy find Covid-19 information confusing and difficult to understand (Okan et al., 2021; McCaffery et al., 2020). Furthermore, associations have been found between limited health literacy and poor attitudes towards preventive strategies against Covid-19, less knowledge about Covid-19 symptoms, and preventing behaviours such as physical distancing, handwashing, and wearing a face mask (McCaffery et al., 2020; Okan, et al., 2021; Turhan et al., 2021). Moreover, associations have been found between limited health literacy and higher anxiety and fear regarding Covid-19, and vaccine hesitancy (Turhan et al., 2021; McCaffery et al., 2020).

Health literacy in the context of Covid-19 is important not only for people's personal health, but also for public health in general and for social justice. People who do not follow restrictions or get vaccinated

because of limited health literacy may put both themselves at increased risk of ill-health and risk the health of others. In the fight against Covid-19, everyone in society should take action.

However, it is also important not to stigmatise those with limited health literacy. Instead, the focus should be on the societal level and the importance of increasing organisational responsiveness to health literacy (Trezona et al., 2017). Therefore, the focus should be on making it easier for individuals in the society to access, understand, appraise, and understand information about Covid-19 and other important health issues.

Health literacy: Political choice and commitment

As health literacy relates to the competences and skills of the individual and the complexity of the societal system, it requires a holistic societal approach, in which multiple sectors and actors work together to improve individual and societal health literacy to promote health equity and well-being for all. This approach requires action at the policy level, as policy-makers create the framework for the policies and strategies under which individuals live and under which society and its systems operate (Kickbusch et al., 2013; Sørensen et al., 2012).

"According to WHO, the work on health literacy should be seen as a political priority and a political commitment. Health literacy has also been a part of the WHO commitment since the Ottawa Charter for Health Promotion was derived in 1986."

According to WHO, the work on health literacy should be seen as a political priority and a political commitment. Health literacy has also been a part of the WHO commitment since the Ottawa Charter for Health Promotion was derived in 1986. In the Shanghai Declaration from 2016 on promoting health in the 2030 Agenda for Sustainable Development, health literacy is highlighted and emphasised as an essential tool to empowering citizens and creating equity in health. It calls for political commitment and financial investment in health promotion to accelerate the implementation of the SDGs and to achieve the aim of the Shanghai Declaration, which is to leave no one behind (WHO, 2016).

In the EU, health literacy is also being more prioritised on the political health agenda, which can affect the Nordic countries that are member states of the EU. For example, the European Commission funded the European Health Literacy Project HLS-EU in 2009–2012 (Sørensen et al., 2015).

WHO/Europe, of which the Nordic countries are all member states, also has health literacy high on the agenda. In 2013, WHO/Europe published the report *Health literacy: The solid facts*, based in part on the HLS-EU findings and contributing to the raised status of health literacy on the European programme of WHO. More publications have since been published, for example, on guiding and supporting policymakers in the member states to adopt and implement national and other integrated policies and strategies on health literacy (WHO Europe, 2019a; WHO Europe, 2021a). M-POHL, the Measuring Population and Organizational Health Literacy Action Network was, as has already been mentioned, initiated by WHO/Europe based on the recommendations of *Health literacy: The solid facts*.

As health literacy is gaining more attention on the agenda of WHO, WHO/Europe, and the EU, it also reflects the attention on health literacy in the Nordic countries. There has been an increase in Nordic research with a focus on health literacy over the last decade, and the topic is also finding its way onto the strategic and political arenas in the Nordic countries, but at different speed. Norway is the first and so far the only Nordic country to have a national strategy for health literacy, *Strategi for å øke helsekompetansen i befolkningen 2019–2023* (Helse- og omsorgsdepartementet, 2019).

Migration, refugees, and health literacy

According to the United Nations Refugee Agency (UNHCR), at least 82.4 million people worldwide had been forced to flee their homes by the end of 2020 due to persecution, conflict, violence, human rights violations, or events that seriously disrupted public order. Nearly 26.4 million of them are refugees (UNHCR, 2021).

The demographic changes in the world have also had an impact on the demographic changes in the Nordic countries, which have experienced an increase in the number of refugees.

As already mentioned, migrants and refugees are at risk of limited health literacy. It is therefore important to focus on and understand their health literacy level in order to help them and their families to better health.

Migration to the Nordic region

In 1990–2019, the population of the Nordic region increased by 17.7 percent. Around two-thirds of the total population increase is due to net migration: emigrants are outnumbered by immigrants. In 2019 the total population of the Nordic region was around 27.3 million.

The population increase in 1990–2019 is uneven across the Nordic region. The population increase was 20 percent or higher in Sweden, Åland Islands, Norway, and Iceland; 13 percent in Denmark; and 11 percent in Finland. In the Faroe Islands the increase was around 7.5 percent, while Greenland only had a 0.8 percent increase. In Sweden, Norway, Denmark, and Åland Islands, immigration was the main reason for population growth. In Finland, natural increase and net migration were almost at equivalent levels, whereas natural increase in Iceland, Faroe Islands, and Greenland was the main reason for population growth. While there are between-country differences, immigration has overall played the key role in population change in the Nordic region, with Sweden having an absolute net migration of more than 1.2 million people during 1990–2019 (Grunfelder et al., 2020).

The migrant composition has also changed significantly in 1990–2019, shifting from primarily exchange of people between the Nordic countries in the 1990s to inflows from an increasingly diverse range of countries from 2000s and up until today. During the decade of 2010–2019, the focus was on refugees, and during the 2015 refugee crisis

the Nordic countries received a large number of asylum seekers in comparison with many other European countries. Sweden stands out as the Nordic country with by far the largest refugee in-flow. The majority of refugees seeking asylum in Sweden, Norway, Denmark, and Finland during 2014–2017 came from Syria, Somalia, Iraq, Eritrea, and Afghanistan (Karlsdóttir et al., 2018).

FACTS: Definitions of migrants and refugees

Migrants is an umbrella term for people who move away from their place of usual residence. The reason for migrating can be either out of choice (for example, due to a job or education), or out of necessity (for example, due to war, torture, persecution, or poverty). Refugees are migrants who have migrated out of necessity (United Nations, n.d.; WHO Europe, 2018).

Refugees are people who are unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion. Refugees are people who have fled war, violence, conflict, or persecution and have crossed an international border to find safety in another country (UNHCR, n.d.).

Refugees' health

As the number of refugees in the Nordic countries has increased significantly since 2010, they are an important group to focus on in terms of health, too.

Refugees are a heterogeneous group with individuals from different countries with various backgrounds and previous experiences, but there are some health problems – such as psychological ill-health and low perceived self-rated health – that are often seen among refugees. Such lifestyle factors as stress, smoking, and physical inactivity are also common among refugees as are different lifestyle-related diseases such as type 2 diabetes. Other health problems such as sexual and reproductive health, perinatal and maternal mortality, and violence in close relationships leading to death are also prevalent in some refugee groups. At the same time, many refugees refrain from seeking healthcare even when they need it, and their participation in health promotion and disease prevention such as screening and vaccination programmes is less common than among the majority population (Wångdahl & Sørensen, 2020; Wångdahl et al., 2018).

The refugees' health problems are often related to the social determinants of health, including age, gender, literacy, level of education, and socioeconomic factors. Exposure to health risks in the country of origin and during the flight such as violence, oppression, sanitary nuisances, lack of food and clean water, and healthcare can also be contributing factors. Factors related to resettlement in the new country include the risk of poverty, unemployment, social isolation, discrimination, and limited access to health information and healthcare due to language barriers (Wångdahl, 2017; Hempler et al., 2020). Migration is also seen as an independent social determinant for health (Thomas, 2016).

There are thus barriers that limit migrants' and refugees' access to healthcare and also limit their participation in health-promoting and disease-preventing activities. This is often due to the challenge of finding and understanding information about health and healthcare, not trusting the healthcare system, and not knowing how to get in contact with it. Communication problems related to both language and cultural issues between refugees and healthcare professionals are also common and can relate to limited health literacy on both an individual and organisational level (Wångdahl & Sørensen, 2020; Wångdahl, 2017).

Refugee women's health literacy and family health

Among some groups of refugees, it may be relevant to focus on the cultural differences in family structure and gender roles, as these may also have an impact on family health.

Some refugees come from countries where gender inequality is high, where the family structure is often patriarchal, and where women's educational attainment and employment tends to be low. The women's fertility rate tends to remain high in the host country, too, which is a key challenge for women's integration in the new country both in terms of the labour market and health, and not only in relation to their own health but also the health of their family (Liebig & Tronstad, 2018).

A study from Norway on Somali refugee women shows that Somali women's limited health literacy can have a significant impact on health information exchange and help-seeking for immigrant families. This is because women often play a central caring role in their families and the immediate community. Health planners should therefore pay particular attention to the limited health literacy of refugee women, as this can have significant implications for the

health outcomes of migrant families (Gele et al., 2016).

Also, the new host countries' welfare institutions are designed to serve citizens with a relatively homogeneous cultural background and with a life course normally taking place in the host country. With increasing immigration, this is no longer a sustainable assumption. Immigrants arrive with different linguistic, cultural, and social experiences, norms and knowledge, and welfare institutions must adapt to this new reality if they are to serve their purpose of treating everyone equally (Hempler et al., 2020).

Two studies on participation in cervical cancer screening from Finland (Idehen et al., 2020) and Denmark (Hertzum-Larsen et al., 2019) both indicate that the lowest participation rate is among Somali women compared to other groups of immigrant women and native-born women. Neither of the two studies directly measures health literacy, but they do point out some barriers that might be a contributing factor to why the participation rate is so low among some immigrant women. These barriers relate to health literacy on both an individual and an organisational level. Some individual barriers pertain to low socioeconomic status, unemployment, illiteracy, poor language proficiency, lower awareness of the objective of screening, lower perceived cancer risk, mistrust in healthcare authorities, and cultural/religious beliefs. It may also be that information about the screening is given in the national language only, the invitation comes in a letter, there are no female screeners, the women have limited access to healthcare, and interpretation services are inadequate (Hertzum-Larsen et al., 2019; Idehen et al., 2020) – all of which constitute institutional barriers.

"It is therefore important that the host country focuses on the people who have a disease, not on the disease itself."

It is therefore important that the host country focuses on the people who have a disease, not on the disease itself, and on the possibility of early integration of migrants into a tailored health system. This may also help to determine the long-term health status of the migrant population (Gele et al., 2016; Sodemann, 2020).

Health literacy: A tool for integration

Good health is a prerequisite for migrants who are to establish themselves and integrate in a new country. It increases their opportunities to participate in various integration activities, such as language courses, other studies, job search, performing in and maintaining a job, as well as to participate in society in general (Wångdahl, 2017). Health literacy can be an important tool to help migrants achieve good health and a good integration process.

Health problems among refugees can often be explained by risk factors related to the social determinants of health, exposure to health risks in the country of origin, during the flight, and in the new country to which they have migrated and are resettling (Wångdahl, 2017; Hempler et al., 2020). Refugees may face barriers to seeking help for their health problems in the new country because it is hard for them to find and understand health information. There may also be communication problems between refugees and healthcare professionals due to limited health literacy at both individual and organisational level (Wångdahl & Sørensen, 2020; Wångdahl, 2017). Furthermore, the health of many refugees deteriorates over time, which can also be explained by the fact that it is a challenging process to establish oneself in a new country where the language, culture, and social structure is not the same as in the country of origin (Zdravkovic et al., 2016; MILSA, 2015).

However, studies in Sweden show that the deterioration of migrants' health over time can be reduced by offering health communication to, for example, newly arrived refugees as part of the civic orientation courses available to people who have recently been granted residence in Sweden. Such health communication is based on a culturally sensitive approach using civic and health communicators who speak the refugees' mother tongue. Culturally sensitive approaches to health communication can increase migrants' health literacy and improve their chances of good health (Svensson et al., 2017; Al-Adhami, 2015), which can benefit the integration process as a whole.

The Nordic countries each have their own organisational structures dealing with the migrants' and refugees' settlement process, the content and scope of introduction programmes, and who the responsible authorities are. This does not mean that there are no similarities between the Nordic countries. For example, the introduction programmes share similar features and typically last two to three years, and are primarily targeted at adult refugees and reunified families. The overall aim of the introduction programmes is

also similar across the Nordic countries, namely the transition to work or education and, in the longer term, economic independence for the individual. In order to achieve this goal, all participants must complete an individually tailored programme, including language training and social/civic orientation courses, adapted to their specific circumstances and needs (Jönsson, 2017). Health communication is now an integral part of civic orientation courses in Sweden. Given that it can help improve the whole integration process, the other Nordic countries might want to consider whether health communication should be part of their induction programmes, too.

Specific areas of action to promote health literacy among migrants

The WHO/Europe recommends four specific interventions for migrants that are relevant in disease prevention and health promotion work in the Nordic countries. The recommendations are based on American and Australian research on health literacy, and they are known to work. The recommendations cover both the community level and the healthcare sector (Wångdahl & Sørensen, 2020; Kickbusch et al., 2013).

Promising areas for action concerning health literacy for migrants, according to WHO/Europe:

1. Develop specific health literacy strategies for migrants. Specific migrant-friendly strategies can make systems more responsive to migrant needs. Migrant users and communities can be engaged in planning, implementing, and evaluating these strategies through patients, cultural mediators in health settings, and patients' organisations.
2. Environmental interventions. Effective interventions include the use of patient navigators, translated signage or pictograms, and providing healthcare interpreters. Providing signage in minority languages not only helps ethnic minority patients find their way around hospitals but also creates a sense of belonging and inclusiveness. Although plain language is important in conveying messages, other means of communication such as images, photographs, graphic illustrations, audio, and videos should be considered in producing materials.

3. Health provider training can improve communication by taking into account simplified messaging and cultural sensitivity. Migrant-friendly health providers should elicit information about health literacy and language proficiency that may affect people's ability to undertake healthcare. People should receive appropriate treatment and care sensitive to their ethnicity, sex, abilities, age, religion, and sexual orientation. Diagnosis with relevant information and explanations should be communicated to people in their preferred language. Cultural mediators who explain and make understood various perspectives on health and disease are critical for many issues such as diagnostic treatment, surgery, or treatment procedures. Professional interpreters should be used in obtaining informed consent from migrant patients.
4. Networking and intersectoral interventions. Healthcare organisations can catalyse migrant-friendly action with other sectoral and stakeholder organisations such as pharmacies, social work departments, schools, criminal and justice departments, voluntary organisations, and companies (Kickbusch et al., 2013).

Health literacy in the Nordic region

There is a growing focus on health literacy in the Nordic countries, partly because the World Health Organization, WHO/Europe, and the EU are increasingly focusing on the issue. As mentioned earlier, Norway has a national strategy on health literacy, and Denmark and Norway have participated in the Health Literacy Population Survey Project 2019–2021 (HLS₁₉) study under the Measuring Population and Organizational Health Literacy Action Network (M-POHL).

Although the Nordic countries, from a national and strategic perspective, have only had a limited specific focus on health literacy in the past, they have previously, too, worked on interventions that can relate to or influence health literacy. Such work includes interventions focusing on health communication, and motivation and empowerment of people. This may well apply to projects based in other organisations and promoters.

The following country profiles for the Nordic region include an introduction to the countries' general work and focus on health literacy at national and strategic levels. There are also some examples of initiatives and projects that have been launched or implemented with a focus (either exclusively or partly) on immigrant and refugee groups, and on women, with a view to strengthening health literacy at an individual and/or organisational level.

These examples illustrate actions that can be taken to strengthen the health literacy of migrants and refugees, but it is not an exhaustive list of initiatives and projects. The majority of the examples have been selected either by the countries themselves or from literature on health literacy.

Health literacy is the English and globally used term, but the Nordic countries have also translated health literacy into their own languages. In Finnish and Swedish, however, there is no consensus on any one translation of the concept of health literacy, and therefore several examples are given under the Finnish and Swedish translations.

Table 1: Health literacy translated into the Nordic languages

Health literacy in translation	
Danish	Sundhedskompetence
Finnish	Terveyden lukutaito; terveystosaaminen
Icelandic	Heilsulæsi
Norwegian	Helsekompetanse
Swedish	Hälsokunskap; hälsokompetens; hälsolitteracitet

(Olander et al., 2020; Le et al., 2021a)

Denmark

In 2009, the Danish Health Authority published a report on the concept, implications, and possible interventions of health literacy (Health literacy: Begrebet, konsekvenser og mulige interventioner). Based on international knowledge available at the time, the report highlights the concept itself and the consequences of limited health literacy. The report surveys what can be done and how to meet and improve a low level of health literacy and relate existing knowledge to Danish conditions. It also provides an overview of the concept of health literacy, possible health consequences, and available knowledge about interventions and their effect. This serves to prepare a basis for possible work with health literacy in a Danish municipal context (Sundhedsstyrelsen, 2009). Currently, the Danish Health Authority is working on a new publication on the concept of health literacy. The main focus is on health literacy responsiveness and how organisations within the health sector can use this concept to meet the differences in citizens' health literacy as a means of targeting inequality in health.

In 2019, the Danish Society of Public Health and the Danish Health Literacy Network published the policy brief Health literacy from a structural perspective: A path to equity in health? in collaboration with Danish experts and practitioners. The policy brief includes eight recommendations to improve health literacy in Denmark from a structural perspective. The recommendations aim to prevent limited health literacy and its consequences for Danish citizens by targeting health services at the organisational level. Concrete measures and tools are introduced as a part of the recommendations to support their implementation (Aaby et al., 2019).

The Danish Health Literacy Network is affiliated with the Danish Society of Public Health and seeks to spread awareness of health literacy in Denmark. The Danish Health Literacy Network is open to all. Currently there are more than 300 members engaged in teaching, research, and practice. [Learn more about The Danish Health Literacy Network here.](#)

Denmark is a member of the M-POHL network and participates in the M-POHL HLS₁₉ study.

LIVE – Community stakeholders co-creating health-literate solutions for ethnic minorities

LIVE is a collaboration initiated in 2020 between Aarhus Municipality and Aarhus University focusing on community responses to ethnic minority challenges on health literacy.

A major health literacy challenge among ethnic minorities is the barrier to access healthcare created by inadequate abilities to find, understand, seek out, and use the relevant services. The aim of LIVE is to map local barriers affecting access to healthcare services and co-create initiatives to improve the collective local response to dealing with these barriers.

Located in the community of western Aarhus, LIVE has more than 15 local organisations involved in the project. Through group-based modelling, the organisations have mapped central factors and interactions, and have built a model of how they collectively experience local challenges in access to healthcare. Together they have then used the model for improvement ideas to initiate a range of locally owned initiatives based on local needs and local resources. [Learn more about LIVE here.](#)

MAMA ACT

MAMA ACT is carried out as a large intervention and research project. It was launched in May 2017 and was completed in March 2021. Out of the 20 maternity wards in Denmark, 19 are MAMA ACT members, and the project is estimated to reach 25,000 women.

The aim of the MAMA ACT project is to change the social and ethnic inequity in maternal and child health in Denmark by strengthening the dialogue and communication between pregnant women and the midwives. The primary outcome of the project is that the health literacy of non-Western immigrant women will increase to the level that the ethnic Danish women possessed in the beginning of the project.

Midwives are given a continuing education course in intercultural communication, and health education material such as a pictogram-based information folder, and an app in six languages. The folder and the app explain the most serious signals related to body signs of pregnancy complications, helping the midwives to communicate with the women about how they should respond to these signals.

In some minority groups in Denmark, the risk of a stillborn child is almost twice as high than in the majority population. By increased and better communication between pregnant women and the midwives, some of these deaths can be avoided. The project will also

lead to better health among newborns at birth and reduced infant mortality. [Learn more about MAMA ACT here.](#)

Sundhedsdansk

Adult migrants learning Danish can also learn more about the human body, health, disease, and the Danish healthcare system through Sundhedsdansk, a free online learning platform. The material is developed by Region Zealand, one of the five administrative regions in Denmark, and is designed to be used in an educational context. However, as the material is internet-based, it can be used by anyone who wants to gain knowledge about health and disease and how to communicate with healthcare professionals. The material is intended to support migrants as active residents in Denmark who can act on their own health and the health of their family.

The material provides an opportunity to learn Danish words and concepts that are used in health and healthcare, from what is a health security card to being able to describe one's own body experiences. The learners are also taught to listen to their bodies, and what symptoms to respond to and seek medical attention for. The learning platform also contains knowledge about risk factors for health, such as smoking and alcohol, and helps navigating the Danish healthcare system.

The material is interactive and the project helps to highlight different aspects of health literacy among migrants, such as communication, interaction, and navigation. [Learn more about Sundhedsdansk here.](#)

Finland

At present, Finland does not have a national strategy that focuses exclusively on health literacy. However, health literacy is a concept and a subject with a focus on the national agenda.

To promote the learning of health-related competencies, Finland is the only country in the Nordic region so far to have adopted health literacy as a compulsory part of the national curriculum for basic education (WHO Regional Office for Europe, 2019b). Finland has a history of teaching health issues for more than a hundred years. With the introduction of the most recent Finnish national core curriculum for basic education in 2016, health literacy was adopted as the term covering the teaching objectives and learning criteria for the subject of Health Education in grades 1–9. Having health literacy as a curriculum-based component ensures that all school-aged children are offered the opportunity in an age-appropriate manner to acquire the competencies needed to promote and sustain their health and well-being. Similarly, the law lays out that Health Education teachers must have the required teaching qualifications, that is, such university-level studies in Health Education that clearly approach and focus on health literacy during the teacher training programme

(Paakkari & Paakkari, 2019; Utbildningsstyrelsen, 2014).

Finnish pupils are in fact among the best informed school children about health in Europe partly due to the teaching of health literacy in schools through health education (WHO Regional Office for Europe, 2019b). To explore and measure Finnish adolescents' subjective health literacy, the Health Literacy for School-aged Children instrument was applied as a part of the Finnish study of international Health Behaviour in School-aged Children in 2014. Representative data were collected among 3,833 respondents in 7th and 9th grade from 359 schools around Finland. The findings show that one third of the adolescents had a high level of health literacy, around 60 percent had a moderate level of health literacy, and the level of health literacy among some 10 percent of the respondents was low. In general, the health literacy level was lower for boys than for girls, and lower for 7th graders than for 9th graders (Paakkari et al., 2018).

Furthermore, the new Finnish national literacy strategy, which came out in 2021, targets people of all ages. The goal is to find models to promote literacy at national, regional, and local levels. Although it does not focus on health literacy explicitly, the strategy does consider health literacy by, for example, discussing the importance of multiple literacy and media literacy (Utbildningsstyrelsen, 2021).

Finland is currently not a member of the M-POHL network and did not participate in the M-POHL HLS₁₉ study.

InfoFinland.fi

InfoFinland.fi is a multi-language website providing vital information to people planning to move to Finland and to immigrants already living in Finland. The website also supports authorities with multi-language communications. In addition to Finnish and Swedish, InfoFinland.fi offers users reliable information in ten languages (for example, English, Russian, Somali, Persian, and Arabic) about moving to Finland and regarding work, studying, housing, education, health, family, problem situations, and leisure activities. The language versions are identical in content, and the information is updated continuously. Even though the website offers reliable information in different languages, it seems very heavy in text, and the website also lacks a service of reading the text out loud, which would probably help those to whom the website is aimed.

InfoFinland.fi is funded by the state and the InfoFinland.fi member municipalities. [Learn more about InfoFinland.fi here.](#)

Iceland

At this point, Iceland does not have any specific policies or strategies focusing solely on health literacy. However, the Directorate of Health

in Iceland (DOHI) is interested in the topic and has put health literacy on the agenda in the annual workplan. The aim for 2021–2022 is to develop the work.

DOHI is also preparing a plan to increase health literacy among children and young people. Learning points will be taken from WHO (WHO Europe, 2021b) and the Schools for Health in Europe Network Foundation (Okan et al., 2020). The planning is still at the early stages, but what DOHI aims to do is prepare the data by drawing on the results from the project Health Behaviour in School-aged Children to establish a baseline. The plan is then to work with health promotion in schools to implement health literacy and to develop materials for schools.

During the Covid-19 pandemic, DOHI has emphasised spreading the message about the epidemic and giving advice about determinants of health not only in Icelandic, but also in English and Polish.

As much as 70 percent of the population in Iceland live in or around Reykjavik. Recently the Municipality of Reykjavik published a public health policy which also includes actions aimed at health literacy.

Iceland is currently not a member of the M-POHL network and did not participate in the M-POHL HLS₁₉ study.

Fjölmeningarsetur

Fjölmeningarsetur is a Multicultural Information Centre that provides information about moving to or living in Iceland, including information about the Icelandic healthcare system. Individuals, associations, companies, and Icelandic authorities can also turn to the centre when they need support, advice, and information regarding immigrant and refugee matters in Iceland.

The Multicultural Information Centre seeks to enable every individual to become an active member of the Icelandic society regardless of their background or where they come from. The role of the centre is to facilitate interrelations between people of different roots and to enhance services to immigrants living in Iceland.

The website of the Multicultural Information Centre can be translated into more than 25 languages, but the pages can become very text-heavy and difficult for people with low literate skills. There is also a lack of images to support the text, and the website does not offer the possibility of having the text read aloud. [Learn more about Fjölmeningarsetur here.](#)

Translation and cross-cultural adaption of the European Health Literacy Survey

Iceland is one of many countries with limited knowledge of health literacy in the population as well as no valid health literacy

measurement. A research team with Icelandic researchers in lead conducted a study to translate the short version of the European Health Literacy Survey Questionnaire (HLS-EU-Q16) into Icelandic, adapt the version, explore its psychometric properties, and establish preliminary norms. The HLS-EU-Q16 translation model included three steps: 1) translation and backtranslation of HLS-EU-Q16, including the specialists' review, 2) cognitive interviewing of lay people, and 3) psychometric analysis with survey participants. The study concluded that the Icelandic version of the HLS-EU-Q16 is psychometrically sound, has a reasonably clear factor structure, and is comparable to the original model. This opens for possibilities to study health literacy in Iceland and compare the results internationally. The introduced translation model might furthermore be helpful for other countries where information on health literacy is missing in the absence of validated tools (Gustafsdottir et al., 2020).

Norway

Norway is so far the first and only country in the Nordic region to have a national strategy for health literacy (Strategi for å øke helsekompetensen i befolkningen 2019–2023).

The strategy is a part of the Norwegian Government's effort to create the patient's health service (pasientens helsetjeneste), which implies that patients and healthcare users have the knowledge and abilities to take care of their own health in the best possible way. The healthcare sector must involve patients in the decision-making concerning them and their health by asking the question 'What is important to you?' Sufficient health literacy is a precondition to realising the patient's health service (Helse- og omsorgsdepartementet, 2019).

The overall aim of the strategy is to increase health literacy in the Norwegian population. To do so, different types of measures and instruments can be applied, such as actions aimed directly at the whole or sections of the population, or system-oriented measures that indirectly affect people's health literacy. For example, in discussing how to increase health literacy, the strategy points out that healthcare professionals must be able to use health communication and health pedagogy in their job with different individuals, and there must be more focus on information from the health and care services in clear language that is easy to understand, appraise, and apply. The strategy is primarily targeted at healthcare professionals, decision-makers, and patient and user organisations (Helse- og omsorgsdepartementet, 2019).

Norway is a member of the M-POHL network and participates in the M-POHL HLS₁₉ study. Norway has published two reports on the results of the Norwegian HLS₁₉ survey: *Befolkningens helsekompetanse (part I)*, based on a representative sample of the

Norwegian population, and Befolkningens helsekompetanse (part II), based on data from five immigrant groups in Norway.

Sunn Start

Sunn Start was launched in 2017 to improve health literacy among migrants and refugees in Norway. Sunn Start is a free preventive teaching and guidance pack with focus on food and health, mental health, and dental health.

The target group for Sunn Start are newly arrived people in Norway, as well as people who have lived in the country for a long time but have low language skills and/or a low understanding of health information.

The material has been developed by Migration Health in the Health Service, Oslo Municipality, in collaboration with other actors including migrants to better target the material to the key group.

The Sunn Start material can be used by volunteers who work with migrants, in introduction programmes for newly arrived, employees in the municipality, health personnel, and others.

Sunn Start helps to improve functional, interactive, and critical health literacy among migrants and refugees, which gives them a healthier everyday life. [Learn more about Sunn Start here.](#)

ZANZU.NO

Zanzu.no was launched in 2019 and is developed by the Norwegian Directorate of Health in collaboration with relevant representatives from other executive agencies, healthcare providers, and NGOs. Zanzu was first created as a joint effort by the Belgian sexual health and rights organisation Sensoa and German Health Authorities, financed by the EU Health Programme and supported by an international expert council including members of the WHO. Currently, in addition to Norway, the site has been adopted in the Netherlands, Belgium, and Germany.

Zanzu.no is a website with information on sexual and reproductive health and rights, primarily intended for recently arrived immigrants and people with a limited understanding of the Norwegian language. The Norwegian website is available in nine languages, including Farsi, Arabic, and Somali, thus covering the main immigrant groups in Norway. The pages of the website are written in plain language and make use of visual communication. Furthermore, zanzu.no has a text-to-audio function to reach people with language difficulties/illiteracy. The site can both be used directly by the target audience and as a tool to aid communication between health professionals and patients. [Learn more about Zanzu.no here.](#)

Sweden

At present, Sweden does not have a national strategy that focuses exclusively on health literacy. The Public Health Agency of Sweden is interested in the topic but has not yet decided on whether and how the concept of health literacy should be addressed in the agency's work.

An unpublished report on health literacy serves as a decision basis to the management group at the Public Health Agency regarding the future focus/work on health literacy on a strategic level in Sweden. The report describes different concepts of health literacy and how they are used internationally and nationally from a population and an organisational perspective, but the decision-making process has been stalled by the Covid-19 pandemic.

Sweden has a website on health literacy in Swedish, with national and international information and knowledge on health literacy. The website is run on a voluntary basis by two Swedish health literacy researchers. The website contains, for example, knowledge about measuring health literacy. Many different instruments aimed at measuring health literacy at population level have also been translated into Swedish and into several of the languages spoken by many refugees (for instance, Arabic, Somali, and Dari). The existing instruments are two short forms of the European Health Literacy Questionnaire (HLS-EU-Q16 and HLS-EU-Q6), the Swedish Functional Health Literacy Scale (S-FHL scale), and the Swedish Communicative and Critical Health Literacy Scale (S-C & C HL scale) measuring various dimensions of general health literacy. In addition, there are eHEALS, measuring electronic (also called digital) health literacy. [Learn more about the Swedish website on health literacy here.](#)

Sweden was an observer of the M-POHL network until the end of 2021 but did not participate in the M-POHL HLS₁₉ study.

KomHIT Flykting

KomHIT Flykting was carried out in Region Västra Götaland at the Dart Centre for Augmentative and Alternative Communication and Assistive Technology at Sahlgrenska University Hospital. The project ended in 2019, but project material is still available online.

The project was launched to develop support for information and communication in healthcare and dental care between the healthcare professionals and refugees. The material consists of so-called image supports (information sheets, etc.) with norm-critical photos showing different situations in health and dental care. As a

supplement to the photos, words explain the situation in both Swedish and a relevant language of the refugee. The material is translated into ten languages and can be used as a supplement to or in combination with an interpreter.

Combining photos with words limits the risk of misunderstandings. The communication material serves to increase the healthcare professionals' cultural competences and helps to improve the migrants' functional, communicative, and critical health literacy. The material is free to use, available online, and is used among different actors and organisations both in Sweden and internationally. [Learn more about KomHIT Flykting here.](#)

MILSA

MILSA is a research-based support platform for migration and health, and hosts various projects. One of these projects, the MILSA educational platform for civic and health communication, aims to increase the capacity for the dissemination of qualitative civic orientation and to implement health communication within the civic orientation programme in Sweden. The project collaborated with universities and experts in various fields, county administrative boards, regions, municipalities, and civil society organisations at both national and international levels and was supported by the European Social Fund and the Swedish Ministry of Health and Social Affairs.

In 2018–2021, almost 200 cultural mediators working as communicators within civic orientation participated in the education programme which consisted of 22 online modules, supplemented with practical training sessions and on-site meetings. General areas of knowledge included social studies, health, communication, and learning. The education had a strong health literacy perspective, and one module focused on health literacy specifically. In this the participants learned about the concept of health literacy, why it is important, how to promote the health literacy of newly arrived refugees, and how the participants could facilitate the civic orientation of those with limited health literacy (for example, by making civic orientation more health literacy-friendly). On the course agenda were also source criticism and the health literacy-friendly method Teach-back, which aims to improve the quality of the communication and enable the professionals to control that the information they are giving is understood. Evaluations of the project show that most of the participants now work in a more health literacy-friendly manner and promote health literacy in their daily work of civic orientation. Furthermore, health communication is now integrated into civic orientation in more regions in Sweden than before. [Learn more about the present MILSA project here.](#)

In another MILSA project, running until 2023 and also funded by the

Swedish Ministry of Health and Social Affairs, cultural mediators are trained as study circle leaders in order to run such circles on mental health for newly arrived refugees. The project thus aims to promote newly arrived refugees' mental health literacy and mental health. Mental health literacy is a more specific form of health literacy that focuses on knowledge and thoughts about mental illness and how it can be identified, managed, or prevented (Jorm et al., 1997). The concept has four dimensions: 1) understanding how to obtain and maintain positive mental health, 2) understanding mental disorders and their treatments, 3) decreasing stigma related to mental disorders, and 4) enhancing help-seeking efficacy (Kutcher et al., 2016). Evaluations indicate that cultural mediators' mental literacy has been promoted by participation in this training (Wångdahl & Engström, 2021). Furthermore, the refugees' mental health literacy tends to increase through participation in a study circle about mental health led by the cultural mediators (Wångdahl, 2021). As the research is ongoing, more reliable and in-depth results will follow in the coming years. [Learn more about the present MILSA project here.](#)

Toolbox for health-literate organisations

A toolbox for health literacy-friendly organisations has been compiled in a project within the network for health-promoting healthcare in Sweden (HFS-nätverket). The toolbox consists of material that can be used by healthcare organisations wanting to work actively to make it easier for people to access, understand, evaluate, and use information and services related to healthcare and health. The material is intended to provide a basis for increasing the understanding and awareness of issues related to health literacy and health literacy-friendly organisations, and to offer practical tools that can be used in the meeting with patients in daily activities. Examples include a checklist for health literacy-friendly organisations, leaflets about the Teach-back communication method and how to promote questions from patients, and infographics about health literacy and source criticism. [Learn more about the Toolbox for health-literate organisations here.](#)

Summary

Making healthy choices and finding the way through complex healthcare systems is becoming an increasingly challenging issue in modern societies. People are bombarded with information and misinformation that can be difficult to navigate and relate to. Consequently, this can have an impact on the health of the individual, the use of health services, inequality in health in the population, and the health economy. Health literacy is a determinant of health and therefore important to focus on and prioritise.

Health literacy is a combination of personal competencies and resources that enables us to access, understand, appraise, and apply health information to make healthy decisions. One's health literacy can be different in different contexts and depends on the requirements and the complexity that we encounter when managing our health. Addressing health literacy on a structural level raises the significance of organisational health literacy, as it deals with the way organisations and systems make information and health services accessible and understandable to people with different levels of health literacy.

As we are all different in terms of biology, level of education, social status, etc., the preconditions for being equally health-literate also differ. Some groups in society, such as refugees, are at greater risk of limited health literacy. However, health literacy can be improved throughout life, but it is good to start promoting the personal competencies and resources for health literacy early in life, for example in the educational system. In addition, there is also a political responsibility to prioritise health literacy on a structural level, and preferably also as a part of health and welfare policies in the Nordic countries.

Over the past 30 years, the Nordic countries, and Sweden in particular, have experienced an increase in the number of migrants and refugees. Refugees' health problems are often related to the health risks to which they have been exposed in their home country, during their flight, and during resettlement in the new country. In the new country, the encounter with the healthcare service and healthcare personnel is often characterised by communication problems and misunderstandings due to language and cultural differences, which relate to limited health literacy at both individual and organisational level.

Furthermore, good health is a prerequisite of good integration, which is hugely important from a Nordic societal perspective due to high immigration. Health literacy is therefore an important tool to focus on and prioritise to ensure opportunities for refugees' successful integration into Nordic societies.

As some of the examples of projects and initiatives in the country profiles show, different languages, plain language, visual communication (photos and pictograms), text-to-audio function, education of healthcare professionals in intercultural communication, etc., are important measures to improve health literacy on both an individual and organisational level. These measures are also included in the four areas which WHO/Europe recommends for action for promoting health literacy among migrants.

By prioritising health literacy targeted at refugees, we can foster healthier citizens, better and faster integration, and less inequality in health. All for the benefit of the individual, society, and the economy.

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