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World Health Organization

WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases

Draft Interim Report

WHO GCM/NCD Working Group on

Health Education and Health Literacy for NCDs

(WG 3.3, 2016-2017)

The WHO Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (GCM/NCD) Working Group on health education and health literacy for NCDs was formed under Objective 3 of the GCM/NCD 2016-17 work plan to provide a forum to identify barriers and share innovative solutions and actions for the implementation of the WHO Global NCD Action Plan 2013–2020 and to promote sustained actions across sectors.

Action 3.3:

Establish a Working Group in 2017 to recommend ways and means of encouraging Member States and non-State actors to promote health education and health literacy for NCDs, with a particular focus on populations with low health awareness and/or literacy, and taking into account the cost-effective and affordable interventions for all Member States contained in Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020.

The Working Group is co-chaired by representatives of two Member States, appointed in consultation with all Member States:

- Dr Lixin Jiang, Assistant Director of the National Centre for Cardiovascular Diseases; Co-Director of China Oxford Centre for International Health Research; Editor-in-Chief, The Lancet China
- Professor Sergey Boytsov, Director, National Research Center for Preventive Medicine, Ministry of Healthcare of the Russian Federation

Working Group members available at http://www.who.int/global-coordination-mechanism/working-groups/working-group-3_3/en/
More information on Working Group 3.3 available at http://www.who.int/global-coordination-mechanism/working-groups/working-group-3-3/en/

This interim report from the WHO GCM/NCD Working Group 3.3 provides insight into the Working Group's ongoing deliberations. The Working Group will build on this interim report in preparing its final report containing practical guidance and recommendations for Member States and non-State actors to effectively implement health literacy in support of the development of NCD control and management systems.

Using Health Literacy to impact on NCDs in the SDG-era

1 Why a Call to Action on NCDs through Health Literacy?

Noncommunicable diseases are now the leading cause of death and disability worldwide, threatening social and economic prosperity and wellbeing at individual, household, national, and global levels. Each year, 38 million people die from NCDs, primarily from diabetes, cardiovascular diseases, cancers, and chronic respiratory diseases. Of these deaths, approximately 15 million are premature (between the ages of 30 and 70). Dramatically, most premature deaths from NCDs (representing 27% of all global deaths) could have been prevented. The negative effects on societies, economies and health systems are felt in all countries, but the consequences of the NCD pandemic has been most severe in countries with weak economies and social structures that are struggling to build their health systems to respond to this critical development challenge. The probability of dying prematurely from an NCD is four times higher for people living in developing countries than in developed countries. This is resulting in a vicious cycle whereby NCDs and their risk factors worsen poverty, while poverty contributes to rising rates of NCDs. This reduces productivity, curtails economic growth, and traps populations in poverty - threatening the achievement of the Sustainable Development Goals 2016-2030[1] in high- and low-income countries alike.

The commitments, tools and frameworks are in place. Heads of State and Government have made political commitments[2] to tackle NCDs (2011[3] , 2014[4], and 2015), a road map, a menu of policy options and interventions are available, a monitoring framework is approved, and there is readiness to move from planning to action. However, there is clear evidence of insufficient uptake and implementation of programmes and of key indicators for NCD prevention and control in most countries to mitigate this burden, or in many cases they do not reach a sufficient proportion of society[5]. Through WHO's Global NCD Action Plan 2013-2020[6], cost-effective and high-impact 'best buy' interventions to prevent and control NCDs are available and, at individual level, they cost next to nothing. In order to ensure that these interventions are scaled up and delivered in an efficient and effective manner and have the desired impact especially in light of the prevailing economic difficulties, a paradigm shift in our approach is necessary. As part of the 2030 Agenda for Sustainable Development, world leaders agreed to by 2030, to reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and wellbeing (SDG target 3.4). Attaining SDG target 3.4 on NCDs will also create co-benefits for many other SDG targets by reducing poverty, hunger and inequity, ensuring that all human beings can enjoy prosperous and fulfilling lives, and that economic progress occurs in harmony with health.

[1] Transforming our world: the 2030 Agenda for Sustainable Development. A/RES/70/1, available at http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/1
[2] At the General Assembly of the United Nations High-level Meetings on Non-communicable Diseases
[3] Available at http://www.un.org/ga/search/view_doc.asp?symbol=A/66/L.1
[4] Available at http://www.who.int/nmh/events/2014/a-res-68-300.pdf
[5] WHO NCD Progress Monitor 2015 and 2017, available at http://apps.who.int/iris/bitstream/10665/184688/1/9789241509459_eng.pdf?ua=1
[6] Available at http://www.who.int/nmh/events/ncd_action_plan/en/

The Shanghai Declaration[7] recognizes that health literacy is a critical determinant of health and promotes focused investments in its development; it highlights the importance of empowering individuals and enabling active engagement in collective health promotion action; and it offers a set of key actions, which key stakeholders should act on and report progress against over time. By taking a health literacy approach to policy and programmes, and to service development or improvement, progress towards Governments' high-level commitments to prevent and control NCDs can be accelerated. This can be achieved through improvements in access, reach and use of services, triggered by a broad-based, coordinated, and "whole of society" engagement and response, guided by the principles of universal access, social justice and equity.

All health systems and service providers need to prioritize and utilize health literacy so that they provide services that are effective for all users and reach all members of society. This is especially important for NCDs because the causes of NCDs relate to decisions and actions at the individual and community level. Health literacy is necessary for effective management of the causes of NCDs, i.e., for generating effective disease prevention systems (e.g., for tobacco control, healthy diet, harmful use of alcohol and physical activity), and also for the management of NCDs as people must access, understand and engage in lifelong disease management. Health literacy is seen a key mechanism to improve NCD prevention and management systems.

Individuals need health literacy to access, understand, appraise and use information and services to make decisions about health. Health literacy includes the capacity to communicate, assert and enact these decisions.

Communities, as a whole need health literacy so that *no one is left behind*. Community health literacy is the assets and capacities existing within communities that promote health literacy, including the number of people who have strong health knowledge and influence health decisions, the availability of trustworthy information, and the number and accessibility of places community members can receive and share information. The stronger the health literacy across a community is, the more likely individuals and families with low health can be supported and not left behind.

Healthcare and health promotion systems need to understand and use health literacy so that environments, services and products all enable health information and services to be accessible to all people across societies. This will also maximize disease prevention and management efforts to ensure *no one is left behind* and every country reaches the 2030 UN Sustainable Development Goals (SDGs).

Governments need to understand the health literacy of their communities and ensure health systems are responsive to the health literacy needs of all individuals. This means ensuring policies and programmes use health literacy to optimise services (e.g., UHC, screening, prevention efforts), enabling them to be more inclusive and effective for more people.

[7] Available at http://www.who.int/healthpromotion/conferences/9gchp/shanghai-declaration.pdf

Health literacy refers to the personal characteristics and social resources needed for individuals and communities to access, understand, retrieve, appraise and use information, services and information and communication technologies (ICT) to make decisions about health. Health literacy includes the capacity to communicate, assert and enact these decisions.

Health literacy responsiveness describes the way in which policies, services, environments and products make health information available and accessible to people with different health literacy strengths and limitations.[8]

2 The mandate for health literacy

The United Nations ECOSOC Ministerial Declaration of 2009 provided a clear mandate for action: "We stress that health literacy is an important factor in ensuring significant health outcomes and in this regard, call for the development of appropriate action plans to promote health literacy."

In 2014, through the outcome document of the High-level meeting of the General Assembly on the comprehensive review and assessment of the progress achieved in the prevention and control of NCDs, Ministers and representatives of States and Governments committed to addressing NCDs as a matter of priority in national development plans, and to take, among others, the following measures with the engagement of all relevant sectors, including civil society and communities, as appropriate "To continue to develop, strengthen and implement, as appropriate, multisectoral public policies and action plans to promote health education and health literacy, with a particular focus on populations with low health awareness and/or literacy."

The Shanghai Declaration recognized, in 2016, that "Healthy lives and increased wellbeing for people at all ages can be only achieved by promoting health through all the SDGs and by engaging the whole of society in the health development process."

Through the Shanghai Declaration, Member States committed to invest in health literacy through:

- The recognition that health literacy is a critical determinant of health and there is a need to invest in its development;
- To develop, implement and monitor intersectoral national and local strategies for strengthening health literacy in all populations and in all educational settings;
- To increase individuals control of their own health and its determinants, through harnessing the potential of digital technology (digital or e-health literacy);
- Ensure that consumer environments support healthy choices through pricing policies, transparent information and clear labelling.

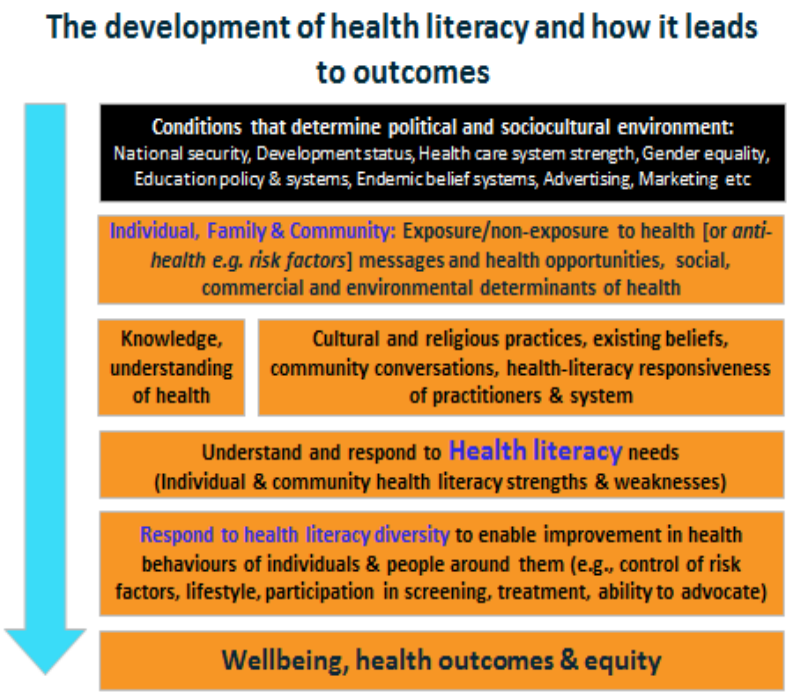
[8] World Health Organization: Health Promotion Glossary. Health Promotion International. 1998, 13 (4): 349-364. 10.1093/heapro/13.4.349.

3 How can health literacy be operationalised in the policy agenda?

There are two contrasting platforms for health literacy policy, one is a *standalone* health literacy policy that seeks to guide cross-sectoral health literacy actions and programs, the other is the *integration* of health literacy principles and practices within existing policy, i.e., within current NCD policy and strategies. A potentially effective way to develop inter-relationship between specific health literacy policies and the overall policy context is the so-called "health literacy by design", embedding health literacy components in programme areas where health literacy is known to be a clear determinant of access, engagement or use of health information and health services. The strongest policy structure may be where there is a combination of standalone and integrated policy. A standalone policy may give health literacy greater profile and thus may attract specific funding, whereas an integrated policy may enable health literacy to be better integrated into practice. Examples of these policy approaches exist in some countries.

- Countries with examples of specific *standalone* health literacy policies: Scotland, USA, Austria, Australia.
- Countries with examples of *integrated* health literacy policies and programmes (e.g., specific Health Literacy Unit, plus policy integration): New Zealand, Myanmar, China, Canada

Figure 1 Overview of the link between health messages, health literacy and health outcomes.



4 Elements of a health literacy strategy

To curb the growing epidemic in NCDs and to meet the SDG targets, bold action must be taken. Key areas for action include:

Member States develop a national policy, strategy and action plan to implement national health literacy demonstration projects, collate local and international evidence, and build capacity among leaders (especially Mayors/Provincial/Community leaders, etc) to contextualize and embed health literacy programs across sectors and levels. To realize the benefits of a health literacy-augmented response to NCDs, dedicated long-term funding and capacity building is required that is aligned with national and context-specific targets.

Build a digital health system that maximises participation, ensuring digital products and processes optimise reach and access, in particular including those with low literacy, disabilities and living in low resource settings. “Access” includes both physical access (i.e. a mobile phone, a computer, internet) and the skills to access, understand, retrieve, appraise and apply digital health-related information. Ensure developers and suppliers meet user, system and interaction requirements within a e-health literacy framework.

Establish national and regional collaborations for action, mandating multisectoral and multistakeholder partnerships to ensure health literacy is integrated within and across sectors. To generate health and equity transformations over the coming decade, decision-makers need to take responsibility and ensure that multisectoral, co-designed processes across sectors such as education, employment, infrastructure, agriculture, industry, migration and others are engaged alongside the health sector.

Strengthen health literacy leadership through generating authorising environments of leaders and political decision makers, particularly through Mayors /Provincial/Community leaders

Build individual health literacy through strengthening the education of children, and through health literacy-informed health promotion campaigns for mothers, families and the general population. Undertake national and targeted health literacy surveys to generate current and contextually relevant interventions to build on health literacy strengths and impact on health literacy limitations of all community members.

Build community health literacy by undertaking detailed assessments of community capacity health literacy, i.e., the community resources (assets), such as new mothers groups, men’s groups, religious groups, etc, are all supported with health literacy development resources in different formats.

Build health literacy responsiveness of the health care system, generating people-centred and inclusive services and practitioners. Provide adequate health literacy training, both at the undergraduate, postgraduate and professional levels. Establish national incentives and awards for health literacy responsiveness.

Build partnerships with academia and industry, and support corporate responsibility to enable community members to access healthy options as the easy/preferred/available option.

5 Specific actions to operationalise health literacy in controlling and managing NCDs

There is a need to build the evidence base around health literacy, particularly to demonstrate the global scope and scale of the impact of health literacy as an asset for investment. The Working group identified five action areas. These are outlined below with specific activities that may be operationalised in low, middle and high income settings.

5.1 Enhance current NCD programmes and policies

Heath literacy is a tool that can be used to improve the reach, impact and effectiveness of current NCD prevention and management programs. The health literacy concept therefore needs to be promoted across health, social and other sectors. Given that current NCD programmes may neither reach all members of the community, nor are effective for all, action needs to be taken so that the '*leave no one behind*' mission of the Shanghai Declaration and the SDGs can be enacted. Health literacy, including digital health literacy, can assist in this mission by being used as a specific tool to improve or enhance the reach and effectiveness of current programmes and policies.

Health literacy capacity of countries, however, needs to be strengthened. This means the inclusion of health literacy tools in routine processes by researchers, programme teams, NGOs and other non-State actors, and by government sectors. The inclusion of health literacy concepts in policy and funding agendas, in particular through mechanisms to ensure communication/education programmes and NCD-specific interventions reach all community members.

It is important that governments take leadership in the development and implementation of health literacy and digital health literacy initiatives in support of impacting on the NCDs and, consequently, on the SDGs. Health literacy messages should be understandable by all members of the community and ideally be developed and delivered in partnerships across sectors and with multiple actors, including industry and consumers.

Below are some practical approaches to enhancing current NCD programmes and policies:

- A specific, and high priority NCD, such as diabetes, cardiovascular disease, cancer, or chronic respiratory disease, can be used as a showcase to demonstrate the role and potential of health literacy in improving programmes to impact on NCDs and provide working examples for other NCDs.
- Diversify the workforce such that non-healthcare professionals are utilized in service delivery settings where consumers are supported in managing their long-term (i.e., NCD) health conditions, particularly in understanding what to do and why, and in setting goals. Non-healthcare professions/community health workers are an important resource as they have the potential to spend more time with people with low health literacy and support their understanding and engagement in self-management.
- Include health literacy goals in clinical management guidelines for the prevention and treatment of people with NCDs. Health literacy approaches, including digital health literacy, need to become integrated into routine health and social service provision

5.2 Improve the reach, quality and impact of new NCD interventions through incorporating health literacy in design and implementation

NCDs have a complex array of interconnected causes, determinants and risk factors, therefore for interventions to be effective they need to be delivered in a range of settings and addressing a range of elements. Many of the causes of NCDs and the determinants of the effectiveness of NCD interventions are likely to be strongly related to health literacy. It is therefore important to establish a multistakeholder platform for the development of any health literacy programme or strategy in order to consider or address as many of these elements as possible so that a range of interventions can be put in place across the causal path ways.

Multistakeholder-designed initiatives are likely to be valuable and necessary when using health literacy approaches that aim at modifying and improving the impact of current programmes and building new interventions. However, while all stakeholders (from individuals to central government) should be encouraged to engage in and co-design context-specific health literacy-informed or digital health literacy programs, clear national leadership is recommended in order to facilitate and accelerate reach and impact and to maximise knowledge sharing and capacity building.

Below are some practical approaches to enhancing current NCD programmes:

- In order to improve the community's ability to find, understanding, use and engage in NCD prevention and management services, the co-design of health literacy-informed interventions should be undertaken with community members in the context in which the interventions are to be applied. This generates a better fit of the interventions / refined services with the community, including opportunities for local ownership and embedding. The NHLDPs (National Health Literacy Demonstration Projects) use the Ophelia (OPtimising HEalth LIteracy and Access) process to enable systematic application of this approach.
- It is important to develop flexible and adaptable health literacy and digital health literacy tools and processes because the health literacy strengths and weakness of both individuals and communities vary. These tools could then be made available for considerations in other countries in similar contexts to more rapidly expand the repertoire of interventions available.

5.3 Make health care systems health literacy responsive

Health Literacy responsiveness is broadly defined as the provision of services, programs and information in ways that promote equitable access and engagement, that meet the diverse health literacy needs and preferences of individuals, families and communities, and that support people to participate in decisions regarding their health and social wellbeing [9,10].

For countries with developing and/or under-resourced health care systems, the critical focus needs to be on two parallel activities; 1) health services actively supporting community members to

[9] World Health Organization, Regional Office for South-East Asia. Health literacy toolkit for low- and middle-income countries: a series of information sheets to empower communities and strengthen health systems. New Delhi, 2015.
[10] Trezona A, Dodson S, Osborne RH. Development of the Organisational Health Literacy Responsiveness (Org-HLR) Framework in Collaboration with Health and Social Services Professionals. BMC Health Services Research 2017

understand available services and their rights of access, as well as 2) strengthening the range of services available and ensuring the accessibility of these services. This work also includes understanding how local cultures and religious beliefs affect access and use of services, and that these are respected and incorporated into the design and provision of services. In line with these priorities, it seems necessary that health literacy should be included in universal health coverage (UHC) service packages.

As health care systems are strengthened, ensuring they are health literacy responsive will increase the quality, reach and equity of services provided. Ultimately, health literacy responsiveness could be incorporated as an indicator within a monitoring and evaluation (M&E) framework, and thus promote continuous quality improvement.

Below are some practical approaches to enhancing health literacy responsiveness:

- Implement programs such as the Agency for Healthcare Research and Quality Health Literacy Universal Precautions Toolkit[11]
- Undertaken regional or national surveys to understand the health literacy needs of the community and how services should respond to the identified needs
- Develop local indicators of health literacy responsiveness
- Incorporate health literacy indicators into M&E framework for health services
- Use health literacy to evaluate the capacity of a health system to control and manage NCDs
- Implement programs that enable an organisation to become health literacy responsive

5.4 Build the health literacy of communities across the life course

Community health literacy, in contrast to individual health literacy, relates to the collective strengths and weaknesses that may be present across a whole community (village, town, region, etc). Individual heath literacy relates to the specific skills and abilities an individual may possess. Community health literacy includes the total number and strength of health literacy-related assets in a community. These assets may include the number of individual community members with strong health literacy and who have influence on what the community believes in and how they behave, the quality of information (oral, written, broadcasts) local services provide, and the health promoting customs existing either as embedded cultural beliefs, religious practices, or social norms. Community health literacy can also relate to the number and availability of physical assets such community gardens, safe places to get physical activity, and physical access to reliable community or medical health services. Community health literacy also includes prevailing beliefs and trust in Western or traditional diagnosis and treatment approaches. A community may have a wide range of both positive and negative community assets that determine health literacy at the individual level.

Building community health literacy on specific topics such as infection control during Ebola or Avian Flu epidemics, or availability of a new service within UHC, can involve specific health education programs and positive effects can be observed over months. However without strong health literacy-informed and digital health literacy approaches, people who are hard to reach, or for whom

[11] Available at https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

the standard health education approach is unsuitable, may be left behind. Long term strategies need to include school curriculum such that health literacy capacity is embedded into the understandings, conversations and action of future generations. A recent illustration of this, at least in part, has been health-health-related critical appraisal training of primary school children in Uganda [12]. School children demonstrated improvement in their ability to assess claims about the effects of treatments from participation in nine lessons during school time.

Comprehensive generation of health literacy across the life course, vital for NCD prevention and control, involves antenatal education for future parents, education for children and adult education opportunities. In many cultures, information in communities is under the control of religious leaders and other community leaders, therefore the development and implementation of effective community health literacy programs will need to involve many stakeholders (see next section).

The building of health literacy or digital health literacy of communities cannot be effectively accomplished using a top-down approach. Modern approaches to community engagement, including the genuine assigning of leadership to local communities is necessary. This is in line with the Shanghai Declaration with the locating of principal leadership among Mayors, Provincial leaders or Governors. The leaders need to be in context, be embedded in the communities, and be responsive to the people they directly serve. In effect, it is the local leaders who are best placed to uncover which health literacy and digital health literacy activities are required. Ultimately, responsibility for action and the autonomy to make decisions needs to be distributed across all stakeholders but following bottom-up prioritization and staying within the agreed framework.

Below are some practical approaches to understanding and enhancing community health literacy:

- Undertake community health literacy surveys and/or community consultation to map community assets and needs.
- Identify strong communal and cultural practices in order to facilitate community engagement.
- Develop and implement programmes to enhance, strengthen and/or develop community level health literacy assets. Use community members as well as local leaders to co-design and implement programmes. Implement through religious leaders, chiefs, elders, teachers, and other local relevant authorities
- Develop, train and support networks of community health workers who are members of local communities who provide local health education, healthcare navigation support and advocacy.
- Apply effective community education campaigns to promote healthy behaviours and dispel myths.
- Use systematic health literacy community intervention approaches such as the Ophelia (OPtimise HEalth LIteracy and Access) process that prioritize local wisdom for intervention development and implementation.

[12] Nsangi et al. Effects of the Informed Health Choices primary school intervention on the ability of children in Uganda to assess the reliability of claims about treatment effects: a cluster-randomized controlled trial. Lancet http://dx.doi.org/10.1016/S0140-6736(17)31226-6

5.5 Capacity building (educators and curricula; healthcare work force competencies; policy makers; researchers)

The capacity of most Governments to use health literacy as a tool to control and manage NCDs, and to respond to the SDG targets, is limited. For national responses to become systematic and effective, capacity needs to be actively built through substantial investments. An overarching response by countries wishing to build capacity will be through the development of effective educational systems for multiple stakeholders, with short term and long term targets, and assignment of accountability across key stakeholders. There are four broad groups that required focused development to increase the capacity of countries to realize systematic health literacy action.

Educational institutions (i.e. schools, technical training facilities, universities) already do some work in support of developing health literacy. School children in many countries receive extensive health education, however, specific programs are an exception. The most fundamental educational requirements are the basic concepts of biomedical health (including anatomy, reproduction, causal mechanisms) with systematic processes to ensure both girls and boys are supported to complete basic education programs. Given that health education curricula are often already crowed, health literacy concepts need to be incorporated into lifelong learning.

The education and training programmes of healthcare workers is a critical component of health literacy and digital health literacy responsiveness. This not only includes medical professionals, but nursing, allied health and community health workers. It is important that all health workers understand and respond to the health literacy diversity in their communities. Irrespective of the health literacy competency of any community member seeking care, healthcare workers need to be able to maximise each individual's chances of understanding, finding and using the health information, treatments and services they need. In most settings, health workers require training, resources and infrastructure to achieve this ambitious goal.

Digital health literacy should also be part of the curriculum at all institutions educating health professionals, providing an understanding of the givers and receivers of healthcare in relation to digital services.

Health literacy and digital health literacy are a relatively new field of research. While there is a growing number of academic publications from some countries (namely USA, Australia, Canada, China, and some countries in Europe), research is often academic project based and not incorporated into main stream initiatives. A recent rapid review of health literacy from Nepal[13] , a developing country, demonstrated that while health literacy has great capacity to impact on the SDGs, there is very little specific research on the topic. A substantial challenge for the field is the need for research on country-wide programs that, although not specifically called health literacy programs, do include numerous health literacy principals and are achieving health literacy outcomes for communities. The most striking example of this are large-scale programs involving village health workers such as those in India, Thailand, Egypt and other countries who are in effect, health literacy workers supporting households with topics such as maternal and child health, HIV/AIDS control and

[13] Available at https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2183-6

Hepatitis C management. In the past five years the breadth of research has greatly increased, as have the number of tools and approaches to apply health literacy in the fields of disease prevention and control. The capacity of researches will rapidly improve in coming years with the increasing recognition that most health literacy interventions are about improving outcomes for people with limited health literacy not about improving health literacy itself.

For the effective development of national and local systems that enable health literacy to be integrated into policy, programs and education systems, policymakers need to understand the relevance of health literacy, understand that it is a determinant of health, and that it is a key pillar for the achievement of the SDGs. Work needs to be done to provide roadmaps and case studies to empower policymakers to take action on incorporating health literacy and digital health literacy into policies and programmes.

Some specific activities arising that will enable capacity building include:

- Health literacy and digital health literacy included in all health professional training
- Government-led revision of curriculum for health care workers to prepare them for multisectoral and multistakeholder action to generate effective public health intervention to achieve the SDG targets.
- Develop local academic-governmental platforms to educate and inform policy makers
- Make use of international platforms (e.g. UN system) to inform parliamentarians/policy makers

5.6 Research & innovation, and the systematic collation and dissemination of this information

There is a need to develop and test evidence-based approaches to understanding health literacy and digital health literacy interventions for NCDs (and their risk factors and determinants), in different settings (from high income to low income countries), and in different cultures such that researchers in all regions of the world are equipped to rapidly build fit-for-purpose and effective interventions to promptly impact on NCDs. Measuring and monitoring health literacy is also critical for identifying progress and groups at risk. This research priority is, in part, being implemented through the WHO GCM/NCD National Health Literacy Demonstration Project initiative with projects already underway in China, Egypt and Myanmar.

Health literacy is one of the three pillars highlighted in the Shanghai Declaration, for health literacy, the Declaration specifically calls for the actions noted above (section 2):

Given the political mandate for health literacy, countries need to establish these as research priorities, and allocate adequate seed funding to promote innovation and substantial long-term funding for scaling up of health literacy initiatives. Specific emphasis must also be placed on digital health literacy and how this can be operationalised. It will be critical that the knowledge base is collated in real time to maximise global learning and to accelerate the generation of effective programs across contexts.

Governments should:

- Promote the establishment of and participate in local and regional communities of practice, including a repository of resources, that inform and support implementation and scaling of health literacy interventions
- Promote and resource the development of trusted sources of information and use current technology and social media to operationalize these
- Enhance the resources for and strengthen the role of academia so that it is not only able to create evidence but also to communicate evidence and evaluate programs.