Health Literacy and the Millennium Development Goals: United Nations Economic and Social Council (ECOSOC) Regional Meeting Background Paper (Abstracted)

UNITED NATIONS ECONOMIC AND SOCIAL COUNCIL (ECOSOC)

Based on the ECOSOC Background Note, prepared by WHO, for the Annual Ministerial Review Regional Preparatory Meeting on Promoting Health Literacy, Beijing, China 29–30 April 2009 and the Report of the ECOSOC Annual Ministerial Review Regional Preparatory Meeting on Promoting Health Literacy

This paper uses a health literacy “lens” to look at key global health challenges, including the achievement of health-related Millennium Development Goals (MDGs) and the reduction of disease burden due to non-communicable diseases (NCDs). Available global evidence is summarized related to: assessment of the impact of health literacy on health and development; identification of measures for reporting progress; exploring ways to strengthen multisectoral collaboration at the national, regional, and international levels to undertake joint actions for increasing health literacy; finding ways to promote better access and use of information through information and communication technology and empowerment; and building capacity for sustained action to increase health literacy. Key action messages are identified. Findings presented informed the 2009 ECOSOC Ministerial Declaration on Health Literacy.

Background

The Annual Ministerial Review (AMR) of the United Nations Economic and Social Council (ECOSOC) was established by Heads of State and Government at the 2005 World Summit. It serves as instrument to track progress and step up efforts toward the realization of the internationally agreed development goals (IADGs), including the Millennium Development Goals (MDGs), by the 2015 target date. The theme for the 2009 AMR was “Implementing the internationally agreed goals and commitments in regard to global public health.” The AMR process features three main elements: national voluntary presentations, country-led regional reviews and a global review, based on a comprehensive report by the Secretary-General. These elements

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were complemented by an innovation fair, a global preparatory meeting, e-forums on the theme and engagement with philanthropic foundation communities in support of the global public health agenda.

As part of the AMR, a regional meeting on health literacy was held in Beijing, China in April 2009. The overall objective of that regional consultation was to support the Council’s deliberations and recommendations in its high level segment meeting on health in Geneva in July 2009. Final recommendations on the need for health literacy development were included in the Ministerial declaration that emerged from the Geneva meeting.

Health-Related Millennium Development Goals and Non-Communicable Diseases

While the level of health literacy in many countries is not known, it is clear that all countries are confronted with a wide range of development and public health priority issues on which health literacy can have an impact. To name a few, these concerns include the achievement of MDGs, the reduction of disease burdens due to non-communicable diseases (NCDs), the effective management of public health emergencies such as Pandemic Influenza, as well as the development of worldwide actions to combat issues that pose a threat to sustainable development, such as climate change.

The Beijing meeting focused on some of the most pressing issues for the WHO Asian Pacific region, such as (1) the achievement of health-related MDGs—the reduction of maternal and child mortality, under-nutrition and HIV transmission in particular; and (2) the reduction of disease burden due to NCDs, through implementation of initiatives such as the Global Strategy on Diet, Physical Activity and Health (DPAS) and the Framework Convention on Tobacco Control (FCTC).

Since the 1990s, progress has been made within the Asia and Pacific region to reduce maternal and child mortality, under-nutrition and HIV infection. Results have been uneven, however. Many women and children continue to die at an early stage of life. In brief, East Asia has seen a considerable decline in the proportion of children under five who die or are underweight. The proportion of maternal death and adult women living with HIV has also dropped in East Asia. However, these proportions continue to be high in Southern Asia and Oceania, where they are among the worst worldwide (UN 2008). Additionally, inequities arising from gender differences and urban/rural divides are not uncommon.

NCDs have become a major public health threat not only in high income countries, but also in low and middle income countries. In many countries in the Asia and Pacific Region, including China, India, Pakistan, and the Russian Federation (WHO, 2005a, p. 44), NCD death rates are now higher than those from communicable diseases, maternal and perinatal conditions and nutritional deficiencies combined. Some 18 million people die every year from cardiovascular diseases, for which diabetes and hypertension are major predisposing factors (WHO, 2002; Hossain et al., 2007). Overweight and obesity have increasingly become prevalent even in low and middle income countries, particularly in urban areas. More than 1.1 billion adults worldwide are overweight, and 312 million of them are obese. In addition, at least 155 million children worldwide are overweight or obese. If a broader definition of obesity is used (adjusted for ethnic differences), the number of people classified as overweight reaches 1.7 billion
(Hossain et al., 2007). The Asian continent concentrates the majority of deaths related to tobacco use. Actions have already been taken to combat NCDs worldwide, notably through the implementation of the NCD Action Plan by WHO (WHO, 2008), amongst other things. Improving health literacy has been highlighted as a key action area in the European Strategy for the Prevention and Control of NCDs and DPAS. Moreover, countries in the Region have adapted the MDG targets and indicators to include NCDs that are most relevant to their country. As such, heart disease was added by Thailand and tobacco use by Indonesia (WHO, 2005a). Health gains have been made through the actions taken so far, but unless those actions are accelerated and broadened, the possibility of meeting the development goals and public health commitments will become increasingly challenging.

**Links Between Health, Education, and Development**

Improved health literacy is considered critical to the achievement of health and development. Examples of success have been found in patient education in clinical settings and in advocacy and community action in community settings across many health and disease issues, including those targeted by the many IADGs and public health commitments. Issues include improving maternal health, reducing child mortality, eradicating child hunger and combating HIV/AIDS, as well as implementing the FCTC and the Global Strategy on Diet, Physical Activity and Health (WHO, 2005a; WHO, 2002a; UK DoH, 2009; Coulter & Ellins, 2007; CSDH, 2007; Guise et al., 2003; Assai et al., 2006; Costello et al., 2004; Ohnishi et al., 2005).

While the link between health literacy and development is not well documented, strong links exist between health literacy and education and also between education and development (Agency for Healthcare Research & quality; UNESCO, 2005). It has been found that health literacy increased with the level of formal education attained (Rootman & Gordon-El-Bihbety, 2008) and that every dollar spent on education could lead to a yield of more than seven dollars (some twelve percent) in return (Patrinos, 2007; University of Phoenix).

**Objectives of the Regional Ministerial Meeting**

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

To this end, the following issues were discussed at the regional meeting:

1. Assessing the impact of health literacy on health and development;
2. Identifying of measures for reporting progress;
3. Exploring ways to strengthen multisectoral collaboration at the national, regional, and international levels to undertake joint actions for increasing health literacy;
4. Finding ways to promote better access and use of information through information and communication technology and empowerment; and
5. Building capacity for sustained action to increase health literacy.
4.1. **Assess the Impact of Health Literacy on Health and Development and Identify and Develop Measures for Reporting Progress**

*Key message:* Scale up effective health literacy interventions in order to accelerate progress towards the achievement of the health-related MDGs and public health commitments, including the consideration of developing a regional action plan to promote health literacy.

**Impact of Health Literacy on Health and Development**

Over the years, there has been evidence of effective interventions to increase health literacy. The evidence largely comes from the United States, however, on patient-focused interventions (Coulter & Ellins, 2007; Rootman, 2004; Pignone, DeWalt, Sheridan, Berkman, & Lohr, 2005). While it was found that the applicability of such evidence outside of the United States might well be questionable (Rootman, 2004), there has also been evidence of effective interventions in some other countries in and outside the Asia and Pacific Region. Education on breastfeeding, for example, has been found to be the most effective single intervention for increasing breastfeeding initiation (Guise et al., 2003). Increased health literacy through improved knowledge, adherence and access to anti retroviral treatment has shown to lead to increased prevention and treatment of opportunistic infections among people living with HIV/AIDS in Thailand (Kumphitak et al., 2007). Mandatory health warnings on tobacco packaging have also been found to increase the number of calls to smoking “quitlines” in Thailand. Well executed social marketing campaigns could also increase public support for key policy changes such as smoke-free public places1. Health education and media campaigns have been found to be effective in reducing tobacco use in India, mainly due to the paucity of information among the population on the impact of tobacco use (Reddy & Gupta, 2004).

In tobacco control, many of the demand reduction strategies were linked to increased health literacy, whereby individuals, organizations and governments were able to gain better access to information on the full extent of the risks of tobacco, and increase their capacity to make fully informed decisions relating to tobacco. Health education through broadcast and print media focusing on body mass index and cholesterol concentrations has been found to be cost-effective in limiting cardiovascular disease by lowering systolic blood pressure and cholesterol (Murray et al., 2003). Health education was also a key strategy used effectively to reduce dietary salt intake in the late 1980s in Japan and China (Iso et al., 1996; Tian et al., 1995). Increased health literacy has also been reported to be effective in preventing diarrhoeal disease in Bangladesh (Jahan, 2000) and in promoting healthy lifestyles in Japan (Yajima et al., 2001), and in a number of countries in the Eastern Mediterranean States through Community Based Initiatives. In increasing physical activity, two informational approaches—community-wide campaigns and point of decision prompts (i.e., signs placed by elevators and escalators)—have been reported as being effective. However, insufficient evidence has as yet been found to conclude that mass media campaigns and classroom-based health education are also effective in preventing diarrhoeal diseases (Zaza et al., 2005).

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1TFI Briefing Note on Health Literacy and Tobacco Control.
Apart from the above-mentioned examples from peer reviewed articles, anecdotal reports indicate that there are a number of successes in countries at different levels of development: for example, in the uptake of immunization to eradicate polio in the Democratic Republic of Congo through media campaign and community mobilization (WHO, 2008b), and in school health and community-based health education through modern information and communication technologies (eLearning) in Egypt and Jordan (WHO, 2004).

Based on available information, the examples of success can be grouped into two broad categories: (1) actions targeted to individuals in clinical settings and (2) actions focused on disadvantaged groups in community settings. In the clinical settings, improvements among patients were made in disease management, medical adherence and service use, essentially in high income countries. In community settings, improvements were made in community participation, mobilization of community resources and creation of opportunities for meeting basic development needs in low income countries (Assai et al., 2006; Costello et al., 2004) and promoting healthy lifestyles, essentially in high income countries (Yajima et al., 2001).

Turning to the lessons learned, the hygiene education component of a project that focused on drinking safe water, the installation and use of latrines and hand-washing to prevent and control diarrhoeal diseases in Bangladesh in the early 1990s has shown minimum positive behavioral changes due to the failure to communicate effectively with the targets of intervention and to field test the intervention message prior to dissemination (Jahan, 2000). In Australia in the early 1990s, the quality of antenatal education classes varied as they differed widely in length, focus and content. Quality concerns were raised about standards of practice, instructor training, and course content (Renkert & Nutbeam, 2000). More recently, it has also been found, in a number of countries studied, that the readability and suitability of the majority of educational print resources related to physical activity were often not adequate, making these resources limited in their effectiveness in affecting behavioral change (Vallance et al., 2008).

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

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

Key message: Develop a country-specific set of recommendations on the core content areas of health literacy and a set of guidelines for undertaking measurement.

There is no data available to determine the level of health literacy in most countries in the Asia and Pacific region. To increase health literacy, baselines, indicators and benchmarks at the individual and community levels need to be developed to inform action and report on progress. Though measures for quantifying health literacy are available, such as IALS (International Adult Literacy Survey), TOFHLA (Test of Functional Health Literacy in Adults) and REALM (Rapid Estimate of Adult Literacy in Medicine), their use is mainly confined to developed countries and effort is still needed to improve the validity and reliability of these measures (Nutbeam, 2000; Kickbusch, 2000). The applicability of these measures to countries with different levels of development, different languages, customs, etc., is also unclear. Moreover, as the way people define and manage health and illness varies from one culture to another, the meaning of health literacy may well also differ. Unless the concept of health literacy and the determinants are known, it is difficult to develop a measure which is valid and reliable.

Baselines, targets and benchmarks for achieving the above-mentioned international goals and agreements will also be required at the impact level, for example in terms of behavioural change and service use. Examples include increase in breastfeeding and use of antenatal services, universal access to sexual education, increase in availability of school meals, reduction in smoking prevalence among young people and women, increase in rates of cessation of smoking, daily activity levels and consumption of fruit and vegetables, and reduced consumption of dietary salt. The development of baselines, targets and benchmarks requires systematic collection of valid and reliable data over time. Moreover, the data collected must be properly used. There are both financial and human resource implications for the collection and use of data, which may be seen as a barrier to data collection and use, particularly in low income countries. Yet the Community Health Audit of Gonoshathaya Kendra, a NGO in Bangladesh, is an example of success that demonstrates how data can be collected and used for reporting progress and achieving accountability, with limited resources (World Bank, 2007).

4.3. Strengthen Multi-Sectoral Collaboration

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

While efforts to improve health literacy and education have mainly been made under the leadership of the health sector, experiences from Healthy Cities and other settings have demonstrated many advantages of involving communities in
the process of health education. More recently, the WHO Commission on Social Determinants of Health has made the case for and supported such a strategy to tackle inequities. A similar social determinants approach can be argued as being effective in tackling the social factors influencing health literacy. In this regard, the active involvement of the local government and participation of people in the wider community is critical, as reflected in the approach being undertaken by Gonoshasthaya Kendra in Bangladesh, in which mechanisms and processes are set for government officials to work in collaboration with the villagers to examine health issues of grave concern, determine responsibility and suggest improvements. Through village solidarity and self knowledge, this process helps to come up with informed answers and avoid repetition of mistakes in the future (World Bank, 2007).

In addition to the health sector, other sectors and actors can make a substantial contribution to developing health literacy, such as (1) the education sector through the curriculum (St Leger, 2000), (2) community-based organizations, such as by Gonoshasthaya Kendra in Bangladesh through the provision of a wide range of health and development programmes, or the World Alliance for Breastfeeding Action through the promotion of breastfeeding, and (3) professional associations, such as the medical and pharmacists associations who take stances against tobacco use, for example.

The business sector has also been playing a role in promoting health literacy through occupational health services. The economic consequences of lost productivity and the shift of the financial burden for medical coverage to employers suggest that the corporate sector will increasingly support these initiatives. Recently, some countries, such as Japan, have subjected employers to fines and penalties for their overweight employees. However, the extent to which the business sector can be engaged in health literacy activities with a focus that may run counter to its interests—for example, the promotion of food items such as baby formula milk (Lal, 2008) and medicines (WHO, 2002b)—should be further explored. While it is important to look at how to engage the business sector to promote health literacy through responsible marketing, for example, it is of equal importance to look at the extent to which the business sector’s involvement will potentially lead to conflicts of interest and, more importantly, the measures that can be undertaken to avoid such conflicts. This has been particularly the case for the tobacco industry.

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

To better inform policy and service development, the views of all the actors need to be sought and their respective roles defined, taking the specific country context into consideration. Though there are different approaches to raising health literacy at the country level, the individual approach (immediate focus of interventions is on

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See, for example, http://www.idrc.ca/fr/ev-127030-201-1-DO_TOPIC.html
the individual’s changes in attitude, knowledge and skills) and structural approach (immediate focus of interventions is on infrastructure and policy change), it is difficult to come up with the right mix and select an approach, unless the views and roles of the relevant actors as well as the country context are known.

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

4.4. Promote Better Access to and Use of Information through Information and Communication Technology and Empowerment

Key message: Actions should be taken to develop and deploy relevant and sustainable national information programmes based on the available technologies in the countries. There should also be collaboration among countries in the region to share best practices. Key indicators should be developed to measure and evaluate the benefits of ICT as a tool for enhancing health literacy in the region.

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

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

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

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

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

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

4.5. Empowering People to Increase Health Literacy—Building Capacity for Sustained Action to Increase Health Literacy

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

Access to information and knowledge is necessary for making decisions on health, but how the information is used is of critical importance. Further, such use is affected by power relations between individuals. Kickbusch argues that it is important to clarify the issue of power in the health literacy debate and maintains that the failure of efforts to promote health literacy, particularly among women in sexuality and reproductive health, was due to the lack of concern for empowerment (Kickbusch, 2000).

To make decisions on their own health and the health of the wider community, in addition to being informed, individuals must be empowered with increased skills and resources, so that they can “apply their skills and resources in collective efforts to address health priorities and meet their respective health needs” (WHO, 1986) and “make governments and the private sector accountable for the health consequences of their policy and practices” (WHO, 2005b).

Communication is not only dissemination of information, but also a means for fostering participation and ownership, facilitating mutual understanding and building trust among key stakeholders (Mefalopulos, 2005), as well as a process of community involvement to “espouse common values of humankind” (Ratzan, 2000). Participation, ownership, stakeholder management, as well as common values of humankind are all elements of participation. Other critical elements include self
esteem, confidence and worth (UNESCO, 2001). Health literacy is a means to empower people to control the factors that affect their health through the acquisition of knowledge and skills in self development and influencing others. Vice versa, empowerment can also help to improve health literacy through advocacy and community action for health (Kickbusch, 2006).

Evidence of interventions that show improved health from empowerment through health literacy is still limited in many countries, particularly in low and middle income countries. However, there are some examples of success, such as those adopted by the Healthy Cities approach and those that promote mutual aid and collective action among individuals in community groups in the Regional Offices in East Mediterranean, South East Asia, Western Pacific and also Americas, which have made a contribution to meeting development goals and public health commitments (Goetz & Gaventa, 2001; Loewenson, 2003; Vega-Romero & Torres-Tovar, 2007).

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

Even when effective interventions are available at low cost, the desired health outcomes will not be achieved if the interventions are not made context-specific, successfully delivered and implemented. For example, child mortality and HIV transmission are not reduced by the respective availability of childhood immunization and antiretroviral drugs per se (UNAID, 2009).

One of the most important barriers to delivery and implementation of effective interventions is the shortage of human resources, particularly in low income countries and remote areas. The shortage of health workers has become the most serious obstacle to implementing national treatment plans and is among the most significant constraints to achieving the health-related MDGs. To overcome the shortage requires, among other strategies, the expansion of village volunteers and traditional health practitioners such as birth attendants and a shift to community-based care (WHO, 2006). Attempts must be made to examine how these community-based and traditional human resources can be used more effectively for health gains. The use of traditional birth attendants has led to an improvement in health, including a reduction in perinatal and maternal mortality as well as perinatal transmission of HIV (Jokhio, 2005; Bultery et al., 2002). The evidence of success in using traditional birth attendants can further be enhanced by better training and health system support strengthening (Kruske & Barclay, 2004). It is also important to prepare the health workforce to respond more effectively to the “new paradigms of care” (WHO, 2006) to combat NCDs, which have become the major disease burden. This can be done through preventive care for example, by doctors prescribing not only medicines but also lifestyle changes, such as physical activity and healthy eating advice, as well as through community-based care by allied health practitioners, such as pharmacists and dentists providing advice on ways to quit smoking.

3Healthy Cities Projects in WPRO; Faces, Voices and Places in PAHO; SEWA in SEARO http://www.searo.who.int/en/Section1174/Section1458/Section2545.htm
4WHO WPRO, Weak health services block progress in Asia and the Pacific.
Apart from a skilled workforce and funding for interventions, the support to be given to the workforce system-wide is of equal importance. A system-wide approach targets the capacity of all of the organizations providing services within the system. The term “capacity” refers to a number of key capacity building areas organization-wide, particularly with regard to the workforce, such as information, leadership, funding, supplies and equipment and coordinated actions of the organizations, as reflected in health system strengthening building blocks (WHO, 2007) and the health promotion capacity wheel (Catford, 2005).

Concluding Remarks

This paper set the scene for the deliberations by the participants at the regional consultations by providing a snapshot of a number of key issues that are important for developing and implementing outcome-oriented health literacy interventions. Through the deliberations, recommendations were made as to how effective health literacy interventions can be scaled up so as to accelerate progress toward the achievement of the health-related MDGs and public health goals and commitments.

Final recommendations on the need for health literacy development were included in the Ministerial declaration which emerged from the Geneva meeting, in July 2009 (see Box 1).

Box 1—UN Economic and Social Council Ministers Declaration July 9, 2009

“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.”

References


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