WHO National Health Literacy Demonstration Projects (NHLDP) for the Control and Management of NCDs

Concept Note for WHO GCM/NCD Working Group 3.3 on Health Education and Health Literacy for NCDs

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Overview and purpose

National Health Literacy Demonstration Projects (NHLDPs) launched by WHO GCM/NCD, aim to advance international health literacy practice in support of accelerated progress in countries towards realizing high-level commitments for the prevention and control of NCDs. In order to better fulfil the commitments of Shanghai Declaration from 9th Global Conference on Health Promotion, and also the Beijing Declaration from the “Belt and Road” Forum, the NHLDPs seek to build a pathway for a better, healthier future for people all over the world. Systematic development, implementation and scaling of NHLDPs across nations will build the necessary local, regional and inter-regional knowledge base to accelerate global progress towards meeting the UN Sustainable Development Goals (SDGs).

It is necessary for all Member States to underpin actions towards the SDGs with the three pillars identified in the Shanghai declaration. Of these, health literacy is a critical element to ensure all actions structurally and systematically seek to fulfil the SDG commitment to “leave no one behind”.

The purpose of this Concept Note is to call for Expressions of Interest (EOI), initially from WG 3.3 members, and then more broadly across Member States, to undertake a NHLDP in their country.

A short term goal is to mobilise members of the WG3.3 to implement projects and build local capacity in health literacy. In the longer term, the NHLDPs, across member states and regions, will build capacity for developing and implementing systematic regional and national health literacy action plans.

Member States wishing to consider undertaking a WHO NHLDP should consult the NHLDP Prospectus (Attachment 1).
Background

The 9th Global Conference on Health Promotion delivered the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development. This declaration commits to three pillars to structure effective actions towards achieving the SDGs. The pillars are 1) Good governance, 2) Healthy cities and communities, and 3) Health Literacy. With this mandate, member states have committed to undertake the following actions in the area of Health Literacy:

- Recognize health literacy as a critical determinant of health and invest in its development;
- Develop, implement and monitor intersectoral national and local strategies for strengthening health literacy in all populations and in all educational settings;
- Increase citizens’ control of their own health and its determinants, through harnessing the potential of digital technology;
- Ensure that consumer environments support healthy choices through pricing policies, transparent information and clear labelling.

These high-level commitments require health literacy programs to be developed, implemented, scaled-up and monitored such that real improvements are observed at the individual, family, community, city and regional levels. They also need to be designed and implemented in such a way that they become embedded across policy, including structurally integrated in to Universal Health Coverage (UHC).

It was proposed that NHLDP should go beyond theory and measurement to generate evidence on how health literacy can inform interventions that can be efficiently developed and applied across contexts, cultures and health care systems to improve health outcomes and reduce health inequities:

- The interventions should seek to impact on the management of NCDs and their shared risk factors.
- The projects should focus on underserved groups and groups with low health literacy who have, or are at risk of, NCDs.

The NHLDP should be consistent with the WHO Global Action Plan for the prevention and control of Noncommunicable Diseases 2013–2020, the 2030 Agenda for Sustainable Development and the objectives of the Shanghai Declaration. The Shanghai Declaration recognizes 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.” Therefore, consistent with the Shanghai Declaration:

i) It is important that the NHLDPs consider health literacy as a determinant of health, and that these determinants arise from a wide range of factors. The NHLDPs should consider and promote Good Governance, including multisectoral and multistakeholder engagement with local, regional and national level authorities and agencies, and make full use of the mechanisms available to governments to protect health and promote wellbeing through public policies. Good Governance includes a Health in All Policies approach, that will underpin effective and sustainable health literacy interventions at all levels (individual, local, regional, national, international).
ii) The NHLDPs should be implemented in contexts of everyday life - in the settings, neighborhoods and communities where people live, love, work, shop and play – thus generation Healthy Cities and Communities. Leadership at the Province / Municipality / Mayoral levels is critical to ensure local relevance, ownership and embedding health literacy-related solutions that respond to the full range of needs of local communities.

iii) Health literacy is used as a tool to understand relative strengths and weaknesses, at both the individual- and community-levels, to enable services and systems to be responsive to the health literacy needs of the community, and to engage in collective action that addresses NCDs and their shared risk factors and relevant determinants of health.

Members of WG3.3 on Health Education and Health Literacy are invited to nominate a WHO NHLDP Site and focus on one or more NCDs and/or their shared risk factors. NHLDP sites will use best practice tools such as those outlined in the WHO SEARO Health Literacy Toolkit for Low- and Middle Income Countries. They will commit to undertake process and outcomes evaluation to inform the WG in the practical operationalization of health literacy.

Projects may focus, broadly on:

a) using health literacy to **improve current programs or to develop new programs** to reduce the gap between those with and without the resources needed to access, understand, appraise and use information and services;

b) using health literacy **to empower communities and/or individuals** (considering the continuum from highly communal societies to more individualistic societies) to make decisions and engage in healthy behaviors and access appropriate services;

c) **improve health education and service provision** including stakeholder outreach, engagement and commitment; and

d) scaling up best practices and strategies in organizations **to ensure organizations are responsive to the health literacy needs of the communities they serve**, including through sustained improvements to practice, culture and policy.
Establishing a WHO NHLDP

Given that the context and needs of individuals and communities, societal structures and healthcare systems differ so much across WHO Member States, a NHLDP guidance document cannot be prescriptive regarding the actual intervention/service improvement actions to be applied. However, the careful implementation of a project within strong guiding principles is important.

The WHO-SEARO Toolkit outlines eight principles for health literacy interventions that align with the foundations of good practice in development, the SDGs, and the Shanghai Declaration. These include: a focus on health outcomes; equity driven; a focus on locally-identified health literacy needs; dynamic response to the evolving local health literacy needs; multistakeholder engagement for shared identification, development and implementation of solutions; driven by local wisdom culture and systems; systematically applied; and sustainable. These principles were derived from extensive community engagement and implementation of specific health literacy interventions¹.

Overview of setting up a WHO NHLDP

The resources required for initiating, negotiating, training, implementing and evaluating an NHLDP are the responsibility of the Project Sponsor – i.e., the institution, Member State or other relevant stakeholder seeking to establish a site. A Project Sponsor must be defined at the nomination stage. The Project Sponsor is responsible for funding all aspects of the project and they will lead, drive and implement the NHLDP in their respective jurisdiction.

Executing a NHLDP involves multidisciplinary and multisectoral engagement, and requires specific skills in health promotion/public health, including facilitation of stakeholders to obtain local and regional information of health literacy needs, intervention co-design and implementation. It is expected that on-the-ground staff of Demonstration Projects will require specific training in some of the processes. Teams with extensive experience in quality improvement and/or health promotion and development may require minimal training.

The WHO-SEARO Health Literacy Toolkit outlines the Ophelia process, which is based on well-established processes used in health promotion, public health and development more broadly². The Phases of an Ophelia health literacy project are outlined below.

Health literacy data are collected from a representative sample of the target population. Data are presented to stakeholders for interpretation. Effective local practices and innovative solutions are identified.

Health literacy interventions are applied as quality improvement cycles where organisations implement trials and actively improve the effectiveness, local uptake and sustainability of the interventions.

Phases of the Ophelia approach

**Phase 1**: Identifying local strengths, needs and issues
- Health literacy data are collected from a representative sample of the target population. Data are presented to stakeholders for interpretation. Effective local practices and innovative solutions are identified.

**Phase 2**: Co-design of interventions
- Local stakeholders make decisions about priorities for action. Interventions with potential to respond to local health literacy needs or improve information and service access are designed and planned.

**Phase 3**: Implementation, evaluation and ongoing improvement
- Health literacy interventions are applied as quality improvement cycles where organisations implement trials and actively improve the effectiveness, local uptake and sustainability of the interventions.

**Steps for each phase**

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**Specific activities may include the following:**

1. Define target condition(s) among the NCDs e.g., Cardiovascular health and risk factor modification
2. Identify setting, e.g., municipality(s) with a high proportion of people with low education and high prevalence of CVD risk factors
3. Engage 4 to 6 communities to work together to generate, apply and evaluate health literacy-informed intervention(s).
4. Undertake health literacy needs assessment using a suitable questionnaire (Information Sheet 10 in the Toolkit). The needs assessment relies on a health literacy questionnaire that identifies specific health literacy strengths and weaknesses of individuals and communities. The Toolkit identifies two questionnaires designed for this purpose; the Health Literacy Questionnaire (HLQ) and the Information and Support for Action Questionnaire (ISHAQ designed for communal cultures / developing healthcare systems). Administer the questionnaire to 80 to 100+ people in each community (the number varies according to the diversity of the community and local requirements to understand health literacy needs more broadly).
5. Using the data collected and analyzed in Step 3, develop and document case studies of typical community members. These case studies are then used in workshops and other
consultations with community members, practitioners, managers and policy makers to co-design health literacy interventions. Undertake 1 to 2 workshops for each stakeholder group in each community.

6. The intervention ideas are organized into cogent intervention plans across the system using the framework below to ensure the health literacy interventions are applied to and impact the whole system. See Figure 1 below.

7. Careful consideration of local customs, care pathways, beliefs and misbeliefs, the range and type of available services and providers, and their costs, all need to be considered.

8. Select a range of doable interventions and apply these within quality improvement cycles (i.e., PDSA - Plan-Do-Study-Act) cycles.

**Figure 1: A framework for health literacy interventions with health and community organizations**

- **C1: Changes in organization:**
  - Prioritization of responding to diversity (including outreach and intake procedures)
  - Systematic processes to support access
  - Systematic processes to respond to diversity (and to enable staff to do so)

- **C2: Changes in staff:**
  - Knowledge about health literacy
  - Knowledge of HL diversity in their community
  - Skills and knowledge of good practice

- **C3: Changes in community engagement:**
  - Activate and equip change leaders
  - Sustainable mutual support
  - Activating diverse groups

- **C4: Changes in client groups:**
  - Increased health literacy
  - Increased mutual support in accessing and using health information
  - Improved access and health related behaviours

**Evaluation**
A standard evaluation framework will be provided to guide the NHLDPs in Step 5 (Phase 2) of the Ophelia process. The evaluation framework will support rapid knowledge transfer from the field to the CoP. The evaluation will be both about the process (setting up and running the intervention) and outcomes (impact on NCD risk factors and disease management).

The WG will jointly oversee the implementation of the 2-4 NHLDPs in 2017. Moving to the mid-to-longer-term objective outlined at the outset of this concept note, new NHLDPs will be enhanced and scaled-up through the CoP (beyond 2017). This longer-term objective will also include the identification of new implementing partners and resources through the CoP.

**Resources and materials**
The recommended methods for setting up and running the NHLDP will be provided in resource materials which include:

- WHO/SEARO Deakin Health Literacy Toolkit for Low and Middle Income Countries
- Technical protocol (BMC Public Health Batterham et al 2014)

Face-to-face training can be provided by Deakin University at a cost-recovery basis. The content and location of training can be negotiated on a case-by-case basis, and preferably
undertaken at a regional level in support or developing regional expertise. The aim of the training should be to build local, sustainable capacity for ongoing health literacy work.

The most effective training model for health literacy intervention development using the model above will vary from site to site. Some NHLDP may elect to commence training in Step 1 of Phase 1, while other sites with greater capacity for project design may arrange training to commence after NHLDP sites have already collected the health literacy needs assessment data (i.e., with HLQ), and the onsite training is provided by the facilitator over a few days.
Timeframe for running an Ophelia project

Phase 1: Steps 1 to 3

Step 1: Project set-up
Purpose: To define the project aims and scope, and to identify staff who will be involved.
Time frame: 1 to 2 months

Step 2: Data collection and/or extraction
Purpose: To source local data and use this to identify local needs, strengths and issues.
Time frame: 2 to 3 months

Step 3: Response ideas consultation
Purpose: To identify effective local practices and innovative intervention ideas.
Time frame: 1 month

Phase 2: Steps 4 to 6

Step 4: Intervention design
Purpose: To identify intervention elements and how they might produce the desired outcomes.
Time frame: 1 to 3 months

Step 5: Intervention planning
Purpose: To identify who will deliver the intervention, when, how, and using what materials.
Time frame: 1 to 3 months

Step 6: Intervention refinement
Purpose: To test and refine intervention materials and processes.
Time frame: 2 to 4 months

Phase 3: Steps 7 and 8

Step 7: Implementation and evaluation
Purpose: Apply interventions, and evaluate outcomes and processes.
Time frame: will vary according to the intervention; 2-3 months is suggested for observing change in short to medium-term outcomes.

Step 8: Development of an ongoing quality improvement strategy
Purpose: Develop and embed mechanisms for continuously improving intervention effectiveness, uptake and sustainability
Time frame: Ongoing