

# Improving health literacy in refugee populations

We must ensure that people of refugee background have the confidence, support and resources to manage their health

**H**ealth literacy is defined as the degree to which an individual can obtain, communicate, process and understand basic health information and health services to make appropriate decisions about their health.<sup>1</sup> Low health literacy is inextricably linked to poor health outcomes. Individuals with limited health literacy have higher rates of illness and more hospitalisations.<sup>2</sup> Acquiring good health is a process that requires access to health care and health knowledge to inform positive health behaviour coupled with ongoing access to necessary resources.

The refugee experience is often characterised by displacement with limited access to services and basic necessities. For resettled refugees, low health literacy can be expected as they navigate a new country, language and culture. The stressors of cultural and language differences, and securing housing and employment may exacerbate trauma, leading people to feel isolated and helpless, with attendant symptoms of sleeplessness, poor concentration and emotional issues. The psychological effects of trauma may be long term and experienced intergenerationally.<sup>3</sup> Many may have had disrupted education owing to protracted time in precarious living situations, so it cannot be assumed that they have reading ability in their own language. Further, due to displacement and changes in family composition, traditional ways of sharing health information may be fragmented.

Such experiences have a profound impact on the way people engage with health information, health care services and preventive health activities.<sup>4</sup> Being clear about the role of health services and health care providers, and explaining the purpose of appointments, benefits of preventive activities and recommended treatment regimens may assist. The situation is complex — a standard knowledge base cannot be assumed, precaution is necessary and the provision of information needs to be modified.<sup>5</sup> Clinicians could mindfully adapt their skills to care for this population; however, we recognise that the provision of information is not necessarily straightforward. Our research found little consistency in the approach that maternity care providers take to providing health information.<sup>6</sup> Afghan families reported that they mostly received brief verbal information, a few received written information in their own language, and some had seen pictorial information. Many sought information and advice from family members overseas, and several obtained information from the internet.

Providing the best possible standards of professional interpreting requires systems to facilitate access, training



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and practice.<sup>7</sup> Enabling people to communicate freely in their own language supports the development of trust, respect, rapport, cultural safety and relationship-centred care.<sup>8</sup> The role of interpreters is to provide a language service with strict parameters with no ongoing relationship. Bicultural workers, however, may assist people to navigate health services, get to appointments and negotiate expectations. They also act as an aid for clinicians to understand differing health beliefs and social circumstances that may affect decision making. Bicultural workers provide a bridge to reduce the social distance that often exists between health professionals and clients.

The health care setting offers a dynamic learning environment in which clinicians are in a key position to improve health literacy.<sup>9</sup> A tool that encourages two-way participation is teach-back. Teach-back is an evidence-based communication strategy that requires health professionals to ask the individual to repeat back what

they have explained but in their own words. It is not a test of the individual's memory.<sup>10</sup>

Some health literacy advocates suggest that assessing health literacy is an important step in addressing health disparities.<sup>2</sup> However, this has the potential to create shame and stigma. Many measurement tools do not inquire about the full scope of health literacy and are narrowly focused on reading, writing and numeracy deficits. If applied, assessments need to be completed in the context of relationship-centred care.<sup>8</sup>

The health system needs to support clinicians to adopt novel ways of responding to low health literacy.<sup>11</sup> A health-literate organisation is defined as one that makes it easier for people to navigate, understand and use information and services to take care of their health.<sup>12</sup> A health-literate organisation would recognise that refugees may have concerns that are perceived as more immediate than their personal health status.<sup>13</sup> People of refugee background are often worried about finances, learning English and family members who remain in dangerous situations. To support clinicians working with diverse communities, health services need

*“Low health literacy is inextricably linked to poor health outcomes”*

to develop stronger local service partnerships that broaden access to existing community and local resources.

We believe that improving health literacy in this population involves much more than access to information — it is about people having the confidence, support and resources to manage their health. Health literacy in refugee populations could be tackled by multifaceted, multidisciplinary interventions and policies that are responsive to these unique circumstances.<sup>14</sup>

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