Health Literacy in Five Immigrant Populations in Norway: Pakistan, Poland, Somalia, Turkey, and Vietnam

English summary

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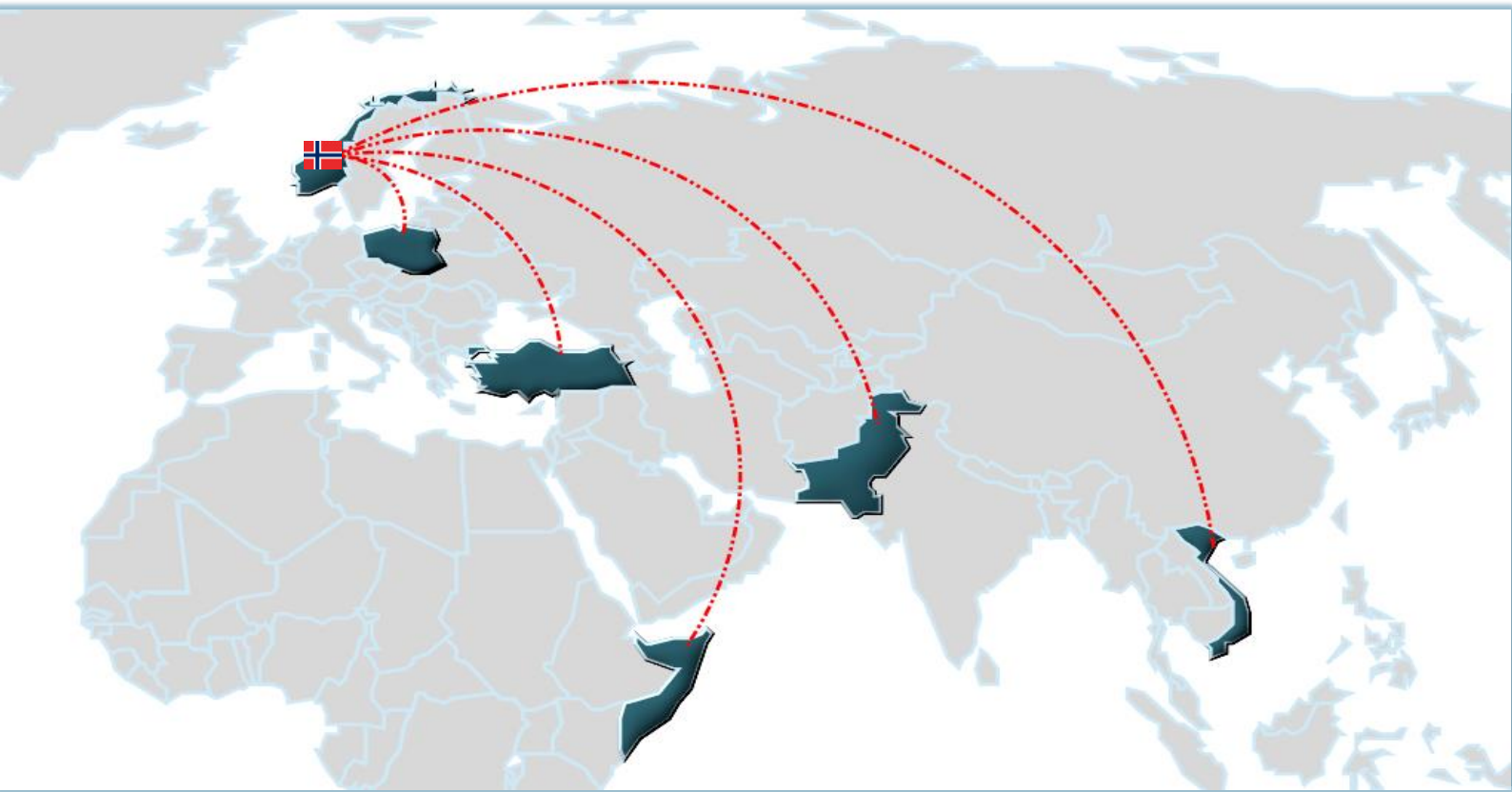

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https://www.helsedirektoratet.no/rapporter/befolkningens-helsekompetanse

Summary

The report *Befolkningens helsekompetanse, part I* was published in January 2021. The present part (Part II) describes health literacy in five immigrant populations in Norway: immigrants from Pakistan, Poland, Somalia, Turkey, or Vietnam. The findings indicate the need for initiating short-term and long-term interventions aimed at immigrants in Norway.

The objective of the HLS_{19} survey project was to obtain new evidence in support of authorities' policy-based interventions to strengthen population health literacy. It is known that segments of the Norwegian immigrant population have public health challenges and experience barriers when interacting with health services, making it essential to collect data on various health literacy aspects among immigrants. Thus, HLS_{19} in Norway was expanded to include five immigrant populations with a background from Pakistan (*n* = 200), Poland (*n* = 400), Somalia (*n* = 379), Turkey (*n* = 352), or Vietnam (*n* = 402). The data was collected using two different sets of questionnaires (from 1733 persons in total). We only applied one set of the questionnaires to collect data from the Pakistani sample.

Challenges

Reaching a sufficient number of respondents with an immigrant background is relatively challenging in Norway. It is also challenging to analyse data collected from diverse population groups, and it is difficult to translate a questionnaire into diverse languages. This is due to factors such as linguistic nuances, usage and content of concepts and terms, and the fact that cultural background influences how people interpret and understand questions. It is striking, for instance, that respondents with a background from Somalia report a higher level of health literacy than the general population and other immigrant populations, especially in the light of the shorter duration of their residence in Norway, the smaller proportion with high educational attainment and relatively disadvantaged living conditions. It is difficult to account for this phenomenon, but conditions in the country of origin may have influenced their responses.

Vaccines and vaccination

Against the background of the ongoing COVID-19 vaccination programme, we draw particular attention to the fact that people with a background from Pakistan, Turkey, or Vietnam reported greater difficulty in *finding* and *understanding information about vaccines*, as well as *judging* and *deciding which vaccines they need* (see page 50-52) than people from the general population. Immigrants with low economic status, measured by their ability to pay bills and meet expenses, find this even more difficult than others.

Among immigrants from Pakistan or Poland, a large proportion of those with limited oral language proficiency in Norwegian, and/or who have difficulty understanding written information in Norwegian, reported that it is (very) difficult to *deal with and process information about vaccines*. Among immigrants from Poland or Turkey, a higher proportion of males than females stated that they find this (very) difficult.

Health literacy in five immigrant populations

Compared to the sample of general population, where 1 in 3 were at or below the lowest level (level 1) of general health literacy, a larger proportion of immigrants with a background from Turkey or Vietnam are at this level. Somewhat unexpectedly, a lower proportion of people with a background from Pakistan, Poland, or Somalia are at the same level. People who score at or below this level will have limited options to deal with and process health information. Immigrants appear to experience challenges especially in finding information about treatments of illnesses. This type of information should thus be made more accessible, such as by translating it into different languages. Furthermore, it will be important to identify the best information channels for reaching the different target audiences. In order to encourage user participation and adapt information, immigrants should to a greater extent be involved in compiling information materials and planning various information campaigns.

In most samples of immigrants, low health literacy is associated with low educational attainment and low economic status. Here, low educational attainment means no education beyond upper secondary education, and economic status is measured by the ability to pay bills and meet expenses. It is uncertain whether the respondents based their responses on their familiarity with the Norwegian health services, or on their experiences with the health services in their country of origin. It is thus possible that the challenges posed by low-level health literacy could actually be even more severe than assumed in their interaction with the Norwegian health services.

Compared to the general population, a higher proportion of the Turkish sample score lower within the *Health promoting domain* – i.e., finding, understanding, appraising, and applying health information in health-promotion contexts. People with low scores will typically experience challenges in assessing how living conditions might affect their health and well-being, in making decisions to improve their health and well-being, and in influencing the living conditions that affect health and well-being. In our samples, immigrants' health literacy within the *Health promoting domain* is associated with economic status (Pakistan, Turkey, and Vietnam) and age (Pakistan).

Within the *Disease prevention domain*, which refers to disease prevention contexts, a higher proportion of immigrants with a background from Pakistan, Turkey, or Vietnam score less well than the general population. There appears to be a pattern whereby health literacy in this domain is associated with education and economic status (Pakistan, Turkey, and Vietnam).

Within the *Healthcare domain* – which concerns finding, understanding, appraising, and applying health information as a user of health services, people with a background from Turkey or Vietnam score less well than for the general population. People whose score is low within healthcare contexts are likely to have problems understanding what a doctor says, finding information about treatment of illnesses, and understanding information about what to do in a medical emergency. The score within the *Healthcare domain* seems to be associated with educational attainment (Poland and Vietnam) and economic status (Turkey and Vietnam).

Digital health literacy in the immigrant population

Limited *general digital skills* make it difficult to find quality-assured *digital health information* that promotes health and prevents disease, to gain proficiency in using *digital health services,* and to use electronic resources for following up on personal health and illness. Limited *digital health information* skills can have an excluding effect in terms of non-access to new and up-to-date health information. Conceivable consequences are reduced opportunities for achieving their health potential and an increased likelihood of health loss and thus exclusion from the labour market, and limited finances are in some cases associated with poor health literacy. People who can find, understand, appraise and apply *digital health information* in health-related decision-making, are probably better equipped in a lifelong perspective.

In our samples, immigrants show extensive adoption of digital online devices, yet spend less time searching for health information than the general population. Nearly 30% of both males and females in the immigrant samples stated that they "never" searched for health information on the Internet. Skills in searching for *digital health information* vary with educational attainment. Compared with the sample of general population, people with a background from Turkey or Vietnam report a lower level of *digital health information* literacy.

Immigrants in our samples report significantly lower *general digital skills* than the general population, and *general digital skills* in immigrant groups vary with age, level of educational attainment, economic status, and long-term illness. Limited *general digital skills* make people less prepared to use *digital health services.* Immigrants' readiness to use digital health services appears to vary with level of educational attainment and economic status, age (applied to people with a background from Poland or Vietnam) and long-term illness (applied to people with a background from Poland or Turkey).

Ability to navigate the health service

Immigrants are surprisingly "well" informed about the structure and workings of the Norwegian health service (navigating at system level), and how to access the services they wish to use (navigating at organisational level). According to the insight report "Life event New in Norway" and the source data it relies on in "Information gathering for the Life Event New in Norway" (see the chapter on navigating the health service), practical information about health and the Norwegian Labour and Welfare Administration (NAV) is provided to newly arrived immigrants, and this may include information about responsibilities and rights, various public health services and the structure of the health service. However, the ability to navigate the health service seems to be associated with economic status, and in some immigrant groups, this navigational literacy correlates with long-term illness (Turkey and Vietnam).

The questions concerning "navigation health literacy" may be regarded as inquiring into relatively advanced skills, and the analyses indicated that the type of language influenced the responses to certain questions. The findings must thus be interpreted with caution, and inter-group comparison is problematic. This phenomenon should be investigated further in qualitative cohort studies.

Ability to communicate with healthcare professionals

The questions included in the construct "ability to communicate with healthcare professionals" concern skills for engaging actively in dialogue with healthcare professionals in order to make sound decisions concerning health. Immigrants in our samples, except for the people with a background from Somalia, report having poorer communication skills than the general population. With the exception of people from Somalia, the communication skills of immigrants are associated with their level of educational attainment and economic status. In some immigrant groups (Poland and Somalia), there was also an association between age and skills in communicating with healthcare professionals, where elderly individuals reported poorer skills. Among people with a background from Poland, males report somewhat poorer communication skills than females, and older people report poorer skills than younger individuals. The latter also applies to people with a background from Somalia.

Health costs and health-related quality of life

General health literacy correlates with the number of GP consultations and with health-related quality of life, as measured by the EQ-5D-5L questionnaire, which measures overall health and health-related quality of life. Health literacy is correlated with the number of GP consultations for people with a background from Pakistan, from Somalia, or from Turkey, and for all five immigrant groups as a whole. For people with a background from Pakistan, from Turkey, or from Vietnam, health literacy correlates with health-related quality of life. This also applies to the five immigrant groups taken as one and to the sample of the general population. Health literacy appears to be stronger associated with the number of GP consultations and health-related quality of life in immigrant samples than in the sample of general population.

Possible implications

For the first time in Norway, we now have a report presenting evidence of the *health literacy* in five immigrant populations. The data can provide a basis for preparing and implementing evidence-informed interventions for groups with specific health literacy challenges, such as people with low educational attainment and people with low economic status. In order to gain broader and deeper evidence of immigrants' health literacy in Norway, more quantitative and qualitative research should be initiated – as well as research directed at populations other than the five discussed in this report.

This report may also provide a basis for assessing organisational and communication-related changes in the Norwegian health services in order to strengthen and further develop health communication between institutions and individuals. Such adaptations are a prerequisite for achieving the goal of "the patient's health service".

Educational institutions are responsible for providing students with education in health literacy. This report (Part I and Part II) may support the development and formulation of intended learning outcomes within health literacy (cf. National Curriculum Regulations for Norwegian Health and Welfare Education (RETHOS), the implementation of which is being evaluated by NOKUT (Norwegian Agency for Quality Assurance in Education)), and the implementation of the interdisciplinary topic *public health and life skills* in compulsory school (cf. the 2020 educational literacy reform (*Kunnskapsløftet 2020*)). Secondary and upper secondary schools should develop adolescents' proficiency in health literacy, such as how to prevent transmission of infectious diseases, identify examples of a healthy lifestyle and taking on a critical approach to sources of information. The implications proposed are supported by the empirical evidence

of this report but have also emerged in the wake of the experiences gained by the Norwegian health authorities from communicating COVID-19 information to both immigrant groups and the general population.

Further interventions are needed for adapting health communication to the varying level of (digital) health literacy among immigrants in Norway, and in order to increase immigrants' digital skills. More information needs to be disseminated in the different languages that immigrant populations are most proficient at. Good examples of user-adapted digital platforms with linguistic adaptations, such as fully translated information pages with audio files in different languages, include www.zanzu.no.

The attainment of (digital) health literacy should be considered a natural component and success factor in ongoing national development processes. Digitalisation of the public sector is one example where Norway needs to take into account factors such as the population's digital health literacy and general digital skills. This is particularly the case for target groups undergoing the complex life event of being "New in Norway". Furthermore, the health literacy focus should be integrated in established "healthcare communities" (helsefelleskap), the aim of which is to improve healthcare cooperation between hospitals and local authority primary care. The concept of "healthcare communities" is designed to realise "the patient's health service" which must necessarily be founded on a health literacy-friendly organisational model. A health literacy-friendly health service/institution/organisation makes it easier for users to navigate and use health information and health services in order to attend to their own and relatives' health.

In its letter of allocation for 2020 to the Directorate of Health, the Norwegian Ministry of Health and Care Services tasked the Directorate with conducting a national survey of health literacy-friendly organisations (within the frameworks of the M-POHL action network). This forthcoming survey will form an evidence-informed basis for further development of the health literacy-friendliness of health services in Norway.

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