REPORT

PROMOTING HEALTH LITERACY AND HUMAN RIGHTS TO REDUCE STIGMA AND DISCRIMINATION

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Promoting health literacy and human rights to reduce stigma and discrimination

The AI programme Perplexity has been used for language editing and support in the analysis of health literacy and human rights concerning stigma and discrimination in eight population groups.

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EXECUTIVE SUMMARY

Health literacy in Europe is constrained by the fact that a substantial proportion of the population, often estimated at around one-third to nearly half of adults, has limited capacities to access, understand, appraise, and apply health-related information, which in turn undermines effective self-care, healthcare, disease prevention and health promotion.

This health literacy challenge is not evenly distributed: it clusters in groups facing financial deprivation, low education, older age, and immigrant or minority backgrounds, reflecting a marked social gradient that reinforces existing health inequities. Moreover, complex health information, medical jargon, and rapidly expanding digital channels often exceed people's skills, making it difficult to navigate services, evaluate online content, and engage in shared decision-making with professionals.

Health literacy is not merely a public health concern but a fundamental human rights imperative since it is a gap that disproportionately impacts people in vulnerable situations and violates their right to the protection of health enshrined in the Revised European Social Charter (Article 11), the European Convention on Human Rights (Articles 2, 3, 8), and the Oviedo Convention on Human Rights and Biomedicine. The Revised European Social Charter establishes a direct right to health protection. The European Convention on Human Rights protects health indirectly through fundamental rights such as life, dignity, and privacy, and the Oviedo Convention ensures ethical and human-rights-based governance of medicine and biomedicine.

Stigma and discrimination create profound barriers to health literacy and human rights for e.g. Roma communities, persons experiencing homelessness, persons with disabilities, migrants, LGBTI+ individuals, detained persons, older persons, and youth. These barriers manifest as language exclusion, culturally insensitive healthcare, inaccessible information formats, systemic discrimination, and denial of services based on housing status or appearance that prevent effective exercise of health rights. The COVID-19 pandemic starkly illuminated these inequities: countries with higher health literacy achieved better public compliance and vaccine uptake, while vulnerable populations faced heightened risks due to digital divides, misinformation, and institutional shortcomings.

This report presents an analysis of low health literacy, stigma and discrimination in eight population groups. The insights are used to suggest a governance agenda to promote health literacy and human rights to reduce health stigma and discrimination.

Coordinated action across Council of Europe member states to eliminate stigma, empower vulnerable populations, and guarantee equitable access to health information and services, is recommended. Closing health literacy gaps is essential to upholding human dignity, reducing health disparities, and fulfilling the Council of Europe's mandate to protect the most vulnerable in our societies.

INTRODUCTION

Health literacy entailing the capacity to access, understand, appraise, and apply health information to inform and make decisions to manage health and well-being, is not merely a public health concern but a fundamental human rights imperative[1]. Across Europe, nearly half the population struggles with inadequate health literacy[2], a challenge that disproportionately impacts people in vulnerable situations and violates their right to the protection of health enshrined in the Council of Europe's Revised European Social Charter (Article 11), the European Convention on Human Rights (Articles 2, 3, 8), and the Oviedo Convention on Human Rights and Biomedicine[3–5].

In Germany, the second national Health Literacy Survey found that 58.8% of adults had limited health literacy[6]. In the Netherlands, a study of health insurance literacy showed that people with lower general health literacy scored significantly lower on health insurance literacy and relied on fewer information sources, underlining that many citizens struggle to compare policies and make informed choices in a managed-competition system.[6,7]

In Denmark, a large population-based survey of more than 29,000 adults found that between 8.8% and 20.2% of people perceived specific tasks related to understanding written health information or actively engaging with healthcare providers as "difficult" or "very difficult," with the lowest scores concentrated among those with low income, low education, living alone, or of non-Danish ethnicity. In Southern Europe, a 2021 nationally representative Italian survey of 3,500 adults reported that around 40% of respondents had inadequate or problematic health literacy, and these lower levels were strongly associated with poorer financial status, foreign nationality, older age, and unhealthy lifestyles such as physical inactivity and smoking, highlighting the combined impact of social disadvantage and behavioral risks[8].

Health literacy and human rights are deeply interconnected when it comes to stigma and discrimination[1]. Importantly, health literacy is not only about people's ability to read and understand health information but also a matter of whether societies create fair conditions that enable everyone to access, understand, appraise, and use information to protect their health. When these conditions are absent, the burden is shifted onto individuals, and those already in vulnerable situations are disproportionately harmed[9,10].

From a human rights perspective, the right to the protection of health requires states to ensure that information, services, and systems are available, accessible, acceptable, and of good quality for all, without discrimination[11]. Stigma and discrimination undermine each of these dimensions. When e.g. Roma, homeless persons, people with disabilities, migrants, LGBTI+ persons, detained people, older people, and youth are stereotyped, ignored, or mistreated in health settings, they face additional barriers to information, communication, and trust. These barriers prevent them from understanding their options, participating in decisions, and seeking timely care, thereby obstructing the effective exercise of their right to the protection of health[12].

Stigma operates at multiple levels such as internalised, interpersonal, and structural levels[13,14]. In health systems, it may appear as dismissive attitudes, failure to provide interpreters or accessible formats, segregated services, or policies that implicitly exclude those without stable housing or legal status[15]. Discrimination turns these patterns into systematic rights violations. In practice, this means people may be denied clear explanations, respectful dialogue, and meaningful participation in decisions that affect their bodies and lives.

> *Essentially, stigma and discrimination deprive individuals of their human dignity and opportunities to realise their full potential.*

Framing health literacy as a human rights concern shifts responsibility from “fixing” individuals to transforming systems[1]. It emphasises the duties of states and institutions to listen to people in vulnerable situations, to recognise and remove stigmatising practices, and to co-create information, support and services with those most affected[16]. In this view, improving health literacy is not just a technical public health intervention; it is part of a broader justice agenda to ensure that no one’s health rights depend on their education, language, identity, housing status, or social position.

SCOPE AND PURPOSE

The aim of this report is to present a comprehensive evidence-based governance framework that positions health literacy as a fundamental enabler of human rights, specifically addressing stigma and discrimination faced by people in vulnerable situations across Council of Europe member states.

The objectives include:

1. Reframing health literacy from an individual deficit to a systemic responsibility requiring coordinated action by governments, healthcare systems, educational institutions, and civil society.
2. Eliminating structural barriers, triggered by stigma and discrimination, that prevent people in vulnerable situations, such as Roma communities, homeless persons, disabled persons, migrants, LGBTI+ individuals, detained persons, women, older persons, and youth, from exercising their right to health protection.
3. Reinforcing accountability mechanisms within Council of Europe frameworks to monitor member state compliance with health literacy obligations under existing conventions.
4. Fostering inclusive health systems where people in vulnerable situations are not merely consulted but empowered as active participants in health decision-making, policy design, and service delivery.

THE APPROACH USED IN THIS REPORT

Given the rapid review format of the report and the data and methodological challenges inherent in studying stigma and discrimination across Council of Europe member states, this report draws on a scan of a variety of published data sources to explore the state and effects of promoting health literacy to reduce stigma and discrimination. The report presents the conceptual foundations of health literacy, stigma and discrimination, and social vulnerability followed by a general analysis of the impact of stigma and discrimination in relation to low health literacy. The insights were applied to a specific analysis showcasing the impact from the perspectives of eight different population groups and how it can be mitigated from a governance point of view. The findings serve as foundation for a policy roadmap including recommendations on how Council of Europe and its member states may proceed to promote health literacy and human rights to reduce stigma and discrimination in the future.

WHY IT MATTERS NOW

The confluence of multiple crises such as pandemic recovery, migration pressures, aging populations, digital transformation, and rising health misinformation, has exposed the fragility of health systems that fail to serve people in vulnerable situations[17]. Health literacy limitations represent a structural and widespread challenge across Europe, and the burden is not evenly distributed[18]. European Health Literacy Survey data reveals that almost half of Europeans have inadequate health literacy, with significantly higher rates among low-education populations, older persons, and migrants[2]. The low health literacy challenge translates directly into preventable mortality, medication errors, delayed diagnoses, and unnecessary healthcare costs estimated at billions of euros annually[19]. Digital health literacy gaps further compound exclusion, affecting approximately 40% of the population, with older adults and rural communities most affected[20].

Population-specific evidence also reveals persistent and structured gaps. Among Roma communities, research by the European Union Agency for Fundamental Rights documents that 41% experienced discrimination in healthcare within a five-year period, including informal payment demands, segregated facilities, and refusal of treatment. Life expectancy among Roma populations is estimated to be 5–15 years lower than the general population, and immunisation coverage remains 30–50% lower[21]. Persons with disabilities make up around 135 million people in Europe, yet they consistently face greater barriers in accessing and understanding health information than people without disabilities. Only about half of persons with disabilities in the Region can afford needed health care, and just one in ten have access to essential assistive devices, underscoring how cost and lack of adapted equipment limit effective use of services. Communication and information barriers are repeatedly highlighted, with reports showing that inaccessible formats, unclear information about patients’ rights, and poor communication practices contribute to higher unmet health needs and worse health outcomes for people with disabilities[22].

These figures demonstrate that health literacy is not a marginal issue, but a systemic equity challenge embedded within European health systems.

THE MAGNITUDE OF THE PROBLEM

The economic and social costs are substantial. Low health literacy is associated with 3–5% higher healthcare expenditures, due to preventable hospitalisations, medication errors, and emergency department overuse[19]. The COVID-19 pandemic further demonstrated that health literacy is not merely an individual attribute but a collective determinant of public health resilience[23]. Misinformation disproportionately affected populations with lower health literacy, contributing to excess mortality.

Ultimately, the issue extends beyond efficiency or cost containment to one of justice and legal obligation. Article 25 of the Universal Declaration of Human Rights establishes health as a fundamental right. When structural barriers such as stigma, discrimination, inaccessible information, and fragmented systems, prevent individuals from exercising this right, governments fail in their obligations as duty-bearers under international human rights law. Therefore, health literacy is not a peripheral policy concern; it is the essential enabler that transforms the right to health protection from an abstract principle into a lived reality.

More fundamentally, low health literacy can engender a violation of human rights[1]. When a Roma woman cannot understand prenatal care instructions due to language barriers and healthcare discrimination, when a detained person is denied accessible mental health information, when an older person cannot navigate digital health platforms, their health protection can be challenged pursuant to Article 11 of the European Social Charter [3]. The European Committee of Social Rights stresses that effective access to healthcare must be ensured to everyone without discrimination and that people in vulnerable situations require adequate protection[24].

DEFINITIONS AND CONCEPTUAL FRAMEWORK

HEALTH LITERACY AND ORGANISATIONAL HEALTH LITERACY

Health literacy is linked to literacy and entails people’s knowledge, motivation and competences to access, understand, appraise and apply information to make judgments and decisions in everyday life concerning healthcare, disease prevention and health promotion, to maintain or improve quality of life during the life course[25].

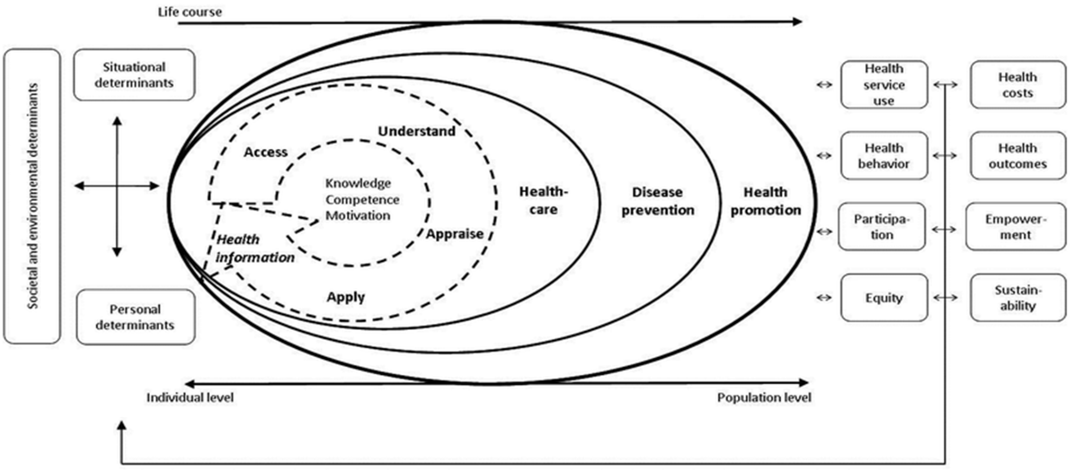


Figure 1: Comprehensive conceptual model of health literacy (Sørensen et al., 2012)[25].

Importantly, health literacy is a product of interaction between personal capacities and systemic factors such as education quality, health system complexity, information accessibility, cultural competence of providers, and socio-economic conditions[11,25]. In this regard, Prof. Don Nutbeam describes three progressive levels of health literacy that reflect increasing autonomy and empowerment[26,27]:

- *Functional health literacy* refers to basic reading and writing skills that enable individuals to understand health information and navigate healthcare settings.
- *Interactive health literacy* involves more advanced cognitive and social skills, allowing people to actively engage with health professionals, apply information in changing circumstances, and participate in shared decision-making.
- *Critical health literacy* represents the most advanced level, encompassing the ability to critically analyse information, understand the social determinants of health, and take individual or collective action to improve health conditions.

To address the challenges from a systems perspective, *organisational health literacy* refers to the way institutions design their structures, processes, and communication so that people can easily find, understand, and use health information and services[28]. Instead of placing responsibility solely on individuals to "be health-literate," it asks whether hospitals, clinics, public health agencies, and social services are creating environments that are easy to navigate for everyone, including people with limited literacy, language barriers, disabilities, or social vulnerabilities. Health-literate organisations commit their leadership, staff training, communication materials, digital tools, and physical spaces to clarity, accessibility, and inclusion. They use plain language, multiple formats, active support (like interpreters, mediators, and teach-back), and co-design with communities to reduce complexity, prevent misunderstanding, and counter stigma and discrimination in routine care[29].

Low health literacy has profound societal consequences from both an economic and a governance perspective. It is associated with higher use of emergency care, poorer management of chronic diseases, avoidable complications, and longer hospital stays, all of which drive up public and private health expenditures and reduce productivity through sickness absence and early retirement[19]. From a governance standpoint, low health literacy undermines the effectiveness and legitimacy of public policy: people struggle to understand rights, entitlements, and health guidance, leading to lower compliance with prevention measures, weaker trust in institutions, and greater vulnerability to misinformation. This, in turn, complicates policy implementation, widens health and social inequalities, and forces governments to spend more resources on remedial and crisis responses instead of strategic, preventive action[30].

SOCIAL VULNERABILITY

Social vulnerability refers to the way a person's or community's overall social situation makes them more susceptible to harm and poorer health outcomes. It arises from the accumulation of disadvantages across factors such as income, education, housing, employment, social support, discrimination, and access to services, which together limit people's ability to cope with risks, respond to crises, and recover from setbacks[31]. In the context of health, social vulnerability helps explain why certain groups experience higher burdens of disease, barriers to care, and worse outcomes, not because of individual failings, but because of structurally unequal living conditions and power relations[9].

To exemplify the impact of social vulnerability and health literacy as a human rights concern, this policy brief addresses eight populations identified in Council of Europe conventions.

Population group	**Individual perception**	**Structural perception**
Roma/Sinti/Travellers	Highly alienated	Systematically marginalised
Homeless persons	Highly excluded	Structurally excluded
Persons with disabilities	Highly regulated	Rights frequently constrained
Migrants	Highly complex	Entitlements fragmented
LGBTI+ individuals	Highly stigmatised	Protection inconsistently guaranteed
Detained persons	Highly controlled	Health rights dependent on institutions
Older persons	Highly dependent	Support and access under-prioritised
Youth	Highly overlooked	Participation and voice under-recognised

Roma, Sinti and Travelers are often highly alienated from mainstream institutions, carrying a legacy of systemic marginalisation, forced segregation, and discriminatory treatment in health and social services[21]. This alienation undermines trust, reduces willingness to seek care, and limits opportunities to build health literacy through respectful dialogue, while stereotypes about Roma “non-compliance” reinforce stigma and justify substandard or segregated services.

Homeless persons are highly and structurally excluded, as unstable housing, poverty, and survival priorities make it difficult to register with primary care, keep appointments, or store medicines and documents safely. Health literacy is constrained when information is delivered through channels, they cannot reliably access, and when services require a fixed address or identification, reinforcing discrimination based on housing status[32].

People with disabilities often live in highly regulated environments where decisions about their health are mediated by laws, guardians, institutions, or family members[22]. Their rights to accessible information, communication support, and autonomous decision-making are frequently constrained, and when services fail to provide accessible formats or reasonable accommodation, this constitutes discrimination that directly blocks the development and exercise of health literacy.

Migrants and refugees face highly complex and fragmented entitlements shaped by legal status, asylum procedures, and administrative rules that vary across and within countries. Limited language support, unfamiliar health systems, and fear of authorities or deportation combine with xenophobic stigma to create powerful barriers to understanding rights, navigating services, and trusting health information[33].

LGBTI+ individuals are highly stigmatised in many settings, encountering providers who lack competence or hold prejudiced views about sexual orientation, gender identity, or sex characteristics[34]. This leads to avoidance of care, under-disclosure of relevant information, and erasure of LGBTI+-specific health needs, all of which reduce opportunities for person-centered communication and health literacy.

Detained people live in highly controlled environments where access to health information, services, and second opinions depends on institutional practices and security priorities[35]. Overcrowding, under-resourcing, and punitive cultures can normalise neglect and discrimination, leaving people with little autonomy to ask questions, seek clarification, or participate meaningfully in health decisions.

Older persons are often highly dependent on family members, caregivers, or institutions to interpret information, manage medications, or navigate increasingly digitalised health systems. Ageism, combined with assumptions about cognitive decline or “non-technology users,” can lead to rushed explanations, exclusion from decision-making, and limited adaptation of information to sensory or cognitive needs[36].

Youth are frequently highly overlooked as rights-holders in their own health, with adults and institutions controlling what information is shared, when, and on what terms. At the same time, they are intensely exposed to digital misinformation and stigma around mental and sexual health, making it harder to find trustworthy, age-appropriate information and to speak openly about their concerns[37].

Population group	Specific vulnerabilities related to health literacy
Roma/Sinti/Travellers	Systematic discrimination, transience disrupting care continuity, distrust of healthcare systems, language barriers, informal payment demands, segregated healthcare facilities
Homeless persons	Housing status as barrier to service access, lack of fixed address preventing registration, extreme poverty limiting information access, physical and mental health complexity, social stigma and discrimination by providers, competing survival priorities, chaotic lifestyles disrupting care continuity

Population group	Specific vulnerabilities related to health literacy
Persons with disabilities	Physical barriers to facilities, sensory barriers to information (visual, auditory), cognitive processing challenges, social isolation, attitudinal discrimination by providers
Migrants	Language barriers, trauma affecting comprehension, unfamiliarity with health systems, legal status fears, cultural misunderstandings, lack of translated materials
LGBTI+ individuals	Provider stigma and discrimination, lack of culturally competent care, higher mental health burdens, avoidance of healthcare due to past negative experiences
Detained persons	Restricted access to information, inadequate healthcare in detention facilities, mental health stigma, limited autonomy over health decisions
Older persons	Cognitive decline, sensory impairments (vision, hearing), low digital literacy, multiple chronic conditions requiring complex management, social isolation
Youth	Dependence on adults for information, developmental stage cognitive limitations, restricted autonomy, mental health stigma, digital misinformation exposure

STIGMA AND DISCRIMINATION

Stigma operates through several interconnected mechanisms.[38]

- **Stereotyping** involves negative generalisations about groups (for example, assuming Roma are “non-compliant” or older people are “technologically incompetent”).
- **Prejudice** refers to the negative attitudes and emotional reactions that build on these stereotypes.
- **Discrimination** is the behavioural expression of stigma, such as denying services, providing substandard care, excluding people from essential health information, or using coercive practices.

Health-related stigma manifests both in interpersonal encounters (such as provider–patient interactions) and in structural arrangements (including policies, resource allocation, and system design), and these forms of discrimination directly impede the development of health literacy and the effective exercise of health rights[38].

THE HEALTH STIGMA AND DISCRIMINATION FRAMEWORK

The Health Stigma and Discrimination Framework by Stangl et al.[38] is a global, cross-cutting model that explains how stigma related to health conditions emerges, operates, and can be transformed. It links upstream drivers (such as laws, norms, power relations, and misinformation) to the processes of stigmatisation (including labelling, stereotyping, separation, status loss, and discrimination) and to downstream outcomes for individuals, communities, services, and systems. By distinguishing between stigma experiences (like internalised or anticipated stigma) and stigma practices (such as discriminatory behaviour and policies), the framework helps researchers, practitioners, and policymakers identify concrete entry points for action. It is designed to guide the development of interventions and policies that do not only target individual attitudes but also address structural conditions, ensuring that efforts to reduce stigma and discrimination are systematic, evidence-informed, and rights-based.

HEALTH LITERACY STIGMA AND DISCRIMINATION

Inspired by the Health Stigma and Discrimination Framework, figure 2 illustrates how low health literacy based on drivers and facilitators may be perceived as a marking leading to stigma experience and stigma practice with harming outcomes. Yet the model also entails several leverage points where health literacy can directly reduce stigma and discrimination across drivers, manifestations, and outcomes.

ACTING ON DRIVERS AND FACILITATORS

Many stigma drivers are rooted in misinformation, fear of contagion, moral judgment, and myths about productivity or responsibility. Strengthening population and professional health literacy can:

- Replace fear-based beliefs (for example, exaggerated contagion risk) with accurate risk understanding, reducing avoidance and exclusion of stigmatised groups.
- Challenge causal attributions that “blame” individuals by making social determinants and treatment effectiveness visible.
- Equip health professionals with evidence, communication skills, and rights-based norms so that quality and safety concerns are managed by protocols and guidelines rather than discriminatory practices.

By improving functional, communicative, and critical health literacy[27] at public, provider, and policymaker level, the informational and normative conditions that drive stigma are weakened before stigma “marking” occurs.

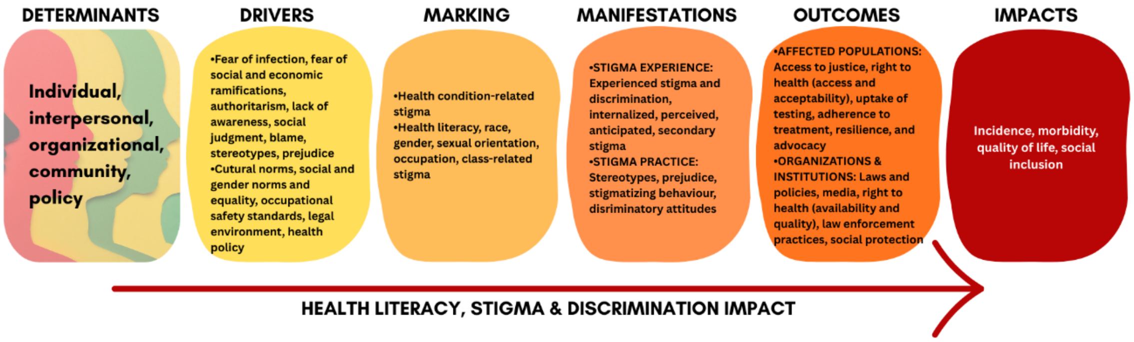


Figure 2: Health literacy, stigma and discrimination model inspired by Stangl et al.'s Health Stigma and Discrimination Framework (2019)[38].

INTERRUPTING STIGMA MANIFESTATIONS

The framework distinguishes stigma experiences (anticipated, perceived, internalised, experienced, associative) and practices (stereotypes, prejudice, discriminatory behaviour). Health literacy contributes to interrupting both:

- For affected people, higher personal health literacy can reduce internalised stigma by helping them understand their condition, available treatments, and rights, supporting self-efficacy, coping, and advocacy.
- For communities and frontline staff, structured health literacy interventions (dialogues, peer education, co-designed materials) can challenge stereotypes and prejudice, leading to fewer discriminatory practices in families, workplaces, and health facilities.

In this way, health literacy interventions operate as anti-stigma tools that change how conditions are understood and talked about, making stigmatising narratives less socially acceptable.

IMPROVING ACCESS, ENGAGEMENT, AND OUTCOMES

The framework links stigma manifestations to outcomes such as service access, acceptability of care, testing uptake, adherence, resilience, and advocacy. Health literacy can mitigate stigma effects at this stage by:

- Making health systems, information, and procedures more navigable, so that people who anticipate or experience stigma still have clear, safe pathways to care.
- Supporting shared decision-making and "teach-back" approaches that affirm dignity and agency, countering the disempowerment produced by stigma.
- Building individual and collective capacity to recognise discrimination, use complaint mechanisms, and engage in rights-based advocacy, thereby transforming stigma into organised pressure for institutional change.

For organisations and institutions, embedding health literacy into policies, staff training, and service design can change laws, policies, and routine practices that currently facilitate stigma, aligning them with non-discrimination norms.

ADDRESSING INTERSECTING STIGMAS THROUGH MULTI-LEVEL ACTION

The framework stresses intersecting stigmas (e.g., related to gender, race, sexual orientation, poverty) and the need for multi-level interventions across policy, organisational, community, interpersonal, and individual levels. Health literacy aligns with this by:

- Designing multi-level, cross-condition interventions that simultaneously build individual skills, reshape community norms, and revise institutional procedures.
- Ensuring that information and communication strategies explicitly acknowledge and counter intersecting stigmas instead of treating conditions in isolation.

Within this framework, health literacy functions as a cross-cutting strategy to reduce stigma drivers, transform stigma practices, buffer stigma experiences, and improve health and rights outcomes for affected populations and institutions alike.

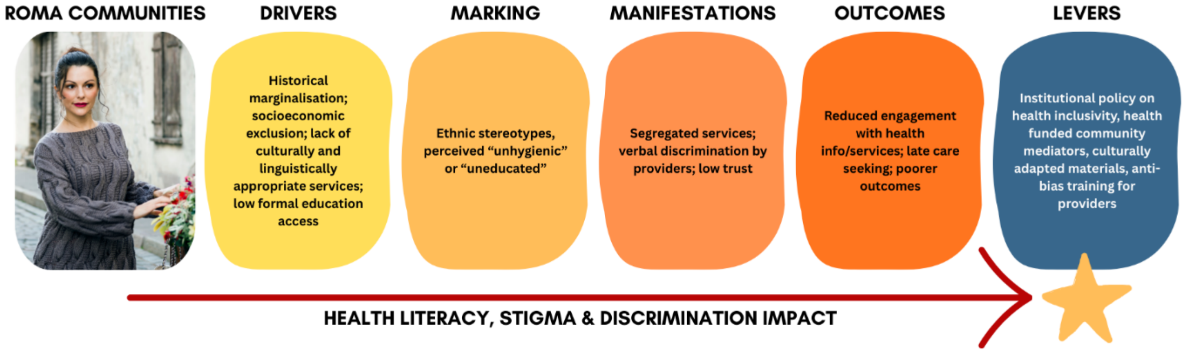
EIGHT PERSPECTIVES ON HEALTH LITERACY, STIGMA AND DISCRIMINATION

The health literacy, stigma and discrimination framework inspired by Stangl and colleagues was used to analyse how structural drivers, stigma marking, and health literacy interact to shape health outcomes among eight population groups in vulnerable situations. The emphasis was on how stigma and low health literacy mutually reinforce one another and how structural disruption is required to break the cycle.

Across all groups, health literacy and organisational health literacy may act as critical levers to disrupt stigma pathways and enable rights for people in vulnerable situations. Population health literacy reduces the drivers of stigma (fear, blame, misinformation), while organisational health literacy reshapes environments so that stigma is neither reproduced nor rewarded in routine practice, and rights to information, dignity, and non-discrimination can be effectively exercised.

ROMA, SINTI AND TRAVELLERS COMMUNITIES

According to the United Nations, Roma, Sinti, and Traveller communities across Europe experience longstanding structural marginalisation, poverty, and educational exclusion[39]. These factors contribute to lower average formal educational attainment, which can limit opportunities to develop health literacy skills within systems that are primarily designed around the majority language and culture. Stigma marking often frames individuals from these communities as “unhygienic,” “uneducated,” or “non-compliant,” reinforcing discriminatory attitudes in healthcare settings. This kind of stigma manifests in segregated services, dismissive communication, and a lack of culturally adapted information. When health information is inaccessible or not trusted, health literacy becomes relationally constrained. The resulting outcomes include delayed care seeking, reduced uptake of preventive services, and persistent mistrust in institutions. Addressing these challenges requires structural disruption through institutional commitment to inclusive communication strategies, the use of trained health mediators, culturally adapted materials, and the enforcement of anti-discrimination policies within healthcare systems.


ROMA COMMUNITIES

DRIVERS

Historical marginalisation; socioeconomic exclusion; lack of culturally and linguistically appropriate services; low formal education access

MARKING

Ethnic stereotypes, perceived “unhygienic” or “uneducated”

MANIFESTATIONS

Segregated services; verbal discrimination by providers; low trust

OUTCOMES

Reduced engagement with health info/services; late care seeking; poorer outcomes

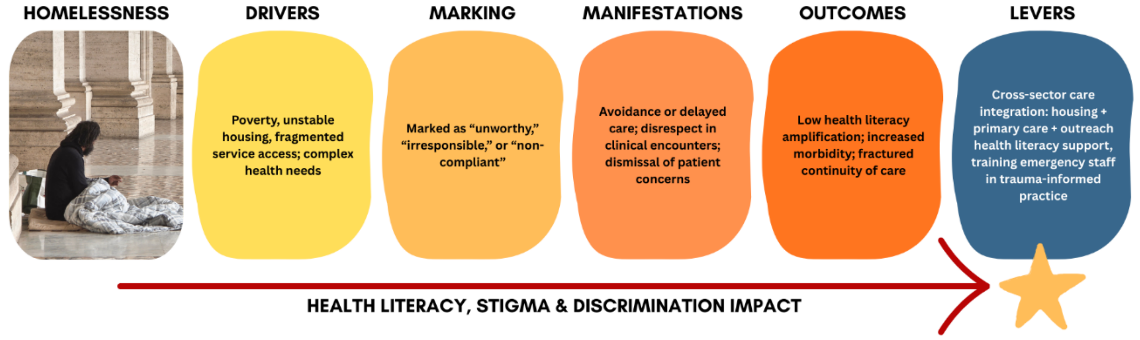
LEVERS

Institutional policy on health inclusivity, health funded community mediators, culturally adapted materials, anti-bias training for providers

HEALTH LITERACY, STIGMA & DISCRIMINATION IMPACT

PERSONS EXPERIENCING HOMELESSNESS

People experiencing homelessness face intersecting drivers such as poverty, trauma, unstable housing, and fragmented service systems[40,41]. Stigma marking frequently portrays them as “irresponsible,” “substance-dependent,” or “undeserving,” which influences provider behavior and public attitudes. In practice, stigma manifests in rushed consultations, dismissal of symptoms, and structural barriers such as lack of identification or fixed address requirements. Health literacy challenges are compounded by competing survival priorities. Even when individuals possess health knowledge, the structural context limits its application. In this case, outcomes include poor chronic disease management, high emergency department use, and increased morbidity. Structural levers must, therefore, integrate housing policy with health systems (“housing first” approaches), embed trauma-informed care, and ensure continuity of health literacy support through outreach and cross-sector collaboration.


HOMELESSNESS

DRIVERS

Poverty, unstable housing, fragmented service access; complex health needs

MARKING

Marked as “unworthy,” “irresponsible,” or “non-compliant”

MANIFESTATIONS

Avoidance or delayed care; disrespect in clinical encounters; dismissal of patient concerns

OUTCOMES

Low health literacy amplification; increased morbidity; fractured continuity of care

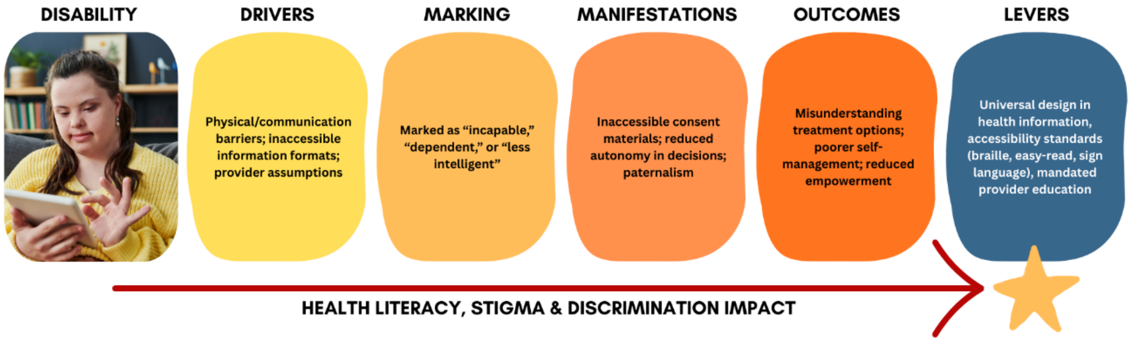
LEVERS

Cross-sector care integration: housing + primary care + outreach health literacy support, training emergency staff in trauma-informed practice

HEALTH LITERACY, STIGMA & DISCRIMINATION IMPACT

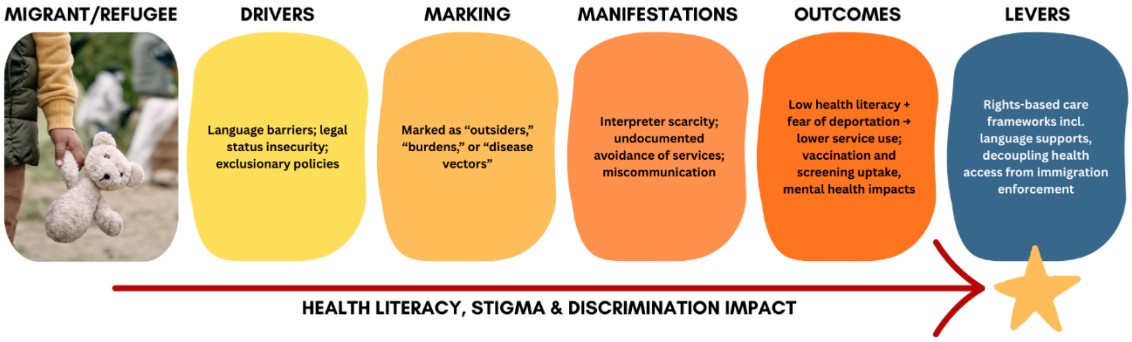
PERSONS WITH DISABILITIES

Persons with disabilities face physical, communication, and attitudinal barriers embedded within healthcare systems. Stigma marking often frames them as “incapable,” “dependent,” or cognitively limited, which can lead to paternalistic communication practices. These stigmas manifest in inaccessible consent forms, lack of sign language interpretation, absence of easy-read materials, and exclusion from shared decision-making. Health literacy is frequently misjudged as an individual deficit, when in reality the true barrier lies in inaccessible systems[22,42,43]. The outcomes of these barriers include reduced autonomy, misunderstandings of treatment options, and inequitable health outcomes. Addressing these challenges requires structural interventions, including universal design standards in health communication, mandatory accessibility compliance, and provider training that reinforces autonomy and rights-based care.



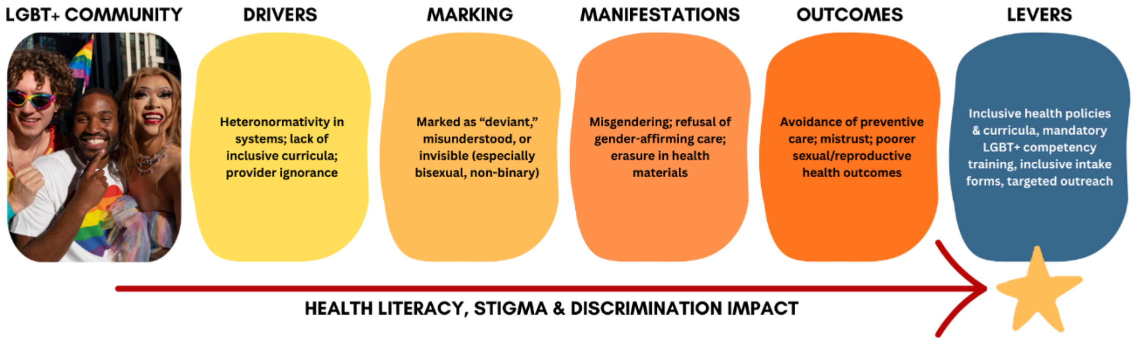
MIGRANTS (INCLUDING REFUGEES AND ASYLUM SEEKERS)

Migrants often experience language barriers, insecure legal status, cultural dissonance, and exclusionary policies[44]. Stigma marking can portray them as "burdens," "outsiders," or even "disease carriers," particularly during public health crises. This stigma manifests through limited access to interpreters, culturally incongruent information, and fear of seeking care due to immigration enforcement. Even migrants with strong health literacy in their country of origin may experience situation-based low health literacy in a new system. The consequences include reduced vaccination uptake, delayed screenings, untreated mental health conditions, and mistrust in institutions. Addressing these challenges requires structural interventions such as guaranteed interpreter services, legal firewalls between health and immigration authorities, and culturally responsive system design.



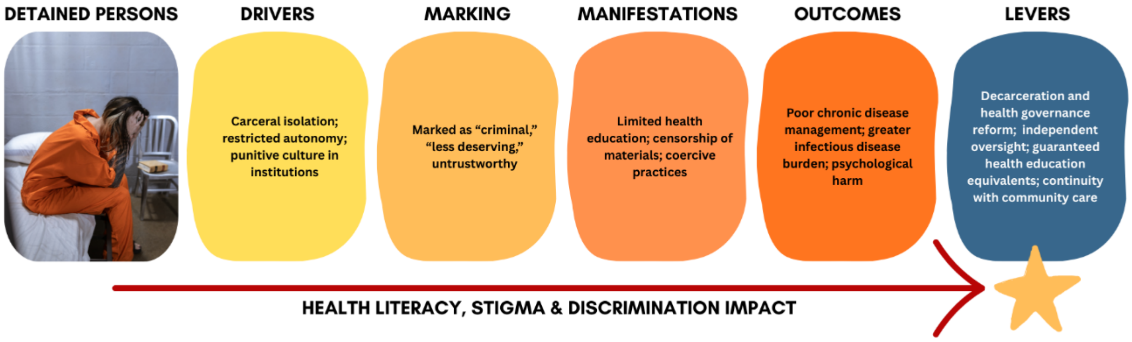
LGBTI+ INDIVIDUALS

LGBTI+ individuals encounter heteronormative health systems that often lack inclusive language, training, or representation[34]. Stigma markings may characterise the sexual and gender diversity as deviant or invisible, particularly affecting transgender and non-binary persons. The resulting manifestations include misgendering, refusal of gender-affirming care, heteronormative assumptions in consultations, and exclusion from health information materials. Such environments erode trust and constrain open communication, limiting interactive and critical health literacy engagement. This may in turn lead to outcomes including avoidance of preventive services, increased mental health burdens, and poorer sexual and reproductive health outcomes. Structural disruption in this case requires inclusive intake systems, mandatory competency training, explicit non-discrimination policies, and co-designed services with LGBTI+ communities.



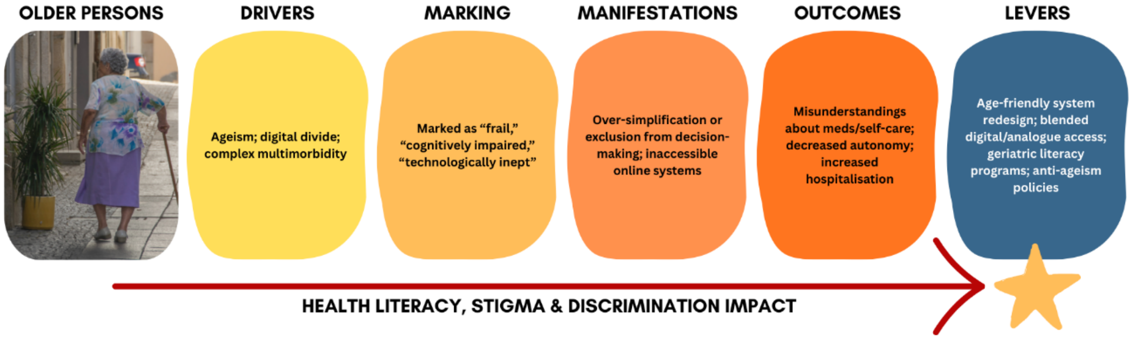
DETAINED PERSONS

Detained persons live within carceral systems characterised by restricted autonomy and punitive norms. Stigma marking frames them as "criminal" or "undeserving," which can justify neglectful care practices. This stigma manifests through restricted access to health education materials, coercive treatment contexts, limited confidentiality, and disrupted continuity of care. Health literacy development is structurally suppressed when individuals lack agency or reliable information as well as negligence regarding illness[45]. The outcomes include unmanaged chronic disease, higher rates of infectious disease transmission, and worsened mental health. Structural levers to address these challenges may include independent health oversight, ensuring equivalence of care with community standards, strengthened health education rights, and continuity planning after release[46].



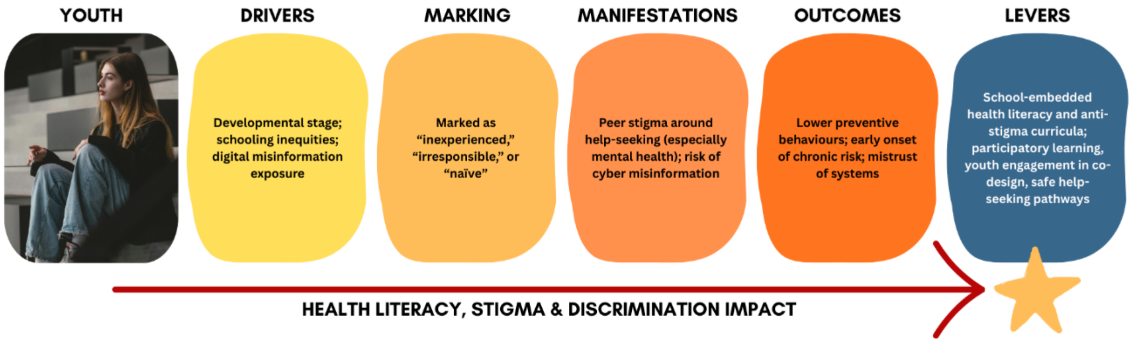
OLDER PERSONS

Older adults face drivers such as ageism, multimorbidity, and the digitalisation of services without adequate support[47]. Stigma marking often portrays them as frail, cognitively incapable, or technologically incompetent. This stigma manifests through exclusion from shared decision-making, over-simplified explanations, and digital-only appointment systems that create access barriers. Even when health literacy is strong, it can be rendered ineffective in systems that are not age-friendly. The outcomes include medication mismanagement, avoidable hospitalisations, and reduced autonomy. Structural disruption requires age-friendly system redesign, blended digital and non-digital pathways, anti-ageism policies, and lifelong health literacy initiatives[36].



YOUTH

Youth are shaped by developmental transitions, schooling inequities, and high exposure to digital misinformation[37,48,49]. Stigma marking may label them as irresponsible or immature, particularly in relation to mental and sexual health. This stigma manifests through peer stigma around help-seeking, limited youth-tailored communication, and exposure to misinformation ecosystems. Health literacy development is highly context-dependent and influenced by both education systems and digital platforms. The outcomes include risk-taking behaviors, delayed access to mental health support, and increased vulnerability to misinformation-driven harm. Structural levers to address these challenges include embedding health literacy and anti-stigma curricula within schools, fostering participatory youth engagement in service design, and implementing safe digital governance policies[48].



A EUROPEAN ROADMAP FOR HEALTH LITERACY, EQUITY, AND ACCOUNTABILITY

The scale and persistence of health literacy gaps across Europe demand a structural and coordinated response at the level of the Council of Europe and its 46 member states. Incremental initiatives are insufficient. What is required is a rights-based, system-wide transformation that embeds health literacy as a foundational element of the right to health protection[1,50]. The following recommendations outline a comprehensive governance, accountability, and implementation framework capable of achieving this shift.

ESTABLISHING A BINDING EUROPEAN COMMITMENT

The first step is the development of a binding commitment on health literacy and health rights, modelled on e.g. the structure of the Oviedo Convention[51]. Such a commitment would formally recognise health literacy as an essential enabler of the right to health protection and establish minimum standards across healthcare, disease prevention, and health promotion domains. It would mandate specific protection for people in vulnerable situations and reinforce monitoring mechanisms notably the European Committee of Social Rights. Member states would be required to report periodically on health literacy gaps, interventions, and measurable outcomes. While existing European conventions protect the right to health protection, none provide explicit provisions addressing health literacy as the operational bridge between rights and access. A dedicated framework would create accountability, harmonise standards, and elevate health literacy from a policy aspiration to a legal commitment.

OPERATIONALISING RIGHTS THROUGH NATIONAL HEALTH LITERACY ACTION PLANS

To translate principles into practice, all member states should adopt National Health Literacy Action Plans with a rights-based focus e.g. on availability, accessibility, acceptability, and quality. Under availability, governments could e.g., commit a minimum allocation of health budgets to health literacy resources, establish community health mediator programs in regions with vulnerable populations, deploy mobile health units in underserved areas, and develop population-specific materials addressing at least ten priority topics per vulnerable group.

Accessibility would require plain language legislation ensuring that essential health information is provided in lay language with an adequate reading level. Essential materials should be translated into minority languages spoken by more than five percent of the regional population. Universal design standards must govern digital health platforms to ensure access for elderly and disabled persons, while informal payments and financial barriers to preventive care must be eliminated. Free digital literacy training programs targeting older persons and low-income populations would further close access gaps.

Acceptability would be strengthened through mandatory annual cultural competence training for healthcare providers, co-design requirements ensuring that vulnerable populations participate in developing health literacy materials, LGBTI+-inclusive standards in all public facilities, and gender-sensitive programming addressing reproductive health, violence, and autonomy.

Quality would be ensured through national health literacy standards and certification systems, independent review of health information accuracy, evidence-based intervention guidelines, and regular population assessments using validated measurement tools. Annual reporting to the Council of Europe, peer review mechanisms, and sanctions for persistent non-compliance would ensure accountability.

TARGETED ANTI-STIGMA AND DISCRIMINATION INITIATIVES

Health literacy cannot advance without confronting stigma. Multi-year initiatives should address specific patterns of discrimination experienced by people in vulnerable situations.

- For Roma, Sinti and Travellers communities, this includes expanding community health mediator networks, implementing anti-discrimination training addressing entrenched stereotypes, eliminating segregated facilities and informal payment practices, and launching public awareness campaigns to counter harmful narratives.
- Persons experiencing homelessness require elimination of fixed address requirements for registration, mobile and shelter-based care models, health navigators with lived experience, integrated care pathways, anti-stigma training for providers, flexible appointment systems, plain language materials aligned with survival priorities, continuity of care protocols across regions, and explicit legal protections against discrimination based on housing status.
- For persons with disabilities, systematic accessibility audits with mandatory remediation timelines are required, alongside “Easy Read” standards, disability equality training, and personal health budgets to strengthen autonomy.
- Migrants and refugees require professional interpretation services across all healthcare settings, multilingual resources covering the vast majority of migrant languages, trauma-informed care training, and legal protections guaranteeing access regardless of documentation status.
- LGBTI+ individuals would benefit from cultural competence certification for facilities, regional LGBTI+ health coordinators, targeted mental health literacy programs, and explicit prohibition of conversion therapy practices.
- Detained persons require health literacy assessments at entry, independent health ombudspersons, peer support programs, and guaranteed continuity of care during and after detention.

- Older adults need tailored digital literacy training, large-print and audio information standards, medication reviews using teach-back methods, and intergenerational support programs.
- Youth require comprehensive health literacy curricula in schools, digital misinformation resilience training, mental health literacy programs reducing stigma, and meaningful participation in health policy design.

TRANSFORMING HEALTHCARE INSTITUTIONS INTO HEALTH LITERATE ORGANISATIONS

All healthcare and public health institutions should address health literacy and be asked to achieve certification as Health Literate Organisations, aligned with internationally recognised standards. This transformation includes leadership commitment, integration of health literacy into strategic planning, workforce-wide training, simplified navigation systems, patient engagement in governance, routine use of plain language and teach-back methods, accessible multilingual communication formats, community partnerships, and continuous quality improvement.

CROSS-SECTORAL GOVERNANCE

Health literacy cannot be confined to health ministries. National inter-ministerial councils should coordinate across health, education, social affairs, justice, and digital sectors, supported by dedicated budget lines and health literacy impact assessments for major policies. At the Council of Europe level, a sustainable Health Literacy Project could be established, accompanied by an annual Health Literacy Forum, technical assistance mechanisms, and targeted research funding. Civil society must be formally embedded in governance structures through consultation mechanisms, co-production requirements, and dedicated funding for community-led initiatives.

BUILDING EVIDENCE AND ACCOUNTABILITY

Robust monitoring systems are essential. The European Health Literacy Survey should be conducted biennially in member states with oversampling of vulnerable populations. National indicators must be integrated into routine health information systems, with equity-stratified reporting to ensure transparency. Longitudinal cohort studies, economic evaluations demonstrating return on investment, and dedicated research funding would strengthen the evidence base. Accountability mechanisms should empower the European Committee of Social Rights to investigate complaints, establish peer review processes among member states, enable civil society shadow reporting, and publish public scorecards ranking performance.

CLOSING THE DIGITAL DIVIDE

Finally, digital health literacy must be addressed as an urgent infrastructure priority. Universal digital literacy programs in primary care, senior technology support centres in municipalities, simplified voice-enabled health applications, mandatory digital accessibility standards, hybrid service delivery preserving non-digital options, community technology hubs, and digital mediator training programs should be implemented.

DEVELOPING A RIGHTS-BASED EUROPEAN HEALTH LITERACY ARCHITECTURE

Taken together, these recommendations outline a comprehensive transformation: from fragmented, reactive measures to a coherent, rights-based European health literacy architecture. By embedding legal commitments, operational standards, targeted anti-stigma action, institutional transformation, cross-sectoral governance, rigorous accountability, and digital inclusion, Council of Europe and its member states can ensure that health literacy becomes the structural foundation for equity, dignity, and the full realisation of the right to health.

> *A blueprint for health literacy matters little unless it is built into the system with durable funding and structures.*

CONCLUSION: FROM OBLIGATION TO OPPORTUNITY

Health literacy is the connective tissue linking human rights principles to health outcomes. When Council of Europe member states enable individuals to access, understand, appraise, and apply health information, they do more than improve clinical indicators, they uphold human dignity, advance social justice, and build resilient societies.

The evidence is incontrovertible: people in vulnerable situations across Council of Europe member states face systematic barriers to health literacy rooted in stigma and discrimination. These barriers violate existing human rights obligations and impose substantial health, economic, and social costs. Yet this challenge also presents an opportunity.

By adopting the governance agenda outlined in this report such as establishing a policy commitment, operationalising rights-based health literacy principles, dismantling stigma, transforming organisations, building cross-sectoral partnerships, and investing in evidence, the Council of Europe can lead a transformative shift where member states can move from systems designed for average populations to systems designed for equity.

The 46 member states of the Council of Europe represent over 700 million people. The decisions made regarding health literacy governance will determine whether these hundreds of millions of people, particularly the most vulnerable among them, can effectively exercise their fundamental right to health protection. This is not merely a policy choice. It is a moral imperative that defines the kind of society governments aspire to build: one where health rights are not conditional on health literacy, literacy, language, identity, or social position, but are truly universal in both principle and practice. Council of Europe's Strategic Plan for Human Rights in Biomedicine and Health. Keeping Human Rights at the Coare of Biomedicine and Health 2062-2028 includes an objective on health literacy which may help pave the way[51].

The time for action is now. The policy framework exists. The evidence is clear. What remains is political will and coordinated implementation to build societies where health literacy empowers every person, where stigma gives way to dignity, and where human rights are not aspirations but lived realities.

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The Council of Europe is the continent's leading human rights organisation. It comprises 46 member states, including all members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law. The European Court of Human Rights oversees the implementation of the Convention in the member states.

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