



Beyond Individual Skills: Community Health Literacy as a Pathway to Community Empowerment, Health Equity, and Resilience — A Narrative Review

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Abstract

Background: Health literacy is one of the strongest modifiable correlates of population health, yet it has been studied almost exclusively as an attribute of individuals. This framing has produced a large evidence base but also a deficit orientation that locates the problem in people rather than in the relationships, organizations, and structures that shape whether health information can be found, trusted, and acted upon.

Purpose: To critically examine the evolution of health literacy from an individual competency toward a collective community capacity, to synthesize the mechanisms through which community health literacy may contribute to community empowerment, health equity, and community resilience, and to propose an integrated conceptual framework.

Method: A structured narrative synthesis of conceptual, empirical, and policy literature in health literacy, health promotion, community development, social capital, and public health resilience, organized around eight guiding questions.

Results: Community health literacy is not the aggregate health literacy of residents but an emergent, context-dependent capacity arising from interactions among individual competencies, social networks, community assets, trust, responsive organizations, information environments, and structural conditions. It contributes to empowerment through critical consciousness, shared knowledge, participation, and collective efficacy; to equity through redistribution of literacy resources, organizational responsiveness, and action on social determinants; and to resilience through anticipation, trusted communication, and adaptive learning. These relationships are reciprocal.

Conclusion: Reframing health literacy as a community resource repositions primary health care, community health workers, and health professionals as builders of collective capacity rather than transmitters of information and opens a research agenda on community-level measurement, intervention, and evaluation.

Keywords: Community Health Literacy; Community Empowerment; Health Equity; Community Resilience; Primary Health Care; Social Capital

Introduction: Why Health Literacy Must Move Beyond the Individual

Health literacy has become one of the most influential concepts in public health, linked to adherence, preventive service use, self-management, hospitalization, and mortality [1, 2]. Population surveys consistently find that a third to a half of adults have limited health literacy, concentrated among those who are older, poorer, less educated, migrant, or chronically ill [3, 4]. Health literacy is therefore a matter of population health and social justice, endorsed as a determinant of health in the Shanghai Declaration on Health Promotion [5].

The dominant framing has nevertheless been individual. The integrated model of Sørensen and colleagues defines health literacy as a person's knowledge, motivation, and competence to access, understand, appraise, and apply health information [6], and measurement has followed: instruments such as the REALM, TOFHLA, Newest Vital Sign, and HLS-EU yield individual scores that are averaged, categorized, and correlated with individual outcomes [7]. This tradition has been productive, and nothing here disputes its findings.

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Yet the individual framing carries a hidden “deficit model” [8, 9]: if health literacy is a skill a person lacks, the natural response is to fix the person, placing responsibility on the least powerful actor in the system. Three lines of critique have converged against this position. First, health literacy is relational: people consult family, peers, caregivers, and trusted community figures, and Edwards and colleagues showed that “health literacy mediators” in social networks read, translate, and advocate for others [10]. Second, health literacy is environmental: the Institute of Medicine framed it as the interaction between individual skills and system demands [11], an insight that underpins the health-literate organization [12] and the inclusion of organizational health literacy in Healthy People 2030 [13]. Third, health literacy is structurally patterned: its social gradient mirrors the gradient in health, and information-based interventions can widen inequities because the already advantaged benefit most [14-16].

From these critiques has grown a second generation of concepts - interactive and critical [17], distributed [10], organizational [12], public [18], and community health literacy [19, 20] - which share a movement outward from the individual but have developed in parallel rather than in dialogue with one another or with the older literatures on community empowerment, social capital, and community resilience.

This matters for community medicine and primary health care, whose founding declarations position them as community-oriented enterprises grounded in participation and empowerment [21]. If health literacy is conceptualized only at the individual level, primary care practitioners inherit a tool misaligned with their discipline. Existing reviews have summarized individual associations [1, 2], described organizational health literacy [12, 22], and proposed definitions of community health literacy [19, 20]; none has synthesized how health literacy across levels relates to empowerment, equity, and resilience, or specified the mechanisms and feedback loops involved. That is the gap addressed here.

The main aim of this review is to critically examine the evolution of health literacy from individual competency toward a collective community capacity, and to synthesize the mechanisms through which community health literacy may contribute to community empowerment, health equity, and community resilience. A secondary aim is to propose an integrated conceptual framework linking individual, relational, organizational, and community-level health literacy with these outcomes. The review is organized around eight guiding questions.

Box 1: Guiding questions

1. How has health literacy evolved from individual competency toward relational, organizational, and community-level concepts?
2. What constitutes community health literacy, and how does it differ from individual, critical, distributed, public, and organizational health literacy?
3. What individual, social, cultural, organizational, environmental, and structural factors contribute to it?
4. Through what mechanisms can it promote community empowerment, participation, agency, and collective action?
5. Through what pathways might it reduce health inequities?
6. How might it strengthen community resilience to emerging and persistent health threats?
7. What roles can primary health care systems, community health workers, and health professionals play in developing health-literate communities?
8. What conceptual, measurement, intervention, and research gaps remain?

Narrative Approach

This is a narrative, conceptually driven review rather than a systematic review, the appropriate design for integrative and theoretical questions that span literature with inconsistent terminology [23]. Literature was identified through searches of PubMed, Scopus, and Google Scholar combining health literacy with community, collective, distributed, relational, organizational, public health literacy, empowerment, social capital, health equity, and resilience, without date restriction; hand-searching of reference lists; and foundational documents from the World Health Organization and the National Academies. Sources were selected purposively for conceptual contribution - a definition, model, mechanism, or community-level empirical illustration relevant to a guiding question - with individual-level association studies used only as background. Sources were mapped against the guiding questions, mechanisms were extracted, and the framework in Section 9 was assembled iteratively.

Conceptual Boundaries

The literature now contains at least seven related constructs, often used interchangeably. Table 1 sets them apart.

Community health literacy is not the mean or aggregate health literacy score of residents

A community whose members all score adequately on the HLS-EU may have low community health literacy if residents distrust health authorities, reliable information has no channels through which to circulate, organizations are unresponsive, and there is no history of collective action. Conversely, a community with many individuals of limited functional literacy may have substantial community health literacy if it contains active mediators, trusted community health workers, strong networks, and adapted organizations [10, 19]. It is a property of the system, not a summary statistic of its members - analogous to the distinction between compositional and contextual effects in social epidemiology [27], and between individual social support and community social capital [28]. An early study found that community-level health literacy predicted self-reported health independently of individual literacy [28].

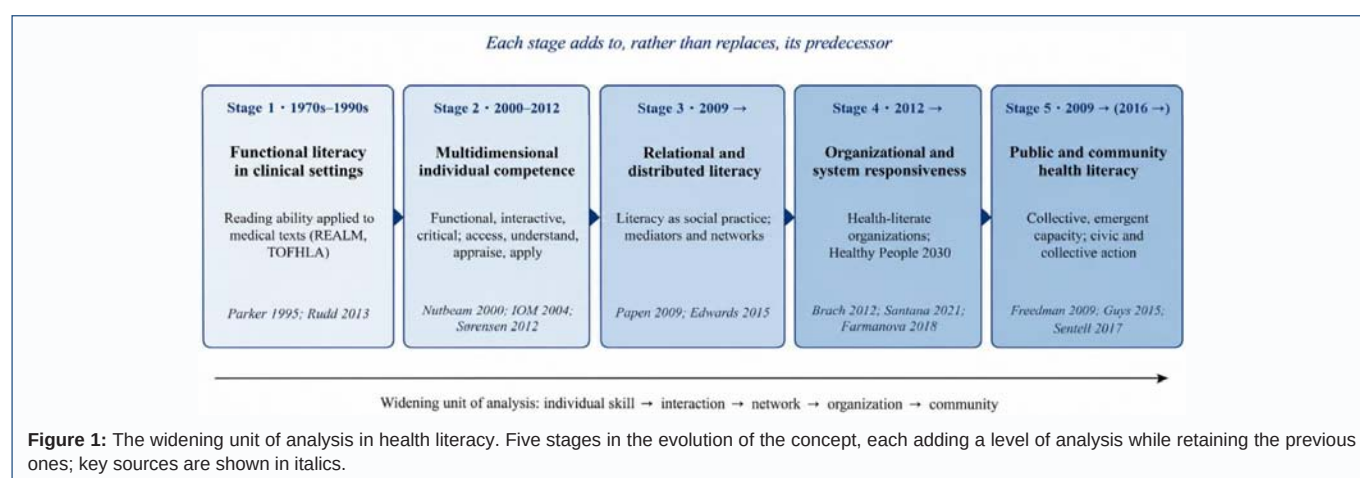
Community health literacy is not merely an individual intervention delivered in a community setting

Label-reading classes in a village hall target individual literacy. An intervention addresses community health literacy when it changes the collective resources - networks, mediators, trust, information infrastructure, organizational practices, capacity for collective action - through which the community as a whole can find, appraise, and act on information [29].

Building on Sentell [19] and Guzys [20], this review adopts the following working definition: Community health literacy is the collective and context-dependent capacity of a community to generate, access, appraise, share, and act on health information and services, emerging from the interaction of individual competencies, family and social networks, community assets, trust and social capital, responsive organizations and professionals, accessible information environments, and the broader social and structural conditions in which the community is situated - and oriented toward participation, resource navigation, critical consciousness, and collective action for health.

Table 1: Conceptual boundaries among health literacy constructs.

Construct	Level	Core content	Key sources	What it does not capture
Individual (functional) health literacy	Person	Ability to access, understand, appraise, communicate, and use health information and services	[6, 11]	Social support, system demands, structural context
Interactive health literacy	Person, in interaction	Advanced cognitive, communication, and social skills to engage actively with information and professionals	[17]	Collective capacity; determinants beyond the encounter
Critical health literacy	Person, oriented to society	Capacity to critically appraise information and social determinants, and to use this for individual and collective action	[17, 24, 25]	Remains an individual attribute
Distributed / relational health literacy	Network	Literacy resources held across families, caregivers, peers, and networks; the role of mediators	[10, 26]	Organizational and structural context
Organizational health literacy	Organization	Extent to which organizations equitably enable people to find, understand, and use information and services	[12, 13]	Community relationships and assets outside the organization
Public health literacy	Population	Knowledge and competences enabling individuals and communities to understand and act on public health information, including civic orientation	[18]	Mechanisms of community action; local assets and trust
Community health literacy	Community	Collective, emergent capacity arising from interactions among individuals, networks, organizations, information environments, and structural conditions, oriented towards collective action	[19, 20]; this review	—



The Evolution of Health Literacy: From Individual Skill to Collective Capacity

The concept's trajectory can be read as a progressive widening of the unit of analysis (Figure 1). Stage 1 (1970s-1990s) treated health literacy as reading ability applied to medical texts, measured by the REALM and TOFHLA [30]. Stage 2 (2000-2012) reframed it as a multidimensional individual competence: Nutbeam's functional, interactive, and critical levels positioned health literacy as an outcome of health education rather than merely a risk factor [17], consolidated by the IOM report [11] and Sørensen's integrated model [6]. Stage 3 (from 2009) established literacy as a social practice: Papen showed people "reading" health texts through conversation and lived experience [26], and Edwards identified health literacy mediators [10], reinforced by work on lay and family perspectives [31]. Stage 4 (from 2012) shifted responsibility onto institutions through Brach's ten attributes of a health-literate organization [12], now embedded in accreditation standards and national definitions [13, 22]. Stage 5 (from 2009, accelerating after 2016) introduced the population and civic dimension through Freedman's public health literacy [18], Sentell's community-level measurement [19], and Guzys's review of health literacy "in the community" [20]; the COVID-19 pandemic then made the collective, infrastructural, and trust-dependent nature of health literacy impossible to ignore [32, 33].

Three observations follow. Each stage added to rather than replaced its predecessor. The outward movement was driven by

empirical anomalies - people with "low" literacy who managed well, well-designed materials that failed - that the individual model could not explain. And Stages 3 to 5 have developed largely in isolation from the well-theorized literatures on community empowerment [34, 35], social capital [28], and community resilience [36]. Bringing them together is the task of the remainder of this review (Figure 1).

What Contributes to Community Health Literacy?

If community health literacy is emergent, the question is what it emerges from. The literature suggests contributors at six interacting levels (Table 2).

Individual competencies remain the foundation, but their distribution matters as much as their average: a few highly literate, well-connected, trusted individuals may serve a community better than uniformly moderate skills with no mediators [10]. Families and networks carry information; dense homogeneous networks amplify whatever circulates within them, accurate or not, whereas bridging ties to professionals import reliable information [28, 37]. Community assets - pharmacists, religious leaders, teachers, village health volunteers, elders - function as informal information hubs to be recognized and strengthened rather than gaps to be filled [38], and trust is the currency that makes them effective: where trust in formal institutions is low, official information is discounted regardless of quality [39]. Social capital and collective efficacy [28, 40] determine whether understanding translates into coordinated action;

Table 2: Contributors to community health literacy by level, with illustrative indicators and intervention entry points.

Level	Contributing elements	Illustrative indicators	Intervention entry points	Key sources
Individual	Functional, interactive, and critical skills; distribution of skills across residents	Population surveys (HLS-EU, HLQ); share of residents able to act as mediators	Adult education; skills-based and school health education	[6, 7, 17]
Family and social network	Kinship and peer ties; mediators; bridging ties to institutions	Network density and composition; reach of accurate vs. inaccurate information	Family-centred care; peer support; strengthening bridging ties	[10, 26, 37]
Community assets and trust	Informal information hubs (pharmacists, faith leaders, teachers, elders); trust in institutions	Asset maps; institutional trust; use of informal vs. formal sources	Asset-based development; partnership with local leaders	[38, 39]
Social capital and collective efficacy	Bonding, bridging, and linking capital; shared willingness to act	Collective efficacy scales; civic participation; history of collective health action	Community organizing; health committees; participatory research	[28, 40, 41]
Organizational responsiveness	Health-literate organizations; professional communication; co-design and feedback	Organizational audits; language services; outreach coverage	Ten attributes; professional training; co-design	[12, 13, 22, 42]
Information environment and structural conditions	Local media; digital access; regulation of misinformation; poverty, education, discrimination, governance	Digital access; language availability; deprivation indices	Policy and regulation; digital inclusion; action on social determinants	[14, 15, 33, 43]

communities with bridging and linking capital can draw on external expertise and hold institutions accountable [41]. Organizational responsiveness lowers the demands placed on individuals and networks, through plain language, opening hours, language services, outreach, and co-design, while professionals contribute through communication practice and their own trustworthiness [12, 42]. Finally, information environments and structural conditions - local media, digital access, regulation of misinformation, poverty, education, discrimination, governance - bound the whole [14, 15, 33, 43]. A community that knows its water is contaminated but lacks the power to change it has knowledge without literacy in the sense used here.

These contributors interact: skills are shaped by structure, networks by residence and migration, trust by organizational behaviour, and collective efficacy by all of these. This is why community health literacy cannot be reduced to any single level and why single-level interventions tend to have limited effects.

Mechanisms Linking Community Health Literacy to Community Empowerment

Community empowerment is the process through which communities gain control over the decisions and resources that affect their health [34], and Laverack's domains - participation, leadership, organizational structures, problem assessment, resource mobilization, "asking why," links with others, role of outside agents, and program management - provide a useful lens [35]. Community health literacy contributes through four mechanisms.

Critical consciousness: Critical health literacy [17, 24, 25] is the capacity to understand not only what to do but why health is distributed as it is. At community level this becomes a shared analysis of local determinants - the factory upstream, the absent clinic - Freire's conscientização applied to health [44] and the precondition for "asking why."

Shared and validated knowledge: Empowerment requires speaking credibly to power. Community health literacy provides the collective capacity to gather, appraise, and present evidence through community health assessment, participatory surveillance, or citizen science [45]; a community that can document its own disease burden moves from petitioner to interlocutor.

Participation and dialogue: Interactive literacy at community level means two-way engagement with health systems - committees, co-design, structured feedback [21, 46]. Participation is both

mechanism and outcome, building the skills and confidence that sustain further participation, as community-based participatory research documents [47].

Collective efficacy and action: Understanding converts into coordinated behaviour through social capital and collective efficacy [40]: community-led total sanitation, in which shared understanding of transmission catalyzes community-wide norms [48]; community health worker programs that evolve into advocacy networks [49]; community organizations that reshape services [46].

The relationship is reciprocal. Empowered communities create participatory structures, trust, and responsive organizations that raise community health literacy; disempowered communities may experience health information as imposition and disengage from sources they regard as illegitimate, lowering it over time.

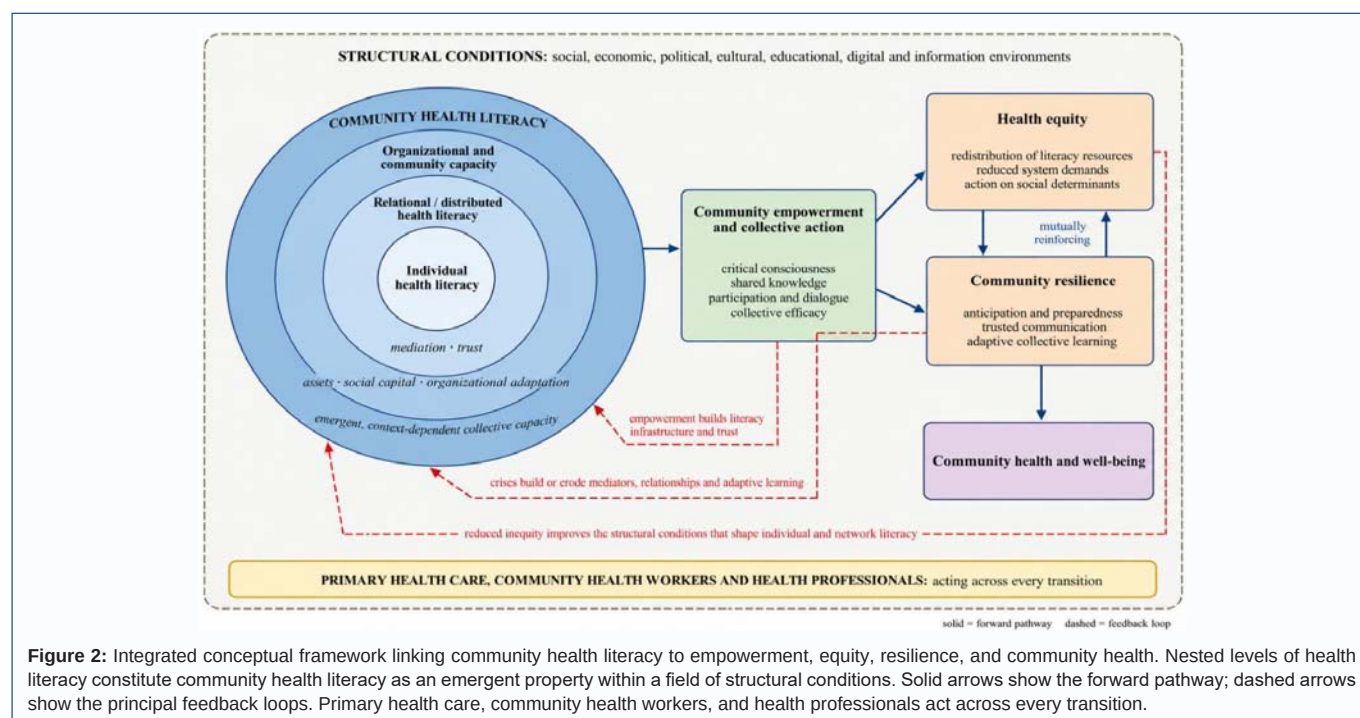
Pathways from Community Health Literacy to Health Equity

Individual health literacy interventions have an uncomfortable equity record, because uptake and benefit are often greatest among the already advantaged [16]. Community health literacy offers three pathways by which this may be reversed.

Redistribution of literacy resources: If literacy is distributed through networks and mediators, equity can be pursued by strengthening the literacy available to disadvantaged groups rather than only the skills of disadvantaged individuals. Community health workers, peer support, and promotora models place a trusted, trained mediator inside communities lacking bridging ties to the system [49, 50], and are by design concentrated where individual literacy and institutional trust are lowest.

Reduced system demands through organizational responsiveness: Organizational health literacy is inherently pro-equity when applied universally, because people with limited skills gain most from navigable, multilingual, welcoming services [12, 22] proportionate universalism applied to information, with targeted outreach adding intensity where need is greatest [14]. Adapting services to local cultural frames, languages, and time constraints reduces the literacy "tax" paid disproportionately by marginalized groups.

Collective action on social determinants: The deepest pathway runs through empowerment: communities with high critical literacy and collective efficacy can act on housing, sanitation, environmental



exposure, and service allocation, which no individual skill can address [15, 24]. This pathway is slow and hard to measure, but it alone addresses the root of the gradient.

Two cautions apply. Community health literacy can be unequally distributed within communities - mediators serve their own kin, networks exclude newcomers, organizations reflect dominant groups [41]. And the concept must not become a new way of shifting responsibility, from individuals to communities, while structural actors remain unaccountable; it complements, and does not substitute for, structural action on the social determinants of health.

Community Health Literacy and Community Resilience

Community resilience is the capacity to anticipate, absorb, adapt to, and recover from adverse events while maintaining or improving function [36, 51]. Of Norris's four networked adaptive capacities - economic development, social capital, information and communication, community competence [36] - community health literacy maps directly onto the last two and supports the others. Its contribution can be traced across the phases of a threat.

In anticipation and preparedness, health-literate communities recognize emerging risks and interpret early warnings, which requires trusted channels through which surveillance information reaches communities; where these exist, communities have detected outbreaks and hazards before formal systems responded [45, 52]. In absorption and response, the decisive capacities are rapid trusted communication and coordinated action: during COVID-19, the effectiveness of messaging depended less on message clarity than on pre-existing trust, the density of mediators, and communities' capacity to adapt guidance locally, and communities with strong literacy infrastructure absorbed the "infodemic" better because misinformation was appraised within trusted networks rather than left to spread [32, 33, 43, 53]. In adaptation and learning, communities that reflect collectively on how they handled a threat - what worked,

who was left out - build literacy for the next event, a form of critical health literacy applied to the community's own performance [54]. And for persistent threats - non-communicable disease, environmental degradation, climate impacts - community health literacy supports the sustained collective action adaptive capacity requires [51].

Here too the relationship is reciprocal: crises can build community health literacy through shared experience and new relationships with health systems, or erode it by destroying trust and exhausting networks, depending on how systems engage communities during the event. Investment in community health literacy is therefore a form of resilience investment, and resilience planning should attend explicitly to community information capacities.

An Integrated Conceptual Framework

Table 3 summarizes the mechanisms identified in Sections 6-8, and Figure 2 proposes an integrated framework.

The framework's core pathway runs from individual health literacy, through relational or distributed literacy in families and networks, to the organizational and community capacity within which those networks operate. Community health literacy emerges from the interaction of these three levels and provides the basis for community empowerment and collective action, which in turn contribute to health equity and community resilience and, through them, to community health and well-being. The pathway is not linear, and five features of the framework qualify that reading.

1. Nested levels, not a ladder: Individual skills operate within networks, networks within communities and organizations, and community health literacy is the emergent property of the whole, not the final rung.
2. Structural conditions as context, not input: Social, economic, political, cultural, and digital conditions surround the entire pathway, constraining or enabling every transition.
3. Feedback loops: Empowered communities create the structures

Table 3: Mechanisms and pathways linking community health literacy to empowerment, equity, and resilience.

Outcome domain	Mechanism or pathway	What community health literacy contributes	Illustrative evidence	Principal caution
Community empowerment	Critical consciousness	Shared analysis of local determinants; capacity to "ask why"	[17, 24, 25, 44]	Consciousness without resources can produce frustration rather than action
	Shared and validated knowledge	Collective capacity to gather, appraise, and present evidence	[45, 47]	Evidence held by professionals alone does not empower
	Participation and dialogue	Two-way engagement with health systems; co-design	[21, 46]	Tokenistic participation erodes trust
	Collective efficacy and action	Conversion of understanding into coordinated behaviour	[40, 48, 49]	Action may reflect dominant groups within a community
Health equity	Redistribution of literacy resources	Trusted mediators placed where individual literacy and trust are lowest	[49, 50]	Mediators may serve their own networks
	Reduced system demands	Universal design plus targeted intensity	[12, 14, 22]	Organizational change alone leaves structural causes untouched
	Action on social determinants	Collective action on upstream causes	[15, 24]	Slow, hard to measure; risk of shifting responsibility to communities
Community resilience	Anticipation and preparedness	Interpretation of early warnings through trusted channels	[36, 45, 52]	Requires prior investment; cannot be built during a crisis
	Absorption and response	Rapid trusted communication; local adaptation; countering misinformation	[32, 33, 43, 53]	Crises can also destroy trust and exhaust networks
	Adaptation and learning	Collective reflection; literacy for the next event	[36, 51, 54]	Requires structures for reflection that many communities lack

Table 4: Roles of primary health care actors in building community health literacy.

Actor	Primary contribution	Illustrative practices	Framework transition most affected
Primary health care system	Institutional home; bridging institution	Asset and mediator mapping; health committees; co-design; organizational health literacy standards; community-oriented primary care cycle [21, 46, 55]	Relational → organizational and community capacity; organizational responsiveness ↔ community demand
Community health workers	Trusted embedded mediators; seeds of collective action	Household visits; translation between community and system; peer education; advocacy [49, 50]	Individual → relational; literacy → empowerment; equity pathway 1
Physicians	Clinical communication; community standing	Plain-language practice; engagement with community organizations and governance; partnership with mediators [42]	Organizational responsiveness; trust
Pharmacists	Most accessible professional contact; information hub	Counselling; appraisal of health claims; screening and health promotion in community pharmacies [56]	Community assets and trust; individual → relational
Nurses and allied health professionals	Outreach and group-based work reaching networks	Home visiting; group education; identification and support of family mediators	Individual → relational; organizational responsiveness
Local organizations and networks	Existing infrastructure of community literacy	Schools, faith organizations, women's and youth groups, local media as partners [38]	Community assets, social capital, collective efficacy

and trust that raise collective literacy (Section 6); reduced inequity improves the conditions that determine individual and network literacy (Section 7); successfully navigated threats build mediators and adaptive learning, while failures erode them (Section 8); and responsive organizations raise community literacy while literate communities demand more responsive organizations.

4. Mechanisms specified: Each transition carries the mechanisms of Sections 5-8: mediation and trust; asset recognition, social capital, and organizational adaptation; critical consciousness, shared knowledge, participation, and collective efficacy; redistribution, reduced demands, and action on determinants; anticipation, trusted communication, and adaptive learning.

5. Health systems as actors throughout: Primary health care, community health workers, and professionals can strengthen or weaken every transition (Section 10).

The framework is a heuristic rather than a tested causal model; its testable propositions are set out in Section 11.

Implications for Primary Health Care and Health Professionals

Reframing health literacy as a community capacity changes what health systems are asked to do: from transmitting information to building the collective conditions under which information can be found, trusted, and acted on. Table 4 summarizes the roles.

Primary health care is the natural institutional home: its community orientation, continuity, and proximity allow it to map

local assets, establish participatory structures, co-design services, embed organizational standards, and link communities to specialist and public health resources, for which community-oriented primary care offers an established methodology [21, 46, 55]. Community health workers are the single most important professional resource, effective precisely because they are trusted mediators embedded in networks and frequently the seed of collective action; investment in their training, supervision, remuneration, and team inclusion is investment in community literacy infrastructure [49, 50]. Physicians contribute through communication but also through their standing, when they treat community mediators as colleagues rather than unqualified intermediaries [42]. Pharmacists, often the first point of contact in low- and middle-income settings, are natural information hubs [56]. Nurses and allied professionals carry the outreach, group education, and home-visiting work through which systems reach networks rather than individuals. Local organizations are the existing infrastructure of community literacy; systems that partner with them gain trust and reach they cannot build alone [38].

Three principles follow: start from assets (identify and strengthen those who already mediate health information); build trust before content (information from an untrusted source has little literacy value); and design for participation (structures through which communities can question, feedback, and shape services are themselves literacy-building).

Conceptual, Measurement, Intervention, and Research Gaps

Conceptually, the definition of community health literacy

Table 5: Summary of gaps and priority research directions.

Domain	Principal gap	Priority direction
Conceptual	Definition contested; boundaries with social capital and community capacity unclear; capacity vs. practice unresolved	Consensus definition through Delphi or concept-mapping with community participation [20]
Measurement	No validated collective measure; aggregation of individual scores dominates [19, 20]	Social network analysis of information flow; asset and mediator mapping; trust and collective-efficacy measures; multilevel designs separating compositional and contextual effects [27, 40, 58]
Intervention	Most “community” interventions target individuals in community settings	Interventions targeting mediator networks, trust, participatory structures, and information infrastructure; realist and complex-intervention evaluation [29, 57]
Evidence base	Concentrating on high-income settings	Studies in low- and middle-income countries; longitudinal and mixed-methods designs

remains contested, its boundaries with social capital and community competence unclear, and the question of whether it is a capacity (something a community has) or a practice (something it does) unresolved; this review treats it as both. No validated instrument measures it as a collective construct: Sentell’s early work found a contextual effect of community literacy on health [58], but the subsequent review showed how rarely social context has been operationalized beyond the individual [19], and aggregation is precisely what the concept resists. Most interventions labelled “community health literacy” are individual programs in community settings; those that deliberately target collective resources are few and poorly evaluated, and complex-intervention and realist designs suit them better than randomized trials alone [57].

The framework generates testable propositions: (a) community-level indicators of literacy infrastructure predict outcomes independently of aggregated individual scores; (b) interventions that strengthen mediators and trust produce larger equity effects than skills-based interventions; (c) communities with higher pre-crisis literacy infrastructure recover faster from health shocks; and (d) participatory structures produce measurable increases in collective literacy over time. Almost all existing evidence comes from high-income settings; research in low- and middle-income countries, where informal mediators and community health workers carry most of the load, is a priority (Table 5).

Conclusion

Health literacy has been one of the most productive concepts in public health of the last three decades, but its individual framing has limited both its explanatory power and its practical reach. This review has argued that health literacy is better understood as a nested and emergent capacity: rooted in individual skills, distributed through relationships, enabled or constrained by organizations and information environments, bounded by structural conditions, and expressed at community level as the collective ability to generate, share, appraise, and act on health information.

So understood, community health literacy is a pathway rather than an end. It contributes to empowerment through critical consciousness, shared knowledge, participation, and collective efficacy; to equity through redistribution of literacy resources, responsive organizations, and action on social determinants; and to resilience through anticipation, trusted communication, and adaptive learning - with feedback loops that mean investment at any level can strengthen the whole. For community medicine and primary health care, the implication is a change of role: from informing individuals to building the collective conditions under which communities can inform themselves and act. That is a role the discipline has always claimed; community health literacy gives it a conceptual vocabulary and a research agenda through which to fulfil it.

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