



CREATING SOCIETAL
COGNITIVE RESILIENCE
AGAINST INFORMATION
DISORDERS

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JEAN MONNET
CENTRE OF EXCELLENCE

A RIGHT-BASED, INEQUALITY- SENSITIVE AND MULTI-STAKEHOLDER POLICY FRAMEWORK FOR HEALTH LITERACY

Policy Paper No 6 | 2026



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A Right-Based, Inequality-Sensitive and Multi-Stakeholder Policy Framework for Health Literacy

Gölin Çavuş

Introduction

In the information landscape of the digital age, health decisions are no longer shaped solely in doctors' surgeries and hospital corridors, but also in social media feeds, on YouTube channels and in WhatsApp groups. This transformation has both made access to health information extraordinarily easy and rendered it critically unreliable. Reliable scientific information sits side by side with unverified, misleading or outright harmful content on the same platform screen; it is becoming increasingly difficult for ordinary users to distinguish between the two.

This policy document aims to address the vulnerability created by this transformation as a matter of rights. My central thesis is this: health literacy is not a matter of individual skill, but a structural health right. The right to a healthy life necessitates the right to access health information; the right to access health information, in turn, necessitates the capacity to understand and critically evaluate that information. Consequently, health literacy policies are as much a matter of public policy aimed at ensuring structural access to reliable information as they are an educational issue aimed at enhancing the individual's cognitive capacity. This paper aims to address four key areas in the context of Türkiye's unique epidemiological and digital information landscape: **the importance of health and science literacy from a rights perspective; the strategic role of science communication in this process; the threats posed by health disinformation; and the factors connecting these areas.**

Chapter 1: Why Should We Reframe Health Literacy?

1.1 The International Framework for the Right to Health

The right to health is defined in Article 12 of the 1966 United Nations International Covenant on Economic, Social and Cultural Rights as "the right of everyone to the highest

attainable standard of physical and mental health”.¹ The World Health Organisation (WHO), however, defines health not just as the absence of disease, but as a state of complete physical, mental and social well-being.²

However, this right remains a subject of debate. Academic and legal discussions continue regarding how health is defined, which minimum requirements fall within this scope, and which institutions are responsible for safeguarding this right. The right to health should encompass not only access to healthcare services but also the structural determinants of health, such as housing, food, education and employment. In this context, health literacy is not simply a matter of information, but also a matter of rights violations. An information environment that fails to provide individuals with accurate health information or exposes them to misleading health information effectively restricts the exercise of the right to health by undermining the individual’s capacity for informed decision-making.

1.2 Health Literacy: From Individual Skills to Systems Thinking

The concept of health literacy is defined as the ability to access, understand, evaluate and use information relating to healthcare services.³ However, the current literature also points to the inadequacy of this definition: literacy levels are directly linked not only to an individual’s educational background, but also to the clarity of the healthcare system, the quality of the media environment and the level of social trust.⁴ The World Health Organisation emphasises that health literacy is not just an individual skill; it is an area that must be addressed at personal, organisational and systemic levels.⁵ However, Healthy People 2030 defines personal health literacy and organisational health literacy as two distinct yet interrelated concepts.⁶ These approaches distribute responsibility not only to citizens but also to institutions, the health system, and the wider information environment.

¹United Nations. (1966). *International Covenant on Economic, Social and Cultural Rights*. <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>

²World Health Organization. (1948). *Constitution of the World Health Organization*. <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>

³Sørensen, K., Van den Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z., & Brand, H. (2012). Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health*, 12, 80.

⁴Nutbeam, D. (2008). The evolving concept of health literacy. *Social Science & Medicine*, 67(12), 2072-2078.

⁵World Health Organization. (n.d.). *Health literacy*. <https://www.who.int/news-room/fact-sheets/detail/health-literacy>

⁶Office of Disease Prevention and Health Promotion. (n.d.). *Health literacy in Healthy People 2030*. <https://odphp.health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030>

If a person is left to navigate complex medical information, unsimplified risk descriptions, jargon-laden institutional language, unreliable digital content, and conflicting media narratives, the problem here is not solely one of individual capacity. It is also a matter of health equity. Furthermore, treating health literacy solely as an issue specific to the healthcare system is insufficient to address the reality of health misinformation that is increasingly spreading through non-clinical channels. Therefore, health literacy must be reframed. This field is no longer simply a public health subfield aimed at individual behavior change; it is simultaneously a realm of inequality, institutional design, trust, media quality, and democratic participation. What is needed, both in Türkiye and around the world, is not “providing people with more information,” but rather establishing a more equitable information system that enables people to make informed health decisions.

1.3 Why Should Health Literacy Be Considered in Conjunction with Science Communication?

A significant portion of the information problems currently facing the healthcare sector does not stem solely from the complexity of the healthcare system. Much of the problem arises from the processes of simplification, incomplete translation, sensationalization, over-generalization, or removal from context that scientific information undergoes as it enters the public sphere. People are not just asking, “Which information is true?”; they are also confronted with questions such as “Is this study reliable?” “Why do experts say different things?” and “Why does science change over time?” For this reason, it is becoming increasingly difficult to draw a strict distinction between health literacy and scientific literacy.

Scientific literacy refers to an individual’s capacity to evaluate scientific processes, scientific practices, evidence, and appropriate scientific expertise; in this regard, it is a fundamental component that supports health literacy in terms of evaluating health-related information and claims.⁷ Science communication plays a decisive role in building this dual literacy capacity within society. According to Lindenfeld and colleagues’ strategic approach to science communication⁸ effective science communication relies not only on the transfer of information but also on developing intentional, evidence-based communication strategies that will have a real-world impact on what people think, feel,

⁷National Academies of Sciences, Engineering, and Medicine. (2016). *Science literacy: Concepts, contexts, and consequences*. The National Academies Press.

⁸Lindenfeld, L., Besley, J. C., Zheng, X., Dudo, A., & Newman, T. P. (2026). *Science communication for scientists: Linking strategy with creativity, practice, and respect*. Routledge.

and do. The same framework also emphasizes that communication is not merely “telling others,” but also involves listening to different social actors, receiving feedback from them, and building relationships of trust. The book **Science Communication for Scientists** defines science communication not only as the task of popularizing or simplifying scientific knowledge, but as a strategic, evidence-based, and ethical process. According to the authors, effective communication is not about randomly selecting specific tactics; rather, it involves first determining the purpose of the communication, the target audience, and the desired behavioral outcome, and then selecting the appropriate tools accordingly.

Chapter 2: The Problem in Türkiye Is Not Just the Healthcare System, but the Knowledge Ecosystem

The official policy language in Türkiye is increasingly adopting a broader framework. The Ministry of Health’s **Health Literacy Action Plan 2025–2028** highlights the importance of raising health literacy levels through programs that involve all stakeholders. The document emphasizes the dimensions of guidelines, education, and awareness-raising. This is an important step; however, to truly make health literacy equitable, a clearer language of rights and equality is needed. This is because it is clear that the same health-related information does not have the same impact on everyone. The pathways to accessing accurate information for an urban, educated person with high digital access will not be the same as those for a person living with chronic illnesses, struggling with caregiving responsibilities, or facing low income or refugee status.

When discussing health literacy in Türkiye, the issue is not simply access to health care; it is also the public circulation of health information. Health news, social media videos, expert opinions, influencer content, messaging groups, advertisements, sponsored content, and artificial intelligence-powered summarization tools are all intertwined. In such an environment, people do not merely experience a lack of information; they also face information overload, conflicting claims, and crises of trust. The World Health Organization (WHO) defines this situation as an “infodemic” and emphasizes that an effective response involves not only correcting misinformation but also listening to the public’s concerns, making accurate information accessible, building resilience, and empowering communities.

When we look at the current state of health literacy in Türkiye, according to Ministry of Health sources, the 2023 Türkiye Health Literacy Survey shows that the proportion of the population with “adequate and excellent” health literacy increased from 31.1% in 2017

to 46.1%; while the “inadequate and limited” level decreased from 68.9% to 53.9%.⁹ Although these findings indicate an improvement in health literacy in Türkiye compared to the past, the fact that more than half of the population still has inadequate or limited health literacy highlights that the issue remains significant in terms of inequality and public capacity.

2.1 Media, Health Journalism, and Specialization

The media’s approach to health news in Türkiye is also one of the weak links in this information ecosystem. Pelin Öğüt’s study, which examines the historical development of health journalism in Türkiye, shows that health journalism should be regarded as a specialized field directly related to public health; however, discussions regarding specialization in this field have been ongoing for a long time. According to Öğüt, health news became more prominent in mainstream newspapers in the 1990s; the first steps toward the organization of health journalists and specialization were taken during this period, while the effects of commercialization in health journalism became more apparent in the 2000s.¹⁰

A 2024 study on health journalism in Türkiye reveals serious standardization issues in the production process of online health content. In 23.2% of the news articles examined, there was no reliable source cited; in 63%, the author’s name was not provided. In the same study, the vast majority of participants stated that false health news poses a risk to public health and view the media as one of the primary drivers of the infodemic. These findings suggest that the problem is not merely a matter of “occasional false reports,” but rather a structural issue.¹¹

More qualitative studies also point to a similar picture. A 2023 article examining the printed media’s approach to cancer news in Türkiye notes that, due to the technical nature of health news, it is important for reporters to specialize and for news stories to be prepared with care. It is evident that health news is caught between the public interest and the pressure to attract attention, and often carries the risk of becoming sensationalized. This issue is not just a matter of editorial choice; it is also a result of the institutional news

⁹T.C. Sağlık Bakanlığı. (n.d.). *Sağlık okuryazarlığı ulusal eylem planı 2025-2028*. <https://dosyamerkez.saglik.gov.tr/Eklenti/51749/0/saglik-okuryazarligi-ulusal-eylem-planı-2025-2028-v2pdf.pdf>

¹⁰Öğüt, P. (2017). Türkiye’de sağlık haberciliğinin tarihsel gelişimi. *Atatürk İletişim Dergisi*, 14, 5-26.

¹¹Öntaş, E., Bahar-Özvarış, Ş., & Şimşek, B. (2024). Creating, publishing, and spreading processes of health-related contents in internet news sites: Evaluation of the opinions of actors in health communication. *Front Public Health*.

economy and a lack of specialization in health journalism.¹² This is precisely where the educational aspect comes into play. Although some communication faculties in Türkiye offer courses in health communication or health, science, and technology journalism, these courses are often offered as electives. At Anadolu University, “Health, Science, and Technology Journalism” is listed as a professional elective course.¹³ Galatasaray University’s communication program offers “Health Communication,”¹⁴ and Yeditepe University’s Faculty of Communication offers “Health Communication”¹⁵ as elective courses. This situation demonstrates that, although the field is not absent, it has not yet become a strong and integral component of journalism education.

A similar fragmentation is also evident in medical education. A study examining the curricula of medical schools in Türkiye shows that communication training exists in most schools but is largely theoretical and delivered in various formats. Therefore, the problem is not the complete absence of communication training; rather, it is that it has not been sufficiently established as a standardized, practical, interdisciplinary, and robust core component. When healthcare professionals communicate with patients, the media, and the public, they need not only clinical knowledge but also skills in communicating uncertainty, framing risks, building trust, and addressing misinformation.¹⁶

Finally, an analysis published by the European Journalism Observatory also noted that many expert health reporters in Türkiye have lost their jobs due to pressure on the media, and that journalists who toe the official line are reluctant to ask tough questions.¹⁷ This situation serves as a reminder of why high-quality, expert journalism is a public necessity during health crises.

2.2 The Digital Information Environment and the Erosion of Trust

When we look at the digital landscape, however, the situation is no different. Türkiye ranks among Europe’s leading countries in terms of social media penetration; the number of

¹²Suiçmez, M. (2023). Türkiye’de yazılı basının kanser haberlerine yaklaşımı. *Intermedia International E-journal*, 10(18), 234–256. <https://doi.org/10.56133/intermedia.1255949>

¹³<https://www.anadolu.edu.tr/akademik/fakulteler/ders/214464/saglik-bilim-ve-teknoloji-haberciligi/ders-tanitimi>

¹⁴ <https://ects.gsu.edu.tr/tr/program/coursedetails/17844>

¹⁵ <https://iletisimfakultesi.yeditepe.edu.tr/en/elective-detail?secmeliID=25163>

¹⁶ Karabulut, S. D., Zengin, H. Y., Yıldırım, R. V., & Çelik, Z. Y. (2020). Tıp fakültesi dönem 1-2-3 öğrencilerinin iletişim ve empati becerilerinin analizi. *Tıp Eğitimi Dünyası*, 19(58), 42–53. <https://doi.org/10.25282/ted.647207>

¹⁷ Özdal, C. (2020). *Turkey: Coronavirus and the media*. European Journalism Observatory. <https://en.ejo.ch/ethics-quality/turkey-coronavirus-and-the-media>

active social media users exceeds 58 million.¹⁸ Video-based platforms—particularly YouTube, Instagram, and TikTok—have become the primary channels for the dissemination of health-related content. On these platforms, content that promotes health literacy and content that spreads misinformation are both subject to the same algorithmic recommendation logic.

The findings for Türkiye in the Reuters Institute Digital News Report reveal that trust in traditional media has declined significantly over the past decade, while social circles, particularly family and groups of friends, have risen to become the primary source of news.¹⁹ This dynamic is particularly dangerous when it comes to health information. This is because health advice from sources perceived as trustworthy but unverified can easily be accepted in the absence of clinical authority.

This picture shows that the real problem in the health sector is not merely the existence of misinformation; rather, it lies in which content is made visible by whom, within which relationships it gains credibility, and within which platform logics it is circulated. Digital health literacy cannot, therefore, be viewed as limited solely to the ability to ‘access accurate information’; it must also encompass the capacity to evaluate sources, recognise algorithmic visibility mechanisms, question advice circulating within one’s social circle, and distinguish between reliable expert and institutional communication. Otherwise, when high platform usage is combined with low trust in institutions, health-related decisions may increasingly be shaped by networks that are unverified yet appear familiar, close, and reassuring.

Chapter 3: The Health Disinformation Map

3.1 The Scale of the Health Problem in an Environment of Information Disorders

The World Economic Forum’s 2024 Global Risks Report,²⁰ has classified disinformation and the technology that spreads it as one of the world’s greatest global threats. The WHO, meanwhile, has identified misinformation as a priority public health issue; it has characterised the phenomenon of the “infodemic” that erupted during the pandemic as a second crisis unfolding in parallel with the actual pandemic.²¹ The infodemic in question is

¹⁸ DataReportal. (2025). *Digital 2025: Turkey*. <https://datareportal.com/reports/digital-2025-turkey>

¹⁹ Reuters Institute for the Study of Journalism. (2025). *Digital news report 2025*. https://reutersinstitute.politics.ox.ac.uk/sites/default/files/2025-06/Digital_News-Report_2025.pdf

²⁰ World Economic Forum. (2024). *Global risks report 2024*.

²¹ World Health Organization. (n.d.). *Infodemic*. https://www.who.int/health-topics/infodemic#tab=tab_1

not merely a conceptual framework; systematic reviews show that health misinformation on social media can reach significant levels, although this varies depending on the topic and platform. For example, it is reported that up to 87 per cent of content on social media relating to tobacco consumption may be misleading or unfounded.²² Similar proportions of misleading or unsubstantiated information have also been found in more narrowly focused, platform-specific empirical studies on topics such as cancer, detox products, diet pills and vaccines.

A nationally representative survey conducted in the US with over 6,000 participants found that 82% of adults who use social media believe they have encountered false or misleading health information on these platforms; moreover, this perception largely aligns with the findings of objective content analyses. Meanwhile, 67% of those taking part in the same survey stated that they were unable to distinguish whether health information on social media was true or false.²³ This finding clearly highlights the extent to which the literacy gap is a structural problem.

It would be misleading to regard health misinformation simply as an individual misconception or as "noise" in the media stream. Research shows that exposure to false health information leads to measurable psychological and behavioural consequences: fear, anxiety, distrust of the healthcare system, and paranoid attitudes towards official health authorities are among the most prominent of these. Individuals who obtain information predominantly via social media exhibit significantly higher levels of depression and anxiety compared to those who do not use it extensively; this correlation is directly linked to the quality of the content.

According to a 2026 survey in the United States, sponsored by Bayer and conducted by The Harris Poll, 86% of participants believe that false or misleading information relating to health and science has become a greater problem today than it was five years ago.²⁴ In the same survey, 82 per cent of participants stated that they were concerned about their own and their families' well-being due to false or misleading information.

Health disinformation is also undermining the ecosystem of trust. Several studies have documented a paradoxical cycle whereby 'the mistrust generated by misinformation facilitates the spread of that very misinformation': individuals exposed to disinformation

²²Suarez-Lledo, V., & Alvarez-Galvez, J. (2021). Prevalence of health misinformation on social media: Systematic review. *Journal of Medical Internet Research*, 23(1), e17187. <https://doi.org/10.2196/17187>

²³ Stimpson, J. P., & Ortega, A. N. (2023). Social media users' perceptions about health mis- and disinformation on social media. *Health Affairs Scholar*, 1(4), qxad050. <https://doi.org/10.1093/haschl/qxad050>

²⁴The Harris Poll. (2026). *Science under siege: The battle between viral misinformation and shared belief in the value of science*. Bayer.

lose trust in legitimate health authorities; this mistrust drives them towards alternative sources; and the content they encounter in these alternative sources further reinforces their mistrust. This vicious cycle has become a structural problem that threatens the relationship with clinicians, particularly in the context of chronic diseases, including cancer. Healthcare professionals report that they are now forced to work within this information environment; an increasing proportion of doctor-patient consultations is spent correcting false health claims that have made their way into the consultation room.

The commercial aspect of the issue should not be overlooked either. On digital platforms, claims relating to health, wellness, dietary supplements, and alternative therapies are disseminated not only through posts by individual content creators, but also through advertising models, targeting tools, and engagement-focused algorithmic incentives. Zenone, Kenworthy and Maani²⁵ therefore argue that the social media sector should be regarded as a ‘commercial determinant of health’. According to the authors, social media companies, due to their advertising-based revenue models, seek to keep users’ attention on the platform for as long as possible; algorithmic recommendation systems may also pave the way for the spread of misinformation, polarising content, and harmful marketing practices. A system in which platforms derive financial gain from hosting disinformation is doomed to remain unsolvable in the absence of accountability mechanisms.

The work carried out by independent health fact-checking organisations or fact-checking platforms in the health sector serves as a systematic monitoring mechanism in this field; through a global network of scientists, they seek to document the distinction between fact and fiction in health and medical media. One such platform is the UK-based fact-checking organisation Full Fact²⁶, which regularly reports on the tangible harm caused by health disinformation.²⁷ The key findings of these studies reveal that misinformation leads not only to individual decision-making errors but also to a decline in vaccination rates, the unnecessary overcrowding of emergency rooms, and a loss of trust in public health messages.

²⁵Zenone, M., Kenworthy, N., & Maani, N. (2023). The social media industry as a commercial determinant of health. *International Journal of Health Policy and Management*, 12, 6840. <https://doi.org/10.34172/ijhpm.2022.6840>

²⁶ <https://fullfact.org/>

²⁷Full Fact. (2021). *The Full Fact report 2021: Fighting a pandemic needs good information*. <https://www.nuffieldfoundation.org/wp-content/uploads/2021/01/full-fact-report-2021.pdf>

3.2 Mechanisms of Disinformation Spread, Levels of Harm and Emerging Threats

Vaccine Disinformation: A Measurable Public Health Crisis

The sub-field of health disinformation with the best-documented evidence of harm and the broadest population-level impact is vaccine disinformation. It is possible to identify a historical starting point here. A study published in *The Lancet* in 1998, which linked the MMR vaccine to autism, was retracted in 2010 and the lead author's medical licence was revoked; however, this retraction never reached as wide an audience as the harm caused by the original claim. Thirty years on, the mistrust generated by this debunked claim continues to have a negative impact on childhood vaccination rates. This example illustrates the capacity of misinformation to persist even after it has been debunked – in other words, the “stickiness of misinformation”.²⁸

During the 2024–2025 period, the tangible cost of this accumulation can be seen in the case of measles. According to a global assessment published by the WHO in 2025, 59 countries reported major or devastating measles outbreaks in 2024²⁹; this figure is almost three times the number of outbreaks reported in 2021.³⁰ The same assessment states that an estimated 95,000 people worldwide died from measles in 2024, with the majority of deaths occurring among children under the age of five. According to the CDC, MMR vaccination coverage among pre-school children in the US fell from 95.2 per cent in the 2019–2020 academic year to 92.5 % in the 2024–2025 academic year; this decline meant that approximately 286,000 pre-school children were attending school without documentation confirming they had completed their MMR vaccination series.³¹ According to the CDC's interim analysis covering the period 1 January–17 April 2025, 771 of the 800 reported measles cases in the US, that is, 96%, involved people who were unvaccinated or whose vaccination status was unknown.³² When considered alongside the decline in MMR vaccination coverage, this finding demonstrates just how critical a risk low vaccination levels pose in terms of measles outbreaks. The Director of the WHO Department of

²⁸Çavuş, G. (2020). *Wakefield I: Aşı ve otizm arasında ilişki olduğu iddiaları nereden çıktı?* Teyit. <https://teyit.org/dosya/wakefield-i-asi-ve-otizm-arasindaki-iliski-oldugu-iddialari-nereden-cikti>

²⁹ Do, L. A. H., & Mulholland, K. (2025). Measles 2025. *New England Journal of Medicine*, 393(24), 2447–2458. <https://doi.org/10.1056/NEJMra2504516>

³⁰ World Health Organization. (2025). *Measles deaths down 88% since 2000, but cases surge*. <https://www.who.int/news/item/28-11-2025-measles-deaths-down-88--since-2000--but-cases-surge>

³¹ <https://www.cdc.gov/measles/data-research/index.html>

³²Centers for Disease Control and Prevention. (2025). *Measles update — United States*, <https://www.cdc.gov/mmwr/volumes/74/wr/mm7414a1.htm>

Vaccines and Biologicals clearly described this situation in a statement published in September 2025: “The consequences of vaccine misinformation are not hypothetical, but real and tragic.”³³

The COVID-19 pandemic has demonstrated on a global scale that health-related disinformation can develop into a systematic “infodemic”, and that this infodemic can create a public health crisis every bit as real as the pandemic itself. Disinformation has shaped not only individuals’ behavioural decisions, but also the design of vaccination programmes, public compliance with public health measures, and trust in the healthcare system. A study by Vosoughi et al. (2018), published in the journal *Science*,³⁴ has shown that misinformation spreads faster, more widely and more deeply than accurate information; it is clear that this dynamic carries additional significance for health information: postponing decisions on health matters or opting for the wrong treatment leads to real consequences for real people, who are often forced to pay the price immediately.

Cancer Disinformation

Cancer disinformation constitutes the best-documented subcategory within the field of health disinformation and the one with the highest potential for harm. In many countries, particularly in Türkiye, three main patterns of disinformation relating to cancer treatment are widely observed on social media platforms:

- Claims of alternative treatments: Methods claimed to cure cancer ‘naturally’, ranging from olive leaf extract to garlic, and from bicarbonate of soda to ozone therapy. This content is disseminated primarily in video format through testimonial accounts and contains messages aimed at replacing evidence-based treatment.
- The “hidden medicines” narrative: the claim that pharmaceutical companies deliberately withhold effective cancer treatments. By fuelling mistrust of institutional healthcare providers, this narrative delays access to effective treatment that could be sought in the early stages of the disease.
- Content opposing chemotherapy and radiotherapy: Messages claiming that standard treatments are more dangerous than the disease itself. It has been shown

³³World Health Organization. (2025). *Message by the Director of the Department of Immunization, Vaccines and Biologicals at WHO*. Geneva: WHO. <https://www.who.int/news/item/22-09-2025-message-by-the-director-of-the-department-of-immunization--vaccines-and-biologicals-at-who---september-2025>

³⁴Vosoughi, S., Roy, D. & Aral, S. (2018). The spread of true and false news online. *Science*, 359(6380), 1146–1151. <https://doi.org/10.1126/science.aap9559>

that such content is linked to decisions to discontinue treatment and deviate from recommended protocols.

These patterns of disinformation do not merely cause harm to individuals. They also structurally undermine the effectiveness of the healthcare system through late diagnoses, low cancer screening rates, and a lack of trust in oncology clinics. Studies on the impact of cancer disinformation on diagnostic delays³⁵ and the continuation of treatment demonstrate that³⁶, when considered together, this relationship affects mortality rates.³⁷

Mechanisms: How Does Disinformation Spread?

Health disinformation spreads through three interrelated mechanisms, each of which requires a different intervention approach. The first is increased algorithmic visibility. The recommendation logic of social media platforms prioritises content that keeps users in front of their screens for longer and generates more engagement. Content that is highly emotive, surprising, or fear-inducing has a significant advantage in meeting this metric. Misinformation can spread further, faster, more deeply, and more widely than true information. According to a study by Vosoughi, Roy and Aral based on Twitter data,³⁸ the sharing chains of accurate news stories are generally small and often fail to reach more than 1,000 people. In contrast, the top 1 per cent of the most widely shared false news stories, that is, the largest chains of misinformation, can reach between 1,000 and 100,000 people. Platforms have no financial incentive to halt this spread; on the contrary, they generate advertising revenue from content creators whose posts generate high engagement. In this context, the academics argue that the social media sector should be framed as a “commercial determinant of health”.³⁹

Secondly, trusted communication channels. Health-related content from family and friends is shared on closed messaging platforms such as WhatsApp, Telegram and similar services without any assessment of the source’s reliability. This trust-based sharing

³⁵Lazard, A. J., Nicolla, S., Vereen, R. N., Pendleton, S., Charlot, M., Tan, H. J., ... Dasgupta, N. (2023). Exposure and reactions to cancer treatment misinformation and advice: Survey study. *JMIR Cancer*, 9, e43749.

³⁶Ben-Ari, E. (2021). Addressing the challenges of cancer misinformation on social media. *Cancer Currents Blog*. National Cancer Institute. <https://www.cancer.gov/news-events/cancer-currents-blog/2021/cancer-misinformation-social-media>

³⁷Hanna, T. P., King, W. D., Thibodeau, S., Jalink, M., Paulin, G. A., Harvey-Jones, E., ... Aggarwal, A. (2020). Mortality due to cancer treatment delay: Systematic review and meta-analysis. *BMJ*, 371.

³⁸Vosoughi, S., Roy, D., & Aral, S. (2018). The spread of true and false news online. *Science*, 359(6380), 1146–1151. <https://doi.org/10.1126/science.aap9559>

³⁹Zenone, M., Kenworthy, N., & Maani, N. (2023). The social media industry as a commercial determinant of health. *International Journal of Health Policy and Management*, 12, 6840. <https://doi.org/10.34172/ijhpm.2022.6840>

automatically transfers the source's reliability to the content: "My mum sent it; she couldn't possibly have sent anything wrong." This mechanism is of critical importance, particularly in the context of Türkiye. According to data from the Reuters Institute's 2019 Digital News Report,⁴⁰ online platforms and closed messaging groups play a significant role as the primary source of information in Türkiye. Information disseminated through these channels is also altering the trust dynamic. The "illusory truth effect" created by repeated exposure further reinforces this dynamic.⁴¹ The more frequently one encounters a piece of content, the more one tends to feel that it is true.

Thirdly, there are bots and coordinated disinformation networks. Social media bots systematically spread false content by imitating human users, tagging influential accounts, and helping false claims gain momentum at an early stage.⁴² Journalistic investigations and academic studies have documented that these networks are used⁴³ in a coordinated manner, particularly in anti-vaccine campaigns and pandemic disinformation.⁴⁴ One important distinction must be made here: research shows that bots spread both true and false information at a similar rate; consequently, the prevalence of false information stems not from the bots themselves, but largely from people's tendency to share it.

Vulnerability Is Unevenly Distributed

Vulnerability to health misinformation is not distributed equally across the entire population; certain groups are structurally at greater risk. Elderly individuals constitute a group that requires particular attention in this regard. A meta-analysis published in 2025 found that the prevalence of belief in false health information among older adults was 47%.⁴⁵ A digital footprint study published in *Nature Aging* has revealed that older adults

⁴⁰Reuters Institute for the Study of Journalism. (2019). *Digital news report 2019*. <https://reutersinstitute.politics.ox.ac.uk/our-research/digital-news-report-2019>

⁴¹Pennycook, G., Cannon, T. D., & Rand, D. G. (2018). Prior exposure increases perceived accuracy of fake news. *Journal of Experimental Psychology: General*, 147(12), 1865–1880. <https://doi.org/10.1037/xge0000465>

⁴²Shao, C. ve ark. (2018). The spread of low-credibility content by social bots. *Nature Communications*, 9, 4787. <https://doi.org/10.1038/s41467-018-06930-7>

⁴³Suarez-Lledo, V., & Alvarez-Galvez, J. (2022). Assessing the role of social bots during the COVID-19 pandemic: Infodemic, disagreement, and criticism. *Journal of Medical Internet Research*, 24(8), e36085. <https://doi.org/10.2196/36085>

⁴⁴Yuan, X., Schuchard, R. J., & Crooks, A. T. (2019). Examining emergent communities and social bots within the polarized online vaccination debate in Twitter. *Social Media + Society*, 5(3). <https://doi.org/10.1177/2056305119865465>

⁴⁵Hu, B., Liu, X., Lu, C. & Ju, X. (2024). Prevalence and intervention strategies of health misinformation among older adults: A meta-analysis. *Health Psychology Review*, 13591053241298362. <https://doi.org/10.1177/13591053241298362>

encounter far more low-reliability health content than younger people;⁴⁶ the fact that this phenomenon is particularly prevalent amongst those who already hold misguided beliefs about health illustrates how disinformation operates in a cycle. Given that elderly individuals have a stronger motivation to seek information on health matters, whilst their levels of digital literacy remain more limited, it is clear that this dual vulnerability requires a systemic response.

Individuals with low health literacy constitute another critical group. Research consistently shows that low health literacy significantly increases reliance on low-quality information sources on social media.⁴⁷ More importantly, individuals with low literacy levels struggle to distinguish between high-quality and low-quality sources; they tend to give high ratings to unfounded claims as if they were true.⁴⁸ It has been shown that a person who believes in misinformation on one health-related topic is also highly likely to believe in misinformation on other health-related topics. This finding suggests that susceptibility is not topic-specific but rather a general structural characteristic.

For those living in rural areas and low-income urban groups, health disinformation is not merely a matter of individual lack of knowledge; it is a structural issue intertwined with access to healthcare, trust in institutions, and local knowledge networks. For these groups, geographical barriers to accessing healthcare institutions are compounded by a sense of having no alternatives; online platforms serve as both the sole source of information and a space for shaping community norms. Findings from the KFF, which works on health policies relating to rural communities in the US, show that rural adults are frequently exposed to false health claims; regarding a significant proportion of these claims, they are unable to say they are "definitely false" and remain in a state of uncertainty.⁴⁹ The same report reveals that adults in rural areas make extensive use of Facebook and YouTube, but place the greatest trust in their own doctors when it comes to health information.

In the context of COVID-19, a link has been demonstrated between the tendency to turn to unproven treatments and susceptibility to misinformation. In a study conducted by

⁴⁶Lyons, B., King, A. J., Barter, R. L., & Kaphingst, K. A. (2026). Exposure to low-credibility online health content is limited and is concentrated among older adults. *Nature Aging*, 1-9. <https://doi.org/10.1038/s43587-025-01059-x>

⁴⁷ Scherer, L.D. ve ark. (2021). Who is susceptible to online health misinformation? A Test of Four Psychosocial Hypotheses. *Social Science & Medicine*, 289, 114002. <https://doi.org/10.1037/hea0000978>

⁴⁸ Chen, Xuewei et al. "Health literacy and use and trust in health information." *Journal of health communication* vol. 23,8 (2018): 724-734. doi:10.1080/10810730.2018.1511658 <https://pmc.ncbi.nlm.nih.gov/articles/PMC6295319/>

⁴⁹Kearney, A., Lopes, L., Washington, I., Valdes, I., Yilma, H., & Hamel, L. (2023). *Addressing misinformation in rural communities: Snapshot from the KFF Health Misinformation Tracking Poll Pilot*. KFF.

Perlis and colleagues involving 13,438 adults across the US, 5.9 % of those who reported having had COVID-19 stated that they had used ivermectin or hydroxychloroquine. Those who believed in misinformation about the COVID-19 vaccine were found to be more likely to use these unproven treatments; trust in scientists and doctors, however, was inversely associated with such use.⁵⁰

Communities that have experienced historical mistrust and systemic exclusion are also particularly vulnerable. Narratives such as "the government is hiding information" or "pharmaceutical companies are deceiving you" strike groups who have faced genuine injustices at the hands of the institutional healthcare system as more credible. For these groups, combating disinformation is only possible not simply through fact-checking, but by restoring trust.

The Evolving Threat of Artificial Intelligence: Synthetic Health Disinformation

Health disinformation has taken on a qualitatively new dimension with the widespread adoption of generative artificial intelligence technologies. In the past, false health content was fuelled by individual errors or the coordinated activity of bots. Now, the faces, voices, and gestures of real doctors are being reproduced via artificial intelligence to present false health claims that those doctors have never actually made. This development has the potential to render the question "who is saying this?" unanswerable.

This threat is not merely theoretical. In 2024, the image of the renowned Australian scientist Dr Karl Kruszelnicki was used in deepfake content on Facebook to sell pills; users who reported the content were told that it did not breach the platform's standards.⁵¹ In the same year, footage of a diabetes specialist in Australia was used in videos generated by artificial intelligence to promote a dietary supplement he had not endorsed, and the doctor in question was forced to proactively warn his own patients. In France, nutritionist Serge Hercberg discovered that thirty-two videos generated by artificial intelligence had been published in his name on a YouTube channel; none of these videos contained any disclosure stating that the content had been generated by artificial intelligence.⁵²

⁵⁰Perlis, R. H., Lunz Trujillo, K., Green, J., Safarpour, A., Druckman, J. N., Santillana, M., Ognyanova, K., & Lazer, D. (2023). *Misinformation, trust, and use of ivermectin and hydroxychloroquine for COVID-19*. JAMA Health Forum, 4(9), e233257. <https://doi.org/10.1001/jamahealthforum.2023.3257>

⁵¹The Conversation. (2025). *Generative AI and deepfakes are fuelling health misinformation*. <https://theconversation.com/generative-ai-and-deepfakes-are-fuelling-health-misinformation-heres-what-to-look-out-for-so-you-dont-get-scammed-246149>

⁵²Medscape. (2026). *French nutrition expert targeted by health deepfakes*. <https://www.medscape.com/viewarticle/french-nutrition-expert-targeted-health-deepfakes-2026a1000a7z>

Research carried out by Full Fact has revealed that hundreds of manipulated videos have been identified, and that the vast majority of these were produced by scammers specifically targeting vulnerable audiences on topics such as the menopause, weight management and diabetes.⁵³ It is fair to say that deepfake videos impersonating real doctors on social media are reaching an ever-growing audience, and that the platforms' removal processes are extremely slow.

The worrying aspect of this phenomenon is not limited to the quality of the content alone. A two-stage cross-sectional study published in *Frontiers in Public Health* in 2025 shows that, under certain conditions, participants perceived AI-generated video doctors as being as trustworthy as human doctors.⁵⁴ Deepfake health content exploits biases inherent in real people and instrumentalises these biases for the purpose of health disinformation. An assessment paper published by UNESCO describes this development as the "synthetic reality threshold". We are approaching a point where people will be unable to reliably distinguish between authentic and fabricated media without technological assistance.⁵⁵ The same article examines the use of doctor deepfakes for healthcare fraud as part of a wider "evidence crisis" in the medical field. When security measures prove inadequate, these tools can achieve a far greater persuasive power than traditional content formats by both personalising disinformation and presenting it in an authoritative tone. A Guardian article reporting on Full Fact's 2025 study,⁵⁶ reveals that on TikTok and other platforms, the images and voices of real doctors are being manipulated using AI and used in deepfake videos to market unproven supplements. Consequently, when security measures prove inadequate, AI-generated doctor/avatar formats can create a more powerful persuasive effect than traditional content formats by both personalising disinformation and presenting it in the authoritative language of an expert.

The implications of this whole picture in the context of Türkiye are as follows: high social media penetration, a strong culture of closed messaging groups, and declining trust in traditional media are making the country structurally vulnerable to both algorithmic and

⁵³National Public Health Information Coalition. (2025, Aralık). *AI deepfakes of real doctors spreading health misinformation on social media*. <https://www.nphic.org/news/news-highlights/2554>

⁵⁴Liu, T., Wang, P., Pan, D., & Liu, R. (2025). Credibility of AI generated and human video doctors and the relationship to social media use. *Frontiers in Public Health*, 13, 1559378. <https://doi.org/10.3389/fpubh.2025.1559378>

⁵⁵Naffi, N. (2025). *Deepfakes and the crisis of knowing*. UNESCO. <https://www.unesco.org/en/articles/deepfakes-and-crisis-knowing>

⁵⁶Campbell, D. (2025). AI deepfakes of real doctors spreading health misinformation on social media. *The Guardian*. <https://www.theguardian.com/society/2025/dec/05/ai-deepfakes-of-real-doctors-spreading-health-misinformation-on-social-media>

trustworthy network mechanisms. When AI-based deepfake content begins to be produced in Turkish, and examples of this are already beginning to emerge, this vulnerability will increase exponentially. For this reason, policies to combat health disinformation must be designed not based on the current threat level, but based on the impending threat capacity.

Chapter 4: How Shall We Formulate a Response?

4.1 Health Literacy Intervention Models

International experience shows that health literacy interventions can be designed at three different levels: individual, organisational and systemic. Programmes focusing on strengthening skills at the individual level have not, on their own, produced sufficient results. To achieve a lasting impact, they must be combined with organisational and systemic transformations. Presenting health information in a simple, clear and understandable manner, clinical communication practices that support patient engagement, and making the health system more user-friendly form the basis of organisational-level interventions.

4.2 The Role of Strategic Science Communication

Current research in the field of science communication highlights the concept of "strategic science communication", which goes beyond the mere transfer of information. According to this approach, communication efforts should be planned as an evidence-based process aimed at transforming what target audiences think, feel, and do in the real world. In the context of health communication, this framework focuses on three key outcomes: strengthening positive beliefs regarding the credibility of scientific institutions, supporting individual health behaviours, and enhancing critical literacy to counter mechanisms of disinformation.

This approach also requires communication to be based on a model of "with the public" rather than 'from one person to the public'. Establishing a genuine dialogue with target audiences and learning about their concerns and how they make sense of the world is a prerequisite for science communication that is both more effective and more ethical. The "It's Safe to Ask" campaign implemented in Canada transforms this principle into a concrete tool:⁵⁷ Individuals are advised to ask just three questions at every healthcare

⁵⁷Canadian Public Health Association. (n.d.). *Examples of health literacy in practice*. https://www.cpha.ca/sites/default/files/uploads/resources/healthlit/examples_e.pdf

consultation: “What is my health problem?”, “What do I need to do?”, “Why do I need to do this?” This approach highlights the communication responsibilities of both the patient and the healthcare professional without placing blame on the individual, and provides a simple, rights-based tool that could be widely adopted at a community level.

The greatest challenge faced by disadvantaged groups, particularly refugee communities, in accessing their right to healthcare is this complex information environment and the inability to engage in dialogue. In a project in Lisbon, data was first collected from 1,100 newly arrived migrants for migrant and refugee communities, after which 16 typical health literacy profiles were developed. These profiles were then discussed in workshops together with the community itself.⁵⁸ In other words, the solution was not dictated from above, but was co-designed based on experience. The model serves as a direct source of inspiration for the fields of migrant health, women’s health, and cancer navigation in Türkiye.

4.3 Cultural Tools and Participatory Models: Working with the Community

The realisation that health literacy cannot be achieved through the mere transfer of information has prompted the development of creative and participatory approaches in many countries. The CultureForHealth perspective emphasises that culture and the arts are powerful tools for health communication and health promotion; it also highlights that cultural institutions can be repositioned as entry points to health information and support services, particularly for groups lacking equal access.⁵⁹ According to this approach, narrative-based, visual and performative tools make health information more accessible, emotionally resonant and collectively owned.

Viewed from this perspective, the following international examples illustrate both the practical validity of the model and its potential for adaptation in Türkiye.

Narrative and Art-Based Approaches

Developed in the US, “The Bigger Picture” campaign is a youth-led spoken-word poetry initiative that shifts the focus away from viewing type 2 diabetes solely through the lens of individual lifestyle choices and instead links it to structural inequalities, the environment and the food system. In this campaign, where young people from low-income backgrounds

⁵⁸World Health Organization. (2022). *Health literacy development project series: Co-designing health literacy initiatives in migrant communities in Portugal*. <https://www.who.int/news/item/04-12-2022-health-literacy-demonstration-project-series--co-designing-health-literacy-initiatives-in-migrant-communities-in-portugal>

⁵⁹Zbranca, R., Genet, M. T., Chen, N. H.-K., et al. (2022). *CultureForHealth report: Culture’s contribution to health and well-being. A report on evidence and policy recommendations for Europe*. CultureForHealth.

act as both creators and narrators, it has not only enhanced health literacy but also developed the capacity for civic engagement and the ability to recognise the structural determinants of health.⁶⁰

The asthma study in Malaysia, meanwhile, uses the Photovoice method: Adults with limited health literacy document their own experiences through photographs and share these experiences with the public through an exhibition and a community-based sharing process.⁶¹ In that it transforms the individual from a passive target audience into a producer of knowledge, this model can be adapted to studies in Türkiye relating to care work and treatment processes.

The Transformation of Non-Clinical Spaces

Two examples from the UK and Canada illustrate, in different ways, how health literacy can be developed outside the clinical setting. In the UK, public libraries have been redefined as everyday public spaces where children can develop critical health literacy; a children's advisory group has also been involved in the research process.⁶² A model developed by Gonzaga University in the US has brought together an academic health librarian, the university and a local primary school to develop a health literacy partnership focused on nutrition literacy for children and their families.⁶³

Materials Adapted for Low-Literacy Contexts

In a randomised controlled trial conducted in Nepal with pregnant women at risk of anaemia, the educational material was designed entirely without text; illustrations, photographs and nomograms were used. Simply providing the material was not sufficient; supporting it with face-to-face and personalised consultations made a decisive difference.

⁶⁰Machado, S. S., Schillinger, D., Vina, L. A., Cortez, G., Daniels, R., & Thompson, H. R. (2021). Seeing "the bigger picture:" Impact of an arts-focused type 2 diabetes education program in high schools. *Journal of Health Communication, 26*(10), 696–707. <https://doi.org/10.1080/10810730.2021.1998845>

⁶¹Salim, H., Young, I., Lee, P. Y., Sazlina, S.-G., & Pinnock, H. (2022). Insights into how Malaysian adults with limited health literacy self-manage and live with asthma: A photovoice qualitative study. *Health Expectations, 25*(1), 163–176.

⁶²Jenkins, C. L., & Rees, S. (2022). Public libraries as supportive environments for children's development of critical health literacy. *International Journal of Environmental Research and Public Health, 19*(19), 11896.

⁶³Branum, C. (2024). Promoting nutrition literacy in children: A case study of library and university collaboration with an elementary school. *Journal of the Medical Library Association, 112*(3).

In the group that received the training, significant improvements were observed in both haemoglobin levels and health literacy indicators.⁶⁴

In all these examples, the key feature to note is that they are models in which communication does not come from the top down, and in which processes designed to improve health literacy are developed in collaboration with communities.

4.4 Why does the field of cancer present a special case?

Cancer is one of the most prominent areas where health and scientific literacy intersect. This is because, in this context, information is not only clinical; it is intertwined with fear, hope, the burden of care, time pressures, economic uncertainty and the risk of fostering false hope. Incorrect or misleading information about cancer is not merely a theoretical problem; it can delay people from attending screening, steer them away from effective treatment, make products promising ‘miracles’ seem appealing, and directly influence the decisions of patients and their loved ones.

In Türkiye, official communication on cancer tends to focus primarily on early diagnosis, screening, and awareness. Whilst this is important, the cancer information ecosystem extends far beyond this. People must not only understand ‘at what age to undergo cancer screening’, but also whether a second opinion is necessary, which information to trust, what is meant by recommendations presented as ‘alternative’, the difference between hope and manipulation, and how to assess claims of expertise. For this reason, health literacy in the field of cancer must be considered alongside scientific literacy, media literacy, and rights-based communication skills. It is precisely here that initiatives such as **CancerDisinfo**⁶⁵ must take on the role of bringing communities and stakeholders together. The strength of such models lies not only in content corrections, but in their ability to act as interpreters and build bridges between patients, their loved ones, journalists, experts and civil society. The ability to gather questions, use accessible language, cite sources, collaborate with networks of experts, listen to information needs on the ground, and build community trust sets such initiatives apart from traditional fact-checking models. Particularly in areas carrying a high emotional burden, such as cancer, health literacy interventions remain incomplete without a rights-based and community-engaged layer of communication.

⁶⁴Sakai, H., Kawata, R., Adhikari, R., Thapa, Y. O., & Bhandari, T. R. (2024). Effectiveness of art-based health education on anemia and health literacy among pregnant women in Western Nepal: A randomized controlled trial. *PLOS ONE*, 19(9), e0281789. <https://doi.org/10.1371/journal.pone.0281789>

⁶⁵ <https://cancerdisinfo.org/>

Chapter 5: Policy Recommendations

The recommendations set out below are structured in such a way that the individual, societal, organisational and international levels complement one another. Each recommendation is designed to address an existing gap or shortcoming.

5.1 The Ministry of Health and Public Institutions

- National Health Literacy Action Plan: A comprehensive national plan should be drawn up, incorporating measurable targets and monitoring indicators, using the HLS-EU (European Health Literacy Survey) standards as a reference. The plan should adopt a multi-layered approach covering not only individual awareness but also institutional accessibility.
- Health Misinformation Monitoring Unit: An institutional framework should be established to identify rapidly spreading health misinformation, work in coordination with social media platforms, and publish regular public reports.

5.2 Healthcare Professionals and Healthcare Professional Organisations

- Compulsory modules covering health communication, patient education and awareness of misinformation should be integrated into medical and health education curricula.
- "Trusted messenger" training programmes should be designed for general practitioners and pharmacists; these professional development components should be supported as part of continuing medical education.
- The Turkish Medical Association, the Turkish Pharmacists' Association, and relevant professional bodies should establish a joint platform to swiftly share and verify health-related misinformation with the public.

5.3 Media, Journalism and Platform Regulation

- Standards for health journalism should be strengthened; guidelines and training specific to evidence-based health reporting should be developed for journalists.
- Digital platforms should be encouraged to establish transparent and independent oversight mechanisms to tackle health-related disinformation.

5.4 Civil Society, Patient Organisations and Innovative Models

- Patient organisations and chronic disease platforms should have access to capacity-building support so that they can effectively fulfil the role of trusted messengers within their own communities.
- Participatory arts and culture initiatives, such as community exhibitions, should be incorporated into health literacy programmes. Particularly in the areas of cancer, chronic diseases and vaccine literacy, such approaches can counter disinformation on both an emotional and intellectual level.
- Municipal libraries, school parent-teacher associations, and community centres should be transformed into health learning spaces, as seen in the UK and Canada. This transformation would alleviate the excessive burden on clinical institutions while creating a foundation for equitable access to health literacy.
- Simple, rights-based campaign materials, such as “3 questions to ask when visiting the doctor”, should be disseminated through patient organisations and primary care organisations.

5.5 The Education System

- Media and scientific literacy components should be systematically integrated into primary and secondary school curricula; the focus should be on critical thinking and source evaluation skills rather than the mere transfer of knowledge.
- Strategic science communication training should be incorporated into the curriculum at higher education institutions, particularly in faculties of health sciences and communication.

5.6 International Cooperation

- Türkiye’s active participation in the implementation of the WHO Infodemic Management Framework and the EU Digital Services Act should be encouraged, and its institutional capacity in these areas should be strengthened.
- The Council of Europe’s media literacy initiatives and the standards on access to information set out in the Convention on Human Rights should be used as a reference framework for national policy reforms.

Conclusion

Access to health information is a fundamental human right in the modern world. However, the exercise of this right requires an information environment in which reliable information

is available, understandable, and accessible. When health disinformation, low levels of health literacy, and the erosion of trust in Türkiye are considered together, a picture of structural vulnerability emerges that effectively restricts individuals' ability to exercise their right to health.

The policy framework and international examples presented in this document highlight the inadequacy of treating this vulnerability as merely a matter of individual awareness. Experiences ranging from Portugal to Australia and from Canada to Nepal share a common lesson: approaches that position communities not as target audiences but as co-producers, transform non-clinical spaces into spaces for health learning, and convey knowledge not only through text but through relationships, stories, and experience, produce both more effective and fairer outcomes.

Sustainable solutions require the healthcare system to redesign patient communication, ensure that platforms are subject to accountable regulatory mechanisms, strengthen the capacity of civil society, and position science communication as a strategic public investment. For example, a person diagnosed with cancer being unable to access reliable information constitutes a deprivation of rights. Identifying this and developing policies to address this deprivation is a moral and legal responsibility shared by the state and civil society.



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