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Improving Health Literacy of Migrants in Language Courses – Lessons Learned from a Qualitative Textbook Analysis

Melhorar o letramento em saúde de migrantes nos cursos de línguas – Lições aprendidas com uma análise qualitativa de manuais escolares

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Abstract

Health literacy (HL) programs for vulnerable groups with low HL, e.g., migrants and refugees, have been proposed to reduce health inequalities. Adult basic education and second language courses (SLC) are considered particularly important and effective. However, empirical evidence on the process of HL promotion in SLC is scarce. This study aimed to advance the understanding of HL promotion by analyzing SLC materials, deriving best practices, and informing innovative HL promotion programs. We conducted a scoping study, including a systematic literature search in seven academic databases and a grey literature search. We identified 21 manuals as eligible and qualitatively analyzed their content, theories, didactic-methodological principles, and the relationship between language and health. There are numerous, multifaceted ways to promote HL in SLC. Curricula cover various health topics, prioritizing situations in the doctor's office, nutrition, and physical activity, others even mental and social health. Theories from three disciplines are drawn upon, and numerous methods target language skills: receptive, productive, interactive, and even advocacy skills. Three main approaches emerged: language for, information about, and skills for health, which are uniquely linked in each manual. No other educational setting is as far-reaching, innovative, and promising as SLC when implemented thoroughly by interdisciplinary teams.

Keywords: Health Literacy • Second language • Migrants • Adult education • Empowerment

Resumo

Programas de letramento em saúde (LS) para grupos vulneráveis com baixo LS, como migrantes e refugiados, procuram reduzir desigualdades em saúde. Cursos de educação básica para adultos e de segunda língua (CSL) são especialmente eficazes. Contudo, há poucas evidências empíricas sobre a promoção do LS em CSL. Este estudo buscou compreender melhor a promoção do LS analisando materiais de CSL, derivando melhores práticas e informando programas inovadores. Realizamos um estudo de escopo com busca sistemática em sete bases de dados acadêmicas e na literatura cinzenta. Identificamos 21 manuais elegíveis e analisamos qualitativamente seu conteúdo, teorias, princípios didático-metodológicos e a relação entre linguagem e saúde. Há diversas maneiras de promover o LS em CSL, com currículos que abordam temas de saúde como consultas médicas, nutrição, atividade física, saúde mental e social. Teorias de três disciplinas são aplicadas, e métodos diversos visam habilidades linguísticas: receptivas, produtivas, interativas e de defesa. Três abordagens principais emergiram: linguagem para saúde, informação sobre saúde sobre e habilidades para a saúde, cada uma unicamente interligadas em cada manual. Nenhum outro ambiente educacional é tão abrangente, inovador e promissor quanto o CSL quando implementado por equipes interdisciplinares.

Palavras-chave: Letramento em saúde • Segunda língua • Imigrantes • Educação de adultos • Empoderamento

Introduction

Health literacy (HL) is the ability to engage effectively with health-related information (Sørensen et al., 2012). It is an incremental asset for health (Nutbeam, 2008) and can reduce health inequalities (Batterham et al., 2016). Therefore, promoting HL among vulnerable populations is at the core of international and national health action plans (Schaeffer et al., 2017; WHO, 2016, 2021). Studies worldwide have shown that a considerable proportion of the population in each society has insufficient HL levels, such as migrants and refugees (Nielsen-Bohlman et al., 2004; Quenzel & Schaeffer, 2016; Sørensen et al., 2015; WHO, 2013). These populations are becoming increasingly relevant as migration is a major global phenomenon. 281 million people are migrants (IOM, 2021), and 89.3 million people are forcibly displaced, including 27.1 million refugees (UNHCR, 2022). Newcomers are likely to have low HL (Simich, 2009; Wångdahl, 2017) and face various challenges; the most pressing of which are learning the country's official language, navigating a new society with its cultural peculiarities (including in health care), coping with living conditions that are often detrimental to health, and starting a new life (IOM, 2017; Philippi et al., 2018). Overall, the pre-migration situation, transit, early days, and resettlement phases have a tremendous impact on their health (Bradby et al., 2015). Reports from health organizations provide evidence of refugees' health status, associated diseases, and health care needs, highlighting their vulnerability (Frank et al., 2017; WHO, 2018b). They also describe obstacles, such as barriers in the patient-doctor

communication due to language mismatch, different cultural preferences, and lower HL (Schouler-Ocak & Kumeyer, 2017; Zanchetta & Poureslami, 2006). Refugees' HL needs are related to the health care system, mental health-related information, and meaningful activities (Folinsbee et al., 2007; Philippi et al., 2018).

Given these challenges and often inadequate skills, equipping newly arrived migrants with necessary health-related skills, including coping skills and HL, is paramount (Lazarus & Folkman, 1984; WHO, 2018a). Multiple recommendations and guidelines exist for HL promotion, especially for low-literate people (Doak et al., 2007), by medical professionals (especially physicians and nurses) (AHRQ, 2015; WHO, 2013), e.g., reducing the complexity of texts, using plain language and methods such as Teach-Back (Ha Dinh et al., 2016) or Ask-Me-Three method (IROHLA, 2015; ÖPGK, 2018), and training medical professionals in intercultural care (Valero-Garces, 2014). Moreover, to address the language-related challenges, materials in other languages, professional interpreters, or same-language ambassadors are provided (Altgeld, 2018; WHO, 2018a). However, most interventions improve functional HL, but not interactive or critical HL (Fernández-Gutiérrez et al., 2018; Nutbeam, 2000), and none of these recommendations directly improve (second) language skills (Harsch, 2022). To improve migrants' HL, WHO in Europe recommends promoting HL in health education sessions in general or specifically in second language courses (SLCs) for newcomers and other migrants with poor language skills in the country's official language (Kairies, 2013). The term "second language" is not used here in the sense of a language learned second in time, but in the sense of the European Union, which means that the second language, in this case the host language, i.e. the language spoken in the country, is acquired not only through conscious learning (foreign language learning), but also through everyday contact with it (Council of Europe, 2007, p. 50). In this sense, the second language course is aimed at learning the host language.

Integrating HL into education is not a novelty (Okan et al., 2020; Rudd & Moeykens, 1999), but the effectiveness of using SLCs to promote HL among vulnerable and hard-to-reach groups lacks empirical evidence (Chen et al., 2015). SLCs are ideal for promoting HL for five reasons: First, educational settings are good practices for health promotion (WHO, 2018a). Second, health topics have been found to be motivating in adult basic education and language courses worldwide (Lucey et al., 2000). Third, teachers are well equipped and experienced in delivering messages to adults and developing their skills (Hohn, 1997). Fourth, many migrants attend SLCs to acquire the language skills required for a permanent residence. For example, since 2015, more than 2.33 million migrants and new immigrants have attended state-organized language courses in Germany (BAMF, 2021). Fifth, the SLC-specific or adult basic education curricula often include health as a key field of action (Goethe-Institut, 2016) or civics objectives (Diehl, 2006a; Levy et al., 2008). Despite these five reasons, surprisingly little is known about the content and the process of promoting HL in SLCs (Harsch et al, 2020b). Recently, more curricula have been developed to promote HL in SLCs (e.g., Healthy Eating for Life (Martinez

& Nystrom, 2010), Health Education in Integration Courses (VHS Baden-Württemberg e.V., 2010), or Healthwize (Thomas, 2004)), but they have not been thoroughly evaluated.

Moreover, despite three decades of HL research, empirical evidence on the long-term effectiveness of general HL programs is scarce (Soto Mas et al., 2018); exceptions are Berkman et al. for the US context (2011) and Visscher et al. for the European context (2018). These studies show considerable heterogeneity across programs and provide empirical evidence that interventions can improve HL, mostly in the health sector. Recent studies on HL promotion programs in adult basic education (ABE) and English as a Second Language (ESL) classes conclude that HL can be increased in SLCs despite program heterogeneity and limitations (Chen et al., 2015; Soto Mas et al., 2018). Overall, the knowledge on HL promotion in SLC is still selective and shows a great heterogeneity of approaches (information sharing or language-enhancing activities) (Harsch et al., 2024), and no systematic review summarizes how HL can be improved in the course. Additionally, quantitative effectiveness studies cannot thoroughly describe the features of an HL program or the activities used to promote HL. Also, the commonly cited publications on HL (Okan et al., 2019) rarely elucidate the process of promoting HL in educational settings (Okan et al., 2020). Consequently, a better understanding of the process of promoting HL in adult SLCs is needed to inform policy makers, adult educators, and researchers about its potential. **Therefore, this study overall aims to fill this gap by providing a detailed description and critical analysis of how HL is addressed in SLCs.**

Additionally, since HL is defined differently depending on the discipline and focus, it is necessary to explain from which perspective HL will be explored in this study. Three perspectives are relevant here. First, there is the issue of health, literacy, and HL. Although HL includes **the term health,** discussions of HL tend to focus on illness, disease management, and conversations with the doctor (see the HL toolshed (Paasche-Orlow, 2021)). In contrast, a genuinely health-oriented, i.e. salutogenic, understanding of HL would consider everyday health and health practices in a health-promoting environment, with the ultimate goal of helping people to take more control over their health (WHO, 1986). For migrants in particular, a holistic understanding of health (IOM, 2017) helps them to understand their situation, proactively manage, and improve their health. The second component is **literacy** and language-related characteristics, which are often reduced to vocabulary or short sentences in the HL debate (AHRQ, 2015). Rarely does a publication discuss what different language features are needed not only to understand health-related texts but also to advocate for one's health (Nielsen-Bohlman et al., 2004; Robin, 2014; Schmidt-Kaehler et al., 2017). Finally, the compound word **HL** has several different understandings, such as functional, interactive, and even critical levels (Nutbeam, 2000). While functional HL enables individuals to understand, critical HL enables them to speak up for themselves and challenge the often highly influential life contexts and situations, thus contributing to health, well-being, and empowerment (Nutbeam, 2008). Critical HL is relevant for vulnerable groups, such as refugees, to move from roles of inferiority, dependency, and low self-esteem to self-confidence, proactive agency, social participation, and

integration (Freire, 1998; Wallerstein & Bernstein, 1988). Therefore, HL in an educational setting should equip the people to act in these communicative situations; thus, HL is studied as a social practice (Santos et al., 2014). This study examines **which language and health topics are taught and which communicative action situations students are prepared for (Q1).**

Although HL is a key public health issue, our understanding of how **it is acquired and promoted** is still in its infancy. There are only a few theoretical models for improving HL in individuals (Nutbeam, 2008; Ryan et al., 2012; Squiers et al., 2012; Wagner et al., 2009). None of these models explain the even more complex process of HL development among newcomers and migrants from culturally and linguistically diverse backgrounds due to their upbringing in a different environment with its unique required skill set. Methodological traditions and teaching standards may be relevant as the promotion of adult HL in SLC is transdisciplinary and at the interface of health promotion, second language acquisition, and adult education. This study explores **how HL is promoted and what theories, methods, and activities are used to promote HL (Q2).**

This study[1] is part of the SCURA research project, a subproject of the Consortium on *Health Literacy in Childhood and Adolescence*, funded by the German Federal Ministry of Education and Research. We investigated the role of HL in SLCs and developed appropriate interventions (Harsch et al., 2021; Harsch, 2022). This required a comprehensive understanding of the empirical evidence on HL in SLC (Harsch et al., 2024), teaching manuals, and the process of promoting HL. Therefore, we conducted this scoping study to explore how HL manifests and develops in SLCs.

1 Methods

We conducted a systematic literature search in seven academic databases (Medline, PsycINFO, ERIC, Academic Search Primer, Education Source, BASE, and Scopus), following the procedure for scoping studies suggested by Arksey and O'Malley (2005), and supplemented by results from gray literature searches in Google Scholar and Google Engine. Inclusion criteria were publications (curricula, manuals, textbooks) that explicitly promoted health and HL in English or German-as-a-Second-Language (ESL, ESOL, ELL, DaZ) courses for adult migrant/newcomer/refugee/asyl*, in English or German language through November 2022, and were accessible as full text free of charge. We ultimately identified 21 manuals for inclusion.

First, we thoroughly read the manuals multiple times. We developed a coding scheme for data extraction which included each manual's health and language-related objectives, the tasks (related to language, health content, and communicative action), the underlying theories,

[1] This textbook analysis was conducted within the SCURA project, which was part of the research consortium Health Literacy in Childhood and Adolescence, funded by the German Federal Ministry of Education and Research, funding period 2018-2022.

and didactical and methodological principles employed. We extracted data in an Excel Spreadsheet. We used qualitative content analysis to summarize and compare findings, providing an in-depth understanding of the phenomenon under study (Kuckartz, 2012). We identified examples of activities to promote HL components at varying difficulty levels. To explore the manuals thematic orientation, we explored the extent to which the manual promoted between language, content, and life skills. To validate the findings, we extensively discussed them among researchers and at conferences and the feedback received was considered in the revision (i.e., Harsch et al., 2020a).

2 Results

2.1 Sample: Types of HL Promotion in SLC

The **21 manuals** identified are very heterogeneous and diverse in all respects. The promotion of HL in SLCs is not a novelty but was already discussed in the United States in 2001 (MDEACLS, 2001). Most of the manuals were produced in the USA (N = 15), two in Germany, and one each in Canada, Australia, Switzerland, and Austria. Seventeen **manuals** were in English and four were in German. They were developed in collaboration with adult educators/literacy organizations, health insurance companies, universities, government ministries/states, NGOs, and others. Most of the manuals did not specify the language levels of the target groups; others specified high beginner and low intermediate levels or mixed classes for ESL and ABE (see Table 1). While one curriculum was designed for a monolingual group (Spanish-speaking English learners) (Soto Mas et al., 2013), all others targeted multilingual groups. The curricula varied in length, with an average of 10.54 lessons (ranging from 4 to 40). The average program length could not be estimated because some manuals recommended teaching the entire syllable consecutively (Furlong, 2011) or explicitly stated that several lessons could be taught separately (OÖ Gebietskrankenkasse, 2014; VHS Baden-Württemberg e.V., 2010).

The **materials** provided varied widely. Some manuals were comprehensive, including teacher guides (ranging in length from 2 to 40 pages), lesson plans, and complete workbooks. Other manuals included only facilitator's notes/instructor's guides or only student worksheets, photocopiable materials and an assessment, and online materials, referred to additional sources of information, or even supplemented the coursebook materials with presentation slides, video, and audio or an assessment. One explicitly integrates a visit from health professionals (Furlong, 2011). Assessment is available from three curricula that report that HL can be improved (Duncan et al., 2013; Levy, 2008; 2013). Three publications (MDEACLS, 2001; National Center for the Study of Adult Learning and Literacy, 2007; Singleton, 2003) are not manuals per se, but rather guidelines, training courses, or a compendium of HL resources to assist teachers in preparing health-related lessons.

Table 1. Characteristics of the Curricula

#	TITLE	ORGANIZATION, REFERENCE	LANGUAGE/ COUNTRY	TARGET GROUP	UNITS/ PAGES	MATERIALS	PURPOSE
1	Gesundheitsbildung in Integrationskursen (English: Health education in integration courses)	AOK (health insurance) and VHS (adult education center) (VHS Baden-Württemberg e.V., 2010)	German/ Germany	Integration courses for newcomers	U: 7, P: 64 p.	teacher guide; teacher information,	Information (No language/ grammar/ life skill practice)
2	Unterrichtsmappe Gesundheit (English: Folder for health lessons (Switzerland))	Bundesamt für Gesundheit (Federal Office for Health) (BAG, 2018)	German/ Switzerland	Migrants in Switzerland	U: 5*4, P: 331 p.	Teacher guide, lesson plan, worksheet to copy	Information & skill (no grammar)
3	Gesundheit - Arbeitsblätter für Deutsch- und Integrationskurse (English: Health – worksheets for German and integration courses)	OÖ GKK Forum Gesundheit (Health Insurance) (OÖ Gebietskrankenkasse, 2014)	German/ Austria	Migrants	U: 4, P: 40 p	Workbook	Language communication/ information (No grammar)
4	Refugium	HAW Hamburg (Färber et al.)	German/ Germany	Refugee	U: 6+2 P: 33 p.	Teacher guide, lesson plan, copy	Information and skills (no words/ grammar)
5	Health Talk	Calgary Immigrant Women's Association (CIWA, 2011)	English/ Calgary, Canada	ELL	U: 9, P: 538 p	Teacher guide, teacher information	Skills and information (no grammar)
6	Charlottesville Adult Learning Center's Health Curriculum	Charlottesville Adult Learning Centers Health Curriculum (Furlong, 2011)	English/ Virginia, USA	ESL with CASAS score of 190, almost beginning ABE	U: 8, P: 19.	Teacher guide, further information, lesson plan	Skills (agency!) and language (grammar, wordlist)
7	ETB Expecting the best	Coastal Area Health Education Center Sarah Diehl (Diehl, 2006b)	English/ North Carolina, USA	ESL, high beginner, low intermediate	U: 14, P: 241 p	Teacher Guide	Skills and language (incl. grammar)
8	Staying Healthy for Beginners: An English Learner's Guide to Health Care and Healthy Living	Florida Literacy Coalition (2014)	English/ Florida, USA	ELL	U: 5, P: 54 p	Teacher Guide & student workbook	Information and language (communication/ grammar)
9	Language 911: A Health Literacy Curriculum for ESOL Students	KQED (KQED Education Network, n.d.)	English/ California, USA	ESOL students	U: 7, P: 28 p.	Teacher Guide, lesson plans	Information and skill (no grammar)
10	Healthy Eating for Life (HE4L)	(Martinez & Nystrom, 2010)	English/ USA	ELL, low beginner	U: 4, P: 224 p.	Teacher Guide	Language (various) and information
11	Workplace Health and Safety ESOL Curriculum	Massachusetts Worker Education Roundtable (Utech, 2005)	English/ USA	ESOL	U: 11, P: 75 p.	Teacher Guide, lesson plan, handouts	Life skills (critical), also language (grammar)
12	Project Shine	MetLife Foundation (MetLife Foundation, o.J.)	English/ USA	ESL, advanced beginning, and intermediate	U: 5*3, P: 493 p.	Teacher Guide, worksheets	Language (communication)
13	Research-based Health Literacy Materials and Instruction Guide	National Institute of Child Health and Human Development, Office of Vocational and Adult Education, National Institute for Literacy (Levy, 2008)	English/ USA	ABE & Beginning ESL	U: 18, P: 921 p.	Exhaustive teacher guide, lessons outline, worksheets, test	Language (incl. phonetic and grammar)

#	TITLE	ORGANIZATION, REFERENCE	LANGUAGE/ COUNTRY	TARGET GROUP	UNITS/ PAGES	MATERIALS	PURPOSE
14	English for Your Health: A health literacy curriculum for ESOL Learners	Queens Library (Trupin et al., n.d.)	English/ USA	ESOL, beginner & intermediate	U: 20+20	Worksheets	Language (words, sentences, structures)
15	Health Literacy & ESL curriculum	Francisco Soto Mas and colleagues from the University of Texas at El Paso (Soto Mas et al., 2013)	English/ USA	ESL	U: 12, P: 207 p	Teacher guide, lesson plan, worksheets	Language (information), grammar, words
16	Health Wize	The Victorian Foundation for Survivors of Torture Inc (Thomas, 2004)	English/ Australia	Refugees	U: 11, P: 218 p.	Teacher Guide & Worksheets	Life skills (survival) (also language and grammar)
17	Health Literacy in Conjunction with ESL	Dora Lee, University student (University of San Francisco) (2014)	English/ California, USA	ESL	U: 7, P: 179 p.	Lesson plan & worksheets	Language and content (communication)
18	Empowerment-based Health Literacy	Chicago City Wise, Chicago Citywide – Literacy Coalition (2019)	English/ USA	ESL	U: 10 (flexible), P: 278 p.	Lesson plan & PowerPoint presentation	Information (+ discussion)
19	Virginia Adult Education Literacy Toolkit (incl. picture stories)	Kate Singleton (Singleton, 2003, 2012)	English/ USA	ELL	U: 8, P: 222 p.	Picture stories and recommendations	Life Skills (habits), information
20	Massachusetts Adult Basic Education. Curriculum Framework for Health	Massachusetts Department of Education, Adult and Community Learning (MDEACLS) (2001)	English/ USA	ABE/ESL	U: 5, P: 65 p.	Framework and Tipps for Teachers	Teaching skills, language & content objectives
21	HL Study Circle; Facilitator's Guide: Skills for Disease Prevention and Screening	National Center for the Study of Adult Learning and Literacy (NCSALL) (2007)	English/ USA	ESL teachers	U: 5 phases 4, P: 520 p.	Training course for teachers	Teaching skills

Note: ELL: English language learner, ESL: English second language learner, ESOL: English as a second or another language, ABE: Adult Basic Education,

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(I) Objective: language, health, and life skills topics addressed (manuals)

An analysis of the manuals' purposes, as reflected in their objectives and content, revealed three main foci: (a) language-related topics, (b) health-related topics, and (c) the application of these skills in health-related communicative life situations. Six manuals included only language objectives while others referred to nationwide educational standards (CASAS-US (Diehl, 2006b), English CSF 2 (Thomas, 2004), or Canadian Language Benchmark (CIWA, 2011)), two included only health-content objectives (N = 2), and others added life-skills-related objectives. A combination of these types of objectives was often found.

2.2 Language Skills

Nine key language areas emerged, but not all were covered in every manual.

- Mastering the basics such as alphabetics, phonics, and basic sentence structure,
- Knowing health-related vocabulary (nouns, adjectives, verbs, conjunctions) and technical vocabulary, including medical jargon,
- Understanding and using numbers, dates, measurements, analyzing charts and graphs, comparison,
- Understanding instructions and using verbs: imperatives, auxiliary verbs, making suggestions, and giving advice,
- Expressing feelings and preferences, describing symptoms and pain,
- Reporting on experiences, habits, and intentions (in the past, present, and future tenses),
- Asking questions (ask me three), asking for clarification and alternatives,
- Filling out forms,
- Understanding written health information (labels, signs, forms, fact sheets, and brochures).

Some manuals even went further and included

- Strengthening critical and creative communication skills through presentation, argumentation, and discussion.

Rarely were other communicative features such as pronunciation (tone of voice, intonation, rhythm, and stress timing) (Levy, 2008) or specific linguistic registers (everyday life, professional, educational, technical linguistic register) or body language explicitly included in the manuals, although they are important for interpreting the utterances of others (Levy, 2008). All the manuals addressed both comprehension/receptive skills (listening and reading), production/productive skills (asking and writing), and interaction at different intensities (see Table 3). Mediation between language skills and languages, an important language mode in the Common European Framework of References for Languages (Council of Europe, 2018), is rarely used, even though it has a strong impact on migrants' everyday practices. Specific health-related technical vocabulary is addressed in the manuals in various ways, ranging from a single mention by the teachers (VHS Baden-Württemberg e.V., 2010) to a detailed (written) explanation (OÖ Gebietskrankenkasse, 2014), and targeted practice tasks (Levy, 2008). One manual even introduces Greek and Latin prefixes used in health care (Florida Literacy Coalition, 2014). Although language topics are included in all courses, some manuals focus on the use of health-related vocabulary in general (OÖ Gebietskrankenkasse, 2014), while others

focus explicitly on the development of language skills (including grammar) (Diehl, 2006b; Soto Mas et al., 2013) and provide extensive information on language development and teaching strategies (Levy, 2008).

2.3 Health Topics

The manuals covered many topics related to health systems, treatment, diseases, health promotion, and broader health issues. Table 2 categorizes various health topics, provides examples, and lists the number of manuals that address them.

Table 2. Overview of Health-Related Subjects in Each Curriculum

CATEGORY	HEALTH TOPICS	EXAMPLES	#
Health general	Definition	What is health/healthy/unhealthy	1
	Determinants	What makes you healthy – determinants of health, a healthy environment	2
	Lifestyle	Healthy lifestyle nutrition, physical activity, stress management	7
	Advocating for your health	Speaking up for one's health	3
	Body parts	Naming and using body parts	4
	Procedures	Respiration, blood circulation, food intake, internal organs	1
Health System, interacting	Health system	Navigating, family doctors, community HC, GP, emergency call, the health systems' various levels	15
	Health insurance, getting HC	Health insurance, saving on health insurance, rights, and duties, health cards,	5
	Finances (paying for HC)	Premium, deductible, retention	2
	Rights and plights	Right to treatment, self-determination, access to records, secrecy, a duty to show consideration for fellow patients, hospital regulations...	4
	Making an appointment	Calling the doctor, scheduling an appointment	9
	Physician-patient interaction	Visiting the Doctor, Talking to HC professionals, informed consent,	6
	After the doctor's visit	Following the doctor's advice,	2
	Talking about own's health	Reporting your health story, describing health/symptoms, talking about feelings and emotions, expressing likes and dislikes	5
	Asking questions	About health conditions, services, tips …	3
Treatments	Drugs	Drugs, labels, over-usage	10
	Accidents	Emergency, injuries	8
	Self-care/ non-emergency care	Sick - what helps? first aid at home, caution at work, drugs at home, care during hospital	4
	Information reading	Reading about information/articles/leaflets	3
	Filling out forms	In a hospital, at the doctor	2
	Treatment	Medical tests, treatment, surgery	1
Diseases	Symptoms and injuries	Describing symptoms	1
	Communicable diseases	Cold/ flu	1
	Non-communicable diseases	Diabetes, coronary health disease	4
	Risk factors	High blood sugar level, high blood pressure, high cholesterol…	1
	Addiction	Drugs, smoking	3
	Mental health	Stressors, burden, diseases, acculturation, social connection, symptoms of mental disease	6
	Women	Pregnancy, family planning, women's health	1
	Children's Health	Children doing well or are ill, young people with problems	2

CATEGORY	HEALTH TOPICS	EXAMPLES	#
Health Promotion/ Prevention	Nutrition	Food pyramid, food labels, eating/exercising/enjoying healthy and colorful food, normal weight/obesity, 7 food groups, fiber, and vitamins 10 steps to a healthy nutrition, recipes	14
	Physical activity	Recommendations, suggestions to do physical exercise alone and in groups, various exercises	7
	Relax/manage stress	Managing stress, stressors, and what gives strength, wellness	5
	Prevention	vaccination, check-up, lifestyle practices	5
	Environment	Influence on (stress) development	4
	Immunization and screening	Vaccination, screenings, check-up	3
	Hygiene	Healthy skin and hygiene at home, and in the bathroom, for women and men	2
	Oral health	Brushing teeth, behavior for healthy teeth, visiting the dentist	2
	Safety	At workplace	1
	Domestic violence		1
	Social health	Making friends in a new environment	1

Source: Created by the author

Most curricula address health system-related topics, nutrition, reading medical labels, and making an appointment. Furthermore, frequently included topics such as general health vocabulary, explanations of the health care system and finances, making an appointment, and communicating with the doctor clearly emphasized health care system issues but rarely addressed disease and treatment options or well-being. Topics with a clearer connection to *health* were diet and physical activity. Few manuals addressed preventive measures (screening and vaccination), chronic diseases, mental health burdens related to migration and living in a new country, or health determinants (OÖ Gebietskrankenkasse, 2014; Thomas, 2004).

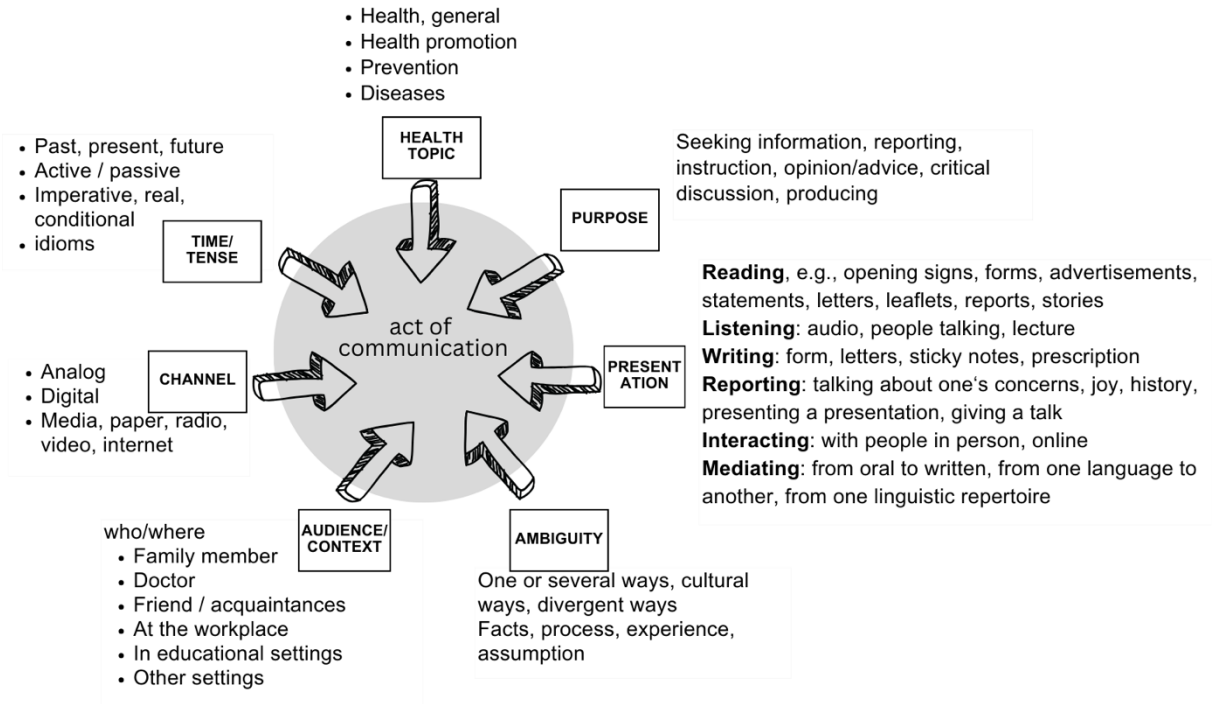
The amount of information per topic varied widely: some curricula provided a lot of information on a specific topic (e.g., nutrition or cardiovascular disease) (Soto Mas et al., 2013), while other manuals reduced the proportional amount of health information to increase learning and correct pronunciation of words and grammar (e.g. Levy, 2008), or focused on influencing students' behavior (OÖ Gebietskrankenkasse, 2014). A notable difference in the topics across countries is related to the discussion of financing systems: health care financing and health insurance are key topics in the US manuals, while this is not a core issue in Germany, where health insurance is mandatory and every refugee registers for it upon arrival.

The difference in the breadth and scope of health is also surprising. Most manuals focused on specific dimensions of health (i.e., physical health). In contrast, few manuals included other dimensions of health (mental and social) and broadened the perspective by including inequality and health (Furlong, 2011), workplace health (Utech, 2005), health promotion (Levy, 2008), and determinants of health (OÖ Gebietskrankenkasse, 2014).

2.4 Communicative Action Situations

While some curricula focus on either literacy skills or health information, most curricula go beyond simply learning vocabulary and health knowledge and aim to enable people to apply their skills in real-life situations to master health-related communicative activities. An in-depth analysis of the manuals identified more than 150 health-related everyday communication situations emerged, such as simple activities involving expressing one's feelings, reading, and actively producing information (recipe book), or critically analyzing conflicting issues. During the analysis, several language-related situational features emerged to describe the situation: Communication with (with whom), mode of presentation (how), time (when), analog/digital (what form), purpose (what for), clarity (how), or ambiguity of content (how). Figure 1 summarizes the key characteristics of each situation.

Figure 1. The Multiple Features of Health-Related Communicative Actions



Source: Created by the author

2.5 Teaching Planning: Theories/Models and Methods/Activities and Material

HL promotion in SLCs takes place in an interdisciplinary field which is evident in the manuals that combine different theories or teaching principles from health promotion, adult education, and second language teaching (Levy, 2008; Soto Mas et al., 2013). Some manuals explicitly mention **theories** such as the health action process approach (Martinez & Nystrom, 2010), the health behavior change framework (Martinez & Nystrom, 2010), health behavior

theories (Soto Mas et al., 2013), ESL principles (Martinez et al., 2013), Lave and Wenger's situated learning theory (Lee, 2014), Vygotsky's sociocultural theory (Lee, 2014), sociocultural approaches to literacy and communication (Soto Mas et al., 2013), content-based ESL instruction (Lee, 2014; McCaffery et al., 2016), practice engagement (Santos et al., 2014), adult learning theories (Soto Mas et al., 2013) and refugee women (Singleton, 2003), learning experience approach (Singleton, 2003), life skills, content-based instructions (Singleton, 2003), problem-solving approach (Singleton, 2003), project-based learning (Singleton, 2012), participatory approach (Singleton, 2003), narrative approach (Singleton, 2003), cooperative learning (Diehl, 2006b) audience-centered (Soto Mas et al., 2013), situated theory of learning (Lee, 2014), and popular second language teaching approaches, e.g., Theory of Systemic Functional Linguistics (Lee, 2014), ABE Frameworks on Health, English Language Arts, Mathematics, History and the Social Sciences; Science and Technology/Engineering (MDEACLS, 2001), ABE/Literacy example (MDEACLS, 2001), ESL Principles (Martinez et al., 2013), English Language Learning (ELL) frameworks (Martinez et al., 2013; National Center for the Study of Adult Learning and Literacy, 2007). However, most manuals do not specify their underlying theories; to the only way to infer the theories and principles is to analyze the activities. Five aspects emerged: stimulus, social format, HL components, level of difficulty level, and progression.

The tasks included various **stimuli** to introduce and deepen the lesson topic. These could be either written, oral, visual, or multisensory prompts: written, such as an opening sign, fill-in-the-blank forms, a statement, pamphlets, reports, charts, diaries, narratives, or oral prompts: such as a question, a narrative of an experiment, a guest lecture by a health professional, or a role play. Visual prompts included icons, pictures of objects and conditions, the human body, symptoms, emotions, symbols, and even complex pictures and comics of varying ambiguity. Furthermore, realia (e.g., food or medicine packaging) and multi-sensory stimuli included videos, research projects, exposure trips, or the task of developing materials (see also Table 3).

All curricula used multiple **social formats**, e.g., activities that required students to work alone, in pairs, in small groups, in plenary, with guest speakers, or even with actors outside the classroom, e.g., interviewing family members (Thomas, 2004).

The in-depth analysis revealed a myriad of aspects that coincided and addressed slightly different **components** of HL-related activities: e.g., understanding health information (knowledge-related), practicing health communication (language-related), setting health goals, practicing healthy behaviors, discussing intentions, strengthening confidence, asking for help, contacting local health services. Based on the manuals, the tasks were identified, described, and clustered. Seven core components of HL emerged. To apply HL in any situation, these seven components are needed at different levels of difficulty. Table 3 displays the increasing complexity of the seven core components, operators, and tasks.

Table 3. Seven Components of HL with Increasing Difficulty

COMPONENTS	EXPLANATION	FUNCTIONAL LEVEL A →	FUNCTIONAL LEVEL B→	INTERACTIVE LEVEL A →	INTERACTIVE LEVEL B→	CRITICAL (CREATIVE) LEVEL
Language	*Words, grammar, texts; comprehension, production, interaction, mediation*	*Understanding* Oral statements, written texts, yes-no questions, (closed) comprehension questions	*Reproduce* Tasks in which the participants reproduce what they have heard orally or in writing	*Produce* Tasks in which the participants create something themselves through a visual/oral/written impulse	*Interact* Tasks in which the participants interact with others directly or virtually, orally or in writing	*Manipulate/ criticize* Tasks in which the participants critically examine the language, manipulate it, and create a new language
Knowledge	*Facts, procedures, personal (narrative) persuasive*	*Recognize* comprehension questions, tasks in which the participants assign	*Naming* Tasks in which the participants label images (e.g., body parts) or name them verbally	*Describe* Tasks in which the participants describe visits, procedures, processes	*Explain* Tasks in which the participants explain the reasons	*Discuss* Tasks in which the participants weigh up the pros and cons, e.g., treatment methods, nutritional behavior, stress
Behavior	*Doing*	*Observe* Tasks in which the participants observe the behavior of the lecturer, other participants, and protagonists	*Imitate* Tasks in which the participants (under supervision) imitate the behavior of others	*Execute autonomously* Tasks in which the participants perform the behavior autonomously.	*Modify* Tasks in which the participants modify the usual behavior/processes	*Develop new* Tasks in which the participants develop new behaviors
Cognitive skills	*Reasoning, numeracy*	*Understanding* Tasks in which the participants receive a stimulus in terms of content and understand it	*Ask* Tasks in which the participants develop questions on a topic, either freely or based on a stimulus	*Find* Tasks in which the participants (online or on-site) find answers to the questions	*Analyze* Tasks in which the participants describe a topic/pictures/story and analyze it by using familiar and new ideas	*Evaluate critically* Tasks in which participants position themselves on a topic, make a statement, and evaluate it critically.
Self-skills	*Emotions, motivation, self-efficacy*	*Know* Tasks in which the participants learn words for feelings, attitudes & self-efficacy (pictures, texts, etc.)	*Perceive* Tasks in which participants can perceive the feelings/attitudes of others	*Naming* Participants are asked to perceive and name their feelings and attitudes on various topics.	*Influence* Tasks in which participants rethink their attitudes /feelings, compare them to other attitudes/feelings and identify ways in which they can influence attitudes/feelings.	*Rebuild* Tasks in which participants critically reflect and reassess their attitudes /feelings and develop new attitudes/feelings and goals
Social skills	*Belonging, receiving, and giving support*	*Membership* Tasks in which participants record and talk about their social network	*Use* Tasks in which participants use their social network to find information and ask for help	*Support others* Tasks in which participants provide information and help others	*Participate together* Tasks in which participants take part in local and supra-regional (possibly online) activities	*Change together* Tasks in which participants work together for the course, place, region, society
Skills to connect with services	*Seeking local and online services, make use*	*Know* Tasks in which local (and online) offers are presented to participants	*Find* Tasks in which participants must find offers on a topic	*Use* Tasks in which participants use local or virtual services	*Design* Tasks in which the participants help to shape and change local and virtual offerings	*Criticize/ improve* Tasks in which the participants critically discuss and improve local and virtual offers

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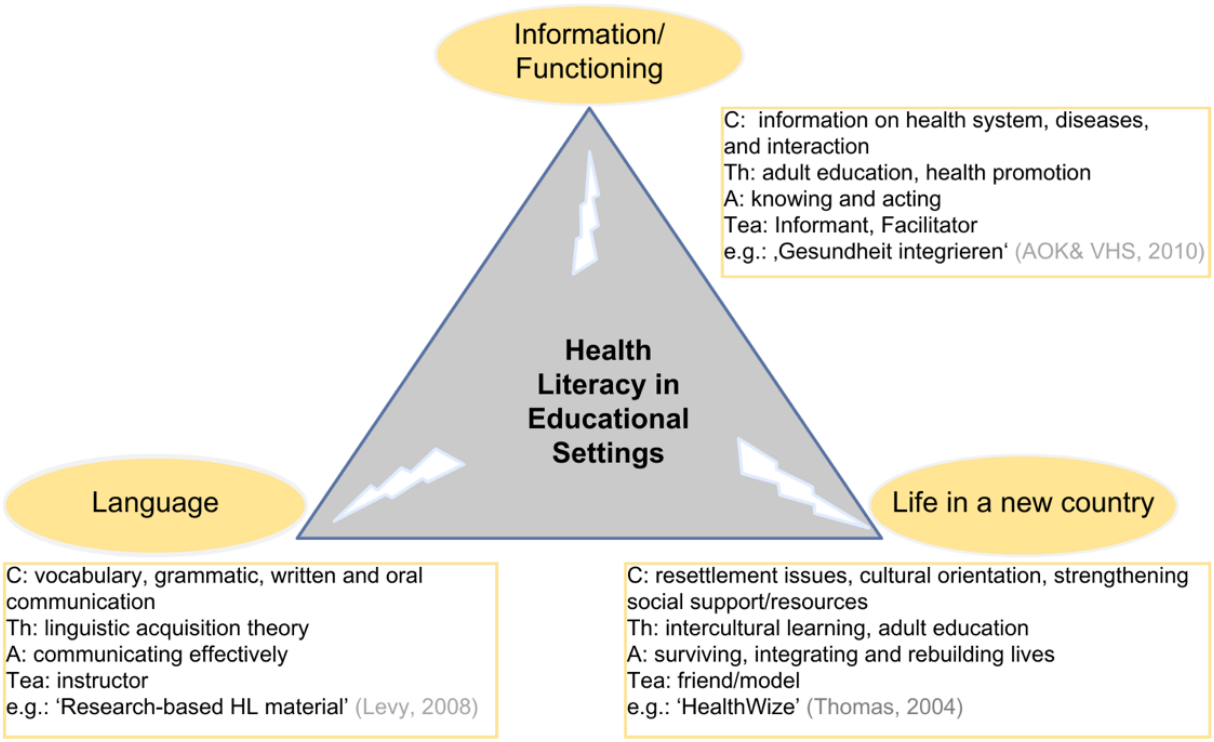
This figure helps to describe the various daily activities in terms of their respective health component and level of **difficulty**. Some activities can be easily assigned to just one component and one level, such as reading a small brochure, but most tasks include several components at variant levels and stages of activities, such as case studies or research projects, exposure trips, developing materials, presentations, discussing with a guest speaker, going on field trips, sharing new information with family members/friends, setting goals, and initiating change. A few manuals included additional digital skills – using the Internet to research topics of interest (Diehl, 2006b) or contacting local health care providers, which were subsumed under *skills for connecting to services*.

In contrast to standard health education sessions, which are not language sensitive, we examined how language was introduced. In most cases, new vocabulary is introduced with the help of a visual depiction, e.g., Oxford Picture Dictionary (Diehl, 2006b), sometimes only a few words (CIWA, 2011), sometimes a list of words and explanations (KQED Education Network, n.d.; OÖ Gebietskrankenkasse, 2014), students read a text and underline and discuss unknown words (KQED Education Network, n.d.), and increasingly the students are asked to engage more proactively with language (identifying words and grammar structures, practicing it in standardized dialogues, writing, using in new and complex situations, etc.). The only curriculum that targets the medical and technical language is *Staying Healthy* (Florida Literacy Coalition, 2014), which supports comprehension with pictures, words, definitions, and even explanations of prefixes. Since the participants of SLCs are very heterogeneous, internal differentiation to adequately support each one is a standard in the second language. Some manuals even provide ideas for internal differentiation, such as different tasks (see Furlong, 2011) and how to make the suggested tasks can be made easier or harder (Martinez & Nystrom, 2010).

In addition to exploring the factors individually, we also investigated the **progression** in the course of the unit. A sequential progression that presents tasks beyond the learner's current level of competence is a common, empirically proven, and successful strategy for improving competence (Vygotskij, 2002). Many manuals begin with a warm-up activity, followed by health topics and extension activities (Diehl, 2006b). Some manuals hardly work sequentially (neither for language nor for health content), but present different health-related tasks separately (VHS Baden-Württemberg e.V., 2010). Others compose their lessons consecutively and combine various components; for example, they introduce vocabulary with pictures, use stories of other newcomers about their health behavior, invite learners to describe and evaluate the protagonists' health behavior, and describe and monitor their own behavior (Thomas, 2004). Following the scaffolding approach, multiple methods were found to introduce, deepen, retrieve and consolidate the health content (BAG, 2018). Most manuals provided a summary of the content (BAG, 2018), highlighted key lessons learned, or even assessed the newly acquired competencies in a test (Levy, 2008). The manuals (see Table 1) provide concrete examples of teaching strategies to improve language and health knowledge.

Until now, we have analyzed the manuals' main objectives, specifically their focus on language, health and life skills separately. Migrants require these three aspects to become and act as a health literate person in a new country. Therefore, it is worthwhile to investigate the extent to which the manuals incorporate and combine these orientations. The thorough analysis revealed that the HL promotion has three main orientations, which are distinct in terms of Core Content (C), Theories/Traditions (Th), Aims (A), and Teacher Role (Tea). It is important to note that these three main orientations should not be viewed as separate approaches in isolation, but rather as different corners of a triangle.

Figure 2. Three Orientations to Health Literacy Promotion in SLCs



Source: Created by the author

Many manuals do not exclusively focus on one orientation, but instead cover aspects of one or both of the other orientations, placing them at a point within the triangle. A manual in the middle would address language, health, and life skills in equal proportions. However, this also means that each orientation receives less attention than if only one were considered. It can be concluded that these three orientations are in a state of tension (lightning bolts). The more time spent on one orientation, the less time can be spent on the other. The analysis revealed that while all manuals incorporate elements of each orientation, none of them treat them equally. Instead, each manual leans more towards one or two orientations, resulting in a stronger emphasis on and development of those aspects. Figure 2 displays which pole(s) dominate(s) and allows the individual programs to be positioned within the three main orientations.

Combining language and health: The analysis of the combination of language and health in the manuals and the extent to which both areas are improved with equal intensity revealed a highly varied picture across all manuals. Some manuals (VHS Baden-Württemberg e.V., 2010) focus on health without explicitly addressing the language difficulty of the tasks. I.e., they present the beginning of a sentence that students can use for their oral utterances in only two tasks. Some manuals deliberately separate different stages of developing linguistic and grammatical structures before teaching health topics (Levy, 2008). However, the analysis of the manuals shows that the content is neither exclusively language- or health-related, but rather that language skills and health knowledge are combined in various situations and for different reasons.

3 Discussion

This study used systematic qualitative document analysis to explore and discuss SLC manuals that focus on promoting HL in culturally and linguistically diverse populations. As our goal was to qualitatively sketch the landscape of existing ESL and HL courses, we selected manuals and cannot answer whether and to what extent HL promotion is effective in SLCs (Harsch, 2023). By comparing different HL curricula in ESL courses, our study provided a highly differentiated and nuanced picture of the relevant aspects, different approaches, and necessary components of HL promotion in SLC materials. This deeper understanding helps to determine whether a particular manual meets the needs of one's second language learners and inspires the development of customized materials.

Due to the richness of the data in this study and the word limit of the article, we restricted our discussion to selected findings.

3.1 Health Literacy Promotion

While most work on **language and literacy related** to HL refers to plain language, reduction of jargon and technical terms, and short sentences (AHRQ, 2015; Schmidt-Kaehler et al., 2017), this study identified various aspects of language needed to understand and express health-related issues (Harsch et al., 2020b; Robin, 2014). Furthermore, while many publications on migrants' HL emphasize the role of interpreters (WHO, 2018a), our study highlighted numerous ways in which individual's language needs can be analyzed and facilitated (Andrulis & Brach, 2007).

Many currently available publications on improving HL target **topics** related to the interaction with the doctor (Schmidt-Kaehler et al., 2017) and functional health (practice), but leave out the many other topics related to health, such as mental or social (family) health, despite ethnographic studies showing the vital role of family and social networks in health information sharing (Samerski, 2019). Moreover, the focus of HL on health care and illness

challenges the labeling of 'health literacy' with 'health' as understood by the WHO (WHO, 2006) and not only with 'disease' or 'sick care' literacy. Although other factors in migrants' lives strongly influence their health (IOM, 2017), such as health determinants or health inequalities, the social dimension of health, including family health, is rarely discussed. A more holistic understanding of health is therefore needed. Migrants and refugees should be explicitly informed about the general factors affecting their lives (living situation, uncertainty about asylum (IOM, 2017; Schouler-Ocak, 2017)) and the necessity to strengthen their own coping and health-promoting skills. Comparable to the various health literacy topics proposed by Singleton (Singleton, 2012, pp. 94–97) and the similarity of the HL components to the National Health Education Standards and the specific role of context in Standard 2 (CDC, n.d.).

The study also highlighted the numerous **everyday situations** in which HL is required beyond the medical field, the variety of interactions, and the need to explore more closely the various linguistic registers in these different communicative action situations and the various HL components. The complexity of HL practice in everyday life has already been described in examples of ethnographic studies (Papen, 2009; Samerski, 2019). However, we have not found any other article on HL that highlights the linguistic components and the multiple facets of health-related interactions. Our proposed differentiation allows researchers and teachers to compare different situations with each other and helps distinguish which aspects describe a situation that makes it difficult for the person to be HL in that specific situation and how to promote it sequentially.

Our study reiterated that empirical evidence on the HL **teaching approaches** is scarce. The analysis revealed that for most interventions, no theory predominates, and no explicit HL promotion theory that includes the first language, health issues, culture, and assets. This heterogeneity of theories and their absence has been mentioned in several other publications (Altgeld, 2018; Pelikan, 2019). Nonetheless, this heterogeneity can be beneficial if current and new health educators have the flexibility to switch between the different approaches to meet the needs of their students. However, the study of this interdisciplinary topic suggests that more attention should be paid to evidence-based theories and theories and didactic and methodological principles explicitly drawn from adult second language teaching, which help to purposefully plan and evaluate effective interventions.

Beyond strategies to reduce the complexity of written texts, oral doctor-patient interaction, and general 'health education' (Okan et al., 2020), little was known about other detailed ways to improve HL. Thus, this study revealed the many stimuli used to improve students' HL and the different approaches in curricula associated with each component of HL (Harsch, 2022). However, this exploratory qualitative study cannot answer which approach is the most effective. Nevertheless, this study has displayed how these seven identified health components can be practiced at different levels of difficulty, similar to Nutbeam's HL levels (Nutbeam, 2000), Bloom's taxonomy (Anderson, 2009), multiliteracies (Cope et al., 2015), and language acquisition levels (Diehl, 2000; Griesshaber, 2013). Table 3 lists the skills,

descriptors, and possible activities for their implementation. This table is not exhaustive, but the most appropriate descriptor and level, as well as the most common activities are listed for each skill to allow for internal differentiation. To achieve higher levels of each component, Nutbeam's description that HL can also lead to empowerment (Nutbeam, 2008), Freire's approach could be goal-oriented (Freire, 1996, 1970), and the educational process must be guided by dialogue, thinking, asking questions, and finding answers (Harsch, 2022). While organizing HL into these seven components emerged from our review of the empirical evidence for promoting HL in SLC, other researchers and teachers categorize it differently (Rudd et al., 1998; Rudd et al., 2005; Singleton, 2003, 2012) such as perceptions and attitudes, behavior and change, prevention, early detection and maintenance, promotion and advocacy, and systems and interdependencies (MDEACLS, 2001). Each categorization is developed by experts in a particular discipline (health, social science, adult education) within a specific background derived from a particular context and serves a specific purpose and function. Our differentiation is particularly appropriate for SLCs (teachers) because it is strongly linked to common methods and procedures in SLC teaching, expands teachers' perspective on their current teaching, and gives practical ideas on how to strengthen language and HL comprehensively and simultaneously.

Furthermore, similar to the debate about the nature of health education, the **nature of HL** promotion can also be discussed along the normative versus critical spectrum. Our study found that some – particularly the manuals developed by health insurance companies – took a normative/directive approach to health education, while others were more enabling/empowering (Papen & Walters, 2008). Some manuals explained in general terms what people should do to be healthy, others encouraged the students to apply the new knowledge to their own lives, reflect on their behavior, set new goals, and take action at the individual level; and still, others supported students in thinking critically about their life situation and the impact of the environmental, social, and political context on their health.

Because health (literacy) practice is a cultural practice (Andrulis & Brach, 2007; Eichler, 2013), studies show that the integration of cultural preferences is necessary for the acceptance and use of health messages, and that HL initiatives work best when they tailor approaches based on an understanding of the different ways in which individuals and communities approach health. The role of family, social context, culture, and education must be considered in the development of all HL messages (WHO, 2013). Because culture is so diverse and culturally tailored messages can easily prescribe culture, interventions should not be **culturally appropriate but sensitive to multiple cultural peculiarities**. To guide the analysis and development of culturally sensitive interventions, the six cultural strategies developed by Kreuter et al. are useful (2003). They structure the strategies from outward representation of people from other cultures to addressing values and discussing evidence of health inequalities. In our study, use varied from no strategy to including multiple strategies, but peripheral adaptation to linguistically and culturally diverse groups predominated. Taken together, the manuals offer a variety of ideas from a single perspective or multiple people

reflecting on their perspectives: using their own experiences, asking questions, and learning through the stories of others.

Although the understanding of the individual (from a deficit or asset perspective) has a strong impact on the teaching, we could find little explicit information about it, but the manuals implicitly reveal that they perceive the individual from a deficit perspective as a learner who lacks language proficiency, is unfamiliar with the system, etc. and rarely from a salutogenic perspective as a capable person with multiple assets (including skills, experiences, social network). This asset-based salutogenic perspective has only recently been seen in second language didactics, with a translanguaging approach (Garcia & Li, 2014) that draws on the richness of the individual's linguistic registers and assets for effective interactions; however, this approach still needs to be integrated and applied comprehensively worldwide.

Our study has highlighted numerous ways of **combining content and language** and integrated them into a model to describe one's approach in relation to these three orientations and to move towards one or the other. However, the manual analysis shows that it is not either language or health content; ethnographic studies on HL show that language skills and health knowledge are not used separately but combined in different situations and for different resources. Also, since the so-called 'communicative shift,' second and foreign language teaching has moved away from primarily teaching grammar but more about preparing students for real-life situations (Cope & Kalantzis, 2009). While there is an increasing focus on content-and-language-integrated learning in second language didactics, we argue for going one step further and combining a competence-and-language-integrated learning approach (the different stages described above are helpful). Combined with Figure 3, it is then possible to identify the component of HL and its level and find new tasks to move forward.

Although this study provided a more detailed understanding of the types of activities and exercises in the manuals, it could not examine language courses in their broader sociopolitical context (Wagner, 2019). We aimed at reviewing the manuals from a radical health promotion advocacy perspective, which requires a critical HL perspective (Nutbeam, 2008) that understands HL as situated in a context and setting (Harsch, 2022) that is often detrimental to the health of migrants/refugees. We found that functional HL is addressed in a significant number of curricula – with the sole focus on being able to read it correctly. Several manuals also modelled how to interact with the doctor (interactive HL), but we rarely found activities that encouraged a critical reflection on how contextual factors influence health (critical health literacy). Consequently, these findings are consistent with Nutbeam's three-level HL model (Nutbeam, 2000). Furthermore, our findings are in the tradition of New Literacy Studies, which emphasizes not only the text itself but what people do with the written (health) information (Papen, 2009; Santos et al., 2018; Street, 2014). Additionally, advancing HL does not only expands one's range of action, "when you gain new practices, new navigation skills, new competencies, you change who you can interact with," but it goes even beyond that, and "classroom talk can serve as HL in action, and HL talk can serve as identity work" (Santos in National Academies of Sciences, Engineering, and Medicine, 2017).

Finally, this study also raises questions about the separation or overlap of disciplines such as Public Health and Applied Linguistics and how experts in each field can contribute to the advancement of HL.

3.2 Limitations

Our study is limited for four reasons. First, despite our attempt to systematically identify all online manuals on HL promotion in SLCs in 2018, we may have missed hard-to-find manuals. As a result, our picture is limited to our findings. Nevertheless, these manuals served the purpose of this scoping review to provide comprehensive and in-depth insights into HL promotion in SLCs and the different topics and approaches. Second, our study cannot assess the actual use of the manuals because we only analyzed the manuals' activities, not their implementation or adoption. Only three curricula (Duncan et al., 2013; Levy, 2008; Soto Mas et al., 2013) published an evaluation. Overall, it is essential to know more about the teachers' use of the manual, as their performance has a significant impact on teaching (Hattie, 2010). Ethnographic studies provide a holistic understanding of HL promotion in practice (Harsch, 2022; Papen, 2009; Wigglesworth, 2003). Third, not all manuals provide exhaustive information on all topics of interest (theories, teacher qualifications, sustainability), so our analysis is limited to the available information. Fourth, in the absence of other reviews of manuals on HL promotion in SLC, we could not compare the results of our study with another study.

Against this backdrop, the in-depth analysis of the manuals showed that the courses, materials, and contents are very heterogeneous in length, topics, and approaches, which is consistent with the enormous heterogeneity of HL tools (Paasche-Orlow, 2021) and HL promotion approaches.

Conclusion

This scoping study and document analysis has analyzed the tasks of HL promotion in SLCs materials and provides an in-depth understanding of the various approaches, components, and relevant aspects. Overall, it stimulates a rethinking of our understanding of HL as a social practice that is inherently a communicative action. Analyzing the process of acquiring HL skills in a new country in SLCs can help.

This study uncovers numerous aspects related to HL practice and shows multiple ways to promote HL. New strategies should be used to advance HL that perceive newcomers as transcultural multilingual beings and holders of various competencies. HL interventions should primarily build bridges to unfold and use the many resources that people have. To this end, the role of teachers should be strengthened, and they could be equipped to play the role of HL-promoting hosts, facilitators, and gatekeepers. Thus, in addition to improving the HL of doctors

and increasing the accessibility of health information, newcomers can quickly engage in health issues in the new country. Nevertheless, beyond this practical application of our study in second language teaching, this study also allows researchers and policy makers to rethink the process of HL promotion and be inspired by its various components to ultimately improve health. Thus, we should not dissect health information from language or action situations, but rather see their interplay and support their development. Furthermore, our empirical evidence supports the argument that HL promotion is not a bank model but a situation where people provide the best learning opportunities to become learners and teachers simultaneously.

In short, this study offers a new way of looking at the adult second language learner, a new approach, and a new opportunity. We hope that the findings presented here will stimulate the promotion of HL as it is already being done in SCURA and other projects. Improving HL is an ethical obligation, and health professionals, researchers, policy makers, and teachers can work together to reduce health inequalities.

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