Media and Health Literacy: A Conceptual Framework—Definitions, Significance, Historical Development, and Core Principles

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Abstract

This chapter examines the conceptual framework of media and health literacy through their definitions, significance, historical development, and core principles. Media literacy is presented as a multidimensional competency that enables individuals to access, analyze, evaluate, and produce media content through critical inquiry. Health literacy, in turn, refers to individuals' ability to locate, understand, evaluate, and apply health-related information in ways that shape both personal decision-making and interactions with the health system. Adequate levels of health literacy are associated with positive health outcomes and more equitable use of health services, yet national-level data indicate substantial room for improvement across society. In the digital era, media literacy and health literacy increasingly intersect, and gains in digital literacy are often linked to gains in health literacy. The chapter is grounded in the principles of critical inquiry, evidence-based information, transparent communication, accessible design, and participation. It argues that comprehensive empowerment in this field depends on both educational policies and health-literacy-sensitive institutional arrangements.

Keywords: Media literacy; health literacy; digital health literacy; critical media literacy; media and health literacy

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1. Introduction

In contemporary societies, the conditions under which individuals access, interpret, and use information have been fundamentally transformed by the expansion of mass, digital, and networked media environments. This transformation is particularly consequential in the field of health, where individuals increasingly encounter health-related information not only through healthcare professionals and formal institutions, but also through news media, social media platforms, search engines, digital applications, influencers, and algorithmically curated content streams. As a result, health-related decision-making is no longer shaped solely within the boundaries of the healthcare system; it is also mediated by communication environments that influence what information becomes visible, credible, persuasive, and actionable.

From this perspective, media literacy and health literacy should no longer be treated as entirely separate domains. Rather, they need to be understood as intersecting and mutually reinforcing capacities that together help explain how individuals navigate complex health information environments. While media literacy equips individuals to access, analyze, evaluate, and produce media messages critically, health literacy enables them to obtain, understand, appraise, and use health information and services in ways that support well-being. In the digital age, however, the boundary between these two domains has become increasingly porous. The ability to make informed health decisions now depends not only on understanding health content, but also on recognizing how media logics, platform dynamics, source credibility, visual framing, and digital circulation shape that content before it reaches audiences.

This intersection places the discussion directly within the field of health communication. Questions of source trustworthiness, risk communication, persuasive health messaging, digital health campaigns, misinformation, and public engagement all demonstrate that media and health literacy are not merely adjacent competencies, but central components of contemporary health communication processes. In this sense, examining the relationship between these two literacies provides a stronger conceptual basis for understanding why individuals may accept, reject, misunderstand, or critically negotiate health information in digitally saturated communication environments.

Accordingly, this chapter argues that media and health literacy together form a conceptual framework essential for understanding health communication in the digital era. Building on this claim, the chapter first examines media literacy through its definitions, historical development, core principles, and theoretical approaches. It then addresses health literacy, including its historical trajectory, conceptual models, and the emergence of digital health literacy. Finally, it discusses the main points of convergence between these fields and highlights why their intersection matters for critical inquiry, evidence-based communication, democratic participation, and equitable access to reliable health information. As the opening chapter of this book, the aim is not only to introduce key concepts, but also to establish the conceptual ground on which the subsequent discussions of media and health literacy can be more systematically developed.

2. Media Literacy

Media literacy is defined as a multidimensional domain of competence that encompasses individuals' abilities to access, analyze, evaluate, create, and communicate print, visual, auditory, and digital media content. It should be understood not merely as a technical skill set, but also as a practice that cultivates critical thinking, interpretive awareness, and social or civic consciousness (Aufderheide, 1993; Potter, 2004). In this sense, media literacy concerns not only how individuals use media, but also how they understand, question, and respond to mediated representations of reality.

This section examines media literacy through four interrelated dimensions: its conceptual definition and historical development, its core principles and competency domains, its major theoretical approaches, and its institutional practices in Türkiye. Taken together, these dimensions demonstrate that media literacy is not a narrow or static concept, but a dynamic and evolving framework that has become increasingly important in the digital age.

2.1. Conceptual Definition and Historical Development

The development of media literacy can be traced to early debates concerned with protecting children and adolescents from the potential negative effects of media. In this respect, the film education movement that emerged in the United Kingdom and France during the 1930s marked an important starting point. Later, the spread of television in the 1950s and 1960s, the growth of home viewing, and the increasing use of television in educational settings further expanded public and academic interest in the analysis and critique of media

content. By the 1970s, media education had become more institutionalized in countries such as Canada, the United Kingdom, and Australia, where curricular approaches increasingly emphasized the structural analysis of media messages and the cultivation of critical reading skills (Koç, 2016; Hobbs & Jensen, 2009; Fedorov, 2008; Masterman, 1985).

Since the 1990s, rapid transformations in communication technologies have further broadened the scope of media literacy. During this period, Potter (2004) conceptualized media literacy as a cognitive process aimed at enhancing individuals' awareness of how media messages are structured, interpreted, and internalized. From this perspective, media literacy involves the systematic evaluation of messages in terms of their purposes, forms, content, and effects. As digital media environments became more pervasive, traditional understandings of literacy expanded to include visual, digital, and multimedia forms of competence.

This broadening of the concept is also reflected in UNESCO's framework of Media and Information Literacy (MIL), which positions media literacy within a wider set of global citizenship competencies. In this framework, individuals are expected not only to engage critically with media content, but also to question information sources more generally and to participate more actively in the production and circulation of meaning (Wilson et al., 2011). Accordingly, media literacy has evolved from a largely protective and text-centered orientation toward a more dynamic and multidimensional framework in which individuals are seen not as passive recipients of media content, but as active interpreters, evaluators, and participants in media culture.

2.2. Core Principles and Competency Domains

Media literacy involves the ability to understand, analyze, and evaluate media messages in both verbal and visual forms. However, this concept extends beyond the technical deconstruction of media texts. It also includes the capacity to recognize the intentions behind messages, the conditions under which they are produced, their potential social effects, and the ethical dimensions of media use. For this reason, media literacy education is grounded in a set of core principles that define how media content should be approached critically.

One of the most influential contributions in this regard is Masterman's (1985) framework, which emphasizes that media do not simply reflect reality in a transparent way; rather, they construct selected and organized versions of reality. From this perspective, every media text carries assumptions, values, and ideological dimensions that need to be examined critically. Masterman's contribution is especially important because it shifts media literacy away from passive consumption and toward a critical awareness of representation, production, and interpretation.

A more pedagogically structured articulation of these competencies is offered by Hobbs (2010, pp. 18–19), who identifies six interrelated domains of media literacy. These include access, analysis, evaluation, communication, production, and reflection. Access refers to understanding how media content is reached and used; analysis involves examining the structures, forms, and techniques through which messages are organized; evaluation concerns judgments about credibility, accuracy, and ethics; communication and production focus on the capacity to express ideas through media and to produce content responsibly; and reflection highlights awareness

of values, biases, and social responsibility. Taken together, these domains show that media literacy includes not only interpretation, but also expression, participation, and ethical engagement.

This broader orientation is also evident in the European Commission's (2009) conceptualization of media literacy, which emphasizes technical, cognitive, social, creative, and civic dimensions. In this framework, individuals are not positioned merely as media consumers, but also as interpreters, producers, and critical actors within media environments. This multidimensional perspective is especially important in the face of disinformation, fake news, and manipulation, as it links media literacy to democratic participation, digital citizenship, and informed public engagement.

Accordingly, media literacy can be understood as a holistic domain of learning that integrates critical thinking, ethical awareness, communication skills, and civic responsibility. Considered together, the contributions of Masterman, Hobbs, and the European Commission demonstrate that media literacy is not confined to decoding messages; it is a broader competency that enables individuals to engage with media in more informed, reflective, and socially responsible ways.

2.3. Theoretical Approaches

The literature on media literacy includes a range of theoretical approaches that differ in how they understand media content, the role of audiences, and the aims of education. Considered together, these approaches reveal an important shift in the field: from models primarily concerned with protecting individuals from harmful media effects toward

perspectives that emphasize critical awareness, active interpretation, and participatory engagement.

Early approaches to media literacy were largely shaped by concerns about media harm, especially in relation to children and young people. The inoculation approach assumes that media messages may exert negative influence on passive recipients and therefore treats media literacy as a form of protection or "vaccination" against potentially harmful content (Kıran, 2020, p. 238; Bilici, 2011, p. 49). Closely related to this is the protectionist approach, which seeks to shield individuals and society from the moral, cultural, or behavioral risks associated with media, particularly violent or corrupting content (Kıran, 2020, p. 238; Bilici, 2011, p. 50). These approaches are historically significant because they reflect the early tendency to position audiences primarily as vulnerable receivers in need of defense.

Later perspectives moved beyond protection and placed greater emphasis on agency, participation, and critique. The empowerment approach argues that individuals should not only understand media, but also use media tools creatively and autonomously. From this perspective, media literacy becomes a developmental process that supports digital citizenship and active participation in public communication (Kıran, 2020, p. 239; Bilici, 2011, p. 51). Similarly, the critical approach examines how media are embedded in ideological, cultural, and social structures. Drawing on Hall's (1980) encoding/decoding model, this perspective emphasizes that media messages are produced within relations of power and interpreted differently depending on audiences' social positions. As a result, media literacy is understood not simply as message comprehension, but as a practice of questioning

representation, ideology, and the reproduction of social norms (Kıran, 2020, p. 239; Okuroğlu, 2016; Bilici, 2011, p. 52; Hobbs & Jensen, 2009).

A more practice-oriented perspective is represented by the analytical approach, which focuses on how media literacy can be taught through concrete classroom activities such as examining films, newspaper pages, news stories, or social media content from multiple perspectives and through discussion (Bilici, 2011, pp. 54–55). This approach is particularly useful because it translates broad principles into teachable practices and supports the application of critical skills in everyday media contexts.

Several influential models further contributed to the pedagogical and cognitive development of the field. Potter's (2004) Cognitive Media Literacy Model conceptualizes media literacy as a process of becoming more aware of how media messages are constructed and how individuals process them through existing mental frameworks and biases. Aufderheide (1993) similarly emphasizes that media literacy requires a structured pedagogical framework in which students are taught to access, analyze, evaluate, and produce media content in systematic ways, rather than encountering media in an ad hoc manner. Buckingham (2003), in turn, argues that media literacy education should not be reduced to the simple transmission of information or a protectionist transmission of correct readings, but should be integrated with the cultivation of critical thinking, inquiry-based learning, and students' active engagement with their own media experiences.

Taken together, these approaches demonstrate that media literacy is a heterogeneous and evolving field. While early models concentrated on protection from harmful effects,

later approaches increasingly emphasized interpretation, participation, critique, and reflective engagement. This theoretical development is important because it shows that media literacy is not merely about resisting media influence, but about equipping individuals to understand, question, and actively engage with media as a central part of contemporary social life.

2.4. Media Literacy Practices in Türkiye

In Türkiye, the institutional implementation of media literacy education began in 2006 through a protocol signed between the Radio and Television Supreme Council (RTÜK) and the Ministry of National Education (MEB). Within this framework, the media literacy course was first introduced in primary schools across five pilot provinces during the 2006–2007 academic year and was then expanded nationwide as an elective course beginning in 2007–2008. This development represented an important step in bringing media literacy into the formal education system and in recognizing it as a matter of public and educational concern.

At the same time, academic evaluations have suggested that the implementation of media literacy education in Türkiye has been shaped predominantly by a protectionist orientation. Although this approach aims to shield children and young people from the possible negative effects of media content, it may also limit the development of more participatory, interpretive, and critically engaged forms of media education (Hasdemir & Demirel, 2012, p. 184). In this respect, the Turkish experience reflects a broader tension in media literacy education between protective aims and critical-empowerment approaches.

Another important issue concerns teacher preparation. Many teachers assigned to media literacy courses do not have formal training in communication, media studies, or media education, which may restrict the depth and quality of classroom practices, particularly in relation to critical analysis and reflective discussion. Empirical research has also shown a meaningful relationship between media literacy competencies and dispositions toward critical thinking, underscoring the importance of strengthening teachers' professional preparation in these areas (Bulut Aşık, 2022; Karagöz, 2021).

Taken together, these developments indicate that media literacy education in Türkiye has achieved a certain degree of institutional visibility, but still faces important pedagogical and structural challenges. Strengthening the field requires not only maintaining its place within formal education, but also moving beyond a narrowly protectionist perspective toward more critical, participatory, and pedagogically grounded approaches.

3. Health Literacy

Health literacy refers to an individual's capacity to access, understand, appraise, and use health-related information and services in ways that support informed decision-making and well-being. In this sense, health literacy encompasses not only access to information, but also the ability to translate that information into appropriate judgments and health-related behaviors. According to the World Health Organization (WHO, 2025), health literacy involves the capacities needed to access, understand, appraise, and apply information and services in ways that promote and sustain good health and well-being. As such, health literacy is widely recognized as a core component

of contemporary public health policy and as a key determinant of how individuals and communities engage with health systems, health communication, and health-promoting practices (Sørensen et al., 2012).

This section examines health literacy through four interrelated dimensions: its conceptual definition and historical development, its core competencies and theoretical models, the rise of digital health literacy, and the practices and research that have emerged in Türkiye. Taken together, these dimensions demonstrate that health literacy should be understood not merely as an individual skill, but as a multidimensional and socially shaped capacity that is central to contemporary health communication and public health.

3.1. Conceptual Definition and Historical Development

The term health literacy was first introduced in 1974 by Scott K. Simonds in the context of health education, particularly in his work Health Education as Social Policy (Simonds, 1974). From the 1990s onward, its use in scientific literature and public health policy increased considerably, especially in relation to health communication, patient education, and public health reform (Berkman et al., 2011; Sørensen et al., 2015).

Over time, the concept of health literacy has developed beyond a narrow understanding of reading and comprehension skills in medical settings. According to the WHO (2025), health literacy refers to individuals' ability to access, understand, appraise, and use information and services in ways that promote and maintain good health and well-being. This perspective emphasizes that health literacy is not limited to the

possession of information, but includes the capacity to interpret, evaluate, and act upon that information in everyday life.

At the same time, health literacy should not be understood solely as an individual characteristic. Contemporary approaches increasingly emphasize that these capacities are also shaped by the accessibility, clarity, and responsiveness of health systems and institutions—an orientation often described as organizational health literacy (WHO, 2025). In this sense, health literacy is both an individual and a structural issue. Evidence from international research further shows that limited health literacy is associated with difficulties in understanding prescriptions, interpreting health messages, navigating health services, and adhering to treatment processes (Berkman et al., 2011). These findings reinforce the view that health literacy functions not merely as a personal skill set, but as a determinant of health that directly affects equity, access, and health outcomes.

In recent decades, the rapid expansion of digital communication environments has further broadened the scope of the concept. Individuals increasingly encounter health information not only through healthcare professionals and institutional channels, but also through websites, social media platforms, search engines, and other digital sources. This development has made health literacy more complex and has paved the way for the emergence of digital health literacy as a more specific area of competence. In this respect, the historical development of health literacy reflects a broader shift from a predominantly clinical and functional understanding toward a multidimensional framework that includes communication, critical evaluation, participation, and digital engagement.

3.2. Core Competencies and Theoretical Approaches

Health literacy is not limited to individual knowledge or technical ability; rather, it is closely connected to socioeconomic conditions, educational background, and the organization of health systems. Findings from the European Health Literacy Survey (HLS-EU) showed that nearly half of respondents in eight countries experienced difficulties in understanding and applying health information, with limited health literacy appearing more frequently among older adults, individuals with lower levels of education, and those facing financial deprivation (Sørensen et al., 2015). These findings indicate that health literacy should be approached not only as an individual competency, but also as a public and structural responsibility.

Within this broader perspective, several theoretical approaches have contributed to the conceptualization of health literacy. One of the most influential frameworks is Nutbeam's (2000) three-level model, which distinguishes between functional, interactive, and critical health literacy. Functional health literacy refers to the basic ability to understand health-related information in routine situations, such as reading prescriptions or appointment details. Interactive health literacy involves more advanced communicative and social skills that enable individuals to engage actively with health professionals and participate in decision-making processes. Critical health literacy, in turn, refers to the ability to evaluate the credibility of information, question health-related claims, and use that evaluation in shaping informed behaviors. This model is particularly important because it shows that health literacy develops from basic comprehension toward more active, reflective, and participatory forms of engagement.

A different but complementary perspective is provided by the causal model developed by Paasche-Orlow and Wolf (2007). In this model, health literacy is conceptualized as a mediating factor that influences health outcomes through three main mechanisms: individuals' capacity to access and process information, the complexity of the healthcare system, and the presence of supportive systems such as social support and environmental resources. This framework is valuable because it demonstrates that health literacy affects not only understanding, but also treatment adherence, self-care, communication with providers, and the broader management of health-related decisions. It also highlights the importance of reducing health inequalities by addressing both personal and systemic barriers.

The expanded model proposed by Zarcadoolas, Pleasant, and Greer (2005) further broadens the concept by organizing health literacy into four interrelated dimensions: fundamental literacy, scientific literacy, cultural literacy, and civic literacy. Fundamental literacy refers to reading, writing, speaking, and numeracy skills; scientific literacy concerns the ability to understand and evaluate scientific information; cultural literacy involves interpreting health beliefs and practices within cultural contexts; and civic literacy emphasizes awareness of rights, responsibilities, and participation in collective decision-making related to health. This model is especially significant because it situates health literacy within wider discussions of democratic participation, social justice, and public engagement.

Taken together, these approaches show that health literacy is not a narrow or static concept. Rather, it is a multidimensional framework that includes understanding, communication, critical evaluation, participation, and structural conditions. While Nutbeam's model highlights levels of competency, Paasche-Orlow and Wolf emphasize pathways to health outcomes, and Zarcadoolas et al. stress the social and civic breadth of the concept. Considered collectively, these models provide a more comprehensive understanding of why health literacy matters not only for individual behavior, but also for equitable, effective, and participatory health systems.

3.3. Digital Health Literacy

Digital health literacy has emerged as a crucial public health competence in an era shaped by rapid digitalization, misinformation, information disorder, and algorithmically mediated communication environments. As health-related content increasingly circulates through websites, social media platforms, search engines, video-sharing services, and mobile applications, individuals are expected not only to access information but also to assess its reliability, interpret it critically, and use it appropriately in decision-making processes. The COVID-19 pandemic, in particular, revealed that limited digital health literacy can increase individuals' exposure to misleading content and contribute to risky health-related behaviors such as vaccine hesitancy, the adoption of unscientific dietary practices, and the use of non-evidence-based treatments (WHO, 2020). In this respect, digital health literacy has become essential not only for individual well-being but also for the protection of public health.

Research conducted in the Turkish context indicates that digital literacy has a positive and significant effect on health literacy. This suggests that digital competence is closely related not only to the technical use of online tools, but also to individuals' ability to access, understand, evaluate, and use health-related information effectively (Yıldırım, 2024). Therefore, digital health literacy should be understood as a multidimensional competence that includes critical evaluation, informed judgement, and responsible engagement with online health information.

At the same time, digital health literacy should not be understood only in relation to risk and misinformation. It also includes the ability to use digital health technologies effectively in ways that support self-management, communication, and access to services. In Türkiye, platforms and tools such as e-Nabız, mobile health applications, and telemedicine services increasingly enable individuals to monitor their health data, manage appointments and records, and participate more actively in their own health processes. For this reason, digital health literacy has strategic importance not only at the individual level but also in reducing health inequalities, promoting digital inclusion, and supporting the broader digital transformation of health systems. From this perspective, education, communication, and technology policies should be designed in ways that strengthen these competencies.

A major theoretical contribution to this field is the digital health literacy model developed by Norman and Skinner (2006), also referred to as the eHealth literacy model. Their "Lily Model" conceptualizes digital health literacy as a composite competence built upon six interrelated forms of literacy: traditional literacy, information literacy, media literacy,

health literacy, computer literacy, and scientific literacy. This model is significant because it shows that effective engagement with digital health information depends not on a single skill, but on the interaction of multiple forms of literacy. Accordingly, digital health literacy can be understood as a multidimensional competency that enables individuals to navigate digital health environments more critically, confidently, and effectively.

3.4. Health Literacy Practices and Research in Türkiye

The concept of health literacy has attracted increasing attention in Türkiye since the early 2000s, with a more visible rise in both institutional and academic initiatives after 2010. Within the broader framework of the Ministry of Health's health transformation program, communication policies aimed at strengthening public health also contributed to the growing importance of health literacy as a policy and research area.

One of the first comprehensive efforts to assess health literacy levels in Türkiye was the Türkiye Health Literacy Survey, published in 2014 by the Health and Social Service Workers' Union. Using the European Health Literacy Survey instrument (HLS-EU), the study reported that 64.6% of the population fell into the categories of "inadequate" (24.5%) or "problematic" (40.1%) health literacy (Durusu Tanrıöver et al., 2014). These findings revealed the scale of the issue and helped bring health literacy into wider policy and academic discussions.

In the 2018 Study on Health Literacy Levels and Associated Factors in Türkiye conducted by the Ministry of Health, researchers used the TSOY-32 scale, which had been

developed with reference to the HLS-EU framework. The results similarly indicated that limited health literacy remained widespread, with approximately four out of every ten adults demonstrating inadequate or problematic levels. The study also showed that health literacy was positively associated with educational attainment, whereas limited health literacy was more common among older adults and individuals facing greater financial deprivation (Özkan, 2018). These findings are consistent with international literature and demonstrate that health literacy in Türkiye is closely linked to broader patterns of social inequality.

The academic literature on health literacy in Türkiye has also expanded substantially in recent years. In a review of theses, Şantaş (2021) reported that more than three out of every four studies (75.8%) were primarily concerned with measuring health literacy levels. A similar pattern is visible in studies indexed in DergiPark, where level measurement, behavior-related analyses, quality of life, and relational findings appear as dominant themes (Altunbaş & Altunbaş, 2022; Kılıç et al., 2023; Akbolat et al., 2022; Kiracılar & Koçak, 2023; Ağralı et al., 2023). This body of research has contributed valuable descriptive knowledge, but it also suggests that the field in Türkiye still relies heavily on level determination studies and would benefit from a broader diversification of research agendas and intervention-oriented work.

Despite these institutional and academic developments, critiques have emphasized that health literacy policies and practices in Türkiye remain relatively limited and fragmented in implementation. One of the main challenges is the insufficient integration of health literacy into the formal education system, which restricts the development of this competence

through systematic and long-term learning processes. In addition, research consistently shows that health literacy levels remain lower among older adults, individuals with lower educational attainment, and those living in rural or socioeconomically disadvantaged settings (Durusu Tanrıöver et al., 2014; Özkan, 2018; Avcı & Özkan, 2020). These findings indicate that strengthening health literacy in Türkiye requires not only more research, but also more coordinated educational, communicative, and institutional strategies.

4. The Relationship Between Media and Health Literacy

Media has emerged as a prominent and evolving conduit for accessing health information. In the past, traditional media outlets such as television, radio, and newspapers played a pivotal role in disseminating health-related knowledge to the public. However, with the rise of digital media, and particularly internet-based platforms, this role has undergone a significant transformation. Contemporary individuals now encounter health-related content not only through health authorities and professional institutions, but also through news websites, social media platforms, online forums, video-sharing services, and personal blogs. While this diversification has broadened access to health information and contributed to its wider circulation, it has also introduced major challenges related to information disorder, source credibility, and the critical evaluation of health claims.

In this context, the relationship between media literacy and health literacy has become more visible and more consequential. Access to health information is no longer simply a matter of availability; it also requires the ability to identify

reliable sources, interpret mediated messages critically, distinguish evidence-based content from misleading claims, and make informed decisions in increasingly complex communication environments. For this reason, media literacy and health literacy should be understood not as isolated competencies, but as intersecting capacities that shape how individuals encounter, assess, and use health-related information in everyday life.

Accordingly, this section examines that relationship across four interrelated dimensions: access to health information through media, fact-checking and critical appraisal skills, the role of social media within the health information ecosystem, and the problem of credibility across different media channels. Taken together, these dimensions demonstrate that media are not merely passive carriers of health information, but active environments in which health meanings are constructed, circulated, contested, and acted upon.

4.1. Accessing Health Information Through Media

The dissemination of health-related information through media directly influences individuals' health perceptions, risk assessments, treatment preferences, and everyday lifestyle practices (Borges do Nascimento et al., 2022; Park et al., 2019; Ferrer & Klein, 2015). For this reason, access to health information through media should not be understood merely as a technical matter of exposure or availability. It also involves the ability to locate relevant information, make sense of mediated content, and recognize that different media environments shape health knowledge in different ways.

In the contemporary communication environment, individuals no longer rely exclusively on health professionals or official institutions for health-related information. Instead, they increasingly encounter such content through a wide range of media sources, including online news platforms, social media, blogs, forums, and video-based channels. This expansion has broadened public access to health information, but it has also complicated the conditions under which such information is encountered and interpreted. As a result, access now takes place in communication environments where information is abundant, uneven in quality, and often presented through competing narratives.

The significance of this issue becomes even more apparent during global health crises such as pandemics. In such periods, media channels play a crucial role in rapidly disseminating public health information to large audiences. At the same time, however, the circulation of misleading, incomplete, or distorted content may intensify information disorder and make access to accurate health information more difficult (Koç Akran, 2021; Borges do Nascimento et al., 2022; Ağralı et al., 2023). In this respect, media function not only as channels that carry health information, but also as social environments in which perceptions of risk, vulnerability, trust, and appropriate action are formed.

Accordingly, the relationship between media literacy and health literacy becomes especially visible at the point of access. Effective access to health information requires more than reaching content; it also depends on the ability to recognize differences between sources, understand the mediated nature of health messages, and approach health-related communication with an appropriate degree of awareness and

selectivity. In this sense, access is the first point at which media literacy and health literacy begin to intersect functionally in everyday life.

4.2. Fact-Checking and Critical Appraisal Skills

As access to health information through media has expanded, the need to evaluate the accuracy and credibility of that information has become increasingly critical. In digital environments where large volumes of content circulate rapidly, individuals are frequently exposed to health-related claims that may lack scientific grounding, be framed in misleading ways, or be shaped by commercial interests. Under such conditions, a critical stance toward health information is not optional but necessary.

Critical appraisal requires attention not only to the content of a message but also to the broader characteristics of the source from which it originates. This includes questioning the purpose of the message, the expertise of the communicator, the evidence on which the claim is based, and the language through which the information is presented. In this sense, the evaluation of health information depends on a combination of health literacy and core media literacy skills, particularly the ability to interpret mediated messages critically rather than accept them at face value.

Empirical research indicates that individuals with higher levels of health literacy are more likely to verify sources, consult expert opinions, and compare multiple references when evaluating online health information (Diviani et al., 2015; Lee & Ramazan, 2021). By contrast, individuals with lower levels of literacy are more likely to rely on content that is emotionally appealing, easily accessible, or superficially

understandable, even when such content has not been adequately verified (Mohamed et al., 2024). This tendency increases the risk that inaccurate or weakly supported health claims may be accepted, shared, and incorporated into decision-making processes.

For this reason, fact-checking and critical appraisal should be supported not only at the individual level but also through structural mechanisms. Fact-checking checklists, independent verification platforms, and the proactive production of accessible digital content by official health authorities can all contribute to strengthening individuals' evaluative capacities. Given the widespread use of digital media, especially among younger generations, integrating these competencies into educational processes is particularly important.

4.3. Social Media and the Health Information Ecosystem

A substantial body of research identifies social media platforms as a primary point of exposure to health-related information (Afful-Dadzie et al., 2023). Platforms such as Facebook, Instagram, X (formerly Twitter), TikTok, and YouTube now play a central role not only in the dissemination of health information but also in its production, circulation, and reinterpretation. This shift has transformed conventional patterns of communication by positioning individuals not merely as recipients of health content, but also as potential producers, sharers, and amplifiers of that content.

Health-related communication on social media is typically characterized by speed, visual emphasis, emotional intensity, and high levels of interaction. These features can significantly expand the reach of health messages and

increase public engagement. At the same time, however, they can weaken scientific accuracy, simplify complex medical issues, and encourage the rapid diffusion of distorted or weakly supported claims. The "infodemic" observed during the COVID-19 pandemic clearly demonstrated that false or misleading health information circulating on social media can generate serious public health risks by shaping perceptions, behaviors, and trust in problematic ways (WHO, 2020).

Social media has also enabled the emergence of new actors within the health information environment, including health influencers, physician influencers, and promoters of alternative medicine. While some of these actors may contribute to the wider dissemination of scientifically grounded information, many operate according to visibility, engagement, and platform logic rather than professional or scientific standards. As a result, public trust may be shaped less by expertise than by relatability, popularity, and algorithmic visibility. In some cases, individuals may orient their health decisions around these actors rather than established health authorities, creating significant challenges for the quality, supervision, and credibility of health information (Kaňková et al., 2025a, 2025b).

At the same time, social media should not be understood solely as a risk environment. When used strategically and responsibly, it can also serve as an important tool for raising awareness, supporting public health campaigns, and facilitating access to services and expert knowledge. For this reason, health authorities and civil society organizations increasingly develop platform-specific content in order to reach wider and more diverse audiences through these channels (Chen & Wang, 2021; Luo et al., 2025).

In this respect, social media constitutes a dual environment within contemporary health communication. It offers important opportunities in terms of accessibility, scalability, and participation, while simultaneously intensifying problems related to misinformation, manipulation, and credibility. Addressing this complexity requires strengthening digital and health literacy at the individual level, while also expecting greater ethical responsibility, transparency, and accountability from the platforms themselves (Zhang et al., 2025; Suárez-Lledó & Alvarez-Gálvez, 2021).

4.4. The Role of Media Channels and the Problem of Credibility

Media channels directly shape the production, circulation, framing, and reception of health information. Because different channels operate according to different content logics and credibility structures, the form, emphasis, and impact of health messages may vary considerably across media environments (Chou, Oh, & Klein, 2018; Suárez-Lledó & Alvarez-Gálvez, 2021). For this reason, the credibility of health information cannot be evaluated solely at the level of message content; it must also be considered in relation to the channel through which the message is communicated and the communicative conditions under which it circulates.

The credibility of a health message is influenced by several interrelated factors, including the origin of the source, the way the message is presented, the internal consistency of the content, and the extent to which it relies on references, expertise, or institutional support. Content associated with academic institutions, health authorities, and recognized experts is generally perceived as more scientifically credible. By

contrast, anonymous, commercial, or sensationalized content is more likely to generate doubts regarding trustworthiness. However, in digital environments, this distinction is not always easy to identify. Visual richness, widespread circulation, emotional storytelling, and persuasive presentation styles may create an appearance of credibility even when the underlying information is weak, selective, or misleading (Chou, Oh, & Klein, 2018; Kouzy et al., 2020; Ziapour et al., 2024).

The problem becomes more pronounced when media organizations or digital platforms prioritize attention-driven metrics such as ratings, clicks, engagement, and advertising revenue. Under such conditions, health-related content may be simplified, exaggerated, or stripped of context in order to attract visibility. Fear appeals, speculative headlines, and sensational framing may increase audience attention, but they also create a higher risk of misunderstanding, especially for individuals with lower levels of health literacy. In this respect, the credibility problem is not merely a matter of false information; it is also linked to how partially accurate information may be framed in distorted or disproportionate ways.

In contemporary digital environments, credibility is shaped not only by content producers but also by platform infrastructures. Search engines and social media recommender systems personalize content according to users' interests and prior behaviors, often exposing them repeatedly to similar claims, viewpoints, and sources. This may confine users within informational "echo chambers," limiting exposure to alternative perspectives and weakening habits of verification and comparison (Devrim, 2023, pp. 119–120; Törnberg, 2018).

As a result, access to health information may appear abundant while remaining filtered, uneven, and epistemically narrow.

For this reason, strengthening the credibility of health information requires coordinated progress across multiple levels. First, content producers and media organizations should adhere to ethical publishing standards and avoid sensationalism, speculation, and context-stripped reporting. Second, digital platforms should reinforce verification and contextualization mechanisms by increasing algorithmic transparency and making indicators of quality and source reliability more visible. Third, individuals need stronger health literacy and critical media literacy skills in order to assess claims more carefully and respond more reflexively to mediated health information. Taken together, these dimensions show that credibility is not a fixed property of information itself, but a dynamic outcome shaped by the interaction of messages, media channels, platforms, and audiences.

5. The Interaction Between Media and Health Literacy: A Critical Appraisal

Although media literacy and health literacy have often been discussed as separate domains, the digital transformation of communication has made their interaction increasingly inseparable. Individuals no longer encounter health information only within clinical settings or through formal public health institutions. Instead, they confront health-related messages in complex communication environments shaped by news media, social media platforms, search engines, user-generated content, visual framing, and algorithmically curated information flows (Livingstone, 2004; Norman & Skinner, 2006; Levin-Zamir et al., 2011; Mutlu et al., 2025). In

such environments, health-related decision-making depends not only on the content of information itself but also on how that information is selected, circulated, amplified, and interpreted across media systems.

For this reason, health literacy alone is no longer sufficient for understanding how individuals navigate contemporary health information ecosystems. Nor can media literacy be considered fully adequate without attention to the specific demands of health-related judgment and action. Health literacy equips individuals to access, understand, appraise, and apply health information in ways that support health and well-being, while media literacy enables them to critically access, analyze, evaluate, and create messages within media systems (Nutbeam, 2000; Sørensen et al., 2012; Livingstone, 2004). In digitally saturated settings, these capacities increasingly overlap. The ability to make informed health decisions now depends not only on understanding health content, but also on recognizing source credibility, identifying persuasive framing, interpreting uncertainty, and evaluating how digital circulation shapes the visibility and authority of health claims (Lee & Ramazan, 2021; Levin-Zamir et al., 2011; Mutlu et al., 2025).

From a health communication perspective, this intersection is especially significant because health-related meanings are not produced by factual information alone. They are also shaped through framing, repetition, emotional tone, visual cues, and the perceived trustworthiness of communicators. A message may be scientifically weak yet highly persuasive if it resonates emotionally or circulates widely through trusted digital networks. Conversely, a scientifically robust message may fail to influence audiences if it is communicated in

inaccessible, overly technical, or weakly distributed forms. This demonstrates that the issue is not merely one of access to information, but of how health knowledge is mediated, framed, and socially interpreted through communication processes.

The COVID-19 pandemic made this relationship especially visible. During the pandemic, reliable guidance circulated alongside rumors, conspiracy narratives, and misleading or politically charged claims. WHO (2020) conceptualized this communication disorder as an "infodemic," emphasizing that the overabundance of information can itself become a public health problem when individuals struggle to identify trustworthy guidance and act appropriately. In parallel, research on COVID-19-related social media communication showed that unreliable and reliable information may spread rapidly in the same media ecologies, making critical evaluation more difficult for users (Cinelli et al., 2020). In this context, media literacy and health literacy emerged not as supplementary skills, but as intertwined capacities central to public resilience.

A critical appraisal of this interaction also requires attention to the architecture of digital media systems. Platform environments do not merely host information; they organize visibility through algorithms, personalization mechanisms, engagement metrics, and commercial priorities. Such dynamics may privilege novelty, speed, emotional intensity, and shareability over scientific caution, nuance, and contextual accuracy (Chou et al., 2018; Cinelli et al., 2020). Consequently, individuals are expected not only to understand health information, but also to assess the trustworthiness of sources, distinguish evidence from opinion, and recognize how digital

systems may amplify misleading content. In this respect, the interaction between media literacy and health literacy is mediated not only by user competence but also by platform power.

This issue becomes even more complex when viewed through the lens of inequality. Access to digital technologies has increased, yet the digital divide increasingly manifests through differences in skills, patterns of use, and outcomes rather than simple connectivity alone (van Deursen & van Dijk, 2014). Applied to health communication, this means that age, education, income, language, prior knowledge, and digital competencies all shape whether individuals can find, interpret, and benefit from online health information. Thus, the interaction between media and health literacy should not be reduced to a purely individual-responsibility model. Structural inequalities also shape who can access reliable information, who can critically evaluate it, and who remains more vulnerable to manipulation, exclusion, or confusion.

Another critical dimension concerns the commercialization of digital health communication. In online environments, health messages are often embedded within attention economies driven by clicks, sponsorships, influencer cultures, and platform monetization. Under such conditions, simplified, emotionally charged, or sensationalized claims may achieve greater visibility than evidence-based but more complex health communication (Chou et al., 2018; Mutlu et al., 2025). This may blur the distinction between information, promotion, and persuasion, while also weakening trust in professional expertise and institutional guidance. Therefore, a critical perspective must address not only whether individuals can identify false or weak claims, but also how media systems

themselves privilege certain forms of visibility, authority, and engagement.

At the same time, the relationship between media literacy and health literacy should not be framed only in terms of risk. When supported by educational policies, ethical communication standards, and health-literate institutional practices, the interaction between these domains can strengthen public participation, improve decision-making, and expand equitable access to reliable information (Nutbeam, 2000; Sørensen et al., 2012; Levin-Zamir et al., 2011). Individuals who possess stronger competencies in both domains are more likely to compare sources, evaluate evidence, interpret uncertainty, and participate more actively in health-related decisions (Lee & Ramazan, 2021; Mutlu et al., 2025). These competencies are valuable not only for individual well-being, but also for more democratic, inclusive, and resilient health communication.

Ultimately, media literacy and health literacy converge in a shared objective: moving individuals beyond passive exposure to information toward critical, informed, and responsible engagement with health knowledge. Yet such engagement cannot be sustained by individual effort alone. It requires communication environments that support clarity, accountability, and evidence; institutions that communicate in accessible and trustworthy ways; and educational approaches that cultivate critical inquiry across the life course. A contemporary understanding of health communication must therefore treat media literacy and health literacy not as parallel topics, but as mutually constitutive dimensions of living, deciding, and participating in digitally mediated health environments.

6. Conclusion

In the digital age, the relationship between media and health can no longer be understood through isolated literacy frameworks. The expansion of digital and networked communication environments has made it necessary to reconsider media literacy and health literacy not as separate competencies, but as intersecting capacities that jointly shape how individuals encounter, interpret, evaluate, and use health-related information. As health knowledge increasingly circulates through news media, social platforms, search engines, digital applications, and algorithmically organized content flows, individuals' health decisions are influenced not only by the quality of information itself but also by the communicative environments in which that information is framed, circulated, and made visible.

This chapter has shown that media literacy contributes a critical understanding of how messages are constructed, represented, and circulated, whereas health literacy focuses on the ability to access, understand, appraise, and apply health information and services in ways that support well-being. Yet in contemporary communication ecologies, these two literacies overlap in significant ways. Individuals are now expected not only to comprehend health information, but also to judge source credibility, identify persuasive intent, recognize misinformation, and interpret uncertainty in digitally saturated environments. For this reason, the intersection of media literacy and health literacy is best understood as a central concern of contemporary health communication.

The chapter has also demonstrated that this intersection should not be reduced to an individual skill problem alone. The circulation of health information is shaped by broader structural conditions, including digital inequalities,

institutional communication practices, platform logics, commercial pressures, and algorithmic forms of visibility. These factors influence which messages gain attention, which actors are perceived as credible, and which audiences are more likely to benefit from—or be harmed by—health communication. Accordingly, strengthening media and health literacy requires not only educational interventions directed at individuals, but also health-literate institutions, ethically responsible media practices, and communication systems designed around clarity, accessibility, and evidence.

At the same time, the convergence of media literacy and health literacy offers an important opportunity. When supported by critical inquiry, transparent communication, inclusive design, and participatory approaches, this interaction can empower individuals to engage more actively in health-related decision-making and to navigate complex information environments more confidently and responsibly. In this sense, media and health literacy are not only defensive competencies against misinformation and manipulation; they are also enabling resources for more equitable, democratic, and resilient public health communication.

As the opening chapter of the book, this chapter has aimed to provide a conceptual foundation for understanding media and health literacy as an interconnected field of inquiry. The discussions that follow in the subsequent chapters can be read against this broader framework, in which the quality of health communication depends not merely on the availability of information, but on the ability of individuals, institutions, and media systems to support critical, informed, and socially responsible engagement with health knowledge.

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Biographies

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