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Enhancing Health Literacy for All. Report on mapping of good practices in nine countries

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Introduction

Non-communicable diseases (NCDs) constitute a major global public health challenge, responsible for the largest share of morbidity, premature mortality, and healthcare expenditures in Europe and beyond (WHO, 2025). The burden of cancers, cardiovascular diseases (CVDs), type 2 diabetes, chronic obstructive pulmonary disease (COPD), and mental disorders continues to rise, largely driven by modifiable behavioral, social, and environmental determinants (WHO, 2025). Strengthening preventive strategies, particularly those targeting upstream determinants of health, has therefore become a key priority for public health systems (Galea et al., 2025). In this context, health literacy (HL) has emerged as an important lever for enabling individuals and communities to make informed health decisions, adopt healthier lifestyles, and engage effectively with healthcare services (WHO, 2013).

“Health literacy refers to the extent to which people are able to access, understand, appraise, and apply information in all its forms, communicate about health concerns, and make appropriate use of services to improve their health and well-being, prevent and manage illness, and support others in these matters or make decisions on their behalf.

HL is influenced by the social, cultural, and organizational contexts in which people grow up, learn, work, live, receive care and age. It results from the interaction between personal motivation, individual competences and the accessibility, understandability, quality and user-friendliness of health-related information and services, and the support available to address health challenges. (M-POHL, 2025)”

In addition to general HL, specific forms of personal HL are recognized. These include digital HL, mental HL, nutrition HL, and oral HL (Griebler, Link, et al., 2025). A growing focus is also on professional and organizational HL. On the one hand, this involves improving healthcare professionals’ abilities to strengthen patients’ HL during interactions (Coleman et al., 2017). On the other hand, it addresses how healthcare organizations can be structured and operate in health-literate ways (Sørensen et al., 2021).

Evidence indicates that HL is linked to healthier lifestyles, fewer risky behaviors, greater use of preventive services, and better health outcomes (Berkman et al., 2011). This also relates to NCDs and their prevention (Kim & Han, 2016; Woudstra et al., 2019; Baccolini et al., 2022; Fan et al., 2021). These findings underscore the urgent need for effective, scalable, and equity-oriented interventions to strengthen population HL, particularly in relation to the prevention of NCDs.

In this context, the [Joint Action Prevent Non-Communicable Diseases](#) (JA Prevent NCD) aims to advance the development of integrated and evidence-based strategies for the prevention of NCDs across Europe. Within this framework, Task 7.4 of Work Package 7 on social inequalities focuses on generating actionable evidence on population HL by identifying, collecting, and critically assessing models of good practice (Le et al., 2025; Bucciardini et al., 2025). The overarching objective is to promote evidence-informed policymaking and public health practices by providing decision-makers and practitioners with validated intervention models. This identification and analysis of good practice models constitute a central component of this evidence-generation process.

The primary objective of this model-of-good-practice activity was to identify interventions¹ that enhance HL and support the primary and secondary prevention of major NCDs, including cancer, CVDs, type 2 diabetes, COPD, and mental health conditions. Particular emphasis was placed on interventions addressing vulnerable populations and health inequalities, as well as those demonstrating potential for scalability, sustainability, and transferability across European contexts. By systematically identifying and

¹ An intervention is a planned set of actions aimed at improving a defined health or behavioral outcome.

assessing these models, this work aims to generate actionable evidence to inform policy development and guide public health strategies.

The study protocol for this collection of good practice models is published on Open Science Framework (Barailla et al., 2025).

Methods

Inclusion and exclusion criteria

Table 1 presents the inclusion and exclusion criteria used to identify models of good practice.

Table 1: Inclusion and exclusion criteria

Criteria	Inclusion	Exclusion
Publication year	2015 onwards	Before 2015
Sources	Grey literature	
Participants	Adults (+18)	
Countries	Countries participating in this task: Austria, Czech Republic, France, Germany, Hungary, Italy, Norway, Spain, Ukraine	All other countries
Language	English and/or official languages of the countries participating in this task	All other languages
Concept	Interventions focusing on strengthening HL for the primary and secondary prevention of NCDs.	Interventions not explicitly designed to improve HL, as well as that address only disease management or treatment without any preventive component.
Outcomes	Primary outcomes: - personal HL - behavioural risk factors for NCDs (e.g., tobacco use, alcohol consumption, physical inactivity, unhealthy diet, inadequate stress management, poor oral hygiene), - uptake of NCD-related vaccinations (e.g., HPV, Hepatitis B), and - utilization of screenings and examinations for early detection of NCD-related risk factors (including check-ups). Secondary outcomes: incidence of NCDs, metabolic outcomes (e.g., overweight, obesity, blood pressure, blood glucose, cholesterol), and adverse effects of the intervention.	Other outcomes
Context	Local, regional, and national initiatives Public and private initiatives and services	

Identification of interventions

The collection of good practices was carried out in the following nine countries: Austria, Czech Republic, France, Germany, Hungary, Italy, Norway, Spain, Ukraine.

Various strategies were applied across countries to identify models of good practices. The detailed search strategies are presented in Table 2.

Table 2: Search strategies applied by each partner

Country	Search strategy
Austria	Sources included national initiatives such as the Austrian Health Literacy Platform (ÖPGK), including its activities and dedicated toolbox for health literacy (https://oepgk.at/oepgk-mitglieder-massnahmen/; https://oepgk.at/toolbox-gesundheitskompetenz/). Additional sources included projects funded by the Austrian Health Promotion Fund, as well as the IDDS database of regional interventions to carry out the national health promotion strategy. To supplement these sources, targeted outreach was conducted via email to relevant stakeholders in the field to identify additional interventions and supporting materials. We also systematically reviewed websites and available grey literature from identified institutions and initiatives.
Czech Republic	Sources included national public health institutions, such as the National Institute of Public Health (SZÚ), as well as the National Health Information Portal. Relevant projects and initiatives were also consulted, including the Philip Project, the Saste Roma Initiative, and the INHEAL Project. A systematic review of websites and available grey literature from these institutions and initiatives was conducted to identify relevant interventions and support.
France	Sources included major national and regional public health institutions, such as the Regional Health Agencies (ARS France) and their regional branches, as well as Santé Publique France (the French Public Health Agency). Relevant networks and organizations were also consulted, including the Francophone Health Literacy Network (Réflis) and regional health promotion associations, such as Promotion Santé Île-de-France. Additional sources included directories of effective or promising prevention and health promotion interventions, as well as national repositories, such as Répertoire Actions (France Assos Santé). Relevant interventions and supporting materials were identified by systematically reviewing websites and available grey literature from these institutions and organizations.
Germany	Search terms were developed using resources from national public health institutions, including the Federal Institute of Public Health (BfÖG) and its thematic keyword list ("Leitbegriffe"). Additionally, relevant networks were consulted, including the German Network for Health Literacy (DNGK). Expert consultations and professional contacts within this network were considered. Other sources included the Good Practice Database of the Health Equity Cooperation Network (Kooperationsverbund Gesundheitliche Chancengleichheit) and web-based reviews of partner organizations, projects, and associated materials identified through these platforms. Combinations of German and English keywords were used to conduct searches, including "health literacy" (Gesundheitskompetenz), "health promotion" (Gesundheitsförderung), "good practice", "best practice", "setting-based approaches" (Settingansätze), and "community-based health

	promotion”. To identify further interventions and supporting materials, websites and available grey literature from relevant institutions and organizations were systematically reviewed.
Hungary	Sources included official government and public health portals, such as Egészségvonal (Health Line), the Educational Authority, and the National Institute of Oncology. Additionally, national networks and initiatives focused on health literacy and health promotion were consulted. These included the Network of Health Promotion Offices and the Health Literacy Prize (Egészségértés: https://egeszsegertes.hu/). Relevant national toolkits, guidelines, and frameworks were reviewed, such as Professional Methodological Development of the Healthcare System (Egészségügyi ellátórendszer szakmai módszertani fejlesztése), the Online Catalogue of Good Practices in Health Care (Egészségügyi Jógyakorlatok Online Katalógusa), and collections of good practices in primary and specialized healthcare, child welfare services, and early intervention and therapeutic care settings. Additional resources included targeted initiatives such as “Ciki a cigi” (Smoking is naff) (https://cikiacigi.hu/) and public health information platforms (e.g. Merőkanál: http://www.merokanal.hu). Academic and professional organizations were also considered, including the Hungarian Society of Cardiology, the Hungarian Society of Oncologists, and the Hungarian Society for the Study of Obesity. Grey literature (e.g. reports, toolkits, and white papers) was identified through Google Scholar using Hungarian and English keywords, including “intervention” (intervenció), “health literacy” (egészségműveltség), and “social media”. An expert consultation was conducted through targeted searches in the Hungarian Scientific Bibliography using health literacy-related terms (egészségműveltség, egészségértés). The identified authors were contacted and invited to share relevant interventions and disseminate the request within their professional networks. The same request was also circulated to stakeholders and the Network of Health Promotion Offices.
Italy	Sources included key international guidance documents such as the Guide to Health Literacy, developed by the Steering Committee for Human Rights in the Fields of Biomedicine and Health (CDBIO), for promoting trust and equitable access to healthcare. The search strategy was based on Italian-language keywords, including “health literacy interventions in Italy” (interventi di alfabetizzazione sanitaria in Italia), “health literacy strategies in Italy” (strategie di alfabetizzazione sanitaria in Italia), and “health literacy actions in Italy” (azioni di alfabetizzazione sanitaria in Italia). The search was supplemented by a review of relevant websites and available grey literature.
Norway	Sources included major Norwegian public health institutions such as the Norwegian Directorate of Health (helsedirektoratet.no), the Norwegian Institute of Public Health (fhi.no), and the Norwegian Health Research Projects Registry (forskningsprosjekter.ihelse.net). Relevant national networks were also consulted, including the National Network for Migrant Health. The initial mapping was based on the Directorate of Health’s internal expertise and established contacts, as well as those of the National Health Literacy Network, including key national initiatives such as the Public Health Programme in Municipalities (2017–2027) and the National Programme for an Age-Friendly Norway. Outreach was conducted with public health and health promotion stakeholders to identify other relevant interventions.

	General web searches were performed using a combination of Norwegian and English keywords, including “health literacy and prevention” (helsekompetanse og forebygging), “digital health literacy interventions” (digital helsekompetanse tiltak), and “NCD prevention and health literacy in Norway”. In addition, websites and available grey literature from relevant public institutions (e.g. helsedirektoratet.no, fhi.no, and municipal websites) were systematically reviewed. Reference lists and linked resources from identified sources were also screened to identify further relevant materials.
Spain	Sources included national and regional public health institutions such as the Ministry of Health (Health Promotion and Prevention Area), as well as thematic initiatives focusing on good practices in addiction and mental health. Relevant territorial actors were also consulted, including the Valencian Federation of Municipalities and Provinces (FVMP). Additionally, an open internet search was conducted to supplement the information obtained from these sources. A combination of keywords in English and Spanish was used for the search, including “health literacy” (alfabetización en salud), “health knowledge” (conocimiento en salud), “digital health literacy” (alfabetización digital en salud), “NCD prevention” (prevención de enfermedades no transmisibles), “risk factors” (factores de riesgo), “good practices” (buenas prácticas), “health promotion” (promoción de la salud), “disease prevention” (prevención de la enfermedad), “health interventions” (intervenciones en salud), “community health” (salud comunitaria), “equity” (equidad), and “health equity” (equidad en salud). Websites and available grey literature from relevant institutions and organizations were systematically reviewed to identify other interventions and supporting materials.
Ukraine	Sources included national public health institutions such as the Ministry of Health (MOH) and the Public Health Center (PHC) of the MOH, including its online learning platform providing training courses and methodological materials. Official documents and guidance materials were also reviewed, including MOH guides on school nutrition, tobacco control, and NCD prevention. Relevant international and professional organizations were consulted, including the WHO Country Office in Ukraine, as well as national professional associations, such as the Ukrainian Association of Family Medicine (uafm.org.ua) and the Ukrainian Association of Ambulatory Physicians (uaap.org.ua). Additional sources included local non-governmental organisations (NGOs) and community health projects (e.g. mobile clinics and primary healthcare interventions), as well as reports and grey literature from international donor-funded projects, including materials available through institutional repositories and partner networks. The Keywords used (in English and Ukrainian) included “health literacy Ukraine” (грамотність з питань здоров’я), “digital health literacy Ukraine” (цифрова грамотність у сфері здоров’я), “public health Ukraine” (громадське здоров’я), “health promotion Ukraine” (просвіта здоров’я), and “NCD prevention Ukraine” (профілактика НІЗ), as well as broader terms such as “toolkit”, “best practices”, “good practices in health” (найкращі практики), and “methodological guidelines” (методичні рекомендації). Searches were supplemented by screening of websites and available grey literature from relevant institutions.

Regarding the target population, the initial approach was deliberately broad, and interventions were identified irrespective of the target population. The eligibility criteria for the target population were later refined to ensure alignment with the scoping review conducted in parallel as part of Task 7.4 (Griebler, Schütze, et al., 2025).

Collected information

The identified interventions were compiled using a standardised Excel template. For each intervention, the title was recorded in both the original language and in English, along with the source, objectives, and implementation setting.

After an initial screening, a more detailed description was completed for eligible interventions. This included additional information on the target population, implementation setting, funding body, activities, methods of evaluation, and reported outcomes.

Assessment

The assessment framework applied to the identified practices was adapted from the criteria used for the European Best Practice Portal (Stepien et al., 2022).

The [original criteria](#) were tested on a subset of identified practices. The pilot testing revealed two necessities for adaptation:

- Insufficient information was available for several criteria, limiting the applicability of the full set of criteria.
- Misalignment of criteria with the objective, as the original framework is designed for developers and implementers of interventions submitting interventions to the European Best Practice Portal and therefore requires information that is difficult to obtain through desk research and exceeds the scope of our research.

In response to these issues, the set of criteria was revised while retaining the key areas of the original framework:

- **Characteristics of the intervention:** What is the practice and what does it do?
- **Effectiveness:** Does it work and how has it been tested?
- **Equity:** Does the practice reach vulnerable or disadvantaged groups?
- **Transferability:** Can it be applied in other settings or countries?
- **Sustainability:** Can the practice continue over time?
- **Participation:** Were stakeholders or target populations involved in the development and implementation of the intervention?

This framework provides a structured and comprehensive set of criteria to ensure that interventions are assessed in a transparent, rigorous, and comparable manner. Together, these dimensions reflect both scientific quality standards and public health relevance, enabling a multidimensional appraisal of interventions.

Table 3 lists the final evaluation criteria. A description of each assessment area can be found in the corresponding section.

Table 3: Final set of criteria

Key area	Criterion
Intervention characteristics	The intervention addresses a priority public health area, a strategic objective or an identified problem at the local/regional level, national, or European level.
	Objectives are clearly defined.
	The target population is clearly defined.

	The intervention and its activities (including implementation) are clearly described.
	Needs of the target population have been collected.
	The intervention is evidence-based and/or builds on a well-founded theory.
Effectiveness of the intervention	The intervention has been evaluated (e.g., process evaluation, outcome evaluation, or cost-effectiveness evaluation).
	The evaluation was carried out by external and independent evaluators.
	The effectiveness of the intervention showed positive results (outcome evaluation): based on a controlled study design; based on a non-controlled study design.
	The evaluation examined factors that have facilitated or hindered the implementation of the intervention.
	The evaluation showed no unexpected/unintended negative effects.
	A cost-effectiveness evaluation showed positive results.
Equity	Equity aspects are considered in the intervention (focusing on vulnerable population groups).
	The intervention reached vulnerable population groups.
Transferability	The intervention has been carried out in other settings and/or countries.
	The intervention can be implemented in other European countries.
	The intervention can be implemented on a large scale with reasonable effort.
Sustainability	The implementation of the intervention is sustainably established.
Participation	The intervention was developed in collaboration with the target population.
	Relevant stakeholders were involved in the development and implementation of the intervention.

Assessment areas

The following provides a brief description of the assessment areas that form the basis of the European Best Practice Portal's criteria set and our own assessment.

Characteristics

The intervention must address a priority public health area, a strategic objective, or a clearly identified problem at the local, regional, national, or European level. This criterion ensures that selected practices respond to population needs and are aligned with public health policies and priorities.

The objectives of the intervention must be clearly described and, ideally, formulated according to the SMART framework. This means that objectives should be *Specific*, clearly stating what is to be achieved; *Measurable*, enabling the assessment of change; *Achievable*, ensuring feasibility; *Realistic*, taking contextual constraints into account; and *Time-bound*, specifying a defined timeframe. The use of SMART objectives enhances clarity, operational feasibility, and evaluability.

The target population should be clearly defined, with explicit identification of demographic, social, or health-related characteristics. In addition, the intervention and its activities, including implementation processes, must be described in sufficient detail. This includes information on content, methods, delivery modes, duration, intensity, and organisational structures, ensuring transparency and enabling reproducibility.

Finally, the needs of the study population should be assessed before the intervention to ensure that the design responds to real-life challenges. Ideally, the intervention would be developed in collaboration with the target population, fostering relevance, cultural sensitivity, and acceptability.

Effectiveness

Interventions should be evidence-based and/or grounded in a well-founded theoretical framework. This ensures that the logic of the intervention is scientifically sound, and that activities are plausibly linked to expected outcomes.

A central requirement is that the intervention has been evaluated. This may include process and outcome evaluation, as well as cost-effectiveness evaluation when feasible. Ideally, these evaluations would be conducted by external, independent evaluators to minimize bias and enhance methodological rigor.

The effectiveness of the intervention should be demonstrated through an evaluation of outcomes. The evaluation should also identify factors that facilitate or hinder implementation, as well as any negative, unexpected, or unintended effects of the intervention. Cost-effectiveness analyses further strengthen the assessment by providing insights into the efficient use of resources, when available.

Equity

Interventions should contribute to reducing health inequalities and explicitly consider equity aspects, particularly by focusing on vulnerable or disadvantaged population groups. Efforts should be made to ensure that these groups are effectively reached.

Transferability

Transferability refers to the potential of an intervention to be implemented in other settings, regions, or countries. An intervention should demonstrate that it has been carried out in different contexts, and/or that it can be realistically implemented in other European countries.

Sustainability

Sustainability assesses whether the intervention is ongoing and whether its implementation is firmly and sustainably established. This includes the availability of long-term funding, institutional embedding, workforce stability, and integration into routine practices or policies.

Participation

Participation refers to the involvement of relevant stakeholders in developing and implementing the intervention. These stakeholders may include members of the target population, health professionals, community organizations, policymakers, and other relevant actors. Participatory approaches promote contextual relevance, acceptability, empowerment, and long-term sustainability. These approaches also facilitate co-creation processes that improve the quality and effectiveness of interventions.

Assessment process

Initially, all relevant information for each intervention was assigned to the corresponding assessment criteria based on the detailed description. Then, each intervention was then independently assessed by two reviewers: one from the country where the intervention was implemented and one from another country. This ensured both contextual relevance and external objectivity. The reviewers systematically assessed each intervention against all predefined criteria and determined whether each criterion was fulfilled (yes, no, or unclear). Based on these assessments, the interventions were classified as either best practices or promising practices, both of which qualify as models of good practice, or rejected if they did not meet the required criteria. In cases of disagreement, a third reviewer consulted until consensus was reached. Promising practices are defined as interventions that show potential for developing into a best practice, but which still be in the early stages of implementation and/or evaluation (Nadia et al. 2017).

The criteria required for an intervention to be classified as best or promising are listed in Table 4.

Table 4: Requirements for the classification as best or promising practice

Criterion	Best practice	Promising practice
The intervention addresses a priority public health area, a strategic objective or an identified problem at the local/regional, national, or European level.	Required	Required
Objectives are clearly defined.	Required	Required
The target population is clearly defined.	Required	Required
The intervention and its activities (including implementation) are clearly described.	Required	Required
Needs of the target population have been collected.	Required	—
The intervention is evidence-based and/or builds on a well-founded theory.	Required	—
The intervention has been evaluated (e.g., process evaluation, outcome evaluation, or cost-effectiveness evaluation).	Required	Required
The evaluation was carried out by external and independent evaluators.	Required	—
The effectiveness of the intervention showed positive results based on a controlled study design (outcome evaluation).	Required	—
The evaluation examined factors that have facilitated or hindered the implementation of the intervention.	Required	—
The evaluation showed no unexpected/unintended negative effects.	Required	—
A cost-effectiveness evaluation showed positive results.	—	—
Equity aspects are considered in the intervention (focusing on vulnerable population groups).	Required	—
The intervention reached vulnerable population groups.	—	—

The intervention has been carried out in other settings and/or countries.	—	—
The intervention can be implemented in other European countries.	—	—
The intervention can be implemented on a large scale with reasonable effort.	—	—
The implementation of the intervention is sustainably established.	—	—
The intervention was developed in collaboration with the target population.	Required	—
Relevant stakeholders were involved in the development and implementation of the intervention.	—	—

Best practice

An HL intervention was classified as a best practice if: it addressed a priority public health area, strategic objective, or an identified problem at the local, regional, national, or European level; a clear objective was specified; the target population was clearly defined; the intervention and its activities, including implementation procedures, were clearly described; the needs of the study population were assessed, and the intervention was developed in collaboration with the target population (Table 4).

Additionally, the intervention had to be evidence-based and/or grounded in a well-established theoretical framework. Equity considerations had to be incorporated, with paying particular attention to vulnerable population groups. The intervention also had to be evaluated using appropriate methods, such as process evaluation, outcome evaluation, or cost-effectiveness analysis. The intervention's effectiveness had to be assessed through outcome evaluation using a controlled study design, and the evaluation had to be conducted by external, independent evaluators. Furthermore, the evaluation had to examine factors that facilitated and/or hindered implementation and assess any negative, unexpected or unintended effects of the intervention.

Promising practice

If one or more of the best practice criteria were not met, an intervention could still be classified as a promising practice if: it addressed a priority public health area, strategic objective, or an identified problem at the local, regional, national, or European level; had a clear objective; had a clearly defined target population; the intervention and its activities, including implementation procedures, were clearly described; and was evaluated (process evaluation and/or outcome evaluation using a non-controlled study design).

Rejected

If the intervention did not meet the criteria for either best or promising practice, it was rejected.

Results

A total of 19 interventions met the inclusion criteria². Seven of these interventions were classified as promising practices. None of the interventions met all the criteria required for a classification as a best practice. Twelve interventions were rejected due to the absence of an outcome evaluation.

² The overview of the assessment results of the interventions is presented in Appendix 1.

Four of the interventions originated from Austria, while one intervention each came from the Czech Republic, France, and Ukraine. Three of the seven interventions focused on general HL, while one intervention each addressed nutrition literacy and oral HL. One intervention targeted both general HL and mental HL, and another intervention focused on professional HL among healthcare professionals (Table 5).

Four of the seven interventions targeted vulnerable groups. Two interventions targeted patients, either those attending general physician and pediatric practices, as well as in inpatient rehabilitation or health-stay programs. One intervention aimed to strengthen the skills of healthcare professionals to improve patients' HL.

The implementation settings vary widely. These include healthcare settings, adult education, community settings; and online and digital services.

The interventions include: evidence-based health information; courses on healthcare system navigation, communication with doctors and critical appraisal of health information; coaching sessions covering healthcare navigation, communication, evaluation of health information and patient rights; communication training for healthcare professionals; culturally adapted health education materials; community outreach activities and an e-learning platform; personalized SMS prevention messages; and participatory nutrition workshops.

Table 5. Characteristics of promising practices included

Practice	Country	HL addressed	Target population	Setting	Key intervention	Evaluation results
EVI-Box – Evidence-based health information in general physician and pediatric practices	Austria	General HL	Patients	Healthcare	Evidence-based health information materials available before, during and after consultations	Materials perceived as understandable, credible and useful; about half of professionals reported using them during consultations
DURCHBLICKer*in	Austria	General HL; mental HL; nutrition literacy	Job-seeking and labor-market-distant adults; health and social care professionals	Adult education (face-to-face)	Courses on healthcare system navigation, communication with doctors, critical appraisal of health information, mental and physical health	Positive results in before–after evaluation of participants' HL
Health Literacy Coaching [Gesundheitskompetenz-Coaching]	Austria	General HL	Insured individuals during inpatient	Healthcare	HL coaching sessions covering healthcare navigation,	Conversations between doctors and patients, and access to reliable

			rehabilitation or health-stay programs		communication, evaluation of health information and patient rights	health information, are important topics. Positive experiences in doctor-patient consultations have been reported.
Communication training for healthcare professionals	Austria	Professional HL	Healthcare professionals	Healthcare; professional training	Evidence-based communication training using simulated patients and video examples	High participant satisfaction and increased self-assessed communication skills
Saste Roma -Promoting better health in socially excluded communities	Czech Republic	General HL	Roma adults, children, and adolescents living in socially excluded communities, as well as educators working with Roma pupils.	Community and online tools	Culturally adapted health education materials, community outreach activities for Roma families and e-learning platform form Roma pupils	Improved health literacy and motivation for a healthy lifestyle among Roma communities, greater awareness of prevention and screening programs, and increased trust in healthcare services.
Preventing Differently: AI-based personalized oral HL campaign	France	Oral HL	Individuals from low socio-economic backgrounds	SMS messages	Personalized or generic SMS prevention messages based on individual knowledge gaps	Increased oral HL scores, especially with personalized messages
Play Positively with Health: From Plate to Shoe	Spain	Nutrition literacy	Women from marginalized Roma and Moroccan communities	Community	Participatory workshops on nutrition, label reading, healthy menus and physical activity	Improvements in knowledge and behaviors; high satisfaction and retention

The following sections describe the seven promising interventions for promoting HL. For each intervention, key characteristics are systematically presented, including the title, source, aim, target population, implementation setting, activities, methods, and evaluation results.

EVI-Box – Evidence-based health information in general physician and pediatric practices (Austria)

Source: <https://evi.at/die-evi-box/>

Aim: To integrate evidence-based health information (EBHI) into routine primary care by providing healthcare professionals with accessible and trustworthy resources to share with patients.

Health literacy addressed: General HL

Target population: Health professionals in primary care and patients

Setting: General and pediatric practices, primary care centers, community health services, and public spaces, such as municipal offices and libraries

Activities: Identifying and quality-checking the most common consultation topics requiring EBHI with the Mapping the Quality of Health Information (MAPPinfo) checklist. The resulting EBHI, such as asthma, coronary heart disease, depression, and type 2 diabetes, are disseminated both as printed brochures and digitally via the project website.

Implementation: All EBHI are available on the EVI website. Participating practices and settings can order printed brochures for free. The materials can be strategically placed in waiting areas, other easily accessible locations, or used directly during patient consultations.

Outcomes: During the project period, EBHI for more than 30 topics were searched, quality-checked and made available on the EVI-website. At the moment, the initiative counts more than 200 active EVI settings. Regular evaluation surveys among participating health professionals showed that easy access to EBHI raised awareness and supported its use in daily practice. The implementation was strengthened by sustained relationships with recruited settings and providing EBHI in different formats. Ongoing dissemination ensured that the initiative remained visible to primary care providers and stakeholders, creating a foundation for future initiatives.

Facilitating factors:

Project Implementation

- Initial face-to-face contact with EVI settings helped build trust and relationships and enabled observation of how materials were integrated into routine practice.
- Direct distribution of printed brochures facilitated adoption.
- Providing EBHI in multiple formats (digital and print) supported use and implementation.
- The university as project lead was perceived as an independent and trusted source of EBHI.
- Growing policy attention highlighted the relevance of EBHI.
- Close collaboration with publishers facilitated user agreements of EBHI.

Target Group

- The EBHI addressed topics relevant to daily practice.
- Free printed brochures ensured easy access.
- Multiple formats (print, digital, QR code) met different user needs.

Barriers:

Project Implementation

- Many highly rated EBHI were not available in both print and digital formats.
- Limited funding restricted printing and dissemination activities.
- Resources for national rollout were insufficient.
- Limited resources prevented a comprehensive promotion campaign for additional/wider target groups.

Target Group

- EBHI were available in only a limited number of languages.
- Time constraints hindered integration into patient consultations.
- Some healthcare professionals perceived low patient interest in reading the EBHI.

Funding body: Currently no funding; previously funded by the Styrian Health Fund

‘DURCHBLICKer*in’ (Austria)

Source: <https://femsued.at/arbeitsbereiche/durchblickerin/>

Aim: To strengthen the HL of job-seeking and labor-market–distant individuals through courses, and to enhance awareness of HL by providing additional training for health and social care professionals.

Health literacy addressed: General health literacy, mental health literacy, and **nutrition** literacy

Target population: People in adult education (job-seeking and labor market–distant women and men, with and without migration experience, within the framework of qualification measures), as well as health and social care professionals

Setting: Institutions of adult education, German language courses

Activities: Courses aimed at improving HL among job-seeking and labor-market-distant individuals, focus on the Austrian healthcare system, mental and physical health, communication with physicians, critical health literacy, and patients' rights. In addition, training sessions for health and social care professionals are provided to raise awareness of HL. In addition, regular networking meetings are held for professionals working in the health and social care sectors. This initiative aims to engage representatives of institutions, decision-makers, and stakeholders from all professional groups, as well as anyone interested in the topic of health literacy.

Implementation:

The training courses to improve HL among job-seeking and labor-market–distant individuals, as well as the training sessions for professionals to promote HL awareness, are implemented in institutions of adult education and German language courses.

Outcomes: A before-and-after comparison shows a clear improvement in the participants' HL.

Facilitating factors:

- Integration into existing labour market qualification programmes: The courses are embedded in established adult education and labour market qualification settings, enabling direct access to individuals with often limited health literacy within their regular learning environment.

- Target group-specific and participatory approach: The project builds on experiences from previous projects that were developed through participatory needs assessments. This enabled the adaptation of content and methods to the specific needs of the target groups.
- Focus on vulnerable population groups: By specifically addressing job-seeking, labour market–distant individuals and people with migration experience, the project reaches groups that are at increased risk of limited health literacy.
- Combination of individual- and organisational-level interventions: In addition to courses for participants, professionals from the health, social care, and education sectors receive training and networking opportunities. This strengthens health literacy not only among individuals but also within relevant support structures.
- High reach and long-term implementation: The multi-year implementation, large number of courses and participants, and continuation across several funding periods indicate strong acceptance and feasibility.
- Demonstrated effectiveness: The evaluation showed significant improvements in health literacy across all competency domains and stages of information processing, supporting acceptance among participants, partner organisations, and funders.
- Strong institutional networking and recognition: Participation in national health literacy networks and the receipt of national awards have increased the project's visibility, credibility, and opportunities for knowledge transfer.

Barriers:

- Heterogeneity of the target group: Differences in educational background, language skills, migration experiences, and prior knowledge require considerable flexibility in teaching methods and adaptation of course content.
- Language-related barriers: As the courses are delivered in German, individuals with limited German language proficiency may be more difficult to reach or may benefit less from the programme.
- Multiple challenges faced by participants: Unemployment and labour market exclusion are often associated with social, financial, and health-related burdens that may affect regular participation and engagement.
- Dependence on partnerships and funding structures: Successful implementation relies on cooperation with adult education providers and labour market programmes, as well as sustained financial support. Changes in these framework conditions may affect long-term sustainability.
- Challenges regarding long-term sustainability of behavioural change: Although improvements in health literacy have been demonstrated, sustained behavioural changes may be hindered by broader structural factors such as social disadvantage and limited access to resources.

Funding body: Vienna Health Promotion Fund and Austrian Health Insurance Fund (ÖGK)

Health Literacy Coaching [Gesundheitskompetenz-Coaching] (Austria)

Source: <https://www.sozialversicherung.at/gesundheitskompetenz-coaching>

Aim: To strengthen the HL of insured persons through HL coaching offered during inpatient stays, such as cures, rehabilitation programs or health weeks.

Health literacy addressed: General HL

Target population: Patients

Setting: Inpatient stays in social insurance institutions (e.g., cure, rehabilitation, health week)

Activities: Health literacy coaching sessions

Implementation: Two group coaching sessions, each lasting 90 minutes and ideally involving eight to twelve participants, are delivered during the inpatient stay and focus on four modules: navigating the healthcare system, effective communication with physicians, evaluating health information and patients' rights.

Outcomes: The pilot project received a positive evaluation. Conversations between doctors and patients, as well as access to reliable health information, were highlighted as key issues. In addition, participants reported first positive experiences with doctor-patient consultations.

Facilitating factors: Growing importance of HL; good HL has a positive impact on patient navigation and guidance within the healthcare system

Barriers: Integrating coaching sessions into existing therapy plans and availability of qualified facilitators for conducting the sessions

Funding body: Social insurance

Communication training for healthcare professionals (Austria)

Source: <https://oepgk.at/schwerpunkte/gute-gespraechsqualitaet-im-gesundheitssystem/trainingsangebote-nach-each/>

Aim: To strengthen patient-centered communication skills through targeted communication skills training for healthcare professionals to promote patients' HL.

Health literacy addressed: Professional HL

Target population: Healthcare professionals

Setting: Professional training

Activities: Practice-oriented, evidence-based, tailored communication skills training based on the Calgary Cambridge Guides and the ÖPGK-tEACH standard using simulated patients.

Implementation: The trainings use simulated patients and video examples to develop patient-centered communication skills and range from short introductory workshops (4h) to comprehensive training programs tailored to specific settings, such as oncology, primary care, rehabilitation, etc. Modules such as intercultural communication, communicating bad news, motivational interviewing, addressing emotions, etc. address specific challenges in clinical consultations.

Outcomes: Very high participant satisfaction and significant increases in self-assessed competencies were observed after the trainings, indicating strong acceptance among the target group.

Facilitating factors: Universal concept with more specific settings and modules, leadership buy in, sustainable systemic/structural and organizational anchorage, internal change agents, engaging change agents in cross organizational networks, clear responsibility for communication skills training (i.e. communication officer)

Barriers: -Sustained implementation depending on individuals, time resources and staff planning, singular trainings, unclear funding timeline

Funding body: Federal Ministry of Labour, Social Affairs, Health, Care and Consumer Protection (Austrian Agenda for Health Promotion) and social insurance

Saste Roma -Promoting better health in socially excluded communities [Projekt Saste Roma – Rozvíjíme zdraví ve vyloučených lokalitách] (Czech Republic)

Source: <https://www.sasteroma.com/o-projektu>

Aim: To reduce health inequalities between excluded communities and the majority population by improving HL and overall well-being.

Health literacy addressed: General HL

Target population:

- Roma communities in socially excluded localities
- Children and youth in Roma communities,
- Schools and educators working with Roma pupils

Setting: Community and online tools

Activities: The project implemented several key activities aimed at improving HL among Roma communities. Culturally adapted health education materials tailored to Roma communities were developed and disseminated, including health education brochures, video clips, and online communication campaigns. Activities were also organized in schools to increase HL among children and young people and to encouraging preventive health behavior, such as healthy lifestyle choices, participation in preventive medical check-ups, and early recognition of health problems.

In addition, the project promoted an online e-learning platform developed within the affiliated HOBIT project. The platform enables users to test their knowledge and practical response skills in cases of stroke or heart attack, recognize symptoms of panic disorder, and identify early signs of type 2 diabetes.

Furthermore, awareness-raising and educational activities were implemented directly within Roma communities. These included community-based events, awareness campaigns, and outreach initiatives aimed at improving HL and promoting preventive health behavior, such as regular health check-ups, healthier lifestyles, and timely recognition of disease symptoms.

Implementation: A community-based approach was applied through direct engagement with Roma families. Members of the target group were involved in the development of educational materials to ensure co-design. Health information was adapted to the language and cultural context of Roma

communities to improve understanding and acceptance. Educational activities were also implemented in schools to support sustainability and early prevention.

Outcomes: The project outcomes were evaluated using post-intervention questionnaire surveys that assessed changes in knowledge and attitudes. The project achieved a significant reach among the target population: more than 80,000 Roma individuals were engaged through targeted communication tools, and over 45,000 culturally sensitive brochures were distributed within Roma communities. The project contributed to improved HL related to non-communicable diseases (NCDs) and increased awareness of prevention and the importance of early diagnosis. In addition, cooperation between Roma communities, NGOs, schools, universities, and public health institutions was strengthened. The project also helped to improve trust and communication between socially excluded communities and healthcare institutions.

Facilitating factors: The project benefited from a community-based and co-designed approach; culturally adapted health information; strong collaboration between community organizations, schools, and health institutions; and the use of multiple communication channels, including online tools.

Barriers: The project addressed low health literacy, limited use of preventive health services, social exclusion, distrust of healthcare institutions, and language, cultural, and digital barriers. Additional challenges included unequal access to healthcare services across Czech regions and limited sustainability after project funding ended.

Funding bodies: EEA funds and collaboration with Czech universities

Preventing Differently: AI-Based Personalized Oral Health Literacy Campaign [Prévenir autrement : une campagne personnalisée de littératie en santé orale basée sur l'intelligence artificielle] (France)

Source: <https://www.quartiersante.fr/quartier-santé-lemasson/>

Aim: To use artificial intelligence–based personalization of SMS prevention messages to improve oral HL.

Health literacy addressed: Oral HL

Target population: Individuals from low socio-economic backgrounds

Setting: SMS messages (mobile phone-based intervention)

Activities: Generic or personalized SMS messages were sent to individuals' mobile phones.

Generic messages included standard oral health prevention recommendations (e.g., brushing twice daily, reducing sugar consumption, regular dental visits).

Personalized messages were tailored to participants' individual knowledge gaps, behaviors, and socio-demographic characteristics. These messages were adapted by the IA in terms of content, language style and timing of delivery (e.g., before shopping or meals) to increase relevance and effectiveness. All AI-generated messages were reviewed and validated by healthcare professionals before being sent, ensuring medical accuracy and ethical oversight.

Implementation: Over a three-month period, this intervention studied how SMS prevention campaigns would affect people's oral HL. Participants completed an initial questionnaire assessing their knowledge, practices, and socio-economic data. They were divided into three groups:

- Group A: control, no SMS intervention
- Group B: Received generic SMS prevention messages.
- Group C: Received personalized SMS messages

The intervention lasted two months of message delivery.

After two months (or after the sending period), a second questionnaire measured changes in knowledge and oral HL. Qualitative interviews explored how participants experienced the messages.

Outcomes: Increases in oral health literacy scores were observed, particularly among participants who received personalized SMS messages (Group C), who reported more positive reception and higher engagement. Lower-income participants showed greater gains when messages were personalized. Overall, the intervention demonstrates that SMS-based prevention campaigns are a promising tool for improving oral health literacy, particularly among vulnerable populations.

Facilitating factors: SMS messages are easy to access and widely used, which supports the reach of the intervention. The low cost makes it scalable and easier to implement in different settings.

Barriers: Legal and regulatory constraints regarding consent and authorization to send SMS messages can represent a barrier to implementation. The effectiveness of the intervention depends on the accuracy of the initial data collected.

Funding body: Montpellier Santé Orale

Play positively with health: from plate to shoe (Spain)

Source:

https://www.sanidad.gob.es/areas/promocionPrevencion/estrategiaSNS/memoriaBBPP/docs/MemoriaBuenasPracticasEstrategia_2017.pdf

Aim: To improve women's nutrition, family nutrition, and regular physical activity.

Health literacy addressed: Nutrition / food literacy

Target population: Women over 18 years old, primarily from marginalized Roma and Moroccan communities.

Setting: Community; at a local school or in a nearby public park

Activities: A 32-hour workshop program, including group discussions, presentations, role-playing, food classification, menu design, label reading and physical activity sessions. The intervention mobilized 16 educators and was delivered through 16 sessions of 120 minutes each (including a follow-up session in June), combining classroom-based and outdoor activities in school and public spaces, and supported by a

wide range of educational materials, including placemats, flipcharts, audiovisual equipment, food models, printed materials, art supplies, and sports equipment.

Implementation: The intervention targeted women from marginalized Roma and Moroccan communities residing in socio-economically disadvantaged neighborhoods. By implementing the program directly within these local high-vulnerability environments, it successfully reached individuals facing the greatest health risks.

The approach was based on participatory and experiential health education, incorporating both individual reflection and group dynamics. The program consisted of 16 sessions of 120 minutes, following a structured sequence that included objectives, content, group work rules, a summary of the previous session, a central reflection activity and assigned “homework.”

A wide range of techniques was used, including group work (focus groups, discussion circles), visual and creative methods (videos, drawings, educational games), interactive learning (role-playing, demonstrations), continuous feedback (weekly food/exercise logs, opinion surveys) and an empowerment-based approach that fostered voice, self-confidence and leadership.

The project was implemented through collaboration between Primary Care health professionals, teachers from the Todos al Cole literacy program, social workers and social integrators, ensuring a multidisciplinary and community-anchored intervention.

Outcomes: Quantitative outcomes showed high retention, with 17 of the 20 women remaining actively engaged throughout the intervention. Significant improvements in knowledge and skills were observed, as at least 70% of participants were able to correctly classify food groups, interpret food labels, design healthy menus, and identify barriers and solutions to healthy behaviors. Moreover, 60% reported positive changes in dietary and physical activity behaviors at both individual and family levels, while more than 70% engaged in at least 30 minutes of physical activity on a minimum of two days per week. These findings indicate strong engagement and meaningful behavioral improvements among the target population.

Qualitative findings indicated increased empowerment and agency, reflected in enhanced self-confidence, active participation and an expressed willingness to act as community health agents and involve their children. Overall satisfaction was very high, with a mean rating of 9.33 out of 10; 25% of participants stated that no changes were needed, while others expressed a desire for the program to be extended.

A significant equity impact was the empowerment of women belonging to at-risk communities. By improving the HL of mothers, the project generated an intergenerational effect, directly influencing the nutritional and physical activity habits of children in socially excluded communities. In doing so, it contributed to breaking the cycle of NCD-related risks from an early age.

Facilitating factors: -

Barriers: The intervention took place in a highly vulnerable setting, specifically in the “San Lázaro” and “Los Monos” neighborhoods. The target population faced substantial barriers, including high unemployment, school absenteeism and functional illiteracy. The Moroccan community in particular experienced additional challenges due to language barriers and cultural differences. The intervention took place in a highly vulnerable -

Funding body: no funding

Discussion

This study identified HL interventions with potential to prevent NCDs using diverse search strategies across participating countries. Approaches varied according to national contexts, data availability, and established networks, and included consultation of grey literature, institutional websites, expert input, and national repositories. While this flexible strategy facilitated the inclusion of contextually relevant initiatives, it introduced variability in the comprehensiveness and comparability of the search process between countries. Differences in documentation practices and information accessibility further influenced the identification and evaluation of interventions. Reliance on non-peer-reviewed sources was essential for capturing practice-based initiatives; however, the quality and detail of available information were inconsistent. This limited the assessment of key criteria, particularly those related to evaluation design and effectiveness, and partly explains why several interventions could not be classified as best practices.

In total, 19 HL interventions aimed at preventing NCDs were identified. Of these, seven were classified as promising practices, while none met the criteria for best practices. This was primarily due to the absence of evaluations or the use of non-controlled evaluation designs. These findings underscore the need for more systematic and rigorous evaluation of national interventions to strengthen the evidence base regarding their effectiveness.

Conclusion

The mapping activity identified HL interventions supporting NCD prevention implemented in participating countries that have not been reported in the scientific literature. The activity was exploratory in nature and does not claim to be exhaustive.

The absence of interventions meeting all criteria for classification as best practices highlights a substantial gap in rigorous and systematic evaluations, particularly regarding relation to outcome assessment. This underscores the need to strengthen the evidence base on population HL interventions through the systematic integration of evaluation frameworks from the early stages of intervention development.

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Supplementary Appendix 1

Overview of the assessment results.

Country	Practice (English title)	Target population	Setting	HL addressed	Key interventions	Evaluation results	Decision
Austria	<u>EVI-Box – Evidence-based health information in GP and paediatric practices</u>	<u>Patients</u>	<u>Healthcare</u>	<u>General HL</u>	Evidence-based health information materials available before, during and after consultations	<u>Materials perceived as understandable, credible and useful; about half of professionals reported using them during consultations</u>	<u>Promising practice</u>
Austria	<u>DURCHBLICKer*in</u>	<u>Adults in education programs, including migrants</u>	<u>Adult education</u>	<u>General, mental, and nutrition HL</u>	<u>Health literacy workshops and professional training sessions</u>	<u>Before–after evaluation shows positive improvements in HL</u>	<u>Promising practice</u>
Austria	<u>Health Literacy Coaching [Gesundheitskompetenz-Coaching]</u>	<u>Insured individuals in inpatient rehabilitation or health stays</u>	<u>Healthcare</u>	<u>General HL</u>	<u>Group coaching sessions on system navigation, communication, and evaluating information</u>	<u>Evaluation of pilot project showed positive results. Conversations between doctors and patients, as well as access to reliable health information, were highlighted as key issues.</u>	<u>Promising practice</u>
Austria	<u>Model region Liezen for health literacy and health promotion</u>	<u>Population in Liezen district</u>	<u>Community / multi-setting</u>	<u>General HL</u>	<u>Regional strategy including campaigns, health offices, and professional training</u>	<u>No evaluation</u>	<u>Reject</u>

<u>Austria</u>	<u>GO-SAFE 2.0</u>	<u>Healthcare professionals and patients</u>	<u>Hospital system</u>	<u>General HL</u>	<u>Communication training and development of high-quality health information</u>	<u>No evaluation</u>	<u>Reject</u>
<u>Austria</u>	<u>Podcast Healthy & Informed</u>	<u>General population</u>	<u>Online</u>	<u>General HL</u>	<u>Podcast providing health information using plain language</u>	<u>No evaluation</u>	<u>Reject</u>
<u>Austria</u>	<u>Club for Healthy Nutrition</u>	<u>Economically disadvantaged residents</u>	<u>Community</u>	<u>Food literacy</u>	<u>Cooking sessions, workshops and gardening activities</u>	<u>No evaluation</u>	<u>Reject</u>
<u>Austria</u>	<u>Communication training for healthcare professionals</u>	<u>Healthcare professionals</u>	<u>Healthcare training</u>	<u>Communication / HL</u>	<u>Patient-centred communication training with simulated patients</u>	<u>High satisfaction and increased self-assessed competencies</u>	<u>Promising practice</u>
<u>Czech Republic</u>	<u>Saste Roma Project</u>	<u>Roma communities in socially excluded localities</u>	<u>Community outreach</u>	<u>General HL</u>	<u>Educational tools and community dissemination through field workers</u>	<u>Reported improvement in health knowledge and awareness</u>	<u>Promising practice</u>

<u>Czech Republic</u>	<u>Effective health support for people at risk of poverty (EPOZ)</u>	<u>Populations at risk of poverty or exclusion</u>	<u>Community programs</u>	<u>General HL</u>	<u>Mediator training and health promotion programs</u>	<u>No clear evaluation results reported</u>	<u>Reject</u>
<u>France</u>	<u>Oral health awareness workshops</u>	<u>General public (children, youth, elderly)</u>	<u>Community / schools</u>	<u>Oral HL</u>	<u>Interactive workshops with demonstrations and games</u>	<u>No evaluation</u>	<u>Reject</u>
<u>France</u>	<u>AI-based personalized SMS oral health campaign</u>	<u>Residents of Montpellier (Lemasson area)</u>	<u>Digital / SMS</u>	<u>Oral HL</u>	<u>Personalized SMS prevention messages based on HL gaps</u>	<u>Pre-post questionnaires show improvement in oral HL scores</u>	<u>Promising practice</u>
<u>Norway</u>	<u>Helsenorge Content Strategy</u>	<u>General population</u>	<u>National health portal</u>	<u>Digital HL</u>	<u>Development of accessible online health information and services</u>	<u>No evaluation</u>	<u>Reject</u>
<u>Norway</u>	<u>Our Digital Life</u>	<u>Society, including vulnerable groups</u>	<u>Hybrid</u>	<u>Digital HL</u>	<u>Toolbox and educational resources on digital vulnerability</u>	<u>No evaluation</u>	<u>Reject</u>
<u>Norway</u>	<u>Health assessments guide for refugees</u>	<u>Refugees and asylum seekers</u>	<u>Healthcare services</u>	<u>General HL</u>	<u>Guidance for healthcare personnel conducting health assessments</u>	<u>No evaluation</u>	<u>Reject</u>

<u>Ukraine</u>	<u>Women's health awareness campaign</u>	<u>Adult women</u>	<u>Online / public transport</u>	<u>General HL</u>	<u>Awareness campaign with posters and videos</u>	<u>No evaluation</u>	<u>Reject</u>
<u>Ukraine</u>	<u>Digital prevention websites (heart disease, smoking cessation, diabetes)</u>	<u>Adult population</u>	<u>Online</u>	<u>General HL</u>	<u>Health information websites with self-assessment tools</u>	<u>No evaluation</u>	<u>Reject</u>
<u>Ukraine</u>	<u>Mental Health Program "How are you?"</u>	<u>General population</u>	<u>Online / national campaign</u>	<u>Mental HL</u>	<u>Online platform and awareness campaign for mental health support</u>	<u>No evaluation</u>	<u>Reject</u>
<u>Spain</u>	<u>Play Positively with Health: From Plate to Shoe</u>	<u>Women from marginalized communities</u>	<u>Community / school</u>	<u>Nutrition literacy</u>	<u>Participatory workshops on diet and physical activity</u>	<u>High participation and reported behaviour change</u>	<u>Promising practice</u>



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