Healthy Communities

# Action plans for the local promotion of health literacy

Co-funded by the European Union

## Partners involved:

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Italy

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### About the Project

With our **HEALTHY COMMUNITIES** project, we illustrate the contribution that adult education can strengthen the health skills of all citizens (including and especially groups with fewer opportunities), counteracting marginalization, and strengthening participation and commitment. One shortcoming of current health skills development programs is that they do not reach all population groups.
The project team has chosen to focus on the local community, in particular through the connection to the living environment in the community, which has so far only been elementary developed.

# CONTENTS

# Action Plan for the sustainable implementation of Health Guides

Healthy Communities aims to strengthen health literacy, especially among vulnerable groups. Low-threshold and everyday offers and activities implemented by trained health multipliers are intended to promote health literacy in neighbourhood settings. A sustainable anchoring of the multiplier approach requires close integration into existing local structures, institutions and networks. The present action plan is a summary of the experiences gained. It should be understood as a roadmap for the sustainable establishment of a multiplier concept to promote of health literacy for vulnerable target groups.

## Starting point and goal of Healthy Communities

Scientific studies show that individual health literacy is low in many European countries. Indicators of this are a negative self-assessment of one's own health skills, but also structural disadvantages of a financial and socio-economic nature. Low health literacy correlates with riskier health behavior and is thus associated with poorer individual health status. The Corona pandemic has highlighted these weaknesses and highlighted the importance of low-threshold health literacy in particular for the promotion of public health.

The challenge is to strengthen health literacy in such a way that groups that are more affected by structural disadvantages in particular benefit from it. Formal ways of health education often fails to reach these groups. Our goal is to strengthen health literacy at a very local level by bringing scientific findings and interventions to the communities in a low-threshold way. We use the local structures and support and empower the multipliers and actors to integrate the topic of health literacy into their activities in the neighbourhood.

(See also: International Report of the European Health Literacy Population Survey 2019-2021 (HLS19) of M-POHL, available at: https://m-pohl.net/sites/m-pohl.net/files/inline-files/HLS19_International%20Report%20(002)_0.pdf)

## 1. Overall goal of Healthy Communities

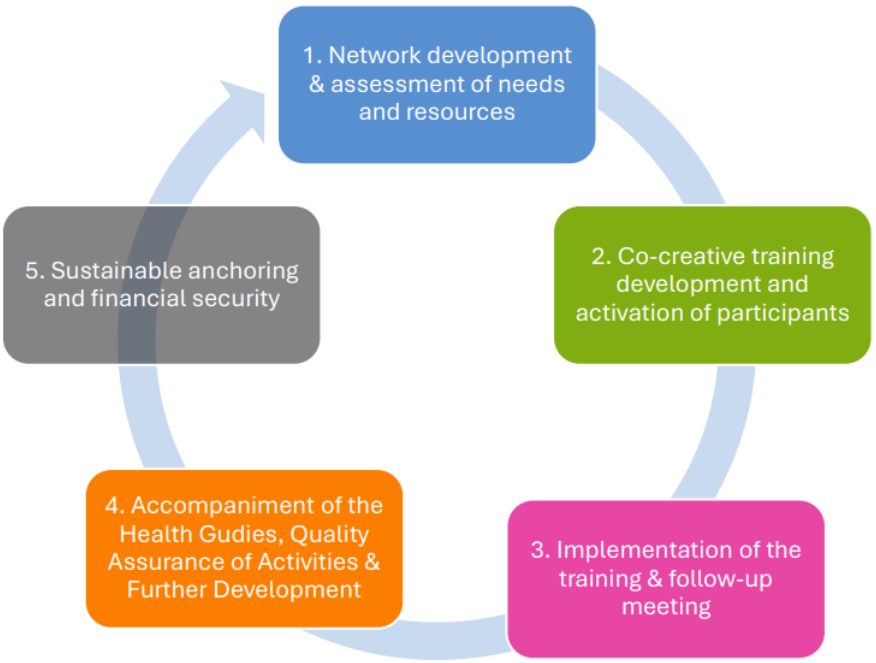
The health literacy of residents in selected districts or neighbourhoods, and especially vulnerable groups, is strengthened through low-threshold, participatory and locally anchored offers.

## 2. Subordinate Goals

- **Survey needs and challenges in local neighbourhoods:** Focus groups and interviews with local stakeholders or multipliers are used to identify specific needs and challenges in the field of health literacy.
- **Capacity building of health multipliers:** Interested and relevant actors and key persons in the districts, neighbourhoods, etc. are trained to share health-related information, initiate activities and act as confidants in the neighbourhood.
- **Participatory development of offers:** Development of needs-based content and activities for specific target groups in the respective setting (whether in a neighbourhood or a specific community).

## 3. Measures and implementation

For a sustainable implementation of the Health Guides Model, we propose a step-by-step plan in five phases, incorporating local and regional resources and contexts. These phases will be described in more detail on the next pages (goals, measures, learnings & experiences, schedules & resources, indicators and expected results).



## Phase 1: Network development & assessment of needs and resources

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| **Goal** | **With the network development, it is possible to reach relevant stakeholders from the areas of social affairs, health and education from the district/district. They articulate and share observed needs on the topic of health literacy and health, as well as the challenges faced by vulnerable target groups. These stakeholders are also involved in further implementation steps.** |
| **Mearsures** | • **Identifying relevant stakeholders and existing networks:** e.g. existing networking forums, topic-related conferences or similar events where many actors from the fields of social affairs, health and education take part are particularly suitable for this purpose.<br>• **Assessing needs and resources:** Different formats and methods can be used for this purpose: either questionnaires, qualitative and guideline-based interviews or workshop formats. In addition to identifying needs and possible barriers, it is important to consider how to assess particularly vulnerable groups.<br>• **Inventory analysis as a basis for the creation and development of offers and trainings for health guides:** Compilation of the results and writing of a report (see National Reports on community-oriented health education). |
| **Experience from the project** | • In Austria (spec. Vienna) and Germany (spec. Berlin), there is a wide variety of health promotion offers and programmes. It is important to bundle the existing information well and to use synergies or to find existing gaps in services. [Austria/Germany]<br>• In Poland the health related and prevention-related information is available, however the awareness among users is low- the posters and websites are not enough: **engagement methods** and active promotion are needed. [Poland]<br>• Reaching vulnerable target groups takes time, personal relationship building and trust: Multipliers who have access to these groups are often involved as volunteers. In order to involve them in Healthy Communities in the long term, it must be taken good care to ensure that they themselves are strengthened in their role and in their self-care. [Austria/Germany]<br>• In the Italian implementation, familiar and informal community spaces such as libraries, neighbourhood meeting points and local associations proved particularly useful for approaching participants and discussing health-related topics. Building trust and personal relationships required |

time and continuous presence within already existing community environments. [Italy]

- In Poland, age and level of education matter in reference to awareness of how to maintain health- seniors (people 65+) and people living in remote areas need more education and information on healthy lifestyle. [Poland]
- In order to meet the requirements of the participatory approach, it is important to present the collected results to colleagues and interviewed partners. [Austria/Germany]

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| **Schedule & Resources** | **Schedule:** At the beginning of the project, 6-7 months, incl. presentation of the results and ongoing networking.<br>**Resources:** Time for research, personal networking meetings and rooms for face-to-face meetings, moderation utensils and catering if needed. |
| **Indicators** | • **Number and diversity** of stakeholders reached (from different areas).<br>• **Quality of the feedback**: detailed documentation of the needs analysis.<br>• **Participation rate**: Number of-stakeholders who agree to actively participate in the next steps (e.g. training of health guides).<br>• **Identification of vulnerable groups**: Concrete naming of barriers and access options by the network partners. |
| **Expected results** | • **Results written in a report**: A well-founded basis for decision-making for the content of the training modules.<br>• **Commitment**: Defined collaborations with local multipliers and institutions to anchor *healthy communities in the long term*. |

## Phase 2: Co-creative training development & activation of multipliers and potential participants

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| **Goal** | **The co-creative development of the training builds on the results of the needs and is carried out with the involvement of relevant stakeholders and already active multipliers. The already existing training modules are adapted to the respective context. Further networking and an active approach to interested persons and multipliers aims to win potential participants for the training and the multipliers as health guides.** |
| **Measures** | • **Needs-oriented content conception of the training:** with key topics derived from the collected results of the analysis of needs and vary depending on the target groups and local contexts. Through the piloting of Healthy Communities, there is already an initial basis for the content and methodological preparation of key topics (see Curriculum for the Trainings Course in Health Education).<br>• **Identification of interested people who want to participate in the training:** It makes sense to use existing networks to address people who are well established in their respective communities, *e.g.* in migrant communities, senior citizens' initiatives or local associations. Personal contacts and outreach conversations are particularly important.<br>• **Development of materials to promote and activate interested people who want to become active as health guides.**<br>• **Establishment of a support infrastructure:** For a long-term establishment of health guides, it is essential to build up a supporting infrastructure and to connect the health guides effectively. This includes the spatial infrastructure, materials, the support and accompaniment in their activities as well as the organization of exchange formats for health guides. It is also important to clarify in advance who will teach the individual training modules. |
| **Experience from the project** | • Personal contacts can facilitate access to networks, especially to multipliers who have access to vulnerable target groups. [Austria/Germany]<br>• It might be useful to reach out to already existing, structured groups that have access to and contact with vulnerable communities, as established relations can shorten the distance and strengthen the impact. [Poland]<br>• For the development of the training, it is useful to have a clear idea of the profile and competencies that the training participants should or need to have. [Austria/Germany] |

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| | • It might be helpful to consider what added value and profit participants in the training get and which knowledge out of the training they will be able to share later actively through their future activities. [Austria/Germany]<br>• For the training itself, it is also advisable to ask about the competence profiles and their resources. If possible, the individual resources can be used during the training. [Germany]<br>• During the Italian pilot phase, some initially planned workshop methods and co-creative tools proved too complex for first-time facilitators. Simpler, and more practice-oriented activities connected to everyday situations proved easier to implement and helped participants feel more confident about future community activities. It also proved more effective to adapt existing community activities rather than to develop completely new formats from scratch. [Italy]<br>• There are already many similar offers in Vienna. The need for one to one support, orientation and personal accompaniment in the healthcare system is very high, so an orientation towards this need seems to make sense in any case. [Austria] |
| **Schedule & Resources** | **Schedule: 6 to 8 months** for the development and elaboration of the training as well as for the acquisition of multipliers and the construction of the infrastructure.<br>**Resources:** Human resources and time for training development and adaption, as well as for outreach, activating work to address interested people, material costs and possible costs for digital elaboration. |
| **Indicators** | • **Quality of the curriculum**: The curriculum is tailored to the needs mentioned and has a good balance between general basics and target group-specific topics.<br>• **Number and diversity of people interested in the training**: the participants have access to different communities and have interest and time resources to participate in the training.<br>• **Stability of the support infrastructure**: spatial, material and qualitative stability is required in order to be able to accompany the multipliers even after the training. |
| **Expected results** | • **A curriculum** including learning materials and materials is available.<br>• **Interested people** who would like to register for and complete the training.<br>• **An association, organization or institution** that can provide the appropriate infrastructure. |

## Phase 3: Implementation of the training and follow-up meeting

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| **Goal** | **The Healthy Communities training is implemented within a fixed period of time. The participants are taught knowledge, can work out tasks and exercises and by the end of the training have a concrete picture of how they can pass on the knowledge they have acquired and share with their networks.** |
| **Measures** | • **Selection of people who take part in the training**: In order to ensure the quality of the training, it makes sense to define criteria for participating in the training in advance. Useful criteria could include: language skills, previous knowledge in the field of health and social affairs, experience in dealing with groups and communication skills, question of personal motivation. Documenting the procedure for participation ensures the quality of the training group.<br>• **Training development:** Adaptation of existing Healthy Communities modules in terms of content and methodology (see training course for Health Guides in health education) to the group of participants. Transparent communication about the goals, role understanding and future activities of the Health Guides is also necessary.<br>• **Clarify framework conditions:** Consider the frequency and duration of the individual modules, attendance regulations, define and communicate criteria for successful completion. Consider appropriate documentation of attendance or replacement work in advance.<br>• **Implementation & Reflection:** Organization and implementation of the training units including preparation and follow-up, feedback processes and strengthening of the group dynamics. A follow-up meeting to support the continuation of the group is arranged for the last date. |
| **Experience from the project** | • When selecting participants, diversity of languages, experiences and professional backgrounds is in any case an asset for building healthy communities in itself. However, it can also be challenging to conduct the training, for some modules extra time might have to be allowed to translate content or input. [Austria/Germany]<br>• When creating the training materials, depending on the target group of multipliers addressed, linguistic adaptation is also important (e.g. easy language, working with symbols). [Austria/Germany]<br>• When applying and developing self-study modules, it is important to think carefully beforehand about the topics for which this seems to make sense. The creation of digital self-learning modules requires professional preparation, which requires appropriate financial resources. [Austria/Germany/Poland] |

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| | • Discuss the advantages and disadvantages of the self-study modules openly with potential participants and other stakeholders. During the pilot in Vienna, we had mixed experiences with the self-learning modules. [Austria/Poland]<br>• For a good transition between training and practice to take place, hints and suggestions are required for the individual training modules so that a good practical transfer can take place. [Austria/Germany/Poland]<br>• It should also be considered that many people participate voluntarily and are not equally motivated for everything. Keep tasks clear, manageable and voluntary. [Austria/Germany]<br>• In Italy, participation in the training course did not always correspond to readiness for independent community activation. Some participants appreciated the learning experience, but required additional accompaniment and practical experience before feeling comfortable facilitating activities autonomously. Participants also expressed the need for more concrete and practical tools connected to everyday situations, such as navigating services and identifying reliable information. [Italy] |
| **Schedule & Resources** | **Schedule:** 3-4 months<br>4–8 weeks in advance: Goal definition & responsibilities<br>2–3 weeks in advance: Detailed planning & material preparation<br>1 week before (starting the workshops): Final check (agenda, technology, communication)<br>Workshop implementation (either 2 whole days or also divided into several dates within 2 to 4 weeks)<br>1-3 days afterwards: Feedback & short follow-up<br>**Resources:** Human resources and time for the reception of the participants, for the implementation and follow-up of the training, including feedback and reflection,<br>moderation materials and printing of the learning materials and digital resources for preparing of the learning materials. |
| **Indicators** | • **Number of participants** who successfully completed the training.<br>• **Quality of the training** is evaluated through qualitative and quantitative feedback from the participants. |
| **Expected results** | • **The training modules are prepared in an understandable and user-oriented** way and are also available after the training has been completed.<br>• The **participants have successfully completed the course** and are willing to share their knowledge and receive a certificate or confirmation. |

## Phase 4: Support of the health guides, quality assurance of the missions & further development

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| **Goal** | **The participants who have successfully completed the training become active as health guides. They share their knowledge within their networks and find suitable methods, activities and opportunities where and how they can share the knowledge. Through accompanying meetings and coaching formats, health guides are supported in their activities and strengthened in their role. The activities of the Health Guides will reach various target groups in everyday life. The users ("end-beneficiaries") receive information and are empowered and motivated to make good decisions about their health.** |
| **Measures** | • **Co-creative development of the deployment and learning scenarios** together with the health guides. This can be done through different approaches. Suggestions from already existing application scenarios or methods such as "Creating Ownership" (Scaffold Cards) or a simple idea fact sheet can form a good basis for encouraging health guides to become active.<br>• **Regular reflection and exchange meetings:** Establishment of a continuous exchange to ensure quality, peer learning and to strengthen the role identity of the health guides. If necessary, new topics can be taken up and worked on during a workshop evening.<br>• **Ensuring the low-threshold approach of the health guides' activities:** All offers remain free of charge, easily accessible and linguistically adapted and take place at suitable times of the day.<br>• **Documentation and qualitative feedback:** The health guides are in regular contact with the project or coordination team and report on their assignments. These are documented by the project team for quality assurance.<br>• **Ongoing and accompanying public relations work** ensures that people from the various communities and the actors in the district and neighbourhoods learn about the offers of the Health Guides. |
| **Experience from the project** | • The willingness of health guides to remain active after successfully completing a training course depends on several factors: among other things, the available time resources, how strongly they identify with the role of health guide and their own private and professional situation. Therefore it is useful if the health guides learn content during the training that they are convinced will also be helpful for people in their communities. [Austria/Germany]<br>• Often the health guides were active in informal settings, where it was often inappropriate to provide concrete evidence (e.g. photos, list of |

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| | participants, etc.) of an implemented activity. To document the quality and impact of the activities and interventions of the health guides, personal exchange between the Health Guides and the coordinating team seems to be a suitable method. [Austria/Germany]<br>• Low-threshold access to users and vulnerable target groups via multipliers from the communities is a beneficial and goal-oriented approach. [Austria/Germany]<br>• Making health guides get to know each other and like each other creates a sense of belonging and strengthens the missions – driven attitude, therefore enough time shall be allocated for the guides to get to know each other and form a group of merit and personal support. [Poland]<br>• Continuous mentoring and exchange meetings proved particularly important during the Italian implementation. Many Health Guides initially preferred collaborative or co-facilitated activities before taking on more active roles independently. Small-scale activities, gradual activation pathways and regular peer exchanges helped to reduce insecurity and maintain motivation over time. [Italy] |
| **Schedule & Resources** | **Schedule:** depending on the willingness of the health guides; useful for a period of 6-12 months (minimum)<br><br>**Resources:** Mainly human resources to continue to accompany the health guides well and to support them as needed (through workshops, reflection meetings, coaching, etc.), learning materials/information materials and flyers and other materials for public relations into several languages if necessary. |
| **Indicators** | • **Activities of the health guides**: These are well and comprehensibly documented.<br>• **Deployment scenarios:** There is a diversity of deployment scenarios that appeal to a diverse user group, and health guides can contribute with different skills.<br>• **People / users reached**: Number and diversity of users / target groups reached. |
| **Expected results** | • **Various activities of the health guides**, which are aimed at different target groups and in which different methods are used.<br>• **Reaching a diverse group of users** who are disadvantaged for different reasons. This is achieved through various activities and interventions by the health guides. |

**Phase 5: Sustainable anchoring and financial security**

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| **Goal** | **For a sustainable anchoring and financial security of healthy communities and the trained health guides, organisations and institutions are found that continue to take over and provide the framework and infrastructure for the activities of the health guides. Sustainable anchoring can be achieved through regular financing of external funding programmes.** |
| **Measures** | • **Relevant funding programmes** are analysed and, in the case of suitable calls for proposals, the model of the health guides is submitted, if necessary, the content is sharpened or adapted to the local context.<br>• **Establishment of strategic partnerships:** Discussions with supporting organisations on long-term takeover into regular financing or institutional structures. |
| **Experience from the project** | • This phase represents the greatest challenge in project implementation. It is important to use synergies with already existing and similar multipliers/peer projects and to find alternatives e.g. to address the specific needs of different target groups. [Austria]<br>• It is helpful to think about sustainable implementation right from the start of the network and to think more about the local and regional context. [Austria]<br>• Establishing partnerships with already existing structures (NGOs, local service institutions) supports the synergy and sustainability of the idea and the continuity of the guides' health literacy work. [Poland]<br>• In Italy, integrating health literacy activities into already existing educational, volunteering or community initiatives was often proved more realistic than creating completely new structures. Small and adaptable activities connected to already familiar community settings were generally easier to maintain over time with limited resources and volunteer availability. [Italy] |
| **Schedule & Resources** | **Period:** 4-8 months,<br>**Resources:** Human resources and time for: access to networks, networking, writing applications etc. |
| **Indicators** | • **Action Plan**, which forms a good basis for grant submissions<br>• **Partners** interested in long-term cooperation |
| **Expected results** | • **Long-term anchoring of the health guide model** or adaptation of certain content for other multiplier programmes. |

## 4. Policy Recommendations

### 1. Recognising informal social spaces as important settings for health promotion

The pilot implementation of Healthy Communities in Austria, Germany, Italy and Poland has shown that vulnerable groups are often primarily reached through informal social networks and trust-based everyday communication and not through formal healthcare services.

Health-related questions frequently arise in social spaces such as chat groups, family contexts, neighbourhood meeting points, conversations in parks or playgrounds, and within associations or migrant communities. Professional health actors are often not present in these spaces. The project experiences demonstrate that Health Guides can play an important bridging role within these informal communication spaces. They help build trust, reduce barriers and facilitate access to health information and support services.

Healthy Communities therefore highlights the need to understand health promotion and health literacy more strongly as community-based and socially embedded processes and to recognise informal community structures as important health-related resources.

### 2. Volunteer Health Guides complement professional systems – they do not replace them

The project experiences clearly show that the strength of volunteer Health Guides does not primarily lie in medical expertise, but in social proximity, cultural understanding and their access to hard-to-reach groups. At the same time, the pilot phase demonstrated that volunteer engagement cannot be considered a permanently stable resource. Volunteers' life situations may change rapidly and affect their ability to remain continuously active.

Volunteers acting as Health Guides should therefore:

- not compensate for structural gaps in healthcare provision,
- not be overburdened with professional responsibilities,
- and be able to engage flexibly over time.

For sustainable implementation, professional support structures are essential – particularly with regard to training, mentoring, quality assurance and establishing links to healthcare and social service professionals. The project experiences show that the combination of informal community-based access and professional support structures is particularly effective.

### 3. Community-based health promotion requires multi-level support structures

The transnational pilot implementation has shown that community-based health promotion can only be sustainably effective if clear support and coordination structures are in place.

| Level | Function |
|---|---|
| **Health Guides / Peers** | Trust-building, informal communication and low-threshold orientation |
| **Local coordination** | Supporting volunteers and organising exchange and support activities |
| **Professional experts** | Professional guidance, supervision, referral pathways and crisis support |
| **Regional or national infrastructure structures** | Quality assurance, common standards, training development, knowledge management and strategic embedding |

The project experiences particularly underline the importance of regional and national infrastructure and coordination structures for quality assurance, knowledge transfer and long-term sustainability.

**4. Strategically connecting Healthy Communities to existing prevention and community health structures**

Experiences from the partner countries show that Healthy Communities is particularly effective when connected to existing local and national structures.

These include:

- municipal health promotion structures, health regions or regional health conferences in Germany,
- Austrian Platform for Health Literacy, Health Conferences or programmes like Community Nursing and Primärversorgungszentren with Social Link Workers
- community-based health structures such as the Case della Comunità in Italy,
- and municipal prevention and NGO structures in Poland.

The transnational collaboration demonstrated that community-based health promotion requires flexible local adaptation rather than a uniform European model.
This adaptive and learning-oriented approach represents a key European added value of the project.

**5. Health literacy is not only an individual responsibility, but also a structural responsibility (Organisational Health Literacy)**

The project experiences show that health literacy should not only be understood as an individual competence. Equally important are health-literate structures within healthcare and social service organisations.

Information and services should therefore be understandable, low-threshold and culturally sensitive while also taking informal access routes and community perspectives into account.
At the same time, the project demonstrated that vulnerable groups particularly benefit from understandable communication, personal orientation and trust-based relationships.

Healthcare professionals should therefore be further sensitised to:

- understandable communication,
- culturally sensitive interaction,
- and the relevance of social realities and informal community networks.

There are already existing programmes in some countries (e.g. Workshops and Trainings for health and medical professionals) that should be scaled up.

**6. Further developing Healthy Communities as a European learning and transfer model**

The pilot implementation of Healthy Communities has shown that peer-based and community-oriented approaches can make an important contribution to strengthening health literacy, social participation and health equity.

The project's added value lies particularly in:

- linking informal community structures with professional support services,
- enabling transnational learning between different healthcare systems,
- jointly developing practical training and support approaches,
- and piloting transferable local implementation models.

**Healthy Communities should therefore be further developed as a European learning and transfer model for community-based health promotion and health literacy.**

**Developed and project coordination:**

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www.healthycommunities.eu

**Project Partner**

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