JA PreventNCD

Joint Action Prevent Non-Communicable Diseases

In brief

Co-funded by
The European Union

JA PreventNCD

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Introduction

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(Joint Action Cancer and other NCDs prevention – Action on Health Determinants)

Cancer and other NCDs make up more than 2/3 of the burden of disease in Europe. At the population level, substantial variations exist according to socio-economic status, geographical area, age, disability, gender, and ethnic groups. A large part of this disease burden is preventable.

In the context of the Europe's Beating Cancer Plan and the need to address NCDs as expressed in the EU Non-Communicable Diseases Initiative – Healthier Together, we will address **health determinants** common to cancer and other NCDs, and their common **underlying risk factors**. The overall aim of JA PreventNCD is to reduce the burden of cancer and other NCDs and common risk factors, both at a personal and societal level, and support member states by taking a holistic approach for the prevention of cancer and other NCDs, through coordinated action.

The specific objectives are to:

- improve joint capacities of member states to plan and implement cancer and other NCD prevention policies and activities both at a national, regional, and local level;
- improve data and the monitoring system for cancer and other NCDs and their common risk factors;
- contribute to reduced social inequalities in cancer and other NCDs;
- engage with and support key actors in the field of cancer and NCD prevention, including decision makers at all levels of government, civil society organizations, professionals, the general population, and patients' groups to facilitate cooperation and joint efforts.

To achieve these objectives, we will analyze the opportunities for **implementing** evidence based intersectoral policies for preventing cancer and other NCDs, and pilot-test innovative practices and **scale-up best practices**, including both population-based and targeted prevention efforts to promote healthy living. Furthermore, we will monitor cancer and other NCDs mortality and morbidity, exposure to the common risk factors, cost of NCD and cancer care, and the impact of health promotion and disease prevention efforts both at a personal and societal level.

Three technical work packages are designed to cover policies and actions across the spectrum from structural measures at societal level to interventions targeting individuals. These are labelled 'Regulation and taxation', Healthy living environment' and 'Identifying individuals at risk'. Another set of technical work packages are cutting across this spectrum and addressing 'Monitoring', 'Social inequalities' and 'Health in all policies'. The common risk factors for cancer and other NCDs such as tobacco and alcohol use, unhealthy eating and physical inactivity are themes cutting across all these six work packages.
The JA PreventNCD is a large project including more than 100 partners from 25 European countries (i.e., 22 member states and Iceland, Norway, and Ukraine), and it has a total budget (EU and member state contributions combined) of more than € 95,5 million. The project started January 1, 2024, and runs through December 31, 2027.

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This JA represents an ambitious effort – both from the European Commission and from the participating countries - to provide strategic guidance and consolidated efforts to the field of cancer and other NCDs prevention. Key outputs include an EU Consortium on Cancer Prevention, high-level annual events, and intervention tools and policy recommendations that will contribute to reduced burden of cancer and other NCDs and inequity across Europe. Furthermore, the ambition is to contribute to reduced fragmentation of actions, duplications, and overlaps, and to promote engagement of national authorities (also at regional and local levels) to increase both the short-term and long-term impact of implemented action.

Through rigorous evaluation of implemented action, we aim to assist authorities in prioritizing the most efficient prevention strategies to meet the global targets to reduce the burden of NCDs.

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Work package 1: Coordination

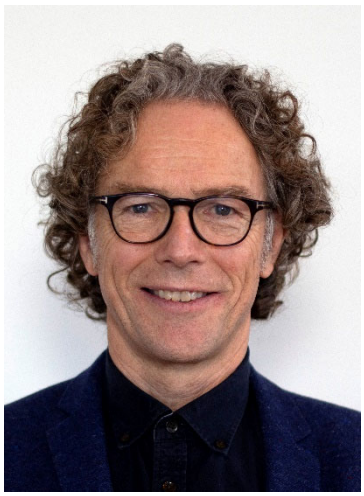
Objectives

The overall objective of WP 1 is to ensure that the JA fulfils the necessary administrative and budgetary requirements, as well as fulfils the general and specific objectives set out in this proposal in compliance with the grant agreement.

The WP has the following five specific objectives:

1. Efficiently manage the entire JA, guaranteeing that the contractual obligations are accomplished;
2. Ensure that products of the JA are scientifically relevant and to align scientific and administrative coordination of the JA;
3. Manage financial and administrative aspects, including management and distribution of the JA funds and supporting partners with administrative and financial issues;
4. Ensure all project objectives are satisfactorily and timely fulfilled, including reporting, quality control and completion of JA deliverables and milestones;
5. Ensure systematic communication with the European Commission including HaDEA and DG SANTE regarding the progress of the JA; with partners and WP-leaders to assure the implementation of the JA activities according to the plan.

WP1 is led by Linda Granlund, Norwegian Directorate of Health (DOH), and the co-lead is Knut-Inge Klepp, Norwegian Institute of Public Health (NIPH), while Arve Paulsen, DOH, is the Project Manager.


Knut-Inge Klepp (NIPH)


Linda Granlund (DOH)

The WP comprises the following six tasks:

1. Scientific coordination; task leader Knut-Inge Klepp (as above);
2. Strategic steering and day-to-day management; task leader Arve Paulsen (as above);
3. Knowledge management and monitoring; task leader Linda Granlund (as above);

4. (internal) Project communication; task leader Arve Paulsen (as above);
5. Technical and financial reporting, including internal reports; task leader Arve Paulsen (as above);
6. Collaboration with action grant projects; task leader Arve Paulsen (as above).

According to the Consortium Agreement, the Coordinator shall in particular be responsible for:

- monitoring compliance by the Beneficiaries with their obligations under this Consortium Agreement and the Grant Agreement
- keeping the address list of Members and other contact persons updated and available
- collecting, reviewing to verify consistency and submitting reports, other deliverables (including financial statements and related certifications) and specific requested documents to the Granting Authority
- transmitting documents and information connected with the Project to any other Parties concerned
- administering the financial contribution of the Granting Authority and fulfilling the financial tasks described in Section 7.2

Providing, upon request, the Parties with official copies or originals of documents that are in the sole possession of the Coordinator when such copies or originals are necessary for the Parties to present claims.

Task 1.1 Scientific coordination

The Scientific Coordinator in collaboration with the Project Coordinator will coordinate and monitor the technical WPs (WP5 to WP10). The coordination team will: (i) ensure the cooperation among WPs, (ii) provide support in harmonising the activities among WPs, (iii) assure that all technical WPs will follow and implement the methodological framework. The Scientific Coordinator together with the Project Coordinator and partners will define general quality criteria for reporting; produce guidelines for quality standards for deliverables; define a monitoring and evaluation WP strategy. Scientific Coordinator will oversee the external scientific communications of the JA in close collaboration with WP2 and other WP leaders, including publishing scientific and policy papers, and will establish and manage an External Expert Advisory Board composed by international and multidisciplinary experts. The Scientific Coordinator will, together with the Project Coordinator, chair the Executive Committee (EC) and run monthly online meetings with technical WP leaders and co-leaders.

Collaborators:
NIPH (NO) (leader), DOH (NO) (co-lead), all partners

Task 1.2 Strategic steering and day-to-day management

WP1 is headed by the Scientific Coordinator and the Project Coordinator. To manage the coordination of JA, a coordination team will be established. The team will consist of technical, scientific and financial staff. In addition, a communication officer and legal expert will be part of the team, which will be led by a project manager and deputy project manager. Scientific Coordinator and Project Coordinator will be the overall leaders of the JA and the coordination team. The coordination team will handle day-to-day activities and monitor the overall

progress of the JA. The team will also be responsible for finalizing the interim and final report to the EC.

Within the coordination of the JA, the General assembly (GA) and the EC will be organised and managed. Decision-making processes and problem-solving mechanisms are in detail described in the Consortium agreement, which is to be signed simultaneously with the Grant Agreement.

WP1 represents the partners in the JA in all formal relationships with the European Commission – DG SANTE and HaDEA. WP1 will also ensure close contact and alignment with JACARDI and other relevant JAs within the same time period.

Collaborators:
DOH (NO), NIPH (NO), all partners.

Task 1.3 Knowledge management and monitoring

WP1 will monitor the overall progress and quality of deliverables and milestones by identifying core indicators on progress and outcome in collaboration with WP3 and WP4. WP1 will collaborate with WP3 to make sure that the indicators and reports are seen in conjunction with those established in WP3, to ensure that the results from WP3 are included in the overall reporting system. Furthermore, WP1 will identify and monitor risks and propose appropriate mitigation measures. To improve risk management, the Coordination team will set up a system to continuously monitor risk, which will visualize the actions in the different WPs and tasks by red, yellow, and green (a traffic light system) to support the EB with reports that are easy to understand. This traffic light system will be managed in each in-person meeting for the EB.

Collaborators:
DOH (NO), NIPH (NO), WP3, WP4, all partners.

Task 1.4 Project communication

WP1 will monitor the overall progress and quality of deliverables and milestones by identifying core indicators on progress and outcome in collaboration with WP3 and WP4. WP1 will collaborate with WP3 to make sure that the indicators and reports are seen in conjunction with those established in WP3, to ensure that the results from WP3 are included in the overall reporting system. Furthermore, WP1 will identify and monitor risks and propose appropriate mitigation measures. To improve risk management, the Coordination team will set up a system to continuously monitor risk, which will visualize the actions in the different WPs and tasks by red, yellow, and green (a traffic light system) to support the EB with reports that are easy to understand. This traffic light system will be managed in each in-person meeting for the EB.

Collaborators:
DOH (NO), NIPH (NO), all partners.

Task 1.5 Technical and Financial reporting

WP1 will manage the submission of the mandatory interim and final technical and financial reports. In addition, WP 1 will conduct 3 internal reports during the project period.

Collaborators:
DOH (NO), NIPH (NO), all partners.

Task 1.6 Collaboration with action grant projects

Tasks and resources need to be allocated to activities aiming at fostering synergies with the action grant projects. The content of these activities will be defined after the signature of the grant agreement'.

The collaboration will contribute to the design and implement of the activities of the 'EU Consortium on Cancer Prevention'.

Collaborators:
DOH (NO), NIPH (NO), all partners.

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Work Package 2: Dissemination and communication

Objectives

The aim of WP2 is to facilitate coherent, effective, and sustainable external and internal communication of the JA and to ensure that its objectives, activities, results and deliverables are known to both the project partners and all other stakeholders of the action.

The WP has the following two specific objectives

1. To develop and implement a comprehensive communication and dissemination plan to raise awareness about the findings as well as to discuss the translatability and applicability of findings for other contexts and MSs in Europe
2. Establish and maintain cooperation with other EU projects and organisations (I.e., JACARDI, JAMRAI 2, WHO, Healthy Cities network, OECD, Euro Health Net)

Task 2.1 Visual identity and brand

Creating a recognisable and strong brand identity for the JA. The communication of JA-PreventNCD across all communication tools will be based on a standardised visual identity. To maximise visibility and impact, a unique visual identity will be created based on the projec"s values (logo, presentation templates, graphical charter for the website and other dissemination materials). The action will ensure and manage the use of the co-funding logos and relevant disclaimers in any of the resulting products of the JA.

Task 2.2 Stakeholder analysis

Identifying and mapping key stakeholders and their needs in collaboration with WP1, WP4 and all technical work packages. The stakeholder analysis will map and identify group and target stakeholders that can benefit from or contribute to the JA at all levels in all participating countries. The task will include preparation and distribution of a survey to participating countries in the JA. Both quantitative and qualitative data will be collected. The results of the survey will be used to divide stakeholders into specific groups based on background and objectives and will be used in the dissemination and communication strategy work. The mapping exercise will build on other prior and ongoing EU projects; i.e. Best ReMaP, STOP, CO-CREATE, CHRODIS PLUS. A stakeholders-board will be established, thus bringing added value to the JA by providing assessment of the project including recommendations for activities that should be undertaken to maximize the potential of the project results. Members of the board will be chosen throughout the stakeholder analysis process. To ensure that GDPR rules are fully followed throughout the process, a legal expert will be involved.

Task 2.3 Project website and social media

The JA will establish a comprehensive web presence, which will include a project website and social media accounts, where any project literature (online newsletters and conference pamphlets), infographics, articles or other content will be published and promoted. The JA website will serve as a repository for information pertaining to the project's partners,

dissemination activities, findings, resources, and other news. It will be designed to be accessible to all audiences.

Task 2.4 Dissemination and communication strategy

A comprehensive dissemination and communication strategy will be developed and implemented in collaboration with WP1. This strategy will describe the activities that the WP2 leader and all partners will undertake to ensure the visibility of the JA and communicate its outcomes and results. The strategy will be based on insight work such as the results of the stakeholder analysis and via integral cooperation from all WP leaders. The document will provide a strategy for internal and external communication, stakeholder involvement, public information, and sustainability of the JA results. One main purpose is to inform the JA partners on how they will contribute to the JA's activities and provide them with communication guidance relating to their tasks and present how all stakeholders will get involved in the dissemination activities at national level but also at European/international level. The document will include a dissemination work strategy for stakeholders to achieve the most effective dissemination and promotion of the results of JA. The strategy will also include the most efficient use of the internal and external dissemination channels related to the specific target groups. The dissemination and communication strategy will be a living document and updated regularly throughout the lifetime of the JA.

Task 2.5 Publication board and publication guidelines

T2.5.1 Publication Board

The role of the Publication Board is to advise on the suitability of publication plans and have final editorial responsibility to approve submission to a journal or a conference, etc. In addition, the board will coordinate activities between different publications, to avoid duplicity or overlapping presentations/publications. A list of the main articles as a result of the creation and evaluation of the JA will be planned. The Publication Board will be chaired by the Scientific Coordinator and the DOHI will be involved in the workflow of the JA publications, as WP2 leader, by receiving proposals from authors, distributing to the publication board, and ensuring that the procedures are followed.

T2.5.2 Publication guidelines

The purpose of the guidelines is to ensure that persons who contribute concept ideas and concrete work within the JA are appropriately included as authors or acknowledged as contributors in any of our dissemination materials, as well as products included under the Intellectual Property Rights. It is designed to ensure compliance with the dissemination-related terms of the JA Consortium Agreement and Grant Agreement and to guide the dissemination timing, taking into account relevant partner experience and preferences.

Task 2.6 Dissemination events and final conference

Various dissemination events will be organised during the four years of the JA, such as annual policy makers meetings to report the breakthroughs of the JA. The final conference at European level will take place by M48. The organization of the events will be in collaboration between WP leaders of WP1 and WP2, the aim being to enhance the visibility of the project's

outputs to stakeholders and potential end-users. Webinars to promote the JA and its activities will take place regularly throughout the four years of the JA. The aim of the webinars is both to introduce the action as well as to inform on the status of the work taking place in the technical WPs. Recordings will be available on the JA YouTube channel and promoted on social media channels. Target audiences and main messages will be defined according to the dissemination strategy and adapted to the needs of the various WPs.

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Work Package 3: Evaluation

Objectives

The **general objective** of this WP is to evaluate the progress of the JA against its internal milestones and deliverables and to ensure that the JA accomplishes its established objectives. Also, this WP aims to ensure that all outcomes of the JA achieve high standards of quality and have a significant impact both, at EU level, as well as at participating MSs level.

The WP has the following five specific objectives

1. Develop and implement the evaluation plan;
2. Develop tools to gather data for evaluation;
3. Evaluate the progress of the JA, including an external evaluation;
4. Elaborate two interim reports;
5. Elaborate one final evaluation report;

Task 3.1 Development of the evaluation plan

In conjunction and close collaboration with the coordination team and all WP leaders, an evaluation plan will be developed. The evaluation plan will be integrated as part of the entire project implementation and will identify all the components of the JA to be evaluated. It will also develop and describe qualitative and quantitative indicators (process, output, outcome, as described in the specific objectives section), activities and timelines for project evaluation. The Evaluation Team will be composed by the WP3 leader and Co-leader, the Scientific Coordinator and the Project Coordinator. The Evaluation Plan will analyse the needs, objectives, and achievements of the entire JA and of each WP task, and the effectiveness of management and cooperation.

Task 3.2 Development of tools for evaluation

Based on the criteria and indicators defined in the evaluation plan, there will be a set of tools developed to gather data for evaluation. Most of the process and output indicators will be measured through routine monitoring systems implemented in the project (e.g., time management, periodic reports of the WP and tasks, meeting minutes, meetings report, etc)

Task 3.3 Evaluation of the progress of the JA

This task will ensure that the milestones and deliverables of the JA are met according to the work plan. This task will be carried out in conjunction and close collaboration with the coordination team and will be periodical. Furthermore, an external evaluation will be carried out midway and by the end of the project.

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Task 3.4 Elaboration of two interim reports and a final evaluation report

Two interim reports and one final evaluation report will be elaborated at months 16, 32 and 48. The evaluation reports will assess if the JA has achieved its objectives and the proposed impact at both, EU and MSs level.

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Work Package 4: Sustainability

Objectives

The overall objective of WP4 is to foster the transfer and sustainable integration of the results and outcomes of the core JAPreventNCD work packages five to ten into national and European policies. Therefore, this WP will strongly collaborate with all the core WPs.

The WP has the following six specific objectives:

1. to collect sustainability elements of the JA policies and activities and thus inform and raise awareness of decision makers at regional, national and EU levels on integrated and sustainable approaches to improve health determinants and healthy lifestyle of European citizens
2. to identify windows of opportunity within EU governance mechanisms for facilitating the sustainability of JA integrated interventions after JA ends
3. to enable sustainability of the actions on cancer in EU by establishment of the EU Consortium on Cancer Prevention
4. to foster the transfer and sustainable integration of the results and outcomes recommendations of the core WPs into regional, national and European policies
5. to foster synergies with JACARDI with the aim for higher level of sustainability of actions of both joint actions while sharing approaches, knowledge and experiences
6. to foster sustainable integration of best practice results and recommendations into national systems, aligned and implemented by participating MSs.

WP4 is led by Mojca Gabrijelčič/Monika Robnik Levart, NIJZ, Slovenia, and the co-lead by Gabrielle Schittecatte, Sciensano, Belgium. The WP is organized in seven tasks and eight subtasks.

Task 4.1 Building on the outcomes of other JAs and initiatives

Task leader: NIJZ (Mojca Gabrijelčič/Nastja Sivec)The objective of this sub-task is to build on the sustainability knowledge base, elements and outcomes of previous and ongoing European initiatives, policies and projects, key strategic documents and EC Best Practice Portal, to give the present JA a solid base by addressing sustainability aspect. Collaboration of four silo lifestyle factors teams (alcohol, tobacco, nutrition and physical activity) and collaboration among chronic diseases (especially cancer) and lifestyle teams in public health will be specially addressed.

The methodology of this task will include: i) desk research to identify facilitating and hindering factors for the sustainability of the concrete policies, projects, practices or other activities (annexed in Integration and sustainability plan) and ii) interviews with key informants.

i) Desk research will be carried out at the official websites of the EU institutions and the MS, the dissemination websites of the JAs and other projects and the archives of the scientific peer-reviewed literature, while grey literature will be taken in consideration, too. Once relevant sustainability plans or elements are collected, barriers and enabling factors to the successful uptake of such policies or best practices will be assessed.

For best practices and actions, this will include searching relevant European Commission websites, including the *Best Practice Portal*, to identify methodologies used in previous sustainability plans for best practices directly and indirectly related to lifestyle factors and chronic diseases (particularly cancer).

ii) The activity of the task will be complemented with the semi-structured key informants interviews with experts and relevant stakeholders to understand what actions/elements of the actions make an initiative sustainable. The experts will be picked up among all relevant DGs (i.e. including DG SANTE, DG ENV, DG RESEARCH, DG REFORM, DG AGRI and others) and colleagues that are leading or have led the WP on sustainability of other JAs and European projects and possible other relevant experts or stakeholders. Also, policy decision makers from MS will be interviewed to understand what the national decision makers expect from this JA from the sustainability point of view.

The final objective of this task is to understand the facilitating and hindering factors of a sustainability plan to best formulate and disseminate a sustainability plan for impact. Sciensano will focus on the aspects of best practices and actions in sustainability plans, while NIJZ will focus on the policy elements. Interviews will complement the desk research to further explore what elements of previous sustainability plans facilitated uptake on policies or best practices amongst decision makers and EU level. Similarly, identified key-informants at the European Parliament level will be identified to interview to assess elements of sustainability plans that promoted national and sub national uptake of best practices or regional/local policies.

Task 4.2 Engagement of policy makers at different levels

Task leader: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

T4.2.1 Establishment of the Policy decision maker forum (PDMF)

Sub-task leader: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

Policy decision maker forum (PDMF) is a policy advisory board to the JA, consisting of the relevant DGs and EC agencies (i.e. EFSA)/bodies (i.e.ERGA), multisectoral representation of EU MSs presidencies(Council). Links to health attaches and representatives of relevant EU Parliament bodies will be established. PDMF will be asked to provide critical feedback on the feasibility of implementation of the proposed JA recommendations and actions at (national and) EU levels and feedback on the concrete proposed institutionalised / legislative policy solutions or best practices if relevant.

There will be minimum four PDMF meetings planned within the JA. This forum will act as catalyst among science, public health and policy implementation levels, while being in synergy with the horizontal WPs. WP 4 will be responsible for coordinating and preparing the meeting documents for the PDMF. Depending on the nature of the proposals, meeting documents and agenda topics, the PDMF will be asked to provide critical feedback on the feasibility of implementation of the proposed actions (policies or practices) at national and EU levels, with a view to the achievement of the proposed outcome and impact indicators. Sciensano will support the sub-task leader in the establishment of the PDMF through (i) identifying relevant actors in DGs, EC agencies and bodies, for example EFSA and ERGA, as well as relevant national stakeholders at EU level in Council and Parliament, including parliamentary working groups, (ii) providing information to members of the PDMF on the

development of best practices and actions to solicit feedback on implementation feasibility of these practices at different levels, and (iii) incorporate the feedback from the PDMF on best practices into the final sustainability plan. In point (ii), Sciensano will collaborate with JACARDI for the presentation of the JACARDI sustainability outcomes and recommendations to the PDMF for feedback, while JACARDI will engage JAPreventNCD in their sustainability processes.

T4.2.2 Follow-up recommendations from the national intersectoral groups in different applied practices and policy domains of JA

Sub-task leader: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

Sub-task co-leader: Sciensano (Gabrielle Schittecatte/Léopold Vandervliet)

Where intersectoral groups in different applied practices and policy domains are foreseen in horizontal WPs 5 – 10, sustainability outcomes and elements will be identified, followed up and summarised.

Compilation / summary of the recommendations for the decision makers' engagement will be prepared, as the input by the horizontal WPs 5 - 10 to the WP4 final recommendations.

T4.2.3 Network of Health Attachés at the EU and WHO levels

Sub-task leader: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

Network of Health Attachés at the EU and Network of Health Attachés at the WHO levels will be approached and regularly informed by JA on developments at the policy and practices levels, at least four times during JA duration. Both networks will be consulted regarding specific policy approaches when appropriate.

T4.2.4 Networking with the EU level and national levels organized youths

Sub-task leader: NIJZ (Mojca Gabrijelčič/Urška Erklavec)

The objectives of this sub-task are to encourage all competent authorities to identify and support them nationally; to engage with youth organizations in the comprehensive WP4 working processes as an important stakeholders group, providing them learning and awareness raising opportunities during that collaboration; to assure that youth stakeholders will be a part of the JA PreventNCD recommendations preparatory process.

Task 4.3 Synthesis and recommendations, based in the outcome recommendations/inputs for sustainable healthy public policies and actions/practices, from WPs 5-10

Task leader: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

Task co-leader: Sciensano (Gabrielle Schittecatte/Léopold Vandervliet)

The objective of this task is to develop methodologies to support sustainability and facilitate their translation into actions based on identified sustainability elements and EC Best Practice Portal (with consideration to promising and emerging practices, too, if WPs 6-10 would

elaborate on them). An accountability framework (by Kraak et all, 2014) will be used to allow for the conceptualisation of the approach in WP4. Therefore, methodological approaches to support the sustainability of policies and actions will be developed, based on the sustainability elements clusters (deliverables and milestones and other possible outputs from WPs 5-10, outcomes from the EU CPP meetings and processes behind, recommendations from GAB, insights, recommendations and agreements from the discussions at the WP leaders meetings, meetings with individuals WPs, outputs from national intersectoral working groups, outputs from PDMS meetings). This action will also take into consideration the evaluation outcomes of the implemented (best) practices and actions, and elaborated policies, all based on the prioritised actions.

T4.3.1 Synthesis and recommendations, based on the outcomes for sustainable healthy public policies

Sub-task leader: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

T4.3.1.1. Approach for sustainability analysis (taking the account)

First, this task will follow up the work of individual WPs (5-10) with searching and exploring the potential of sustainability elements in JA policies and actions/practices.
A methodology for sustainability analysis will be developed. The focus of the analysis will be specifically on the factors related to the sustainability elements identified through WP 5-10. Foreseen sustainability elements of integrated healthy public policies/actions (in the areas of nutrition, PA, tobacco, alcohol; sleep /sleeping patterns; cancer, etc) could include the following examples: joint institutionalized monitoring mechanisms and databases for sustainable monitoring (eg. JRC FLABE database, …); development of indicators for sustainable reporting (eg. Food system indicator, ...); Governance bodies for different healthy lifestyles (eg. Implementation network for N&PA, ...); outcomes and recommendations from intersectoral national and regional intersectoral bodies and summaries of case studies with recommendations from different policies and pilots with lessons learned; legislation of policies; founding mechanisms (defined funding for sustainable implementation of chosen practices), capacity building.
Outcomes of the sustainability analyses will feed back and support the efforts of the WPs 5 – 10 and will outline the basis for the WP4 final recommendations.

T4.3.1.2 Approach for knowledge sharing on sustainability (sharing the account)

Mixed methods approach including structured interviews and questionnaires will be utilized, to collect information to facilitate the consortium members to learn from each other's experiences in the different stages of the implementation process on how to achieve the sustainability of JA results. Sharing evidence with all stakeholders through deliberative and participatory engagement process will be considered in T4.3.2.2
The results will be analysed and will be part of lessons learned (see T4.7.2 below)

T4.3.1.3 Approach for Sustainability Action Plan (holding and responding to account)

Targets to evaluate progress (or its absence) of Sustainability Action Plan will be identified. Measuring participation/dialogue will be essential as it supports improve effectiveness of actions. Furthermore, this action will ensure that different stakeholders/right-holders respond effectively and transparently to matters attributed to them in the scope of their core business focus and take responsibility for their role in the implementation process on pre-defined actions. Relatedly, this actions will ensure opportunities for

stakeholders/rightholders to ask/discussion/question actions and decisions taken by others related to the Sustainability Action Plan (horizontal aspects of accountability).

T4.3.2 Synthesis and recommendations, based in the outcome for sustainable healthy actions/practices

Sub-task Lead – Sciensano (Gabrielle Schittecatte, Léopold Vandervliet)

T4.3.2.1- Approach for sustainability analysis (taking the account)

The goal of this part of the sub-task is to design a methodology for clustering pilot interventions, which will be used to organize the sustainability plan recommendations related to pilots. This methodology will be defined by collecting information on reviewing pilots in WP 5-10, particularly target population, objectives and expected outcomes, and reviewing peer-reviewed literature and previous Joint Actions and EC initiatives with sustainability plans.

Following the definition of the methodology, sustainability action per best practices will be identified (at least one per action) in collaborations with WP 5-10. The methodology for sustainability of best practices will be discussed and shared with the JACARDI Sustainability team and JACARDI sustainability team will engage JAPreventNCD team to their sustainability actions regarding practices.

When reviewing the sustainability actions that will be proposed for the best practices resulting from the pilots, a range of contextual factors such as health and social policies, sex and gender issues, innovation, cultural trends, general economy, and epidemiological trends, which may affect the feasibility and uptake of these actions, will be considered.

T4.3.2.2 - Approach for knowledge sharing on sustainability (sharing the account)

In this part of the sub-task the PDMF, members of the EU-CCP, as well as other key experts identified in tasks 4.1 and 4.2, will be leveraged to (i) communicate best practices from pilots and related sustainability actions, (ii) and receive feedback on related sustainability actions associated with pilot clusters. This feedback will then be shared with WP 5-10 and used to adapt the best practices and associated sustainability actions. We will also enable WP5-10 participants to meet together to discuss their lessons learnt, and how each related to one another.

T4.3.2.3 - Approach for good practices sustainability actions (holding and responding to account)

This part of the subtask will focus on identifying the implementation roles of actors at EU and national levels, and linking the sustainable implementation of the categorized best practices from the pilots to them. To do this (i) previous stakeholder mapping and feedback forums will be levered, to (ii) identify the roles and responsibilities of these various actors and institutes in the sustainable implementation of best practice actions by thematic group, (iii) and design an approach for sustainable implementation of best practices based on actors roles and responsibilities, that includes elements on monitoring the implementation of the best practices.

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Task 4.4 EU Consortium on Cancer Prevention

Task leader: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

This task will focus on building the understanding of the need for creating the EU-CCP, raise awareness of wide range of relevant stakeholders and right-holders on the importance of joint actions in the area of cancer prevention and health promotion at the EU level, allow for the process of defining and establishing of the EU-CCP and to implement the new EU body with optimal operation potential with the sustainable governance structures at the EU and MSs levels. Functions and competences of the Consortium (which should represent each MS in the JA-PreventNCD and engage also non-participating MSs) will be defined and explored together with DG Sante, with the main aim to enable sustainability of the actions in cancer prevention and health promotion in EU. Special focus will be dedicated to the equity and wellbeing perspectives within the concept of One Health.

This Consortium would act to identify and mobilise relevant stakeholders (and rightholders, including non-formal stakeholder groups in EU and nationally), linked to the Task 4.3. Consortium would include multidisciplinary actors beyond research and beyond cancer. EU-CCP will create synergies with other JAs and European actions in the area of cancer prevention and health promotion. Stakeholders views will be collected and considered while formatting recommendations. Engagement with the private sector will be based exclusively on PH priorities and principles of actions. Full attention will be paid on possible conflict of interest, where engagement with the private sector is acceptable.

The goal of the Consortium is to 1) build a momentum on cancer prevention and health promotion at EU level around a common agenda, which will be defined gradually during the course of the Joint Action. Among the first steps, coherent participatory and engaging process will be implemented to define the vision and aim, the strategic and specific goals and relevant tasks of the body. 2) strengthen and expand evidence-based prevention culture across the relevant disease spectrum and provide for inclusive actions in the broader context of health determinants and structure agency relationship. 3) strengthen advocacy by providing information and science-based evidence in the public debate. 4) combat lobbies and misinformation and disinformation. 5) help to deploy validated disease prevention and health promotion interventions at EU level, in accordance of the contents of JA PreventNCD.

Furthermore, **the added value** of such body in comparison with other governance mechanisms already present at national and EU levels will be defined. In this sense, MS governments will be engaged in the operations of the EU CCP, such as governance advisory board, consisting of MSs representatives could be established as the implementation body of EU CCP. Sustainability elements to allow the Consortium to function in the next decade will also be explored and recommended as the priority.

Among the main outcomes will be stakeholders network(ing) and events. Four key annual events EU-CCP will be prepared at the EU level. Organization of the national events will be strongly encouraged at the national levels. Furthermore, recommendations and tools from all WPS will be integrated into tasks of the EU CCP. Reflections on how to asure actors involved in the EU-CCP share/communicate/exchange lessons outside of these events will also be considered in the scope of public health driven actions/activities.

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Task 4.5 Wellbeing economy

Task leader: DOHI (Dóra Guðrún Guðmundsdóttir, Sólveig Karlsdóttir)

Task co-leader: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

Sustainability elements of wellbeing economy paradigm will be explored, in line with the T9.6.

MSs will be surveyed for the wellbeing economy status (exploration of the capacities and awareness: knowledge and human capacities, leadership, funding and institutionalisation capacities, awareness and trust in the concept).

Recommendations for the wellbeing economy sustainable implementation will be drafted for the input in the final WP4 recommendations to EC. Annual Wellbeing Economy Forums will be explored as the possible sustainability element.

Task 4.3 Alignment and synergies between WPs in JACARDI and JA PreventNCD

Task leader: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

The goal of this task is to collaborate with the team working on Sustainability for JACARDI to identify synergies in the sustainability plan.

Alignment with JACARDI for potential synergies high level policy sustainability. (Partners: coordinators, WPs on dissemination and WP on sustainability leaders and coleaders of both JA s; potential participation of other partners).

Task will include constitution of coordination body (from both JA s: coordinators, WPs on dissemination and WP on sustainability).

Subtask 4.6.1, leader NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

Yearly meetings of coordination body (first meeting M3), to assess the opportunities for synergies and elaboration of the yearly joint action plan with identified potential joint activities across coordination/dissemination/sustainability mechanisms/others with an aim to have an in-built flexibility to be able to adapt to changes as they will appear during the 4 years duration ; for example, JACARDI present regularly the work to „Policy decision making forum“ of JA Prevent NCD, and joint capacity building and trainings will be organized for both JAs by JACARDI WP4 team.

Subtask 4.6.2, leader NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

NIJZ will work specifically with their team on joint actions linked to task 4.2.1 (PDMF).

Subtask 4.6.3, leader Sciensano (Gabrielle Schittecatte, Léopold Vandervliet)

Sciensano will work specifically with their team on best practices. To achieve this, they will exchange with JACARDI on methodologies for clustering best practices and actions, as well as lessons learnt during this process. JAPreventNCD team will also be invited to the practices sustainability developmental process.

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Task 4.7 Final recommendations to EC

Task leader: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

Sub-task 4.7.1 - Policy dialogs to check intermediate and final recommendations

Sub-task leader 4.7.1.1 NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

Policy decision makers stakeholders mapping will be aligned with WP2 and WP5 – 10 work with stakeholders, with special focus to WP9 policy makers engagement

Additionally, MSs that indicated more active role in WP4 will check in which actions in WP5-10 they have established national (or regional) intersectoral groups. Identified intersecoral groups should then be connected to provide them presentations of sustainable elements and the emerging plan in the respective MSs. Countries can organize stakeholder meetings, alone or together, on the topic of sustainable JA outputs (ie, in the format of policy dialogues).

Policy dialogs will be incorporated in the annual EC Consortium on Cancer Prevention meetings, where special focus to the sustainability of the good/best practices will be elaborated. In year 4, additional policy dialog will be organized to discuss and comment the proposed WP4 recommendations on policies and practices.

Sub-task Leader 4.7.1.2 – Sciensano (Gabrielle Schittecatte, Léopold Vandervliet)

The intermediate sustainability plan will be designed, with a section focusing on best practices from clusters of pilots. It will then be reviewed externally. This will be done by (i) reviewing with recommendations with external stakeholders at the EU-CPP annual meetings, using policy dialogues as an approach to gather feedback and make adjustments on the recommendations of best practices from the pilot clusters, and (ii) liaising with members of the JA, to identify national bodies in their countries to be invited to provide comments and feedback on the recommendations.

T4.7.2 Intermediate draft outline and final report

Sub-task leader 4.7.2.1: NIJZ (Mojca Gabrijelčič/Monika Robnik Levart)

To inform policy decision makers on the JA processes and actions, to allow space for discussion, the zero ‘Draft Integration and sustainability outline plan’ will be prepared as the first step at the end of year 2. The outputs of the meetings with the PDMF, EC Consortium on Cancer Prevention, Health Attachés network and others relevant stakeholders and bodies will be discussed among WP leaders, the JA coordinator and the sustainability WP leader, to assess the options and make recommendations to foster the transfer and integration of the results and outcomes of the core WPs into regional, national and European policies and actions.

Furthermore, especially tasks 4.1 and 4.3 will provide lessons learned which will be used also in final recommendations. Lessons learned will summarise the knowledge gathered within the large European consortium and varied interventions conducted in different contexts, settings, and levels and thus provide EU added value over and above the JA interventions.

Finally, the results will be then feed into the ‘Final Integration and sustainability plan’ that will summarize the proposed policies and practices to change existing measures and practice procedures at European and MS level at the end of year 4 of the JA.

Sub-task Leader 4.7.2.2 – Sciensano (Gabrielle Schittecatte, Léopold Vandervliet)

In this subtask the feedback on best practices gather in 4.7.1 will be shared with WP 5-10 leads to assess the options and make recommendations to foster the transfer and integration of the results and outcomes of the core WPs into regional, national and European actions. We will also use (i) lessons learnt from desk review and interviews in 4.1 and (ii) the methodology, framework and recommendations from 4.3.2 to feed into the final sustainability plan.

JA PreventNCD

Work package 5: Regulation and taxation

Objectives

The overall objective of WP 5 is to improve compliance, coherence, wider implementation and enforcement of fiscal and regulative measures targeting major NCD-risks factors. The

WP has the following seven specific objectives:

1. To map and analyse policies and legislative frameworks targeting trade of tobacco, alcohol, foods and non-alcoholic beverages as well as exposure to environmental factors;
2. To provide knowledge on the use of health taxes and fiscal policies with the aim to enable healthier behaviours;
3. To promote food reformulation, health-sensitive public food procurement, food portion size standards and the use of a joint nutrient profile model to set different policy actions to address unhealthy diet;
4. To assess and monitor the impact of product labelling for healthier behaviour;
5. To support the implementation of policies to reduce the impact of harmful marketing;
6. To strengthen regulatory provisions related to pollution, exposure to hazardous substances; and
7. To develop policy monitoring indicators for prevention of NCD and cancer.

WP5 is led by Arnfinn Helleve, NIPH, Norway, and the co-lead is Maria João Gregório, DGS, Portugal. The WP is organized in eight tasks and twenty subtasks. The tasks leaders are Jaana Markkula / Thomas Karlsson (during planning), THL, Finland (task 5.1), Daniel Bergsvik, NIPH, Norway (task 5.2), Maria João Gregório, DGS, Portugal (task 5.3), Neza Fras/Mojca Gabrijelcic, NIJZ, Slovenia (task 5.4), Sabrina Teyssier, INRAE, France (task 5.5), Maria João Gregório, DGS, Portugal (task 5.6), Johan Øvrevik, NIPH, Norway (task 5.7); and Arnfinn Helleve, NIPH, Norway (task 5.8). In total, 35 partners from 23 countries participate in the WP.

Task 5.1 Improving compliance and enforcement of existing regulations

T5.1.1 Improving existing alcohol and tobacco regulations

Sub task leader: TBC, THL, Finland (Jaana Markkula, during the planning phase)

The objectives of this sub-task are to map alcohol and tobacco related (incl. novel nicotine products) policies in the European countries, and to compare the present situation to the results of the earlier studies and to further develop the policy scale method paying special attention to regulatory basis of off-premises sales and implementation of regulation.

For this, the following analyses will be conducted: (i) review previous and ongoing attempts to develop an instrument for assessing alcohol and tobacco policies in Europe; (ii) develop

methodology and an instrument to assess alcohol and tobacco policies and applying it to countries in Europe; (iii) apply results obtained from the scaling approach to classify countries according to the scale and to assess policy developments within countries, and to analyze the current situation of alcohol and tobacco policies in Europe and implications for further improvement; (iv) map and discuss effectiveness of local and regional autonomy in alcohol and tobacco regulation

T5.1.2 Regulation of online tobacco and alcohol.

Sub task leader: TBC, THL, Finland (Jaana Markkula, during the preparation phase)

The objective of the sub-task is to map e-commerce (incl. domestic and cross-border online sales, and digital marketing) with alcohol and tobacco and related products (incl. novel nicotine products) and its implications on public health in selected European countries.

The following analysis will be conducted: (i) review existing studies and to map the legal framework of e-commerce (incl. domestic and cross-border online sales and advertising) with alcohol and tobacco and related products (incl. novel nicotine products) in selected European countries (e.g. survey); (ii) identify and assess the monitoring practices of e-commerce of alcohol and tobacco and related products; (iii) map the phenomena of e-commerce online sales of alcohol and tobacco and related products, the implications on public health and the possibilities to regulate the markets; (iv) identify and assess the enforcement mechanisms in regulation of e-commerce and marketing of alcohol and tobacco and related products in selected European countries (e.g. survey); and (v) identify examples and assess solutions for digital age compliance applied in selected European countries (e.g. survey, possible case studies).

Task 5.2 Improving coherence in fiscal policies

T5.2.1 Health taxation

Sub task leader: Arnfinn Helleve, Norway (NIPH)

A leading research group on health economics and policy innovation will be sub-contracted to provide new evidence on five areas of taxation that may provide major opportunities for health improvement, including: tobacco, alcohol, food, non-alcoholic beverages and environmental taxes.

The work will entail: (i) a review of current EU taxation directives and national taxation policies; (ii) the identification of strengths, weaknesses and best practices based on prior evaluations of the impacts of those directives and policies; (iii) the creation of a data and modelling infrastructure to support EU and country efforts in the design and implementation of new fiscal policies; and, (iv) the simulation of tax policy developments in the five areas listed above, based on the Health-GPS policy microsimulation model. Special attention in this work will be paid to how vulnerable groups are affected by, and benefit from, health taxes. The assessment of tax policy scenarios will address key equity dimensions, including

fiscal justice, socioeconomic and health inequalities.

T5.2.2 Alcohol and tobacco excise taxes as an NCD policy instrument and the role of cross-border trade

Sub task leader: Tord Finne Vedøy, Norway (NIPH)

The aim with the sub-tasks is to gather and analyze the evidence on excise taxes to promote price harmonization of alcohol and tobacco products in the internal market and to inform on the relation between excise taxes, prevalence and cross-border trade in identified “heat zones”. The actions within the sub-task are to: (i) summarize of selected country cases – current excise taxes, prices and key measures of alcohol and tobacco use; and how changes in excise tax/price affected prevalence, tax revenues, and leakages through increased cross-border shopping and transition to substitute products; (ii) map and analyze available knowledge about cross-border shopping of alcohol and tobacco by private individuals. This includes reviewing new monitoring tools for cross-border trade and exploring lockdown effects on such trade during the recent pandemic. Focus will be on identified “heat zones” like Finland/Estonia, Denmark/Germany, Norway/Sweden etc. (iii) project how increasing alcohol and tobacco excises would change key measures of alcohol and tobacco use, excise tax incomes, taking leakages to cross-border shopping and substitution into account.

Task 5.3 Improving consumer`s food environment

T5.3.1 Harmonizing/implementing nutrient profile model

Subtask leader: Maria João Gregório, DGS, Portugal

This task is aiming at improving coherence in nutrition policies, by developing a harmonized nutrient profile model to be applied to different policy actions.

The main activities are: (i) to map the existing nutrient profile models that are in place to support the implementation of different nutrition policies (food marketing restrictions, front-of-pack nutrition labelling, regulation of nutrition and health claims, food taxation and food reformulation, nutrition criteria for food standards in different settings) at the EU level; (ii) to design a harmonized of a nutrient profile model approach to be applied to all nutrition policies, aiming at improving coherence in all policies; (iii) to analyze the possibility to consider environmental criteria in the nutrient profile model; and (iv) to model the health benefits of implementing a nutrient profile model within different policy actions.

T5.3.2 Support public policies to promote food reformulation

Subtask leader: Karine Vin and Julie Gauvreau Beziat, ANSES, France

The following activities are planned for:

(i) Integration of new datasets and codification in Best-ReMaP subcategories. Integration of new datasets from countries monitoring at the branded level: recodification of data in Best-Remap subcategories by partners; integration into the database hosted by JRC, in charge of data visualization through the web based tool FABLE.

(ii) Evaluation of digital source of data. Taking into account what was done during Best-ReMaP and the fact that Janpa/Best-ReMaP methodology is burdensome, assess representativeness and reliability of other digital source of data such as Euromonitor.

(iii) Support nutrition policies across Europe and promote reformulation. The objective will be to establish the state of play of the nutritional quality of the food offer in 19 countries and five food categories prioritized during Best-ReMaP (soft drinks, breakfast cereals, dairy products and similar, delicatessen meats and similar and bread products), with the most up to date datasets codified in Best-ReMaP subcategories.

(iv) Follow reformulations for 5 food groups and 15 countries. Considering all data collected by previous European projects and by member states on their own, the objective will be to follow the nutritional quality over time for the countries having both a first and a second snapshot for five food groups and at least 15 countries. Benchmark between countries; Identification of best evolutions in link with nutrition policies.

(v) Assess impact of reformulation on nutrient intakes. The objective will be to assess the impact of present and hypothetic reformulations on the intake of targeted nutrients like sugars, fat, saturated fat and salt on adults and children, for countries having both 2 data collections, and consumption data. The intake of each selected nutrient will be calculated on the basis of composition data at the brand level for the food groups available (the 5 food groups of Best Remap but also other food groups if data are available), completed with generic composition data.

T5.3.3 Promote the reduction of portion sizes

Subtask leader: Marco Silano, ISS, Italy

The activities in this subtask are to: (i) assess the consistency between recommended portions sizes by health authorities, labelled portions sizes by industry and consumed portions sizes by consumers; (ii) assess the level of evidence of portion size information on consumer behaviour in view of their potential integration into public health policies; (iii) develop standard portions by age group and product category to ensure the nutritional quality of meals and avoid excessive energy intake or food waste; (iv) settle weekly healthy menu for children in school age.

Task 5.4 Public food procurement in public settings in the EU

T5.4.1 Identification of challenges within (sustainable) food procurement and mapping of individual Member States.

Subtask leader: Neza Fras/Mojca Gabrijelcic, NIJZ, Slovenia

A template with various questions regarding public food procurement in individual Member States will be prepared in order to get an overview/applicative situation analysis of the existing national public food procurement legislation and implementation of the public food procurement legislation. Situation analysis will be done in three different groups: (i) first group situation analysis will be carried out in MS/participating partners that were not included in the JA Best ReMaP; (ii) second group for the in-depth situation analysis will include the MS participating in Best ReMaP; and (iii) third group for situation analysis will represent all EU countries.

T5.4.2 Actions in alignment with the planned EU sustainable food system framework legislation

Subtask leader: Neza Fras/Mojca Gabrijelcic, NIJZ, Slovenia

Following actions in support of the implementation of the planned EU sustainable food system framework legislation, for which requirements related to sustainable public procurement of food and catering services are envisaged: (i) formation and organization of the inter-sectoral working group in each participating Member State, arranging at least one meeting per year. The working group will build on health in all policies approach and develop multidisciplinary competences. It will have an indicative overview of the EU framework and its recommendations; (ii) actions to support raising awareness and information regarding the EU framework on sustainable public food procurement (organizing webinars, creating leaflets, spreading awareness in individual Member States with regular informative meetings); (iii) engagement with relevant sectors, using minimum sustainability criteria for public food procurement as an initial input in assessing policies, strategies, challenges of the individual sectors, influencing optimal implementation of minimum criteria, looking for possible shortcomings; (iv) overview of the new proposed actions and identification of implementation actions in public settings; (v) review of public food procurement role in the EU school fruit, vegetables and milk scheme.

T5.4.3 Establishment of an EU Network of national focal points for public food procurement and low-threshold network of local/regional public food procurement officers

Subtask leader: Betina Bergmann Madsen, Denmark KK

The aim of this subtask is to establish two levels networks to support the public food procurement regulation implementation: Establishment of an EU Network of national focal points for public food procurement and low-threshold network of local/regional public food procurement officers.

In the first year of the JA, national focal points for public food procurement will be identified, either for the first time or based on findings from the JA Best ReMaP. Four annual meetings of the network are foreseen. Firstly, a meeting of the EU Network of national focal points, and secondly, a meeting with the EU Network of national focal points and public health sector will be held. In the third year of the JA, a meeting with the EU Network of national focal points, public health sector and the representatives from other relevant sectors is planned to be

organized and lastly, fourth and final year of the JA will result in another EU Network of national focal points for public procurement meeting.

Second level of establishment of an EU Network of focal points for public procurement is identifying people who are writing the tenders. This can be done with the help of a questionnaire and in collaboration with national focal points, who will help to recognize relevant institutions and to initiate the network in individual Member States. Each Member State will arrange at least one meeting with the Network of national, regional and local procurement people per year.

T5.4.4 Guidance and recommendation for healthy and sustainable public food procurement

Sub task leader: Neza Fras/Mojca Gabrijelcic, NIJZ, Slovenia

The planned activities in this sub tasks are: (i) Establishing guidance and creating a guidance document for sustainable public procurement of food and food services to be used by food producers and food service providers, based on requirements for healthy and sustainable public food procurement; (ii) Exploring and supporting the development of a European food procurement e-tool, based on Slovene best practice, possible linkage with DG REFORM to upgrade the Slovenian best practice Catalogue of foods; (iii) Further exploration of the JRC Fable database potential for the inputs of the public food procurement data/policy, linked with WP8; (iv) Recommendations for sustainable policy development further developments will be provided in line with WP4, to further support the effective institutionalized implementation of the results and the MS and EU level use. Best ReMaP public food procurement framework will be upgraded; and (v) Coordination of actions with EU Commission and JRC to assure the alignment of DG SANTE actions with the activities of Member States within JA prevent NCD and at the national and regional levels.

Task 5.5 Product labelling for healthier choices

T5.5.1 Alcohol warning labelling

Subtask leader: Karine Gallopel-Morvan, EHESP, France

The aim of the subtask is to extend the knowledge base on alcohol warning labels and to develop a toolbox for emerging regulations of warning labels in the European alcohol market:

(i) Review and synthesize the recent evidence on warning labels and map existing or proposed regulations of warning labels. (ii) Explore and compare alcohol consumers' knowledge of alcohol-related harms and risk perceptions, so as to tailor specific content of warning labels to various consumer groups across Europe. (iii) Explore effectiveness of various formats and contents of alcohol warning labels on consumers' attention, knowledge, and risk perception across jurisdictions and consumer segments that differ with regard to alcohol marketing. Develop and pilot-test knowledge-based warning labels designed according to established health communication principles. (iv) Assess the possible impact of new and various alcohol warnings (cancer, other health outcomes, social problems) on

improving consumers' ability to make informed choices. (v) Assess the influence of commercial actors and NGOs in the decision-making process of regulating alcohol warning labels.

T5.5.2 Front of Pack Labelling (FOPL) EU start up, implementation, use

Subtask leader: Sabrina Teyssier, INRAE, France

The task will assess the magnitude of the effect of FoPL on purchasing behavior and subsequent improvement on overall diets and health, through:

(i) The development of a robust and common methodological framework, to assess and monitor the impact of public health interventions like FoP labels, on consumers' behaviour, people's diet and health, nutritional quality of food purchases and dietary intake, as well as product reformulation and innovation. The method will involve reviews of the theoretical frameworks used to support FoPL and designs assessing the effectiveness of FoPLs as well as a ranking of the studies performed to provide guidelines for FoPL research. The FoPLs included will be those for which published studies exist, and can be anticipated to include multiple traffic lights, Nutri-Score, Reference Intakes and Warning labels.

(ii) The collect of evidence through pilot studies in interested countries to monitor or evaluate the impact of Nutri-Score and other selected FoPL already implemented, on dietary behaviours and promoting healthier food preferences. The level of consumers' exposure to the FoPL will be evaluated with records of food products purchases and questionnaires about food frequency and socio-demographics will be administered to a panel of consumers.

(iii) The collect of evidence through pilot studies to support the deployment of Nutri-Score and/or other selected FoPL (depending of the efficacy data collected in the previous task) in interested countries. Consumers' purchases in online experimental supermarkets will be observed and discussed through the socioeconomically heterogeneity of consumers.

Task 5.6 Control and counter the effects of advertisements and online marketing

T5.6.1 EU Operational structure and the EU-wide Implementation Package to support Member States in implementing policies to reduce harmful marketing (food, tobacco and alcohol)

Sub task leader: Maria João Gregório, DGS, Portugal

In this sub-task (i) an operational structure will be established and an EU-wide Implementation Package to support Member States in implementing policies to reduce harmful marketing will be developed (unhealthy food, breastmilk substitutes, alcohol, tobacco and related products) aiming to promote a more effectively frame and enforce regulation on harmful marketing, specifically targeting children and adolescents.

This EU-wide Implementation Package is intended to provide personalized support and training to MS: a) On developing and implementing legislation to restrict harmful marketing (unhealthy food, breastmilk substitutes, alcohol, tobacco and related products); b) On implementing and adapting the nutrient profile model to the national context; c) On implementing the marketing monitor protocols; d) On how to deal with the industry lobbying and with other barriers for the policy implementation. This EU operational structure will be composed by experts in different fields (legal experts, experts on public health, on marketing, on digital and statistics) and it will be designed to develop and deliver specially designed trainings to MS to develop and implement legal frameworks to restrict harmful marketing and technical training in monitoring harmful marketing, in particular at the digital level. To support the implementation of the EU-wide Implementation Package on marketing restrictions, an user-friendly platform will be developed to host all marketing related tools and to provide guidance to support Member States with the implementation process of policies to restrict food marketing.

(ii) Map the marketing landscape at the EU level, trying to identify emerging marketing strategies and the existing regulation. In this task we aim: to analyse the legal frameworks regulating harmful marketing at the EU level; to understand challenges, barriers and opportunities within the design, implementation and enforcement of existing legislation and to analyse data collected by the marketing monitoring activities in participating countries (data collected through the monitoring activities of the previous subtask). For this subtask we will use data from existing databases, such as the JRC database, WHO and Best-ReMaP data. These existing data will be supplemented by additional information that will be collected by interviews with the Member States.

T5.6.2 Actions to create public awareness of harmful marketing and to promote critical marketing/digital/media literacy

Subtask leader: Maria João Gregório, DGS, Portugal

The public and civil society partners awareness about the harmful marketing might have a positive impact in industry behaviour and also in influencing policy action. With this subtask we aim to: (i) design and implement trainings to promote critical marketing/digital/media literacy, among children, young people and parents/families/caregivers; design a communication campaign to create public awareness of harmful marketing and of the rights of the children to be protect against these harmful practices.

Task 5.7 Strengthen regulatory provisions related to environmental exposures

The purpose of the task is to map current European policies to reduce exposure to pollution and hazardous chemicals, and to evaluate their efficiency as tools for prevention of cancer and NCDs.

T5.7.1 Mapping and modelling the impact of policies for air pollution and noise

Subtask leader: Taina Siponen, THL, Finland

This subtask has four aims: (i) mapping and evaluation of policies and legislative frameworks targeting air pollution and noise reduction on European, national and sub-national level. This will include overarching policy frameworks like the Zero-Pollution Action Plan as well as national exposure limits and guidelines for area planning; (ii) reviewing and evaluation of exposure-reducing interventions performed on a national or subnational level, including white and gray literature. Examples of relevant interventions include measures to limit driving (e.g. road tolls, fuel taxation, speed limits etc.), wood stove exchanges, noise barriers, facade insulation, zero-emission zones, improved walkability and bikeability, green space, etc.; (iii) evaluation of the exposure trends of air pollution and noise in a selection of European countries to assess the impact of historical policies and legislations on national and European level. This will be based on national exposure data from a selection of data sources, including the European Environmental Agency, Copernicus, and national exposure models. This exercise will facilitate the evaluation of the effect of implemented legislative frameworks and include a correlation analysis; and (iv) to facilitate the evaluation of future implementation of legislative frameworks, the impact of selected policies and interventions on air pollution and noise will be modeled to generate population exposure distributions. This detailed modeling, that will only be completed for a selection of countries, will serve as a basis for development of a simplified modeling approach to generate population exposure distributions for a wider selection of European countries.

T5.7.2 Mapping and modelling the impact of policies for environmental chemicals

Subtask lead: Line Småstuen Haug, NIPH, Norway

The aim of this sub task is twofold: (i) map the legislative frameworks and their implementation targeting chemical exposure in Europe, with emphasis on per- and polyfluoroalkyl substances (PFAS), high priority substances in the EU; and (ii) evaluate temporal trends in exposure to PFAS to facilitate evaluation of the effect of implemented legislative frameworks.

To facilitate this we will: (i) compile information on the legislative frameworks implemented for PFAS both on an EU level and on a case national level; (ii) evaluate temporal trends in human blood levels of PFAS in the European population during the last two decades utilizing data from the two major EU projects, the scientific literature, and complementing chemical analyses. The data the projects include harmonized and comparable data from a number of countries (>10) covering all regions of Europe; (iii) establish model projections to foresee trends in exposure the next decade; and (iv) explore the possibility of attributing trends in the exposure to implementation of specific legislative framework.

T5.7.3 Assessing the impact of policy measures on prevention of cancers and NCDs

Subtask lead: Anette Kocbach Bølling, NIPH, Norway

Assess the impact of implementation of measures to reduce air pollution, noise and exposure to environmental chemicals in Europe, utilizing burden of disease estimations and cost-benefit analysis. These activities will be linked to the ongoing EU-projects BEST-COST and PARC and rely on the methodology developed there, but will expand that work in terms of evaluation of a more extensive selection of policies. Moreover, the detailed policy analysis in subtasks 5.7.1 and 5.7.2 will allow for evaluation of interactions of legislative frameworks and interventions across the different environmental exposures. The work will include the following activities:

quantification of the health benefit of measures to reduce exposure to environmental contaminants, focusing on cancers and NCDs; and evaluation of the costs associated with the implementation of the policy measures.

Task 5.8 Policy monitoring tools for MSs policy efforts targeting NCDs and cancer prevention

T5.8.1 Review existing policy monitoring tools and databases

Subtask lead: Kaja Lund Iversen, NIPH, Norway

This subtask aims to identify existing databases of implemented policies across member states on the common risk factors for cancer and NCDs, focusing on structural polices.

T5.8.2 Exploring the potential for using policy data bases as an evaluation tool

Subtask lead: Arnfinn Helleve, NIPH, Norway

This subtask aims to explore requirements for structure and content of policy databases to be used as a potential resource for policy evaluation.

JA PreventNCD

Work package 6: Healthy living environments

Lead by Valencia, (Spain), co-lead by Poland and Croatia

Rationale

The European Region is the region most severely affected by cancer and other noncommunicable diseases. The impact of the major noncommunicable diseases and cancer taken together, accounts for an estimated 86% of the deaths and 77% of the disease burden in the European Region (1). The WHO "best buys" report, healthier together, the European Cancer Plan and the NCD strategy implicitly or explicitly affirm that governance for health, multisectoral action and equity perspective are crucial for achieving health and wellbeing reducing cancer and NCD's (2).

The "Healthy living environment" approach intends to improve health where health is created and lived by people, within the settings of their everyday life; where they are born, grow up learn, work, play and love, a concept that emerges from the Ottawa Charter (3). This approach implies to focus onto the inherent potential of the social and environment determinants of health of the place of living; the social, cultural, political, economic and environmental conditions in which people live and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life (4glossary). These social determinants of health influence a person's opportunity to be healthy, which goes beyond the healthcare sector. Therefore, community participation and inter-sectoral cooperation are required to integrate health promotion actions and transform health determinants.

Municipalities, schools, workplaces or health services and how the social and environment was built in each setting have strong influence on the health of the people life. Major risk factors of cancer and other NCDs are tobacco use, harmful alcohol consumption, an unhealthy diet and physical inactivity. To reduce these risk factors, effective health promotion strategies on the healthy living environments are needed, e.g. by facilitating healthy choices, reducing the availability of unhealthy products, promoting healthy built environments, or strengthening communities by increasing social cohesion. These actions must be developed coherently throughout the life course and considering an equity approach by acting with greater intensity in more deprived places and communities (proportionate universalism). The burden of cancer and other NCDs and their variation in the population is partly explained by the unequal distribution of exposure to their main risk factors depending on the social position of the individual (ref…). The intensity of these social inequalities in cancer and other NCDs is also varying in different places and contexts, showing that the mechanisms underlying the variations in risk by individual social position may be more or less effective depending on the different capacity of different contexts to protect communities from the risks. At the same time, geographical variations in social inequalities demonstrate that somebody has done better than others and that less inequalities in exposure to risk factors can be achieved, i.e. place based variations in risk and the size of risk inequalities are a good indicator of amenable to change. Such integrated strategies with equity perspective across Europe could reduce cancer and other NCDs as much as 70% (healthier together).

Cities or municipalities or counties are the places ("super-setting" or "umbrella-setting") where an integration and cooperation between settings may be realized thanks to the multi-faced competences and responsibilities of the different public authorities (health and social

services, workplace, school…) and of the stakeholders (community associations, businesses, unions, voluntary sector, media…) contributing to a participatory local governance for health. The competences and responsibilities of the elected local politicians in the municipalities can cover the main policy domains that may facilitate health promotion directed to the determinants of cancer and other NCDs, starting from the first 1000 days, including the health services and social care; healthy and active living (such as bicycle lanes and smoke-free public areas), safety and environmental issues for children and older people, working conditions; exposure to hazards and nuisances; healthy urban planning and design (such as neighbourhood planning, removing architectural barriers and the accessibility and proximity of services), and participatory and inclusive processes for citizens (ref Denmark).

A healthy municipality builds a strong movement for reducing cancer and others NCDs determinants more equally. It pursuit a process oriented strategy working in collaboration with public, private, voluntary and community sector organizations and prioritizes policies that create co-benefits between health and well-being within other city and municipalities policies; promotes social inclusion by harnessing the knowledge, skills and priorities of cities' diverse populations through strong community engagement co-creating the ways to implement the interventions as key aspects for sustainability of local health policies. (glossary). Moreover, the mechanisms generating individual and place-based inequalities in cancer and other NCDs risk defer to the responsibility of different sectors, competences and policy domains of the society, and of different levels of the societal organization, from the individual to the local, regional and national level and its institutions. Out of this complex set of responsibilities, the geographic variations in the intensity of social inequalities remind us that "place" is a promising setting for initiatives of prevention and health promotion. Finally, in most of European countries the responsibilities for health are decentralized at the level of local authorities and municipalities with their local authorities are becoming the leading actor of most of the initiatives of health promotion.

The rationale of WP6 is that an initiative for reducing cancer and NCDs risks in Europe should build on the local capacities to involve and coordinate the main local settings and actors in implementing the best practices and piloting innovative actions for reducing the risk. Place-based variations in risk require place-based interventions in the settings where people live: early years, schools, neighbourhood local communities and built and social environments, workplaces, social and health care, digital and communication environment. The setting approach that will be used in Task 6.2-6.5 is recommended by WHO as the best approach for managing health promotion, because it reduces the complexity of the local system of actors, power, responsibilities, competences, rules, structures and processes, and facilitates the implementation of well assessed practices.

However, the complexity of the local system cannot be completely ruled out because a territory is a story of persons, institutions, social relationships, cooperation and conflicts. Each setting should be able to recognize the links, interactions, conflicts, cooperation with other local settings, in order to limit the frictions and value the synergies so multiplying the impact of their respective actions. These connections between settings should be normally regulated promoted and coordinated under the responsibility of the "super-setting" of the municipality, whose governance and infrastructures are essential for playing all the settings as an orchestra. Three special tasks (6.1, 6.6, 6.7) will take care of this need for cooperation and integration between settings, with guidance documents (6.1), capacity building (6.6) and local infrastructures for health promotion (6.7).

JA PreventNCD

Objective

To implement and evaluate interventions with an integrated approach to address the main determinants of cancer and other NCDs in different settings as well as through cross-settings actions covering the population life course. The interventions pursue a strong community action perspective including the co-creation and participation of the different stakeholders for developing sustainable infrastructures and capacities to promote health equity at local level.

The WP has the following seven specific objectives

1. To develop and adapt to different country contexts an integrated methodology of implementation of evidence-based health promotion to deal with the main determinants and risk factors in the different settings arena, under the coordination of the municipal “supersetting".
2. To implement the best practices and test pilot actions in settings / cross- settings tasks (cities, education, workplace, health services).
3. To share the implementation experiences in community action for health between participants
4. Identify limitations, weaknesses, opportunities and strengths of the different implementations in the different settings
5. To develop capacity building digital and interactive material's available on a platform with general access for stakeholders
6. Enable transferability and sustainability of the implemented actions
7. To develop infrastructures for health promotion at the “supersetting” level of the municipality.

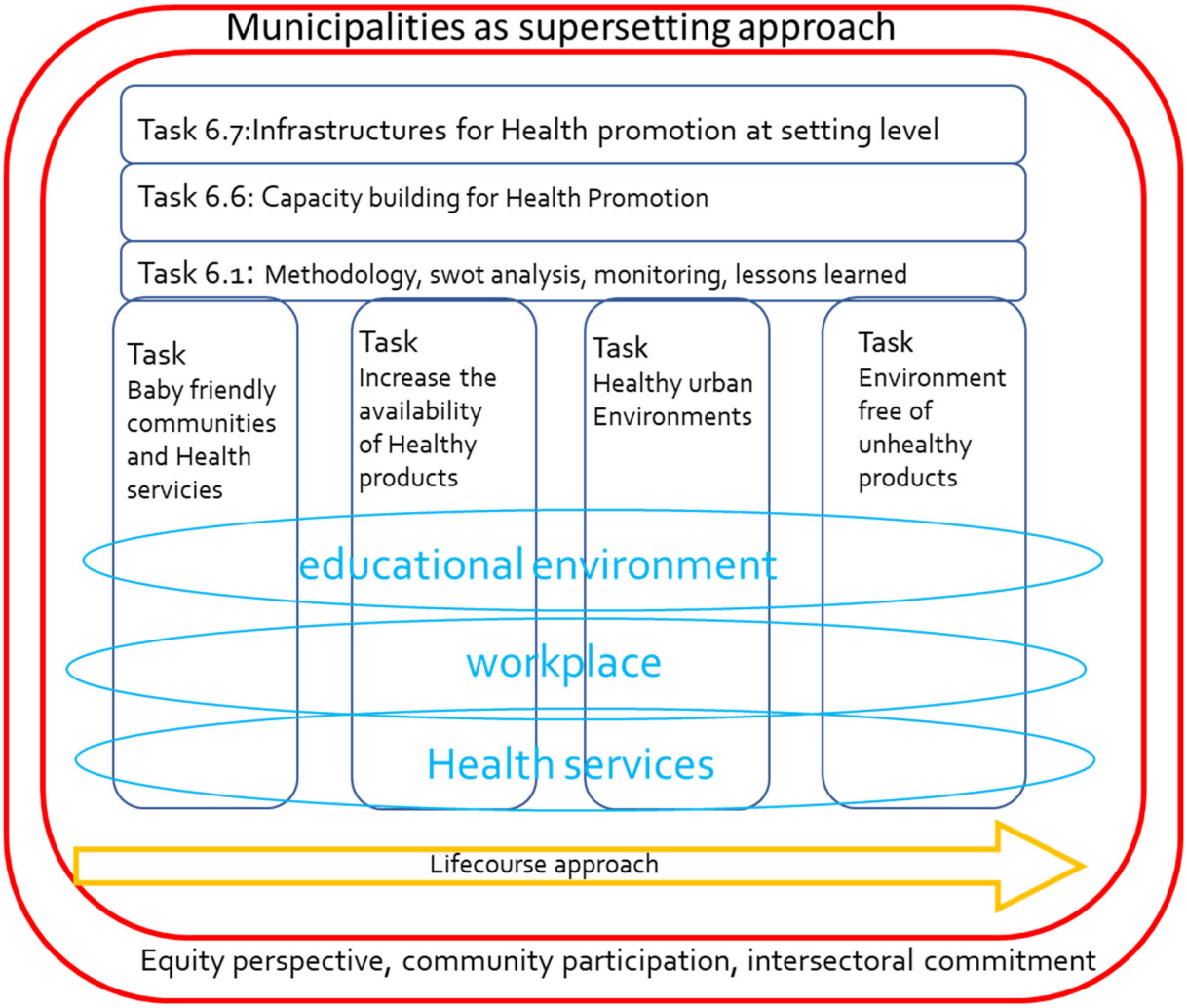

Figure 1: The relation between the 7 main tasks in the WP6 and their relationship with places

Task 6.1 Methodology

Lead by Valencia (Spain) , Turin (Italy), Silesia (Poland), Croatia

The Task will be focused on jointly developing a holistic methodology to identify the situation of the determinants related with cancer and other NCDs, including a framework for the intervention design and the evaluation of the integrated approach and risk factors approach in counties and municipalities and in the different settings as educational environment, workplace, health services and digital environment ensuring intersectoriality, community participation and equity perspective in the process of co-creation and integration of the social innovation for health into their overall city development strategy.

General Objective
The main objective of this task will be to develop a methodological guide on the community development process that is required for all partners to work in WP6 to design, implement and evaluate their best practices and pilots actions under the coordination or cooperation of the suppersetting of counties or municipalities in order to better integrate and connect the

interventions in different settings (educational environment, workplace, health and social services and digital and social media), towards more effective and sustainable local governance for health, multisectoral approach and equity perspective.

The specific objectives of the Task are:

1. Developing a framework for improving governance in integrated local interventions on healthy living environments, based on the best available knowledge (i.e. JAHEE).
2. Based on the standard proposed by the framework on governance, assessing the state of the art in each local context where the best practices and the pilot actions will be implemented
3. Mapping the stakeholders and the community associations to be engaged in each pilot in each setting identified
4. Assuring that equity perspective will be include in all pilots and in all setting, addressing inequalities in health through a health equity impact assessment or health equity audit approach.
5. Developing a health promotion framework for healthy living environment that exploits the best strategies and policies available to based reducing availability and promoting environments free of unhealthy products, increasing the availability and facilities for supporting healthy behaviours, develop and support healthy urban planning, green, clean, child-friendly and age-friendly city environments, invest on as well as health literacy supporting community empowerment, social cohesion, resilience and promoting social inclusion and community-based initiatives.
6. Strengthening disease prevention programmes, with special focus on tobacco, alcohol, unhealthy diets and physical inactivity
7. Developing indicators to monitor the implementation process for the pilots

Task 6.2 Increase the availability of healthy options and physical activity facilities

Lead by Valencia, Spain

Objectives
Increase the availability of healthy options and physical activity facilities by mobilising actions on the determinants of health through the political commitment by intersectoral policies and the participation of the community at local level promoting the social cohesion to co-creating actions for healthy living environments with equity perspective.

The specific objectives of the Task are:

1. Increase the social cohesion of the community increasing the sense of belonging and inclusion, participate actively in public affairs, recognise and tolerate differences, and enjoy relative equity in access to public goods and services and wealth by co-creating the pilot project with the different stake holders
2. Support local authorities to facilitate and enable local partnerships on the wider determinants of health increasing access of healthy products and environments including healthy food, Physical activities facilities
3. Reduce the availability of alcohol in all settings
4. Reduce health inequalities by act with major intensity in the most vulnerable settings.

5. Implement healthy leisure time linking physical activity, sports and cultural activities mainly in adolescences through educational environments or in the communities
6. Implement local policies to contribute to the consumer opting for the healthier choice.

Task 6.3 Promoting healthy urban environments

Lead by NIPH (Norway)

Seventy-five percent of the population of the European Region live in towns and cities (Statista, 2022). Multiple risk factors such as air pollution, noise and social isolation converge in urban environments, and people are at increased risk of noncommunicable diseases. Concurrently, urban environments are a place for change with a range of services and resources available for large integrated interventions, with potential for disease prevention and improved health and quality of life (Nieuwenhuijsen & Khreis, 2019). Improved access to and use of green and blue space and establishing car-free environments are key interventions addressing air pollution, noise, and physical inactivity, important health determinants that are structured by social inequality and affect individuals across the lifecourse (Ganzleben & Marnane, 2020). Green space and pedestrianised areas are neighbourhood meeting places, enhancing social cohesion, especially among vulnerable groups. These interventions also address climate health threats such as from heat. Ensuring equity remains a challenge, however, as improvements in urban environments may not benefit all equally and can potentially further disadvantage vulnerable groups.

Objectives

To promote equitable urbanism that uses nature-based solutions, increases green mobility, access and use of green and blue spaces, and car-free environments, towards creating climate resilient and healthy urban environments

The specific objectives of the Task are:

1. To generate evidence on actions that facilitate active engagement with urban environments through implementation of pilot projects and/or best practices
2. To develop and test evaluation and decision support tools for healthy urban environments
3. To evaluate the process and societal and behavioural impacts of interventions to create healthy urban environments
4. To disseminate recommendations for equitable health enhancing urban planning and design

This task has links with the Healthier Together EU NCDs Initiative through addressing the health determinants air pollution and physical inactivity. Furthermore, it builds on the WHO “Best buys” for prevention of NCDs: Reducing physical inactivity by targeting macro-level urban design, provide adequate facilities in school settings, and access to quality public open space and infrastructure supporting active transport.

JA PreventNCD

Task 6.4 Promoting environments free of unhealthy products

Lead by Finish Lung Health Association (Finland)

This task focuses on prevention of tobacco and nicotine and harmful alcohol use as well as promoting healthy eating habits and will have an impact on both social and personal determinants of health trough different implementation settings. Existing national / EU / WHO recommendations and promising practises will be tailored to meet needs of target group and setting. The process will include coordinating actions within the pilot and sharing experiences between participating countries as well as developing recommendations and policy briefs based on the experiences. Inclusion of the target groups is important in all phases of the project.

Objective

To plan and disseminate actions on prevention and cessation of tobacco and nicotine and harmful alcohol use as well as promoting healthy eating habits based on existing recommendations and promising practises adapted to local settings.

The specific objectives of the Task are:

1. To prevent tobacco and nicotine and harmful alcohol use in both indoor and outdoor spaces as well as promoting healthy eating habits. The pilot will have an impact on both social and personal determinants of health trough different implementation settings.
2. To develop locally adapted recommendations based on existing national / EU / WHO recommendations and promising practises for environments free of unhealthy products.
3. To disseminate recommendations on environments free of unhealthy products in the settings chosen

Task 6.5 Baby-friendly community and health services best practice

Lead by Italy and Norway

To reduce the exposure, vulnerabilities and inequalities in the health determinants and risk factors of cancer and other NCDs, a life course approach with interventions during the first 1000 days of life is essential. Breastfeeding is associated with reduced risk of cancers (Schraw et al. 2022), overweight and obesity and other NCDs in children, and also with reduced risk of breast cancer and ovarian cancer in mothers (Victora et al. 2016). As breastfeeding has been shown to increase the chances of upward social mobility, supporting breastfeeding may be one measure to reduce social inequities from early life (Sacker et al. 2013). Breastfeeding prevalence is, however, lower in Europe than in any other continents. The determinants of breastfeeding are multifactorial and need supportive measures at many levels, from legal and policy directives to social attitudes and values, women's employment conditions and family leave, and health-care services to enable women to breastfeed (Rollins

et al, 2016). When relevant interventions are delivered adequately, breastfeeding practices are responsive and can improve rapidly. The Baby-Friendly Initiatives have been demonstrated to be effective in increasing breastfeeding rates. Despite being recommended by WHO/UNICEF since 1992, this Best Practice (BP) is still only partly implemented in hospitals in Europe and even less in community maternal and child health services after hospital discharge. Therefore, the well assessed Best Practice; the Baby-friendly community health services (Bærug et al. 2016) and also Pilots in other settings such as the communities/municipalities, workplaces, educational, migration/emergencies and the digital environment will be implemented with the overall aim to increase breastfeeding rates.

The specific objectives of the Task are:

1. to implement the Best Practice (BP) "Baby-friendly community (BFC) health services" and pilot actions in new settings, as a contribution to reducing the incidence of cancer and other NCDs later in life, starting from the first 1000 days of life (pregnancy to 0-2 yrs), with a focus on social and health inequalities.

Tasks:
6.5.1 - Implementation of the BFC health services
6.5.2 - Adapt an e-learning program for capacity building
6.5.3 - Special attention to creation of Breastfeeding-friendly environment in all settings
6.5.4 - Promotion of Nurturing Care Framework
6.5.5 - Involving community, regional and national stakeholders.

Task 6.6 Building capacity of health promotion at setting level

Lead by U. of Silesia (Poland)

The created platform will allow not only collecting knowledge, but also to organize it and interactive capacity building of evidenced-based health promotion at local level in different settings, train the future local health promotion trainers and advocacy for strengthen interventions on health determinants in settings - "life-setting-course learning".

Objective

- Interactive capacity building of evidenced-based health promotion at local level in different settings, train the future local health promotion trainers, advocacy for strengthen health promotion on health determinants in settings - "life-setting-course learning".

Task 6.7 Building infrastructures for health promotion at super-settings level

Lead by Germany

In contrast to task 6.6, task 6.7. focuses on the supersetting approach, which is a further development of the setting approach. It considers the significance of integrated and coordinated actions of municipalities together with a participatory approach, in order to attain intersectoral synergies sustainable impact of setting interventions and a relevant policy response in terms of health in all policies. This task is focusing on the necessary infrastructure for the establishment of a municipal supersetting.

As a starting point, various reviews will be carried out: (1) Identification and description of relevant infrastructures for health promotion and prevention as well as for HiAP (2) Tools and methods for the establishment of supersetting measures and HiAP (3) Tools for the evaluation/ assessment of supersetting measures and HiAP. Then, the pilots from task 6.2, 6.3 and 6.4 will be supported and advised in setting up supersetting measures and strategies including a HiAP approach and are motivated to participate in exchange formats that aim to share their experiences and learn from each other's implementations.
At the end of the project, the main outcome should be practice-oriented recommendations for the establishment of a supersetting approach and HiAP, and a guide to support municipalities in initiating them. In addition to recommendations, the guide should also contain a compilation of tools and be made available to relevant municipal stakeholders in Europe.

The specific objectives of the Task are:

1. Definition and identification of important infrastructures that are needed for Health Promotion at supersetting level in European countries.
2. Identification of suitable tools and methods to establish a methodology and strategies for building infrastructures for Health Promotion at supersettings level and consider the Health in All Policies approach throughout European countries
3. Sharing international experience on community participation and co-production for health as well as community participation information systems at local level and Health in All Policies.
4. Sharing international experience (opportunities and challenges) on tools for the planning and implementation of supersetting measures.
5. Investigating and defining criteria to monitor and evaluate infrastructures for Health Promotion at supersettings level.
6. Sharing international experience on evaluation tools of infrastructures for Health Promotion at local level.
7. Monitoring the development of infrastructures for Health Promotion at supersettings level and the consideration of Health in All Policies in Tasks 6.2 to 6.6.
8. Employing evaluation tools for infrastructures for Health Promotion at supersettings level and the consideration of Health in All Policies in Tasks 6.2 to 6.6.
9. Developing actions to improve evaluation of health promotion interventions at local level, with a focus on improving the local interventions in Tasks 6.2 to 6.6.
10. Developing practical recommendations (e.g. a guide) for action on infrastructures for Health Promotion at supersettings level and developing a guide of recommended and implemented tools from different European countries.

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JA PreventNCD

Work package 7: Social Inequalities

Lead: Istituto Superiore di Sanità, Italy;
Co-Lead: National Center for Public Health and Pharmacy, Hungary.

Participating countries:
Austria, Belgium, Bulgaria, Croatia, Czechia, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Malta, Norway, Portugal, Slovenia, Spain, Ukraine.

Objectives

The overall objective is to ensure that the JA contributes to cancer and other NCDs inequalities reduction in Europe.

Specific objectives:

1. Collect scientific evidence on avoidable inequalities in cancer and other NCDs and their risk factors in Europe.
2. Review actions and policies addressing cancer and other NCDs avoidable inequalities in Europe.
3. Plan and implement WP7 specific pilot actions aimed at acting on the mechanisms that play a role in generating health inequalities.
4. Support the thematic WPs in the application of methods that take equity lenses into account, by providing tools and methodological supports to the pilot actions.
5. Contribute to improving health literacy and empowering people to understand and act on health determinants and risk factors for cancer and NCDs at population and organizational levels.

Task 7.1 Collect and synthetize available evidence on inequalities in cancer and other NCDs and their risk factors (cross-cutting task – link with WP)

Timetable:M1-M48.
Task-leader: Sebastián Peña, Finnish Institute for Health and Welfare, Finland.

This task consists of collecting and synthesizing available evidence on avoidable inequalities in relation to morbidity and mortality of cancer/NCDs and their risk factors at European, national and sub-national level by: (i) reviewing scientific literature at European, national and subnational level (if available); (ii) mapping of European, national and subnational data sources (e.g. EuroStat, OECD, WHO Europe, European Cancer Organization, European Cancer Inequalities Registry - ECIR); (iii) providing recommendations on how to further develop/improve the data collection within participating countries. This research focuses primarily on the following four disease groups that account for over 80% of all premature NCDs: cardiovascular disease, cancer, chronic respiratory disease and diabetes, and on the following risk factors: tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets.

Milestone
Report on available evidence of avoidable inequalities in cancer and other NCDs and their risk factors at European, national, and subnational level (Months:12,24,48).

Task 7.2 Identify evidence on actions and policies that address inequalities in cancer and other NCDs (cross-cutting task – link with WP8)

Timetable:M1-M48.
Task-leader: Astri Syse, Norwegian Institute of Public Health Norway.

This task consists of identifying the available evidence on actions and policies addressing avoidable inequalities in cancer and other NCDs (in terms of health determinants and exposure to risk factors) at European, national and sub-national level by: (i) searching scientific literature through a scoping review, consulting repositories such as HEPP, EuroHealthNet portal and the Best Practice Portal (EU BPP)l; (ii) conducting a survey on existing experiences/practices, both at national and local level, among participating countries by utilizing existing national networks; (iii) development of a web-based repository of documents and tools to be embedded in already existing portals (EU BPP, national level). It will be developed in the first twelve months and updated twice during the JA; (iv): ensuring long-term sustainability through fortifying links with WP4, supporting existing and new collaborations between national and European practice portals (e.g., EuroHealthNet thematic working group (TWIG) on Best Practice Portals), and understanding what drives their long-term user engagement (e.g., by practice owners, practice implementers).

Milestone
Repository and report of actions and policies that address avoidable inequalities in cancer and other NCDs (Months:12,24,48).

Task 7.3 Capacity building/training for the working groups implementing the pilot/action (transversal activity – link with thematic WPs)

Timetable:M1-M48.

Task-leaders: Raffaella Bucciardini, Istituto Superiore di Sanità, Italy;
Peter Csizmadia, National Center for Public Health and Pharmacy, Hungary;
Zsofia Kimmel, National Center for Public Health and Pharmacy, Hungary.

This task consists of supporting the working groups responsible for implementation of the pilot actions, both in WP7 and in the other WPs, and particularly, supports the application of tools and methodologies that takes into account the equity lens approach, such as HEA and HEIA. The planned training will guide the choice of the appropriate process/output/outcome indicators for the evaluation of the pilot actions. This task also plans to monitor the pilot actions throughout their duration, through the social inequality lens.

Task 7.4 Strengthening health literacy to reduce inequalities in cancer and other NCDs

Timetable:M1-M48.

Task-leader: Anita Thorolvsen Munch, Norwegian Directorate of Health, Norway.

This task aims to improve health literacy, as an enabling factor to counteract health inequities in cancer and other NCDs, through: (i) the collection of data from national health literacy surveys to help identify difficulties faced by the general population, minorities and key populations; (ii) identifying evidence on individual and organizational health literacy (OHL) such as a collection of promising measures in EU countries, based on available literature;; (iii) selecting and promoting tools to promote digital health literacy and OHL in primary health care settings and hospitals helping people to better navigate across the health system; (iv) developing a comprehensive mental health literacy scale in order to inform mental health promotion in the community setting: (v) supporting pilot actions to strengthen health literacy at population, societal and organizational level.

T7.4.1: Data and evidence for strengthening health literacy in the general population and in key populations.

Task-leader: Robert Griebler, Austrian National Public Health Institute, Austria.

T7.4.2: Promoting individuals' digital health literacy, digital skills and ability to use digital health services to prevent Cancer and NCDs.

Task-leader: Nicolas Giraudeau, Centre Hospitalier Universitaire de Montpellier, France.

T7.4.3: Improving digital health literacy (DHL) from a system and organizational perspective.

Task-leader: Nicolas Giraudeau, Centre Hospitalier Universitaire de Montpellier, France.

T7.4.4: Tools and evidence for promoting Organizational Health Literacy (OHL).

Task-leader: Christa Straßmayr, Austrian National Public Health Institute, Austria.

T7.4.5: Data and evidence for strengthening health literacy in national ethnic minorities and immigrant populations to prevent Cancer and NCDs.

Task-leader: Nicolas Giraudeau, Centre Hospitalier Universitaire de Montpellier, France.

T7.4.6: Developing a Comprehensive Mental Health Literacy Scale.

Task-leader: Pia Solin, Johanna Cresswell-Smith, Finnish Institute for Health and Welfare, Finland.

T7.4.7: Coordination, communication, and establishment of a joint European Health Literacy Arena.

Task-leader: Norwegian Directorate of Health team.

Milestone
Development of a comprehensive Mental Health Literacy Scale (Months:12, 24, 36).

JA PreventNCD

Deliverable

Report on promoting general and digital health literacy tools, as well as OHL in primary health care settings and hospitals, and mental health literacy in the community (Month: 48).

Task 7.5 Plan and implement specific pilot actions which address social determinants of health and/or exposure to risk factors

Timetable:M1-M48.
Task-leaders: Raffaella Bucciardini, Italy; Peter Csizmadia, Hungary; Zsofia Kimmel, Hungary.

This task consists of planning and implementing pilot actions aimed at acting on the mechanisms that play a role in generating health inequalities with the aim of impacting the reduction of inequalities in cancer and NCDs in Europe. The pilot actions are grouped in three different clusters: 1. health inequalities monitoring; 2. education/health literacy;3. fragile and vulnerable groups. The choice of clusters was based on the results of JAHEE (Joint Action Health Equity Europe) funded by the third EU Health Programme, with the main goal of strengthening cooperation between European countries and implementing concrete actions to reduce health inequalities. In total 21 pilot actions will be implemented (8 include Health Inequalities Monitoring, 5 include Education and Health Literacy and 8 include Fragile and Vulnerable Groups). For the implementation of the pilot actions the WP7 leader and co-lead will support the partners in all phases of the action development. In this regard, a specific group of experts will be established at the beginning of the JA consisting of epidemiologists, statisticians, sociologists and other professional figures with the aim of assisting the groups of partners responsible for implementing the actions. The aim is to build capacities among JA partners to apply tools and methodologies that take in consideration the equity lens approach such as HEA and HEIA. This task (task 7.3) consists of supporting all phases of the whole action, including the evaluation of the impact of the actions/interventions and the harmonisation/standardisation of the indicators to be reported to ensure the comparability of the results.

Deliverable

Recommendations for policy makers based on best available knowledge and WP7-pilot actions implemented during the JA (Month:48).

Below is the Joint Action specific objective (number 3) inherent to WP7 with the indicators of process, outcome and output to be achieved during the JA.

Specific Objective ID	Specific Objective
3	**Contribute to reduced inequalities in cancer and other NCDs**

Process Indicator(s)	Rationale	Target value	Due/WP
Proportion of participating countries that identify data at national and/or subnational level on avoidable inequalities in cancer and other NCDs and their risk factors	Extent of access to data on inequalities will indicate to what extent the MSs have relevant information available	At least 60% (15 out of 25) of the JA participating countries contribute to the reports on avoidable inequalities in cancer, other NCDs, and their risk factors	M46/WP7
Proportion of participating countries that detect evidence, at national and/or subnational level, on actions and policies addressing avoidable inequalities in cancer and other NCDs	The extent of policies and actions addressing inequalities will indicate to what extent addressing social inequality is on the policy agendas among the MSs	At least 60% (15 out of 25) of the JA participating countries contribute to the collection of information on actions and policies addressing avoidable inequalities during the entire duration of the JA	M46/WP7
Proportion of pilot actions addressing inequalities in cancer and other NCDs with appropriate process/output/result indicators.	This proportion will indicate to what extent the pilots are addressing social inequality	At least 90% of pilot actions are designed according to appropriate process/ output/result indicators (taking in consideration the equity lens)	M46/WP5-WP10
Proportion of participating countries that completes a survey that identifies health literacy gaps in both general population and in health organizations	Individual and organisational health literacy gaps are necessary to identify before developing actions	At least 56% (14 out of 25) of the JA participating countries contributes to data collection and analysis.	M24/WP7
Output Indicator(s)	**Rationale**	**Target value**	**Due/WP**
Proportion of participating countries that identify indicators and the corresponding data to develop or improve their health inequalities monitoring system (HIMS)	Identifying existing indicators and data is necessary for developing the HIMS	60% (15 out of 25) of the JA participating countries identify data and indicators to be included in their HIMS.	M24/WP7
Proportion of working groups that participates in training courses on HEA and HEIA	The courses in HEA and HEIA will strengthen partners abilities to assess equity aspects of interventions and policy actions	90% of working groups, which implement pilot actions, undergo training	M46/WP7
Number of working groups responsible for implementing the pilot actions meet to strengthen the European cooperative approach on inequalities in cancer and other NCDs	Working group meetings will indicate degree of collaboration between member states in targeting social inequalities	At least 3 three working groups of each cluster of pilot actions initiate cooperation (taking the equity lens into consideration)	M46/WP7
Tools to promote general and digital health literacy both at population and organisational levels	The tools will enable individuals and originations abilities to take healthier actions	One report on tools to promote general and digital health literacy, at individual and organizational levels, in community setting is	M46/WP7

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Pilot actions

Cluster	Pilot Action Title	Country	Contact person	Contact person (Institute)
Health Inequalities Monitoring	Fostering subnational efforts on policies to tackle health inequalities	Finland	Sebastián Peña	Finnish Institute for Health and Welfare
	Nordic Occupational Cancer Study (NOCCA)	Finland	Sanna Heikkinen	Finnish Cancer Registry
	SINACCES (Social INequalities and Access to Care in CancEr Survival)	France	Florence Molinie	F Molinié Francim network of French Cancer Registries / ICO-Unicancer
	Gender-sensitive needs for prevention of cancer and chronic diseases – development of an indicator set for gender-sensitive health reporting	Germany	Martin Thißen; Claudia Hövener	Robert Koch Institute
	Establishing and evaluating a core indicator set to monitor socioeconomic and geographical inequalities in NCDs/cancers and prevention in Germany	Germany	Martin Thißen; Claudia Hövener	Robert Koch Institute
	Prospective Evaluation of the Role of Social Determinants of Health in the liver cancer pathway in representative real-life multicenter cohorts in Italy	Italy	Loreta kondili	Istituto Superiore di Sanità
	Participatory rapid appraisal Health information system at local level to identify inequalities in 14 determinants of health	Spain	Rosana Peiró; Ana Boned	Spain Valencia
	Identification of barriers in access to prevention of breast cancer and cervical cancer among women of reproductive age and prostate cancer among men	Ukraine	Hanna Shchetynina	Public Health Center of the MOH of Ukraine
Health Literacy	Improving health literacy in the regions to reduce health inequalities	Czech Republic	Petra Kamaradova; Eva Uličná	National Institute of Public Health in Prague
	Promoting Health Literacy on Cervical Cancer Prevention in Middle-aged Female Sex Workers: A Pilot Study	Spain	Maria-Jose Lopez Espinosa; Natalia Marin	Environmental Health-FISABIO
	NCDs and Cancer prevention through WHO evidence based oral health interventions using innovative digital tools to support health literacy (specific focus on deprived population) and education of health professionals	France	Nicolas Giraudeau	CHU de Montpellier
	Piloting a qualification concept for peer-to-peer multipliers in Germany and other EU-Countries (stengthening health literacy and empowerment among immigrant populations as well as supporting the development of health promoting structures at the municipal level)	Germany	Jennifer Janice Hubrich	Federal Centre of Health Education
	Implementing health literacy in schools (age 6 – 15)	Iceland	Ingibjörg Guðmundsdóttir - Landl	Directorate of Health
Vulnerable groups	Promote environmental justice and prevent future health risks for Cancer and other NCDs in overburdened communities living in monotowns	Italy	Roberto Pasetto	Istituto Superiore di Sanità

	Cancer prevention in the city of Rome: tailored actions to promote equitable access to vulnerable population	Italy	Massimo Oddone Trinito	ASL Roma 2
	Promote healthy lifestyles for cancer prevention in hard-to-reach population using nudges	Spain	Paula Romeo Cervera; Ana Molina; Mercedes Vanaclocha; Susana Castán	Cancer-Fisabio
	Promotion Of Healthy Habits (Smoking And Alcohol) In Vulnerable Population (Mental Illness & Cpod)	Spain	Paloma González Álvarez	IDIVAL – Instituto de Investigacion Marqués de Valdecilla – Cantabria
	Proposition of a Strategy to Implement WHO ICOPE program	France	Néda Tavassoli	Toulouse University Hospital
	Organize help-desks (physical and virtual) on health and disease prevention for population groups with clear social inequalities#1	Italy	Valeria Pala	Istituto Nazionale dei Tumori
	Organize help-desks (physical and virtual) on health and disease prevention for population groups with clear social inequalities#2	Italy	Giovanna Masala	Istituto per lo Studio e la Prevenzione e la Rete Oncologica
	Pharmacological and behavioural intervention to address nicotine dependence in a low-income migrant population; a 24 months pilot study	Italy	Valeria Pala	Istituto Nazionale dei Tumori
	Systematic assessment of Outermost Regions (ORs) accountedness in public policies: Building and implementing a territorial health equity asset	France	Christine Berling	Ministère des Outre-mer

JA PreventNCD

Work package 8: Monitoring

Objectives

The general objective of WP8 is to enhance the monitoring systems for cancer and other NCDs at several levels (European, national, regional and local scale) in order to support health care policies aimed to control and reduce the disease burden and to contribute to the reduction of health inequalities. This in line with the European Beating Cancer Plan, which promotes the implementation of a European Cancer Information System and includes among the flagship initiatives the setting up of monitoring systems. Furthermore, the IPAAC JA developed a Roadmap in order to support health administrators or anyone in EU member states who have to implement cancer control activities. The Roadmap includes several initiatives to improve the monitoring of cancer burden. WP8 will focus on monitoring of health determinants, risk factors, access to health care and health care costs, from data collection strategies to methods for data visualizations and modelling for forecasting of future scenarios. An important element of WP8 is also to define possible presentations of data for different recipient levels, including individual, population and policymakers' perspectives, to see what is most effective. As of the individual, it applies to self-monitoring and life-style changes – such as visualizations of progress, gamification and sharing with others, whereas in policy-making and management it leads to strategies and practices fine-tuning.

The WP has the following two specific objectives:

1. to identify, describe, harmonize methodologies and data sources for monitoring of health determinants, risk factors and outcomes relating to NCDs and cancer according to both clinical and population perspectives;
2. to provide recommendations for future improvements of systems for collection, integration, analysis and presentation of data aimed to support efficient and effective NCDs and cancer prevention strategies.

WP8 is led by Emil Høstrup, RSYD, Denmark, and the co-lead is Giovanni Capelli, ISS, Italy. The WP is organized in five tasks and seventeen subtasks. The tasks leaders are Morten Sønderskov Frydensberg/Giovanni Capelli, RSYD/ISS, Denmark/Italy (task 8.1), Linda Andersen Justi, RSYD, Denmark (task 8.2), Valentina Possenti, ISS, Italy (task 8.3), Silvia Francisci, ISS, Italy (task 8.4), Emil Høstrup/Giovanni Capelli, RSYD/ISS, Denmark/Italy (task 8.5). In total, 35 partners from 16 countries participate in the WP.

Task 8.1 Research and overview of relevant risk factors, data sources, and implementation/scaling potential

T8.1 aims to provide both a knowledge-based foundation to WP8, even linking up to other WPs, and a baseline for the tasks and testing in the WP. This task will host also the development of a framework for the assessment of monitoring tools in different areas based on the Model for ASsessment of Telemedicine (MAST), evaluating possible extents of implementation, transferability, standards.

T8.1.1 Definitions of monitoring relevant terms and agreement of lists of risk factors, risk markers and health determinants and identification of relevant stakeholders and citizen target groups.

ST8.1.1 includes desk research on the validated information from EU and beyond to identify and describe known risk factors and health determinants relevant across cancer and other NCDs. This also comprises the weighting of the risk factors and health determinants according to diagnosis and patient numbers in Europe. This will lay the foundations for mapping relevant and available methods for identifying and measuring the risk factors. Part of this task is the joint definition of risk factors for cancer and other NCDs. ST8.1.1 will consider the cross-cutting risk factors explicitly mentioned in the Europe's Beating Cancer plan, that "aims to raise awareness of and address key risk factors, such as cancers caused by smoking, harmful alcohol consumption, obesity and lack of physical activity, exposure to pollution, carcinogenic substances and radiation, as well as cancers triggered by infectious agents". In addition, elements such as sleep, mental health, genetic factors and poor nutrition are considered. Moreover, in ST8.1.1 we also explore known health determinants such as education, socio-economic status, gender, age, and employment.

T8.1.2 Mapping of available clinical data, registries, surveys and technologies as well as existing monitoring practices per country.

Given the list of relevant and jointly identified risk factors and health determinants, the participating countries identify which data, tools and practices for collecting relevant monitoring information are available. These include, among others: (i) Current data from sources such as population-based registries and surveillance systems, administrative databases, electronic patient records; (ii) Citizen generated data collected from tools such as interviews, questionnaires (both physical and digital), wearables, smartphone apps and data donation platforms; (iii) Biological data from blood samples, saliva, spinal fluids (both biochemical markers and genetic information).

T8.1.3 Risk factors, markers and health determinants matched with available data and methods to explore possibilities for monitoring.

Identified tools and methods for collecting data about each considered risk factor and health determinant will be evaluated within the overall legal, ethical and security framework of the different countries. Each country will have different possibilities for collecting data as well as different interests. This will also have impact on the pilot studies in the other WP tasks. Collection of data in the participating countries will be done by surveys. Country experts will be interviewed to validate the findings and results displayed in a dashboard.

T8.1.4 Identifying and describing standards and framework for collecting, linking and selecting monitoring data as well as legal and ethical issues associated with monitoring in compliance with the EU GDPR.

ST8.1.4 includes defining common standards and framework for collecting, linking and presenting monitoring data. This comes with the objective of helping Member States to scale the different methods in a sustainable and comparable manner. Guidelines and restrictions for data management and handling of sensitive information in the framework of the EU GDPR will be addressed. This will allow to develop local tools in compliance of standards and frameworks jointly agreed. Legal and ethical issues surrounding collection and sharing of data as well as data linkage and data security issues are crucial elements that will be explored and described in this sub-task.

T8.1.5 Development of a Monitoring Assessment Tool.

In ST8.1.5, a Monitoring Assessment Tool is proposed, adapting the MAST method developed in the Region of Southern Denmark and widely used in European countries. The MAST contains elements such as Health issues and the characteristics of the problem, Safety, Clinical effectiveness, Patient perspectives, Economic aspects, Organizational aspects as well as Socio-cultural, ethical and legal aspects. This is coupled with transferability elements such as cross-border, scalability and generalizability. With participation of the experts who developed the MAST, we will adapt the model for Monitoring Tools allowing countries to evaluate different methods and tools for monitoring in order to better assess whether or not it as applicable in their setting.

Task 8.2 Monitoring on an individual/clinical level to explore values and possibilities in the use of monitoring data on an individual level

The task objective is identifying and testing existing and upcoming methods for monitoring in the clinical/individual setting to identify new methods and test the potentials on behalf of the consortium.

T8.2.1 Mapping of tools and methods for monitoring individual/clinical level including description of utilization and benefits for the different stakeholder groups.

Building on the work of task 8.1 mapping of tools and methods specifically for monitoring on an individual or clinical level is the focus of this task. We also look at ways of presenting the risk factors, health determinants and available data to the individual in an informational and motivational manner enabling the person to change their lifestyle and prevent NCDs. This aligns with Europe's beating cancer plan: "Europe's Beating Cancer Plan will launch actions to give people the information and tools they need to make healthier choices".

Through either digital or physical tools the citizen is presented with information on NCDs and relevant risk factors, ranges for prevention areas such as BMI and their own available data for comparison as well as actions recommended. This could be done on paper, on an app or on a web-based solution. Different methods and tools are already developed and in use – these will be reviewed and relevant solutions recommended. Pilot studies will be launched to test existing solutions. There will be a special emphasis on interactive tools where the citizens are engaged such as logging their progress and answering questionnaires. Focus on how to motivate citizens without scaring them with facts on potential disease will be important in this task. The emerging area of citizen generated data will also be explored in this task incorporating wearables, smart phones and consent forms.

T8.2.2 Workshops to reveal potentials and barriers for the mapped tools and methods (representatives from the different stakeholder groups and participating countries are invited).

With an overview of existing and potential monitoring efforts as a baseline participating organizations are invited to a workshop where we explore the possibilities and also the barriers for using and scaling these methods and tools. Stakeholders from different levels are invited to give their views including legal, ethical and technical areas, but also clinical professionals and citizens are invited.

T8.2.3 Exploring technical feasibility and how the mapped tools and methods can be used/transferred in different European countries.

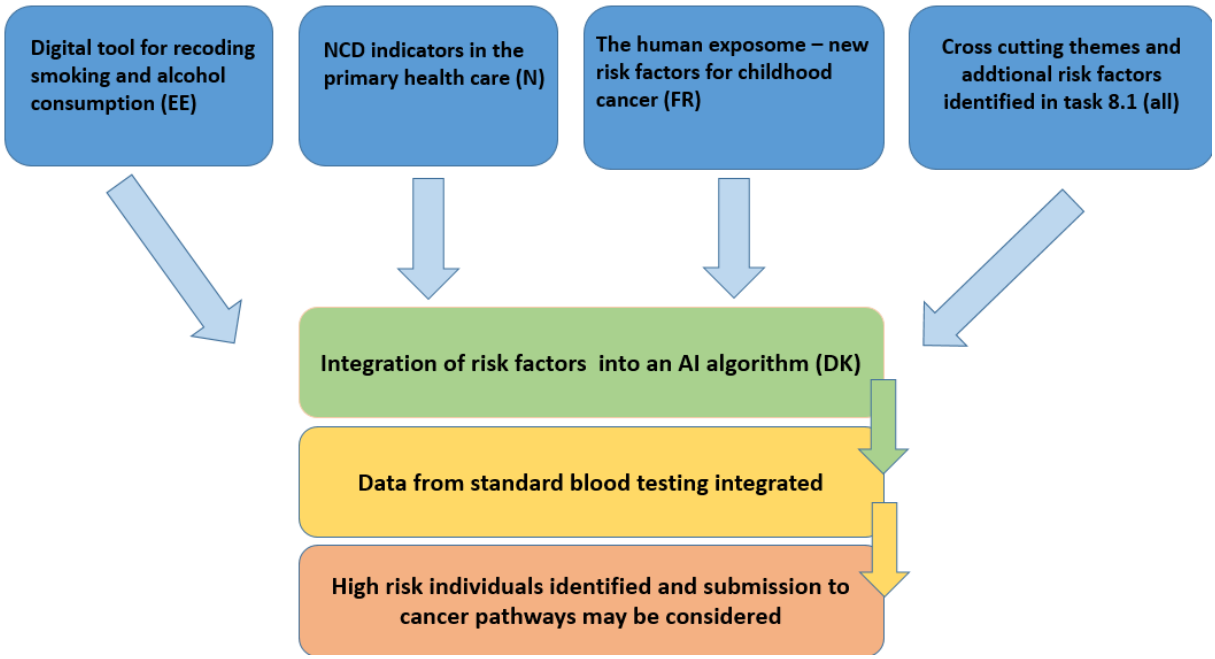
Taking into account the technical framework for scaling the solutions for monitoring at an individual/clinical level this task will look at how the mapped tools can be transferred to European countries. Desk research combined with relevant expert knowledge and developing European frameworks will be taken into account.

T8.2.4 Describing promising practices as inspiration for member states to adapt and explore. The practices will be described in a catalogue.

As an output from the task 8.2 a catalogue of promising practices for monitoring on an individual/clinical level will be described and disseminated. This will enable member states to be inspired to enhance their monitoring efforts and build upon the learnings of this task.
Pilot 8.2.5.a "Data harmonization and new methods for the monitoring of risk factors instrumental in early detection of individuals at an increased risk of cancer"

Pilot leader: Torben Frøstrup Hansen, Claus Lohman Brasen, RSYD, Denmark

The pilot aims to integrate known and new risk factors to detect cancer early, reducing late-stage diagnoses. Using AI and biomarker analyses, the pilot will evaluate individuals' cancer risk comprehensively. The primary testing will be done in Denmark, with other countries serving as validation sites.



The Figure shows the interconnection among the activities in Pilot 8.2.5.a

Monitoring will occur at community and individual levels, addressing various risk factors. will identify high-risk citizens, offering additional biomarker analyses and, if needed, genetic profiling and cancer pathway submissions. The pilot covers multiple cross-cutting themes. Four countries are responsible for primary testing, remaining countries will serve as smaller scaled test sites (for multinational validation of all interventions).

- Develop a harmonized data structure (digital tool) in the national electronic health record for recording smoking and alcohol consumption, testing feasibility in a real-life setting within lung cancer screening by GPs.
- Evaluate the feasibility of mapping the human exposome (the sum total of all environmental exposures that an individual encounters throughout their life, ed.) during prenatal and early childhood stages to identify undiscovered environmental risk factors for pediatric cancers. Use existing EU health studies, questionnaires, and biomarkers to quantify associations with pediatric cancer risk.
- Develop an effective system for measuring and monitoring time trends in key Non-Communicable Disease (NCD) indicators, including salt intake, blood pressure, diabetes, cholesterol, overweight, and obesity. Use a model within the primary health care system, creating a national database for surveillance.
- Utilize AI algorithms to integrate data from cross-cutting themes, sub-pilots, and agreed-upon parameters to identify citizens at the highest risk of cancer and other NCDs. Offer high-risk individuals regular blood test screening and, if needed, referral to a cancer pathway.

8.2.5b Pilot "Monitoring physical activity, sedentary time and sleep as risk factors for cancer & NCDs in population-based samples"

Pilot leader: Tommi Vasankari, UKK, Finland, Ulf Ekelund, NIPH, Norway

This pilot aims to test a system for monitoring key behavioral risk factors (physical activity, sedentary behavior, and sleep) associated with cancer and non-communicable diseases. Goals include harmonizing protocols, organizing training workshops, and recruiting age and gender-balanced adult samples from various European countries. The pilot involves collecting data on measured and self-reported risk factors, including optional biological factors. Success will be assessed based on participation rates, valid data points, and resource requirements. If successful, the project has the potential to scale up to a harmonized surveillance system for health determinants across EU member states.

Task 8.3 Gathering and further exploring population-based monitoring system to address data driven decision making for efficient and effective health-related policies

T8.3 will use mostly the information from the ongoing population-based surveillance systems on behavioural risk factors and health determinants, also linking to data from other existing surveys, disease registries and administrative sources in the EU, ranging from the local level to greater aggregations, such as regional or national extent. The objective is to create basis for effective decisions on policy changes, public health campaigns and prevention, also including information about advice provided by health professionals in cancer and other NCD prevention. Monitoring tools and methods encompass also the measurement of geographic, temporal and social variations both in exposure and in health impact (for example, according to the Global Burden of Disease –GBD– metric), implying either data collection or indicator elaboration. This task will build on a set of common metrics to assess the actual and expected impacts of public health interventions, even to compare the Return On Investment (ROI) from the actions developed under different scenarios.

T8.3.1 Methodological assessment, cross-fertilisation and harmonization of robust data collection systems.

In this ST, the issue of capacity building is aimed to develop, strengthen and homogenise the competencies, processes and resources that the different monitoring systems apply to data collection, considering the potential of local/regional/national current data sources or surveillances in the EU participating countries. The goal of this action is the development of a joint effort to harmonise and implement different-sized integration of the monitoring systems for collecting data on health determinants/risk factors of NCDs and cancer.

Pilot 8.3.a Pooling health surveys to improve identification and monitoring of cancer-related behavioural risk factors.

Pilot leader: Sanna Heikkinen/Sirpa Heinavaara, CSF, Finland, Valentina Possenti/Giovanni Capelli, ISS, Italy

The main pilot objective is to capitalise on the scalability potential of nationwide health surveys and behavioural surveillance systems - possibly linked to cancer registry data - for monitoring the prevalence of lifestyle and other, modifiable or environmental, risk factors for cancer and the associated cancer and NCD burden. Eligible health surveys modules used in the different countries will be identified and pooled. Possible strategies and protocols to link harmonised risk factors and behavioural data to cancer registry data will be proposed. The most applications would be the harmonisation of a pool of key cancer risk factors measurement modules to be used in health surveys and behavioural surveillance systems and the exploitation of cross-sectional health surveys by developing call-back to people who have been diagnosed with cancer in their lifetime. These options relate not only to methodological data collection issues but also to ethical and legal procedures, e.g., acquiring informed consent. Such pilot actions apply to diverse monitoring-related aspects: extend the territorial coverage or focus (e.g., expanding to broader area or oversampling at local level) or add a longitudinal dimension to risk factor population surveys or cause-effects evaluation opportunities through linkage to cancer or disease registries.

T8.3.2 Identify, share and agree methods to produce indicators to monitor changes in policies related to NCDs and major risk factors.

The European Programme of Work, 2020–2025 – “United Action for Better Health” commits to ensuring universal access to people-centred quality health services across the continuum of care, starting from prevention. The European Programme of Work’s flagship initiative on Healthier Behaviours calls for better understanding and incorporation of social, behavioural and cultural insights into improving service responsiveness to people’s health needs. In this perspective, the task covers not only the four main behavioural risk factors for NCDs – tobacco use, alcohol consumption, unhealthy eating and physical inactivity, increased Body Mass Index (BMI) – but provides data also about the monitoring of the compliance level with the primary prevention programs in the general population as well as in specific subgroups or the effect of health professionals’ advice on healthy behaviour change.

T8.3.3 Identify ways to present and visualize data to stakeholders, including foresight modelling.

Elaborating further the T8.1 stakeholder mapping, the third ST will explore tools, techniques and strategies to present data visualizations tailored to be informative at different levels, from

common citizens and public opinion to field experts and policy makers. For foresight modelling we will use historical data and development scenarios (legislation changes, changes in population demographics, etc.) to build models showing what could happen if something is done or not.

Pilot 8.3.b Risk assessment and risk-based projection for cancer and other NCDs.

Pilot leader: Robby De Pauw/Vanessa Gorasso, Sciensano, Belgium

This pilot action on risk-based burden of disease projections will allow 1) to foresee future public health challenges 2) provide insights on how policies to ensure a healthier future based on scenario analysis can be better adapted and implemented. The proposed step-wise research approach is aimed to achieve a methodological framework to be used by interested EU countries to implement risk-based burden of disease projections and scenario analysis. The first ST steps will base on the *burden-eu* network experience, and include both mapping the existing initiatives on disease burden projections within EU countries and a scoping review. As cancer registry data is available in the participating countries, a Cancer Risk Assessment Tool will be designed and would be most useful in common cancers with high absolute risks and well-known risk factors, namely cancers of the lung, breast, and colon. The objective would be to construct a web-based risk calculator and to estimate its predictive value in cancer incidence. The calculator may later be expanded to other cancer types and its use in personalized cancer screening may be piloted. In a later stage, the tool might even be expanded to other NCDs. Existing data will be gathered on disease burden from countries that have implemented such national burden of disease estimations. A risk-based projection methodology will be developed, whereby the prevalence (large health interviews and examination surveys) and incidence (registries) perspectives will be considered. To this end, the focus will be on a predefined set of risk factors (e.g. smoking, physical inactivity), selected based on consensus among the involved countries. The method will then be applied to the existing and identified datasets and adapted to the country-specific situation. The results will be compared against existing open-source tools, if available. Projections under different scenarios will be compared to guide policymakers in making effective guidelines and legislation to ensure optimal future-proof public health. All developed codes and methods will be collected in an open-source directory that can be used by non-participating countries.

Task 8.4 Monitoring access to health care and health care costs on a population level

One of the policy recommendations included in the iPAAC Roadmap addresses the issue of measuring the economic burden associated with cancer and identifying effective policies for minimizing its impact on the health systems. Within the iPAAC the feasibility of implementing a monitoring system of the economic impact of cancer has been successfully piloted in several European countries. Moreover, the Europe's Beating Cancer Plan recalls the need for a European Cancer Information System, monitoring the burden of cancer in Europe. It will include new indicators to help monitoring progress and future needs in addressing cancer at EU and national level. Due to population aging, chronic diseases and the diffusion of new diagnostic and therapeutic technologies, the share of GDP spending on health is predicted to increase in the coming years. Therefore, the sustainability of NCDs control is a challenge for all European governments, and is increasingly central in policy makers' debate. Measuring

economic burden associated with NCDs and identifying effective policies for minimizing its impact are key issues.

In this context, task 8.4 aims to move a step further in the direction of developing and implementing procedures and methodologies to monitor the impact of NCDs in terms of access to health care services and corresponding expenditures related to diagnosis, treatment and follow-up of NCDs patients considering the entire disease pathway from diagnosis to possible recovery or end-of-life. The monitoring in this task is addressed to policy makers and local health care managers, and the ultimate goal is to provide them with evidence about the current and future of NCDs burden useful for addressing health care policies and for better allocating economic resources.

In this task, the focus is on cancer, which is one of the cross-cutting themes of the present Joint Action, as cancer together with cardiovascular diseases is responsible for the biggest share of healthcare costs in OECD countries. Data from population-based cancer registries represent the main data source to identify cancer patients and to link their information on health care access and costs from other data sources. Cancer Registries (CRs) are present in all European countries and collect since decades data in a standardized and comparable way at population level.

Task 8.4 is developed in the following steps: *8.4.1 Mapping of available data for the estimating patterns of care and costs of NCDs; 8.4.2 Identification of healthcare cost components; 8.4.3 Definition of standards and framework for collecting, linking and selecting health care access and costs of cancer patients; 8.4.4 Definition, measurement of indicators of cancer burden, and costs at population level; 8.4.5 Modelling approaches in cancer costs evaluation and projections of cancer burden indicators; 8.4.6 Comparing data on cancer burden costs at across European countries*.

Steps 8.4.4, 8.4.5 and 8.4.6 will be implemented through the following pilot activities:

8.4.a Piloting the implementation of the Epicost model in European countries

Pilot leader: Stefano Guzzinati, Azienda Zero Veneto, Italy

A model focused on CRs data which allows to estimate the amount of people living with a cancer diagnosis (prevalent cases) and to classify them into three phases of care: initial, monitoring and final, reflecting different patterns of care, is proposed. By linking individual data from CRs to administrative data (hospital admissions, ambulatory services, drug prescriptions) profiles of health care direct cost are estimated, in each phase of the disease. This model of analysis has been successfully implemented in Italy in the framework of the EPICOST study and is proposed for application in those countries/regions where a cancer registry is present and linkable at individual level with other data sources reporting costs information.

8.4.b Piloting the estimation of the probability of progressing to cancer recurrence and long-term side-effects.

Pilot leader: Luigino Dal Maso, CRO Aviano, Italy

By combining population-based CRs data, estimates of the cure fraction (from mixture cure models) and survival data of patients with de novo metastatic patients, and available health

system databases, including exhaustive information on medical prescriptions and procedures.

8.4.c Piloting modelling of health care costs at micro-economic level.

Pilot leader: Cristina Mollica, UniRoma1, Italy

This pilot aims to investigate the relationship between the economic burden of cancer and a set of possible predictors, typically involving patients' socio-demographic, as well as clinical conditions and management systems. The modelling of healthcare costs, can be a challenging task due to the peculiar features characterizing the data distribution, that can require the use of specific statistical methods besides the most traditional approaches to obtain reliable estimates.

8.4.d Decision analytic modelling of cancers and other non-communicable diseases.
The pilot uses advanced simulation modelling and unique combinations of linked data sources to inform current and future priority setting. Focus will be on cancers in combinations with other non-communicable diseases (NCDs). The idea here is to construct decision models combining diseases, and specifically produce epidemiological data tailored for the decision models. These will be based on a combination of methods used in epidemiological research and health economic evaluation, such as time-to-event analysis and Markov models.

Task 8.5 Gap analysis, value scores for monitoring risk factors and recommendations for monitoring as well as experience based implementation potential

This task combines the findings in both the individual and population levels and coordinate recommendations for implementation and scaling of monitoring solutions based on the research and testing in the tasks and pilots.

T8.5.1 Finalizing and utilizing the Monitoring assessment tool on explored and tested monitoring systems/methods in order to improve the tool and provide case-based guidelines for future use.

In this subtask the MAST will be finalized including the learnings from the work package and the pilot activities. Which elements of the Monitoring Assessment Tool are important to include? How much should they weigh? And how can countries outside the project use the tool?

The tool and guidelines for usage will be developed and disseminated in this task.

T8.5.2 Defining and describing added value scores for monitoring risk factors.

In this task we will aggregate the findings from the previous tasks to create an overview of the added value of monitoring the identified risk factors for cancer and other NCDs. This will allow European countries to evaluate whether or not a monitoring tool or method has a favourable Return on Investment. This coupled with the MAT tool will enable countries to decide how to enhance their efforts in monitoring.

T8.5.3 Developing a gap analysis on the use of monitoring tools and methods between participating countries.

As an overview of existing practices on monitoring a Gap analysis of the participating countries will be developed to look at the possibilities for expanding monitoring and exchanging knowledge in the field. This will allow for policy makers in the European Commission and in the individual member states to see potentials for advancing monitoring as a tool for prevention of cancer and other NCDs.

T8.5.4 Describing the findings from the WP and providing recommendations for monitoring.

The objective of this task is to summarize the work package findings and recommend further initiatives for other European countries including tools, methods and implementation approaches. The pilot studies under this work package are evaluated and described – and common lessons learned are communicated. The project description asks, e.g. what are known health determinants and risk factors for NCDs and how can they be monitored; how can member states access data and share knowledge across Europe?; how can data be collected, analyzed and presented on same standards and framework?; and lastly: how can we motivate the individual and scale results? Answers will be part of in the output.

The task will also evaluate what type of platforms/systems/channels different countries are using to present their data for different target groups. Also looking at standardized existing data collections across different member states to allow cross country comparisons/benchmarking. Evaluation of the possible obstacles for monitoring health outcomes and health determinants. At the end of the project, a *Kick*off event is held for all countries where the WPs results are communicated.

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Work package 9: Health in all policies

Definition

Health in All Policies (HiAP) is an approach to public policies that systematically takes into account the health, health equity and health systems impact of policies across sectors, so as to improve population health and health equity. [1]

Objectives

The main aim of this work package is to strengthen the implementation of HiAP across different governance levels, focusing particularly on key risk factors and determinants to prevent cancer and other non-communicable diseases (NCDs). This involves:

1. improving our understanding of the the current systems, processes and tools for HiAP,
2. identifying opportunities and challenges with implementing HiAP,
3. assessing the state of art in monitoring and evaluating policy implementation, and
4. providing suggestions to strengthen HiAP implementation and engaging in discussions at both national and EU level.

To strengthen the overall capacity to address health and health equity, Task 9.1 will examine the systems involved in HiAP implementation, including the structures, processes, and overall tools. Task 9.5 will explore the opportunities and challenges of utilizing health impact assessments to reinforce HiAP, while Task 9.6 will focus on developing tools to enhance health and health equity perspectives within Wellbeing Economy. This with include a particular emphasis on tools addressing health and health equity within the broader context of the economy, public financing, and budgeting. Other tasks within this work package will address major risk factors and determinants important for preventing cancer and NCDs within the framework of HiAP.

The need for employing the HiAP approach stems from three basic situations (Figure 1):

1. **Complex health and health equity problems** requiring attention from multiple sectors. This approach is similar to the traditional “intersectoral action for health” approach. For instance, it involved examining how various sectors contribute to mental health or substance use, and determining how the situation could be improved from the health and health equity perspectives through policy amendments and their implementation, extending beyond the health sector. (Tasks 9.2, Task 9.3, and Task 9.4.2 and 9.4.3)
2. Adressing crucial **societal priorities**, such as wellbeing economy, requiring a health and health equity contribution (Task 9.6).
3. Concerning **policy initiatives from sectors** beyond health through the lens of health and health equity. This entails examining health and health equity implications of existing or proposed agricultural and trade policies, urban and rural planning, forestry and financial policies, and proposing amendments if needed. (Task 9.4.1, Task 9.6)

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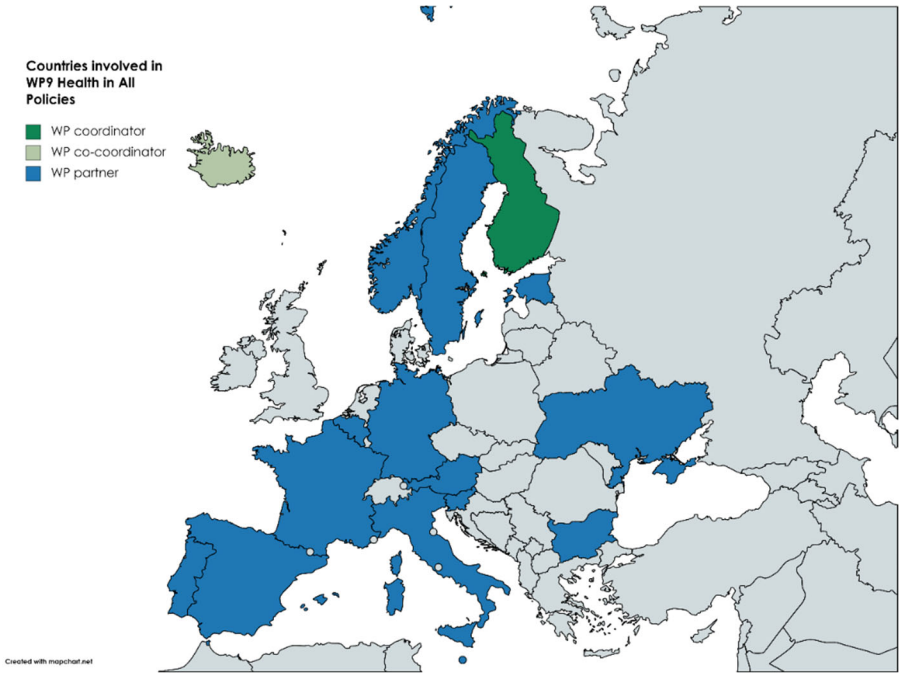

Partners
In total 24 partners from 16 countries participate in WP 9, which is led by Eeva Ollila (CSF, Finland) and Hanna Tolonen (THL, Finland), and co-led by Dóra Guðrún Guðmundsdóttir (DOHI, Iceland) and Gígja Gunnarsdóttir (DOHI, Iceland). (Figure 2)

Task 9.1 Strengthened implementation of Health-in-All-Policies (HiAP) at the various levels of governance to prevent cancer and other NCDs: Framework, structures, practices and resources

Task Leader: Leena Tervonen, CSF, Finland
Partner countries: Austria, Bulgaria, Estonia, Finland, France, Germany, Iceland, Italy, Norway, Portugal, Slovenia, Spain

The aim of Task 1 is to strengthen HiAP implementation at EU, national and subnational levels by updating understanding of current HiAP implementation and providing recommendations for the strengthening of HiAP implementation on various levels of governance. Lessons learned in various countries will be analysed and compiled. National reports will be prepared and discussed in national workshops participated by policymakers from across sectors and policymaking institutions. Findings of national cases will be discussed in international seminar addressed to policymakers.

T9.1.1 HiAP Implementation at national and EU levels

Subtask lead: Leena Tervonen, CSF, Finland
Partner countries: Austria, Bulgaria, Estonia, Finland, Germany, Iceland, Italy, Norway, Portugal, Slovenia

The national frameworks, structures, processes, actors and resources for HiAP will be explored. The national level legal and structural framework as well as processes and tools for

HiAP will be analysed from legal and policy documents and other reports in all participating countries. A few policies will be selected for more detailed analyses focussing on the opportunities and challenges in including health and health equity into policies across sectors while preparing, deciding and implementing policy decisions. Documentary analyses will be made and complemented by semi-structured interviews with policymakers and policy experts.

The EU-level work will explore the HiAP scope and potential in the context of EU institutions and core policies. It will benefit from work done in other subtasks, such as 9.4. and 9.5. The methodology will include documentary and policy analyses and interviews.

T9.1.2 HiAP implementation at subnational levels:

Subtask lead: Maude Luherne, RfVS, France
Partner countries: Finland, France, Iceland, Norway, Slovenia, Spain

Case studies in 6 countries explore implementation of HiAP at subnational levels, with emphases in various reforms in the participating countries affecting implementation, such as changes in governance, public health legislation and health service provision. Based on the WHO Healthy Cities network best practice sharing methodology, and inspired from other methodologies such as the OECD Best Practice Identification framework, a common analysis grid will be proposed for the case studies, in order to get a complete overview of HiAP processes at subnational levels: overview of sub-national levels responsibilities and sharing of competences, structures involved, tools, available data, funding. The methodology will include documentary analyses, interviews and focus groups.

Task 9.2 Developing effective ways to implement Mental Health in All Policies (MiAP)

Task Lead: Solrun Larusdottir, DOHI, Iceland
Partner countries: Belgium, Estonia, Finland, Germany, Malta, Norway, Slovenia

While health should always be seen form the point of physical, mental and social health, in the discussion of health and health equity, mental health is not always included as an integral part.

The aim of task 9.2 is to strengthen mental health in all policies by exploring the roles of various sectors in mental health promotion, and evaluating intersectoral policy interventions for mental health, and exploring policies to reduce stigma. This task will ensure that mental health is included whenever we seek to integrate health and health equity perspectives into policy making. Current state of art regarding sleep strategies will be explored.

T9.2.1. Mapping sectorial roles and the current situation in mental health promotion

Mapping will be conducted through situation analysis questionnaires, review of reports, interviews with key policy stakeholders and actors, and thematic workshops at national level.

T9.2.2. Developing and piloting a tool for evaluating mental health promotion interventions

This will be built on assessment criteria for evidence-based public health interventions that are being developed in Slovenia and will be adapted and modified to apply to a wider range of mental health approaches. The tool will assist policy makers in finding best practices to support mental health and will be piloted in Iceland, Finland and Slovenia.

T9.2.3 Mapping stigma and finding effective ways to fight stigma related to mental health problems

Mapping will be conducted by including by surveys, and findings will be used to develop recommendations on fighting mental health stigma at policy level.

T9.2.4 Conducting a situational analysis on the state of sleep strategies and guidelines.

A situation analysis and a review of cross-sectoral cooperation and “stakeholder and rightsholder” landscape. Based on these analysis, best practices will be recommended.

T9.2.5 Participation at the annual Wellbeing Economy Forum with a symposium on MiAP at the annual Wellbeing Economy Forum.

Subtask Lead:

Good practices that enhance mental health in all policies will be presented and promoted.

Task 9.3 Alcohol and tobacco related perspectives in all policies

Task Lead: Jaana Markkula (during the preparations), THL, Finland
Partner countries: Belgium, Bulgaria, Estonia, Finland, Iceland, Slovenia, Ukraine, Malta

There are several evidence-based policies for the prevention of alcohol- and tobacco-related harms, recommended by the WHO and also required in the field of tobacco control as part of the WHO Framework Convention on Tobacco Control (WHO FCTC). Yet, their implementation varies between and within countries as well as between alcohol and tobacco policies.

The aim of Task 3 is to increase our understanding of the reasons behind variance in implementing evidence-based policies to prevent and reduce harm related to alcohol and tobacco use. The objective is to understand and recognize the similarities and differences in implementation between countries as well as between tobacco and alcohol policies. We seek to understand the reasons behind the differences, how different policy sectors emphaze evidence-based practices and what enables and hinders their active implementation. In addition, the idea is to better understand the possibilities to co-regulate marketing and profit interests by private off-premises outlets as well as what are the experiences using mystery shopping as a method for age limit control in alcohol and tobacco. Also challenges and good practices in preventing-interference of the tobacco industry and related entities are studied.

T9.3.1 Conducting a stakeholder analysis of different actors involved in alcohol and tobacco-related policy processes in selected countries.

The countries for the stakeholder analysis are selected based on policy scale analysis done in task 5.1. The idea is to recognise the countries that have succeeded in the implementation of evidence-based policies (the development has been positive) as well as the countries in which the evidence-based policies have not been yet implemented, and to analyse the possible reasons behind the different situations with the help of stakeholder analysis. Stakeholder analysis include surveys and/or interviews of key stakeholders in selected countries.

T9.3.2 Assessing enablers and obstacles in implementation of evidence-based alcohol and tobacco related policies

in selected countries, i.e., identifying good practices in implementation. Assessment is utilizing stakeholder analysis, documentary analyses, surveys and/or interviews of key stakeholders in selected countries (based on work in T5.1.).

T9.3.3 Identifying strategies used by private off-premises outlets

to maximize alcohol and tobacco sales and the good practices to co-regulate marketing and profit interests. For identification of used strategies, documentary analyses, surveys and/or interviews of key stakeholders will be used.

T9.3.4 Assessing the existence and experiences with mystery shopping

As method for age limit control of alcohol and tobacco (incl. online sales) in selected countries. Information about already used methods will be collected and existing guidelines and tools in alcohol and/or tobacco will be identified and tested in 1-2 municipalities in selected countries (Slovenia, Bulgaria, Estonia and Finland).

T9.3.5 Identifying the challenges and good practices in the implementation of the measures to prevent influence of tobacco industry and vested interests

(WHO FCTC, Article 5.3), and assessing the monitoring and information exchange practices related to tobacco industry interference. Utilizing international tobacco control databases (FCTC implementation database, Global Tobacco Industry Interference Index) supplemented with survey and interviews if appropriate.

T9.3.6 Dissemination of the recognized good practices on implementation of alcohol and tobacco policies.

Dissemination includes pairing together countries with different contexts, policy measures and levels of implementation, different kinds of publications and organizing a webinar.

Task 9.4 Health enhancing environments – emphases on nutrition and physical activity

Task Lead: Anne Høyer-Lund, Helsedir, Norway, supported by Heli Kuusipalo, THL, Finland

JA PreventNCD

Partner countries: Belgium, Bulgaria, Finland, Germany, Iceland, Norway, Portugal, Slovenia, Spain, Sweden, Bulgaria

The aim of Task 4 is i) to analyze major policies, such as agricultural, environmental and urban planning, for their current impacts as well as potential capacities to promote or hinder health and health equity, especially as regards improved nutrition and enhanced physical activity for all; ii) explore commercial determinants of nutrition policies, iii) to foster improved monitoring of intersectoral policies for improved nutrition and enhanced physical activity for all by comparing the use of existing intersectoral indicators and arriving on a suggestion for a realistic set of indicators for everybody to use will be suggested.

T9.4.1. Health and health equity impacts of policies – emphasis on nutrition and physical activity.

EU and national policies related to sustainable and equitable food systems in the context of planetary health are explored for their potential to healthy nutrition for all. Policies to be studied may include agriculture, environment, economy, finance, trade, social, education and communication. National policies on urban planning, environment, climate and forestry are analysed for their potential to further enhance physical activity, in particular, and planetary health more generally. Furthermore, the role of corporate political activities of industry in relation to public health nutrition policies will be explored. Findings with recommendations for improved inclusion aspects on planetary health and well-being, nutritional health and health equity aspects are compiled.

Then main method used for policy analyses will be documentary analyses of policy documents. For the documentary analyses of corporate political activities (CPA) of industry the framework for categorizing the CPA developed by Mialon et al 2015[2] will be used.

9.4.2. Strengthen the use of existing process indicators for policies on improved sustainable nutrition.

A review of the use existing process indicators for healthy sustainable food systems (based on Food EPI) will be conducted including identified challenges in their use and possibly arriving at a simpler set of indicators. Reporting the use of Food-EPI nationally and plan for the way forward.

9.4.3. Review the implementation of policies for enhancing healthy nutrition and physical activity for all.

Review the state of implementation of policies for healthy nutrition and recommend comprehensive policies for healthy sustainable food systems for all. Policies for physical activity enhancing environments are reviewed. Review of the implementation of the comprehensive intersectoral national plans for enhancing physical activity in Finland, Norway and Sweden will be conducted.

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Task 9.5 Review and redesign/strengthen the use of Health (in) impact assessments

Task lead: Gabriele Gruber, GEOG, Austria, supported by Timo Ståhl, THL, Finland and Leonor Guariguata, Sciensano, Belgium

Partner countries: Austria, Belgium, Finland, Germany, Estonia, Spain, Iceland, Italy, Slovenia
Observer: Norway

Prospective health impact assessment is a key process of HiAP implementation. Since many sectors of the government already has some prospective impact assessments in place, there is a huge potential of health, health equity and wellbeing, including social determinants of health views to be better taken into account in policy processes across government, planning and private sector development projects.

Aim of Task 5 is a) to investigate to what extent health and health equity is considered in existing impact assessments, b) to strengthen the health and health equity component in the assessments, and c) to build the capacity for conducting impact assessment with strong health and health equity component.

T9.5.1. Identification of impact assessment tools and procedures in place in relevant European Countries and at the EU-Level

In this subtask we will be identifying various types of impact assessments already in use, such as i) issue/sector specific impact assessments are health impact assessment (HIA), gender impact assessment and environmental impact assessment, and ii) process/mechanism specific assessments, typically generic and comprising several impacts. Impact assessment of draft legislation is a typical process specific impact assessment.

We will identify impact assessments already in use, including guidelines and tools, sector/issue and process/mechanism specifications in the participating member states, as well as guidelines and tools of other relevant European countries, and on EU-level.

T9.5.2. Review of health and health equity considerations in the identified impact assessments in place

We will study how health and health equity impacts, including impacts on health determinants and health systems, are considered in the existing impact assessments for example in legislative proposals by the government. Impact assessment guidance used in the EU processes will be reviewed and suggestions for strengthening health and health equity aspects are made..

T9.5.3. Development and piloting of a comprehensive checklist for health and health equity in impact assessments of various policy sectors

Based on the identified guidelines and tools on integrated impact assessment, we will develop a comprehensive checklist for considering impacts on health and health equity in the

planning phase of policies. The checklist is meant for persons who are conducting impact assessments, for example civil servants in the ministries across sectors. The checklist will be piloted in the member states on a specific measure/policy in line with other tasks of the Joint Action, e. g. restriction of food marketing for children or food taxation measures. The experiences will be described in case studies and discussed in a workshop with the member states teams.

T9.5.4. Review and strengthening of (existing) capacity building mechanisms in the MSs

We seek to strengthen the comprehensive health and health equity component in those assessments where it, according to the reviews conducted in earlier phases, is not strong enough. Existing HIA capacities, e. g. support units or expert networks, in the member states will be assessed and discussed. Recommendations for necessary HIA capacities on different levels will be made. Finally, the capacity of the health sector to conduct health impact assessments and help other ministries in doing assessments of the potential health impacts of their policies, programmes and projects will be strengthened.

T9.5.5. Conceptualization of an online space on the JA Website to provide resulting material of the task

We will deliver an overview of existing good practice tools for conducting impact assessment, existing good, systematic procedures/process of conducting impact assessments and a comprehensive checklist that countries can use for their own purpose. These tools and case studies will be made available on the website of the Joint Action.

Task 9.6 Wellbeing economy

Task lead: Dóra Guðrún Guðmundsdóttir, DOHI, Iceland
Partner countries: Austria, Belgium, Finland, France, Iceland, Italy, Malta, Norway, Portugal Slovenia,

The Aim of Task 6 is to provide a practical framework for the Wellbeing Economy approach, analysing the opportunities, identify and disseminate effective ways to implement it to enhance sustainable wellbeing for people and the planet. Wellbeing economy still lacks a commonly agreed solid definition. The Concept for this particular Task will be defined in the beginning of the work. Health is a crucial aspect of wellbeing, and in that context, we explore the concept of wellbeing economy and develop its tools especially from the point of view of strengthening proper inclusion of health and health equity in wellbeing economy concepts and debates.

T9.6.1. Operationalise the concept of Wellbeing Economy

Evaluating what kind of systems and policy changes/adjustments are needed to move towards a wellbeing economy in EU MSs. Through a literature review a concept of wellbeing economy will be clarified.

T9.6.2 Implementing Wellbeing Economy

Mapping the current situation, identifying enabling and hindering factors in the implementation of Wellbeing Economy. A situation analysis will be conducted to learn about the implementation of wellbeing economy in the MS. Two case studies will be conducted.

T9.6.3. Performing cost benefit analysis of selected wellbeing interventions and report on the results

A selected wellbeing interventions will be analysed.

T9.6.4. Developing Wellbeing budgeting

Mapping best practices in selected EU countries as a basis for successful wellbeing budgeting through situation analysis.

T9.6.5. Developing and implementing Wellbeing Economy toolbox

By presenting available policy instruments at different governance levels to advance well-being economy policies in EU/EEA MSs, reviewing case studies and best practices and identifying obstacles and leverages in the implementation.

T9.6.6. Wellbeing Economy Forum

Annual meeting to share experiences, disseminate and promote best practices. The participants are expected to include JAPrevent NCD partners, high-level representatives of ministries, public health decision-makers, experts and representatives from civil societies, wellbeing economy partners, and advocates from local, national and regional levels.

JA PreventNCD

Work package 10: Identify persons at risk – Prevent and treat

Objectives

The activities of this WP are situated in the context of the European Code Against Cancer/WHO and they aim to steer implementation of interventions directed to individuals and populations-at-risk for cancer and other NCDs, addressing not only individuals but also the health professionals and healthcare services within a full lifecycle perspective (children, adolescents, adults, seniors).

The **general objective** of this work package is to reduce the burden of cancer and other NCDs (C&NCDs) mainly at the personal level by providing guidance and producing further evidence on integrating information from genetic determinants, demographic, behavioral characteristics (individual-level factors) into a holistic approach for C&NCDs prevention. We will integrate outcomes on risk factors such as tobacco use, healthy lifestyle and physical activities including the impact of genetic determinants in our actions.

The WP has the following five specific objectives:

1. Improve joint capacities of MSs to plan and implement C&NCDs risk-based prevention policies and activities at national, regional, and local levels;
2. Improve the monitoring system for genetic determinants for C&NCDs;
3. Contribute to reduce inequalities in C&NCDs;
4. Incorporate lessons learned from the COVID-19 pandemic in terms of effective risk-stratified prevention approaches and communication strategies;
5. Engage with key actors/stakeholders in the field on integrating genetic determinant thinking and joint efforts in C&NCD prevention, including decision makers, civil society organizations, professionals, the general population, and patients' groups.

Organisation

The WP is led by Sciensano, Belgium (Marc Van Den Bulcke and Federica Rossetti) and co-lead by the Region of Southern Denmark, Denmark (Torben Frøstrup Hansen, Emil Høstrup, Malene Vestergaard Runge, and Brit Langballe Sandgren).

The WP is organised in **four tasks**, whose leaders are:

- Task 10.1: Roberta Pastorino, UCSC (Italy);
- Task 10.2: Wannes Van Hoof, Sciensano (Belgium);
- Task 10.3: Stefan Schaub, BZgA (Germany);
- Task 10.4: Malene Vestergaard Runge and Torben Frøstrup Hansen, RSYD (Denmark).

In total, 29 partners from 13 countries participate in the WP.

JA PreventNCD

Task 10.1 State of Play: personalized risk stratified prevention

The main objectives of this task are twofold: (i) to provide an overview of existing personalized and risk-stratified prevention approaches by assessing current evidence in the field of cancer and major NCDs, and (ii) to investigate the effectiveness of these strategies in identifying individuals at risk and improving health outcomes. This task will inform future efforts by project partners responsible for running pilots within the project.

Personalized and risk-stratified prevention is a rapidly evolving field that aims to tailor preventative measures to individual patients' specific needs and characteristics, preventing or reducing the occurrence of diseases and injuries by identifying and addressing the underlying risk factors.

Methodology

To assess the current evidence, we will conduct a literature review of emerging and existing primary, secondary, and tertiary prevention strategies stratified by genetic or non-genetic risk factors. The review will encompass relevant scientific databases, searching for studies on personalized and risk-stratified primary, secondary, and tertiary prevention, as well as pertinent guidelines, best practices, and grey literature. The evaluation of relevant evidence will be conducted using a dedicated framework.

The outcome of this review aims to unveil both existing and implemented approaches, along with the latest scientific evidence available on risk factors and promising preventative interventions. We will explore various factors, such as genetic determinants, smoking cessation, lifestyle health promotion, and the utilization of digital tools and decision support systems, to understand their roles in health promotion for cancer and the major NCDs addressed in the project. The findings from this investigation will be instrumental in guiding the adaptation of pilot studies when applicable.

Task 10.2 ELSI of personalized risk stratified prevention for cancer and other NCDs

The main objective of this task is to deliver Ethical, Legal and Social Implications (ELSI) recommendations for personalized and risk-stratified prevention for cancer and other NCDs based on citizen and patient engagement activities. These activities will also serve to develop a toolkit for citizen engagement on personalized and risk-stratified prevention for cancer and other NCDs to promote continued engagement practices within and beyond the activities of the Joint Action.

Personalized and risk-stratified prevention will identify individuals based on certain risk factors and propose tailor-made strategies to prevent disease occurrence or improve health outcomes. This task will focus on two main ethical and social dimensions related to this new approach to screening:

1. The concept of risk: risk is always a balancing act, where attributing value to different elements and outcomes is key. This task will make sure that citizen and patient values are taken into account together with the public health/scientific approach to risk.

2. The concept of stratification: the goal of risk-stratified prevention is to treat people differently based on their risk profiles. To what extent is it ethically acceptable to stratify prevention, based on which markers, for which purposes?

Methodology

We will address these questions for all the fields of interest of the WP10 pilots, with a special interest in genetic determinants and the use of digital tools and support systems in health promotion. Four studies will be performed:

1. Digital survey to investigate perspectives of risk stratification, readiness for endorsing personalized and risk-stratified approaches, barriers and opportunities in the fields of cancer and mental health (Norway);
2. Engage publics to obtain views and perspectives on the use of genomics for prevention of cancer (Iceland);
3. Co-creation with citizens of a module within the “Mon Espace Santé” App that collects and brings out all the data related to the environment’s user (his workplace, his home, his region of living, his hobby area etc.) (France);
4. Create, test and evaluate pilot studies to prevention and early detection of cancer to better reach and impact vulnerable population sub-groups particularly at risk, e.g. people from low socioeconomic backgrounds, people with disabilities or immigrants backgrounds (Sweden).

Task 10.3 Lessons learned from Covid: Effective health communication n crises and beyond

The main objective of this task is to develop a framework for informed and needs-based approaches for communication strategies based on criteria for effective health communication, drawing from the lessons learnt during the COVID-19 pandemic. This framework will support the population in dealing with a crisis situation in a dialogue-oriented way and strengthening their competences for a gradual adjustment.

The requirements for effective health communication have never been as clear as during the pandemic. Given the drastic increase volume in the amount of information on the one hand, and its comprehensible communication on the other hand, there is a need for an evidence-based information strategy on how to develop, disseminate and address target groups in a way that is clear, up-to-date, free of contradictions, transparent and trustworthy.

Methodology

This task is organised into 5 subtasks:

T10.3.1 Analysis of data on health communication during the COVID-19 pandemic

Subtask leader: TBC

The activities of this subtask include: (i) Identification and gathering of relevant data sources on health communication during the pandemic; (ii) Evaluation of the effectiveness of existing communication strategies in different countries; (iii) Compilation of a report on best practices and challenges in health communication.

T10.3.2 Assessment of data sources for capturing communication behaviour

Subtask leader: TBC

The activities of this subtask include: (i) Examination of available data sources and technologies for capturing communication behaviour related to health information; (ii) Assessment of the accuracy, reliability, and relevance of various data sources; (iii) Development of criteria for selecting optimal data sources for analysing communication behaviour.

T10.3.3 Development of a framework for country-specific effective, risk-adjusted communication strategies

Subtask leader: TBC

The activities of this subtask include: (i) Identification of key factors and risk characteristics associated with NCDs in different countries; (ii) Compilation of information for risk assessment and adaptation for the development of communication strategies; (iii) Creation of a flexible framework for adapting and implementing communication strategies considering specific country needs and risk factors.

T10.3.4 Consultation and collaboration with expert panels and stakeholders

Subtask leader: TBC

The activities of this subtask include: (i) Organization of workshops, discussions, or meetings with health experts, government representatives, and relevant stakeholders to gain insights and feedback on the developed strategies and findings; (ii) Incorporation of feedback and adjustments based on suggestions and insights obtained from these consultations.

T10.3.5 Documentation and reporting

Subtask leader: TBC

The activities of this subtask include: (i) Preparation of detailed reports on the methodology, results, and recommendations from the conducted analyses and developments; (ii) Submission of reports to the Steering Committee of the JA-Prevent NCD and other relevant bodies for review and approval of the developed communication strategies.

Task 10.4 Implementation of Personalized risk stratification for cancer and other NCDs

The main objective of this task is to implement personalized risk stratified prevention and treatment through pilot studies targeting genetic determinants, risk factors (specifically, tobacco and nicotine cessation), health promotion and a holistic approach to patients with cancer.

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Methodology

The task is organised into 4 subtasks:

10.4.1 Genetic determinants

Subtask leader: Hélène Antoine-Poirel, Sciensano (Belgium)

Genetics plays a part in determining lifespan, healthiness and likelihood of developing illnesses. As genetic determinants are to larger extend fixed, it is important to identify the families and individuals at higher risk of cancer on the basis of genetic profiling in order to propose personalized prevention on actionable determinants. There is a need to build clinical utility and to elaborate recommendations on the best integration of cancer genetic risk management into the healthcare pathway. This subtask proposes to address these issues in 6 pluri-country actions grouped into two areas:

1. Identification of genetic predisposition, with a focus on the improvement of the diagnosis of cancer genetic syndrome and the genetic counselling in the young population (children, adolescents and young adults), the harmonized development of pharmacogenetics clinical decision support tools and their integration in existing electronic health records, the analysis of the use of innovative approaches such as polygenic risk scores in identifying individuals-at-risk in order to develop common guidelines on their usage in clinics, the exploration of a population-based approach to NCD prevention in old age;
2. Intervention in targeted group through two different clinical trials: one on primary prevention, aiming to evaluate the impact of a targeted risk based prevention intervention on women at high risk of breast cancer (MYPREV); the other on tertiary prevention, aiming to prevent second cancers with immunotherapy (PREDOSTAR).

T10.4.2 Tobacco and nicotine cessation

Subtask leaders: Tuula Vasankari, FILHA (Finland)

Objectives of this subtask – organised in 8 pilot studies – include co-development of care pathways with health care services based on effective tobacco and nicotine cessation methods such as brief intervention and group counselling. New information about system level reasons for successful implementation of early identification and brief intervention to help tobacco and nicotine users in the quitting process will be gathered as well as information about cessation in vulnerable groups with need of special support in the quitting process. Information about heavy adult smokers' barriers to smoking cessation and their perception of cessation services and tobacco control as well as previously unsuccessful quitters will be gathered.

Existing best practises and recommendations are developed further and disseminated on local level. The work with health care services includes training health care professionals in cessation methods and introducing digital tools. Pregnant women who often have lowered perceived ability for cessation and need more support in quitting, as well as mental health patients that often are heavy smokers will be targeted. Strengthening communication about available cessation services within the health care system as well as in communication directly with the tobacco and nicotine users will be addressed.

Common recommendations derived from current best practises and pilot projects will be produced and disseminated. A best practice recommendation will be developed on free smoking cessation medication in combination with free counselling in European countries.

T10.4.3 Health promotion: Physical activity

Subtask leader: Sophie Denoël, Sciensano (Belgium)

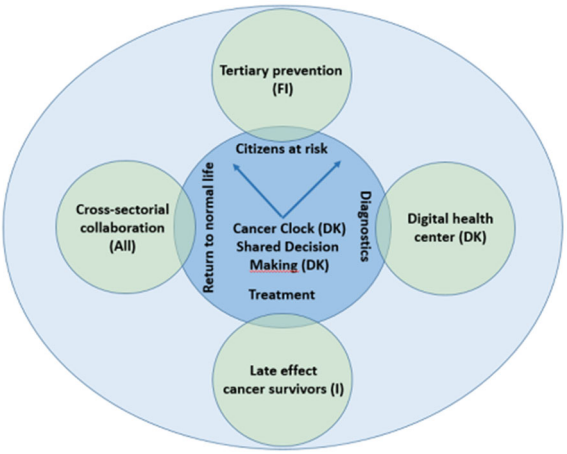
The objective of this subtask is to promote physical activity among adults, but also more specifically among cancer patients and cancer survivors.
A first pilot study targets adults and aims to increase physical activity through health psychological interventions.

A second pilot study targets cancer patients during and after treatment, as well as healthcare professionals in oncology and primary care. This pilot study includes an evidence-based training programme for healthcare professionals and a web-based, group self-care intervention for cancer patients.

T10.4.4 Patients with Cancer - a holistic approach to prevention

Subtask leader: Malene Vestergaard Runge and Torben Frøstrup Hansen, RSYD (Denmark)

The main objective of this subtask is to address several aspects of being diagnosed with cancer, the consequences of treatment, and how an optimal patient involvement may reduce the experienced disease burden for the individual. Patients with cancer face multiple interventions, treatments and decisions that impact their overall health and wellbeing.
The main focus of this combined pilot is the individual diagnosed with cancer. A focus on prevention is just as important in this setting. Through 5 pilots in different countries, we will address several scenarios that calls for improvement with interventions aimed at both the patients and their healthcare providers.



A first pilot study (*Cancer Clock*) aims to ensure that patients with cancer experience a close and coherent healthcare system. It assumes that healthcare actors collaborate and coordinate efforts, so that patients experience a process that is as smooth as possible, independent of the executive actor. The project's parties will collaborate to organize a

coherent process for patients with cancer and focus on organizing efforts related to prevention based on a holistic approach and the individual patient's situation and needs. While prevention receives large attention before diagnosis (primary prevention), it continues as the citizen enters the hospital, when the citizens becomes a patient (i.e., has been diagnosed). The cancer clock will limit prevention to this time in the patient's life. A multidisciplinary team with expert representatives from the hospital, municipality and GPs, will ensure continuous focus on the patient and in case of relapse (or side effects here), the network will quickly catch the problem.

Involvement of patients in treatment decisions is often lacking, with many uninformed about their choices. This deficiency is particularly significant for patients with cancer, as treatment decisions may impact greatly on quality of life and survival. Shared Decision Making (SDM) is the pinnacle of patient engagement and a method to empower patient. In this regard, a second pilot (*Shared Decision Making*) aims to build an European model for implementing SDM on hospitals across the EU that systematically includes patients and relatives in decisions on screening, diagnosis, treatment and follow-up. Actions will include competence building of clinicians and managers, as well as the development of decision aids and patient communication guidelines. *We are looking for English and German speaking test-partners for this pilot.*

The primary objective of the third pilot (*Digital health centre*) is to develop a digital rehabilitation program tailored for cancer patients, with focus on secondary and tertiary prevention measures. In some situations, patients with cancer may, in fact, be more susceptible to an unhealthy lifestyle, due to both disease and treatment, or several other risk factors. Patient education and health promotion may prevent lifestyle diseases and serve as secondary and tertiary prevention. Key objectives include facilitating smoking cessation or reduction and providing patients with strategies for preventing or managing late-stage effects of cancer. Moreover, this pilot aims to address primary prevention by identifying potential touchpoints with individuals at risk of cancer, such as during cancer screenings, and guiding them toward existing digital resources available through the Digital Health Centre. Lastly, the pilot will evaluate the efficacy of the proposed solutions in motivating lifestyle changes among participants and explore the groundwork necessary for scaling the digital platform for enhanced patient education and motivation.

A fourth pilot aims to offer individual and group support for patients with cancer using a motivation interview and counselling. Health promotion interventions in the oncology population are an important part of their comprehensive treatment plans. Smoking, alcohol and mental health problems affect the survival of patients with cancer and the risk of disease recurrence. The pilot study will utilize a smartphone smoking cessation application, which the cancer society of Finland has developed and tested in young people. Focus groups with cancer patients and their treatment units are held as part of the designing of the pilot.
The increasing complexity of cancer treatments, and the expanding number of treatment options, contribute to a growing issue of late effects in cancer survivors. These effects often affect overall health, occupational status, family status, and sometimes the individual's overall survival. The aim of the fifth pilot (*Late effect cancer survivors risk stratification*) is to identify survivors at high risk of late effects to support personalized follow-up strategies. Data from cohorts of adolescent and young adults (15-39 years) cancer survivors will be integrated with clinical data coming from the hospital and data on lifestyle and socioeconomic status in order to develop innovative AI-based models.