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Milestone 9

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2nd Interim Evaluation Report



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Executive Summary

This second interim evaluation report covers the midpoint of the Joint Action on Cancer and other Non-Communicable Diseases Prevention (JA PreventNCD), involving more than 100 institutions across 25 countries. Work Package 3 (WP3) evaluates the project as it progresses. The first interim report looked at how partners collaborate across borders. This second report looks at what outputs the project has produced so far and their potential for application in practice. It presents findings from WP3's peer assessment of knowledge translation outputs (e.g. reports, policy briefs, guidelines and toolkits), first insights from implementation case studies, and updates on progress monitoring and the external evaluation of WP 1–4.

The project is largely on track, though delay reporting needs improvement.

Of the 775 milestones and deliverables due by the end of the project's second year, 82% were completed on time (Section 2). Where delays occurred, most were moderate (i.e. 1–5 months delay). WP1 has strengthened its monitoring through progress trackers, check-ins with every WP and extra review of key deliverables. The reason for the delay was not recorded for 58% of the delayed items. This limits the ability of the project to learn from and mitigate these delays.

Outputs produced so far are considered relevant, but not all participants know them and they suit researchers best.

A peer assessment of 334 participants across WP 5–10 found that key outputs so far are generally relevant to participants' own work (Section 3). However, 15% did not know of any of the listed outputs from their own WP. Outputs currently suit an academic audience best and are less suited to policymakers and practitioners, and consideration of social inequalities is uneven across output types. Participants in close contact with policymakers were far more likely to plan to share outputs. Encouragingly, developing outputs has already built skills, networks and new ideas among contributors.

Case studies show encouraging early progress, with collaboration a recurring strength.

First insights from five implementation case studies show encouraging progress on feasibility and fidelity (Section 4), meaning whether pilots can be delivered with the resources available and as designed, with sensible adaptation. Early lessons show pilots progressed most when they built on existing structures and policy opportunities, adapted to local conditions and had ongoing hands-on support. As pilots mature, future reporting will turn to their reach and potential for long-term sustainability.

The first phase of the external evaluation found WP 1–4's structures and services are well-designed, but sometimes difficult for WP 5–10 to use at scale.

The external evaluation of WP 1–4 by Prognos AG completed its first phase in 2026 (Section 5). It found WP 1–4's collective services are well designed and supported by a strong collaborative culture. The main challenge is not their design but how easily WP 5–10 can use them in their daily work. In response, WP 1–4 agreed five actions to make their services clearer, easier to find and better able to reach task, subtask and pilot level.

Seven recommendations aim to strengthen delivery as the project enters its final phase.

The report makes seven recommendations (Section 6), including: tailoring outputs to their intended users; building equity into practice-oriented outputs; making better use of participants with policy contacts to pass outputs on; and planning for the reach and sustainability of pilots. Put into practice, they would help outputs reach the people who can use them, keep delivery on track, and put the JA in a strong position to achieve its goals.

The final phase of the evaluation will turn from outputs to outcomes and their reach.

WP3's remaining activities will look beyond what the JA produces to what changes as a result. These include a self-assessment of implementation and impact, a stakeholder assessment in selected countries on how outputs reach and are used by key actors, a most significant change assessment capturing national-level change, and full case studies on reach and sustainability. They will show how far the JA's work is reaching stakeholders and engaging with the policy environment and will be presented in a third and final evaluation report at the end of the project.

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List of Abbreviations

Abbreviation	Definition
CFIR	Consolidated Framework for Implementation Research
EU	European Union
GA	Grant Agreement
HaDEA	European Health and Digital Executive Agency
IM	Internal Milestone
ID	Internal Deliverable
JA	Joint Action
JA PreventNCD	Joint Action on Cancer and other NCDs Prevention
KEQ	Key Evaluation Question
KT	Knowledge Translation
KUUT	Knowledge Uptake and Utilisation Tool
M24	Month 24 (of the project)
MS	Member States
MSC	Most Significant Change
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
RKI	Robert Koch Institute
WP(s)	Work Package(s)

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1. Introduction

1.1. Project summary

Cancer and other NCDs make up more than two thirds 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. Much of this disease burden is preventable. The aim of the PreventNCD is to support strategies and policies designed to reduce the burden of cancer and NCDs, and their common risk factors at both individual and population levels. Specific objectives are:

- improve joint capacities of Member States (MS) to plan and implement prevention policies and activities at national, regional, and local levels.
- improve monitoring system for cancer and NCDs and their common risk factors.
- contribute to reduced social inequalities in cancer and NCDs.
- engage with key actors in the field of cancer and NCD prevention, including decision makers, civil society organisations, professionals, the general population, and patient groups to facilitate cooperation and joint efforts.

The JA PreventNCD represents an ambitious effort to provide strategic guidance and consolidated efforts to the field of prevention. Key outputs include an EU Consortium on NCD Prevention, high-level annual events, and intervention tools and policy recommendations that will contribute to reduce cancer and NCD burden and inequality across Europe.

1.2. Deliverable objectives

This is the second interim evaluation report prepared by WP3 for JA PreventNCD. It builds on the [first interim evaluation report](#) and presents progress updates and new evaluation findings from activities conducted since the first report [1].

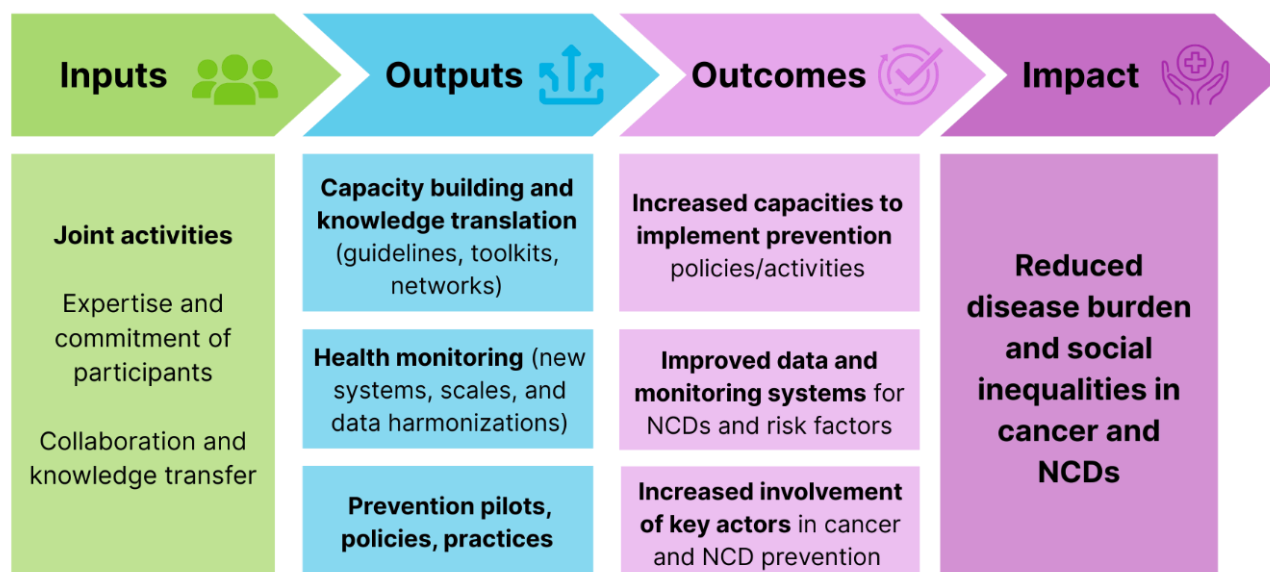
The overall evaluation objectives, as set out in the evaluation plan, are to:

- track progress against project milestones;
- assess how well prevention activities and policies are put into action;
- analyse improvements in the knowledge base for cancer and NCD prevention;
- evaluate the quality and usefulness of knowledge translation materials;
- review the implementation effectiveness of pilots and their potential for wider adoption;
- and explore examples of positive change at EU and MS levels [1, 2].

The evaluation is structured around the JA PreventNCD logic model, which frames the evaluation across four components: inputs, outputs, outcomes and impact (Figure 1). The first interim report focused on the *input* component – specifically, the effectiveness of international collaboration and knowledge transfer in producing knowledge translation (KT) outputs. This second interim report shifts the evaluation focus toward the *output* component, asking whether those outputs are reaching JA participants (i.e. individuals actively contributing to WP 5–10) and are considered relevant and useful in practice.

It also presents first insights from the implementation case studies, which begin to bridge the *output* and *outcomes* components of the logic model by examining the feasibility (i.e. whether an activity can be delivered with the resources available) and fidelity (i.e. whether it is delivered as designed, with reasonable adaptation) of selected JA prevention activities. Upcoming evaluation activities will extend the focus further toward the outcomes and impact components, assessing whether the JA's work is translating into meaningful change at national and EU level. Full details of the methodology are available in the published evaluation framework [2].

Figure 1: Logic model of JA PreventNCD developed by WP3.



1.3. Status of the evaluation

Since the first interim report, the evaluation team has completed or advanced the following activities:

- **Internal webinar:** WP3 hosted an internal webinar for the JA consortium in February 2026 to present key findings from the first interim report and provide guidance on the [Evaluation Resource Repository](#), which was made available to the consortium in September 2025 to support internal evaluation efforts.
- **Peer assessment of KT outputs:** Following completion of the study protocol, data protection approval, and confirmation from the Berlin Medical Association's Ethics Board that no formal ethics approval was required – all finalised in April 2026 – the peer assessment survey was distributed to all participants across WP 5–10 for completion between May and September 2026.
- **Implementation case studies:** In collaboration with the WP leads, one case study was selected per WP (N=6 case studies in total), with the selection process beginning in 2025 and finalised in mid-2026. A 'first insights' version of each case study has been prepared, which highlights the background to the study and initial findings relating to two implementation outcomes: feasibility and fidelity.
- **External evaluation setup and first phase:** The process of setting up the external evaluation of WP 1–4 began in August 2025 with the publication of a national tender in Germany. An external evaluator (Prognos AG) was selected via competitive tender in September 2025 and collaborated with the WP3 evaluation team and WP 1–4 leads to develop the evaluation concept. A kick-off meeting was held in December 2025 to commence the first phase. WP3 assisted the external evaluator with coordination and communication to relevant JA participants to help them carry out their evaluation activities.
- **Bilateral meetings:** Ongoing meetings with WP leads have continued throughout this period, both in-person at WP- or task-specific events and online, to discuss evaluation progress, upcoming activities, and implementation case study developments.

An overview of evaluation activities and their status is provided in Table 1. Most remaining activities are scheduled toward the end of the project period throughout 2027 as outcome and (potential) impact evaluation requires a project to have been running long enough to produce measurable change.

Table 1: Status and description of evaluation activities.

Status	Evaluation activity	Description	Example evaluation questions/focus
Completed (First Interim Report)	Self-assessment of inputs	Survey of all WP 5–10 task and subtask leads on collaboration and experiences with developing KT outputs.	- Effectiveness of international collaboration. - Experiences in developing KT outputs.
Completed (Second Interim Report)	Peer-assessment of outputs	Survey of all WP 5–10 participants on a selection of developed KT outputs.	- Reach and relevance of KT outputs. - Usefulness of outputs in practice.
	Implementation case studies (first insights)	Background and early implementation findings, based on document review and bilateral meetings.	- What's working? What opportunities or challenges have arisen? - Are things going to plan, or what's changed and why?
Upcoming	Self-assessment of implementation and impact	Surveys/interviews with JA participants; assessment of country-level implementation processes.	Were countries able to plan and implement NCD prevention policies and activities at different levels?
	Stakeholder assessment of implementation and impact	Surveys/interviews with key stakeholders in selected countries.	- Were national data and monitoring systems improved? - Did countries regularly engage with and support key actors?
	Implementation case studies (full case studies)	Implementation highlights, lessons learned and relevance for future scale-up initiatives, based on a mixed-methods approach.	- What contextual factors influenced implementation? - What lessons can be drawn to inform the scale-up or adaptation in other contexts?
	Most significant change (MSC) assessment	Interviews with country representatives based on the MSC technique.	What was the most significant national change resulting from the JA?

1.4. Structure of this report

This second interim report is structured as follows:

- **Section 2: Progress Monitoring** – Findings from the most recent progress reporting conducted by WP1.
- **Section 3: Peer Assessment of Knowledge Translation Outputs** – Findings from the most recent evaluation activity, assessing the reach, relevance, and adaptability of KT outputs produced across WP 5–10.
- **Section 4: Implementation Case Studies** – An update on the approach and first insights from the selected implementation case studies.
- **Section 5: External Evaluation First Phase Findings** – An update on the progress and summary of interim findings from the external evaluation of WP 1–4.
- **Section 6: Conclusion and Recommendations** – A summary of the main findings across the report and seven recommendations for strengthening delivery and reach in the final phase of the JA.

2. Progress Monitoring

This section presents findings from the Month 24 (M24) progress monitoring led by WP1.

As described in the evaluation framework, WP1 leads progress monitoring across JA PreventNCD, tracking whether activities are being implemented as planned, identifying deviations from original plans, and documenting the reasons for delays and the measures taken to address them [1, 2]. This forms part of WP1's wider progress monitoring activities, which also include regular meetings with WP leads, updates to WP detailed protocols, and review processes for deliverables.

The first interim report presented findings from the formal reporting round to HaDEA, covering Month 1–16. This report presents findings from the informal progress reporting round covering Month 17–24, which had three aims:

- support effective project and financial management by monitoring progress, results and resource use;
- monitor expenditure and staff effort (measured in person-months) with particular attention to underspending and trends identified in previous reporting; and
- identify deviations from the project plan and support timely corrective action.

The M24 round also extended the scope of monitoring beyond official milestones and deliverables to include internal milestones and deliverables (IM/ID) across WP 5–10. Internal milestones are particularly useful as a monitoring tool because they track progress in finer detail, and delays at the milestone level can signal risks to upcoming major deliverables before they materialise, enabling earlier corrective action. Together, official and internal milestone tracking provide a more complete picture of implementation progress within each WP.

As in the M16 reporting presented in the first interim report, the M24 reporting distinguished between delays and deviations. A *delay* refers to a milestone or deliverable that did not make the agreed deadline outlined in the Grant Agreement or WP detailed protocol. A *deviation* refers to a change from the original plan that did not necessarily cause a delay, such as changes to methods, personnel, or outputs. Delays were further categorised by length of time: moderate (1–5 months); significant (6–9 months); or critical (10 or more months). Reasons for delays and mitigation measures were grouped into predefined categories, defined in Appendix 8.1.

Results

A total of 775 IM/IDs were due up to and including M24 across the consortium. Most IM/ID were completed on time across all WPs ($n = 638$; 82%), with only a small proportion experiencing delays. This proportion was slightly higher among WP 5–10 than WP 1–4. Figures 2 and 3 show this breakdown.

Figure 2: Status of IM/ID up to M24 in WP 1-4 (N = 123 IM/ID).

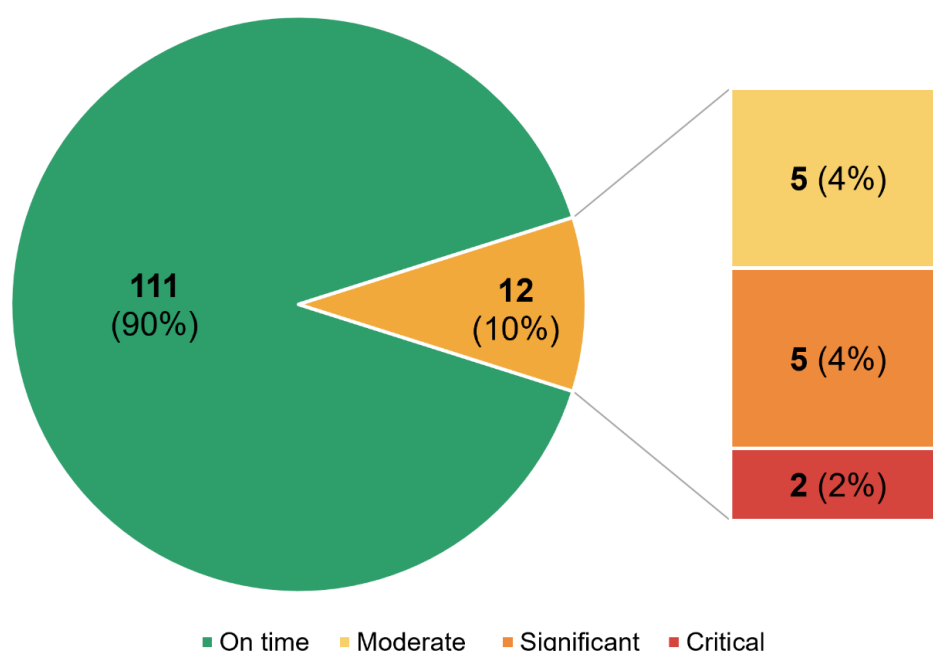


Figure 3: Status of IM/ID up to M24 in WP 5-10 (N = 652 IM/ID).

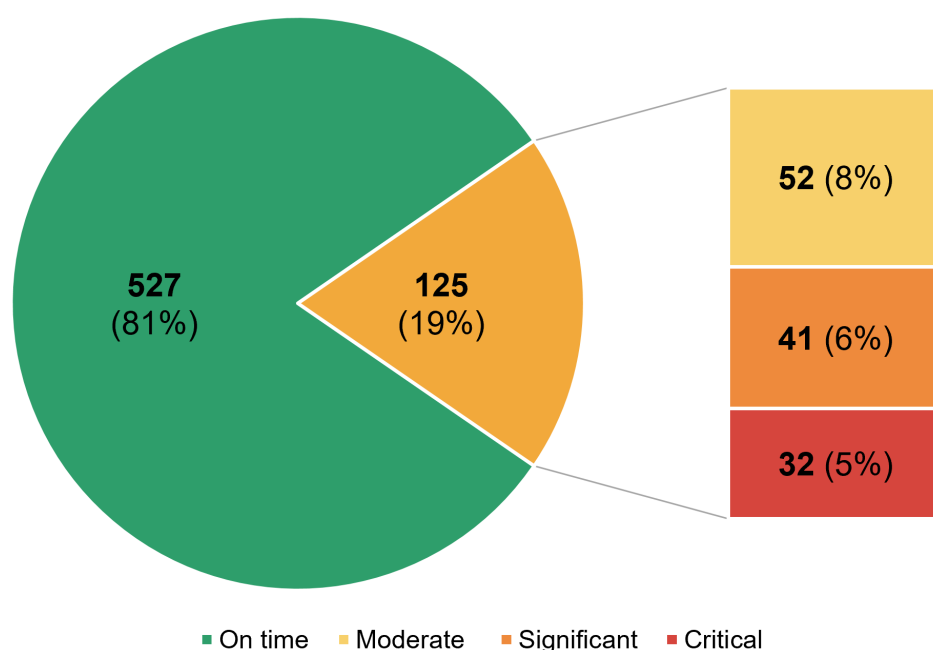


Figure 4 shows the reasons for delay for the delayed IM/ID across WP 5–10, in the form of a heatmap. Darker tiles correspond to a higher number of instances. Of the 125 delayed IM/ID, quality-driven adjustments were the most commonly reported cause (n = 20; 16%), concentrated in WPs 7 (n = 12) and WP 9 and 10 (n = 4 each).

Notably, no reason for the delay was provided for the majority of the delayed IM/ID (n = 73; 58%). Most of these were originally due earlier in the project (between M1 and M16), so by the time of the M24 report, the outputs had been delivered, albeit late.

Figure 4: Reasons for delay among IM/ID by WP (WP 5-10) (N = 125).

	Work package						Total
	5	6	7	8	9	10	
Quality-driven			12		4	4	20
Dependencies & external factors		3	3		1		7
Resource-related	1			1	3	2	7
Admin issues	2	1	3				6
Planning & coordination			2	1	1	2	6
Change in scope		1					1
Other causes			1	2		2	5
Not reported	6	53	5	4	2	3	73
Total	9	58	26	8	11	13	125

Figure 5 shows how mitigation measures are mapped to reasons for delay, as reported at an aggregate subtask level across WPs 5–10 (N = 57). The mitigation measures ranged from administrative and coordination actions, such as clarifying responsibilities or arranging additional partner meetings, to more substantial responses, such as adjustments to the scope, methodology, staffing or timelines. Full definitions and examples for each mitigation category can be found in Appendix 8.1.

Several delay categories were addressed through more than one type of action, suggesting that the mitigation was tailored to specific implementation challenges. Overall, dependencies and external factors were the most frequently mitigated delay category (n = 18 instances), primarily through a combination of adjustments to timelines and work plans (n = 6), staffing and resources (n = 4), coordination and administrative actions, and scope and methodology (n = 2 each).

Figure 5: Mitigation measures by reason for subtask delay in WP 5–10 (N = 57).

	Reason for delay							Total
	Dependencies & external factors	Admin issues	Quality-driven	Planning & coordination	Resource-related	Change in scope	Other causes	
Staffing & resources	4	2			4		1	11
Timeline & workplan	6	2		1			1	10
Coordination & admin	2	4	1	2				9
Scope & method	2		1	1		1		5
Monitoring & support	1	1	1				1	4
No additional action	2	2	2	2			1	9
Not reported	1	1	2		1		4	9
Total	18	12	7	6	5	1	8	57

Activities of WP1 to improve output delivery

WP1 has maintained its focus on strengthening the monitoring and coordination of the project to help the consortium deliver its outputs on time.

During the M24 reporting period, WP1 identified certain internal deliverables as particularly important and arranged for them to undergo additional review by the Scientific Coordinator. These were selected because they capture valuable project results that might not be disseminated through scientific journal papers or policy briefs. This additional review process helps to ensure that valuable outputs are captured, assessed and made visible.

After the M24 deadline, WP1 held individual meetings with each WP to review technical progress and finances. These meetings helped to identify risks early on, clarify priorities and ensure that everyone was on the same page, demonstrating the value of structured monitoring in supporting proactive project management.

The progress trackers introduced for M24 worked well. They provided WP1 with a clearer overview of activities across all WPs, thereby improving reporting and coordination. Feedback from the WPs indicated that the trackers were a useful internal tool for systematically keeping track of their milestones, deliverables and overall progress.

Beyond M24 reporting itself, WP1 collaborated with WP2 to improve the communication of project results. Together, they created a concise reporting template (called *results summary sheets*) that presents results in a clear, accessible and user-friendly format. This makes it easier to share progress with people outside the project and demonstrate what has been achieved beyond academic publications. Key achievement groups and prevention packages were also conceptualised and developed as routines to improve the communication of main results and strengthen the monitoring of progress towards project goals.

Discussion

Overall, the M24 findings indicate that a fifth of the milestones and deliverables across WP 5–10 experienced some degree of delay, but the majority of these were moderate in severity. The monitoring infrastructure now in place, including structured trackers, bilateral meetings and planned reviews of key deliverables, provides a robust foundation for proactive risk management as the consortium progresses towards its final outputs.

→ A key area for improvement in future reporting rounds is the completeness of delay reporting, particularly ensuring that reasons for delay are consistently documented to support more informed monitoring and corrective action.

Next steps

For the remainder of the project, including the M32 reporting period, WP1 will continue to use structured progress monitoring, with the trackers helping to identify delays early on so that problems can be resolved quickly.

WP1 will also maintain the additional review process for significant deliverables, providing WP leads with clear timelines and procedures. In collaboration with WP2, WP1 will continue to work on presenting project results in accessible formats to reach a wider audience. Regular check-in meetings with WPs will remain a core part of how WP1 keeps the project on track, supporting scientific progress and effective project management as the consortium moves towards its final outputs.

3. Peer Assessment of Knowledge Translation Outputs

This section presents findings from WP3's second evaluation activity, which assessed a selection of KT outputs across WP 5–10, from the perspective of the participants in each WP. Because participants were asked to evaluate the outputs from their own WP as informed practitioners, rather than as authors, this activity is referred to as a *peer assessment*.

This survey aims to assess whether the KT outputs produced so far are reaching JA participants, whether they are considered relevant and useful to participants' own work, and whether they are perceived as having potential for adaptation and application by key stakeholders beyond the JA, such as policymakers and practitioners.

This survey targeted WP participants rather than external end users. This reflects the dual role of WP participants: they are involved in developing and using the KT outputs, and they also serve as potential multipliers who disseminate these outputs to relevant target groups in their own countries and institutions, in their capacity as public health experts. This places them in a good position to assess the relevance of the outputs and their potential for adaptation and use by key stakeholders.

Conducting this assessment at the midpoint of the JA allows us to reflect while there is still time to take action. It allows us to identify which outputs are landing well and which may require further development, adaptation, or dissemination efforts within the JA before the project concludes. Insights gained at this stage can meaningfully inform the production of final outputs across WP 5–10, ensuring that the JA's KT efforts result in outputs that are not only timely but genuinely useful for the people and systems they intend to serve.

3.1. Theoretical background

Knowledge translation is a process, not a product

KT is defined as a dynamic and iterative process encompassing the synthesis, dissemination, exchange, and ethically sound application of knowledge to improve health outcomes and strengthen health systems [3, 4]. A critical component of this definition, and across the literature more broadly, is that producing and sharing knowledge is a necessary but insufficient step. The ultimate goal is that those who need knowledge are actually able to use it [5].

A variety of overlapping terms are used across the literature to describe this process, including knowledge translation, knowledge transfer, knowledge exchange, research utilisation, dissemination and diffusion [6]. While the terminology varies, the central idea is consistent: a move beyond simply producing and sharing knowledge toward its active use by those who need it. This report uses the term 'knowledge translation' throughout.

KT resources are the tangible outputs that support this process. These include policy briefs, guidelines, toolkits, case studies and training materials designed to make evidence accessible and actionable for specific audiences, including policymakers, practitioners and the public [3, 7]. While these audiences are the ultimate intended users of KT outputs, this survey asks the JA participants to evaluate them, due to their dual role as both *users* of the outputs and *multipliers* who disseminate them onward to these external audiences.

Why assessing knowledge translation matters

Despite growing investment in knowledge production, the gap between what is known from research and what is actually done in policy and practice remains a persistent challenge in public health [3]. A common but flawed assumption is that, once produced and communicated, knowledge will automatically be adopted by decision-makers. This 'linear model' of KT has been

questioned in the literature, with several scholars arguing that it does not reflect how knowledge is actually used in practice [8, 9]. In reality, research findings are used not only instrumentally but also conceptually and symbolically. Whether they are used at all is shaped by values, political interests, and the specific organisational and cultural contexts in which decision-makers operate [10-13]. Therefore, resources must be actively tailored to the needs and contexts of their intended users [14, 15].

Early and ongoing collaboration with potential knowledge users enhances KT, making sure outputs are more likely to be relevant and applicable to their needs [4, 14, 16, 17]. The quality of relationships and trust between knowledge producers and users also play an important role [10, 12, 15]. However, KT is also heavily context-dependent; what works in one national or organisational setting may not be applicable in another [13, 15]. This is a particularly important consideration for a multi-country initiative like JA PreventNCD, where outputs are developed collaboratively and intended for use across diverse European health systems.

At this stage of the JA, it is important to consider not only whether outputs have been produced, but also whether JA participants consider them relevant and useful for their own work in their role as users, and whether they see potential for these outputs to be shared with and adopted by key stakeholders beyond the JA in their role as multipliers.

Knowledge translation happens in stages, not automatically

Rejecting the linear model does not mean that the uptake of knowledge is random or unstructured. Rather, when uptake occurs, it usually happens gradually, unfolding through distinct stages rather than as a single event. This process is sometimes called a 'continuum', moving from becoming aware that something exists, to engaging with it, and eventually applying it in practice [8, 18, 19]. Similarly, progression through these stages is never guaranteed: a person or organisation may become aware of an output but then take no further action for various contextual, political or practical reasons [8, 13].

Rogers' (1995) Diffusion of Innovations Framework identifies five stages: awareness, interest, evaluation, trial, and adoption [19]. Skinner (2007) simplifies these into two broader dimensions: reach (whether an output has been encountered by its intended audience) and uptake (what people do with it afterwards) [18]. Similarly, Knott and Wildavsky (1980) and Landry et al. (2001, 2003) identify uptake and use as key indicators of genuine KT [20-22]. Reach is the necessary first step, but it does not automatically lead to uptake. As Walter, Nutley and Davies (2005) describe, uptake occurs through active interaction between producers and users working towards a shared goal [11].

Therefore, evaluating KT outputs requires looking beyond dissemination measures such as downloads to examine whether people are genuinely engaging with what has been produced. It is also necessary to establish at which stage the process has stalled, if people are not engaging.

The Knowledge Uptake and Utilisation Measurement Tool

The peer assessment survey is primarily based on the Knowledge Uptake and Utilisation Tool (KUUT) [18], which builds on pioneering knowledge utilisation frameworks by Knott and Wildavsky (1980), Landry et al. (2001, 2003), and Hall et al. (1975) [20-23]. The KUUT breaks down the above continuum into nine measurable stages: awareness, reception, cognition, discussion, reference, effort, adoption, implementation and impact. These represent progressively deeper levels of engagement with a 'knowledge product' (i.e. a KT output) and are measured through a 44-item questionnaire [18].

A key strength of the tool is its framework for the deliberate non-use of resources, which is an additional construct of the KUUT. This recognises that understanding why a resource is *not* used is as important as measuring uptake and categorising barriers at the levels of innovation, organisation, environment and individual [18]. This is valuable in the JA context, where low awareness may indicate gaps in dissemination, while deliberate non-use may suggest issues of relevance or usability that could inform the development of future resources.

One limitation of the tool is that it focuses on the user of an output rather than its producer. While this aligns well with the overall design of the peer assessment survey, we also aimed to evaluate the extent to which producing KT outputs facilitated joint learning and capacity development among the contributors. The broader KT literature identifies three types of capacity building: individual (e.g. acquiring new skills and knowledge); relational (e.g. establishing professional relationships and trust through collaboration); and organisational (e.g. developing the structures necessary for sustained work over time) [12]. In particular, relational capacity building strengthens research relevance and encourages further engagement in KT activities [12]. This survey addressed this gap in the KUUT by adding an additional capacity-building dimension developed specifically to capture these individual and relational benefits for contributors.

3.2. Methods

Key evaluation questions

The survey addressed three key evaluation questions (KEQs), each targeting a different component of participants' engagement with KT outputs:

1. **Relevance and institutional fit** – To what extent are the KT outputs relevant to participants' own work and institutional context?
2. **Adaptability for key actors** – To what extent can the KT outputs be adapted for use by key actors (e.g. health ministries, policymakers, practitioners) at national or subnational level?
3. **Capacity building through development** – To what extent did participating in the development of the KT outputs contribute to joint learning and capacity building among participants?

Operationalisation using the Knowledge Uptake and Utilisation Tool

The survey instrument operationalises seven of the ten constructs from the KUUT, described above [18]. Each construct is mapped to one of the three KEQs (see Table 5 in Appendix 8.2).

KEQ1 (relevance and institutional fit) draws on five constructs. *Awareness* and *reception* capture whether an output is known and has reached its intended audience. These are the entry points of the KT continuum. *Cognition* captures whether the output has been read or is intended to be read. *Adoption* was adapted from its original meaning in the KUUT (adopting a practice from the output) to instead capture intent to adopt, and perceived relevance and fit with the respondent's own work, institutional context, and end users. For respondents who had not read or used an output, *deliberate non-use* identifies the specific reasons, distinguishing non-awareness from a considered decision not to adopt.

KEQ2 (adaptability for key actors) draws on two constructs. *Discussion* captures whether an output has been shared within or beyond the respondent's organisation. A new construct, *transferability and key actor engagement*, was developed specifically for this survey to capture perceived potential for an output to be adapted and taken up by health ministries, policymakers, or practitioners at national level.

KEQ3 (capacity building through development) draws on a single construct, adapted from the KUUT's *impact* construct. Rather than measuring impact on a target population or practice adoption, this was reframed to capture the impact of developing an output on the contributor's own practice, recognising that KT occurs through co-production as well as consumption. This construct was assessed only among respondents who contributed to a given output.

Because respondents are JA participants rather than external end users, responses to KEQ1 and KEQ2 reflect perceived and anticipated relevance and adaptability rather than confirmed uptake or use in practice. The KUUT's *effort* (favouring an output over other sources) and *implementation* (adopted information becoming routine practice) constructs were not assessed, as the outputs are at an early dissemination stage and evidence of practice change would be premature at this point in the project.

Participants and survey design

The survey was distributed to all participants in WP 5–10 ($N \approx 766$), i.e. individuals whose employment is at least partly funded through JA PreventNCD and who contribute substantively to the work of their respective WP. Invitations with survey links were emailed to all WP 5–10 participants regardless of their role. Respondents evaluate the outputs from their WP as a critical friend rather than as an author, which reduces social desirability bias while keeping judgements contextually informed. Participants involved in more than one WP were asked to complete the survey primarily for the WP to which they devote the majority of their time. They were given the option of completing the survey again for any additional WPs in which they are actively involved.

The survey assessed KT outputs produced up to April 2026 (M28), at which point the survey was developed. Based on the M24 milestone and deliverable progress trackers, WP3 first compiled a shortlist of the most relevant KT outputs produced to date in each WP, selecting those that represented tangible KT products with key findings, recommendations, or tools for practice. Each WP lead was then asked to select a maximum of five outputs from this shortlist, or to suggest additional relevant outputs that had not yet been identified. Due to differences in WP work plans and deliverable timelines, three WPs included five outputs, two included four, and one included three (see Table 2 below).

To encourage informed responses, the survey included a brief, plain English description of each output, along with a direct link allowing respondents to access the output while completing the survey. Questions on relevance and usability were only shown to respondents who indicated awareness of a given output. Similarly, capacity building items were only shown to respondents who indicated involvement in their development. Respondents who indicated no awareness of any of the outputs surveyed were screened out of the survey.

The survey was designed and administered using the RKI's survey platform, Voxco, and pre-tested with RKI colleagues to ensure clarity and identify errors. Approval for data protection was obtained from the RKI, and the Ethics Board of the Berlin Medical Association confirmed that no formal ethics approval was required. Data collection ran from May to September 2026. All WP 5–10 participants were emailed an invitation, regardless of their role. In line with privacy regulations, no personally identifying information, such as email addresses, was collected. This meant that it was not possible to track which individuals had or had not completed the survey. This became a significant limitation of the survey design and is discussed further in Section 3.4.

A full printout of the survey is provided in Appendix 8.4.

Outputs surveyed

A total of 26 outputs were assessed across WP 5–10. Table 2 shows the list of selected KT outputs. Appendix 8.3 provides a categorisation (output category and prevention focus) and brief description of each output surveyed.

Table 2: Selected KT outputs, by WP and their designated category (N= 26)

WP	Selected KT outputs
WP5	- State-of-the-art report on the promotion and reduction of portion sizes (<i>evidence review</i>) - Narrative literature review on alcohol cancer warning labels (<i>evidence review</i>) - Alcohol and tobacco policy scales (<i>implementation tool</i>) - Overview of national and EU initiatives targeting air pollution and noise reduction (<i>policy analysis</i>) - Analysis of legislations concerning per- and polyfluoroalkyl substances (PFAS) across Europe (<i>policy analysis</i>)
WP6	- Community Action for Health Methodology Guide (<i>practical guideline</i>) - Workshops/Webinars on the Methodology Guide (<i>community training</i>) - Workshops/Webinars on Tool Selection and Usage of the Methodology Guide (<i>community training</i>) - Checklists to Support Tool Selection of the Methodology Guide (<i>implementation tool</i>) - BreastFEEDucation E-Learning Course for Students and Healthcare Professionals (<i>community training</i>)
WP7	- Country-level mapping of digital health literacy policies (<i>policy analysis</i>) - Reporting on Organisational Health Literacy assessments (<i>implementation tool</i>) - Systematic review of methods to assess environmental health inequalities in health impact assessments of local interventions (<i>evidence review</i>) - Equity Tool for interventions (<i>implementation tool</i>)
WP8	- Country Fact Sheets summarising NCD risk factor monitoring across EU states (<i>monitoring framework</i>) - Interim summary on mapped tools and methods for monitoring NCD risk factors (<i>monitoring framework</i>) - Mapping Data Sources to Monitoring Cancer Burden and Costs: Survey Results (<i>monitoring framework</i>) - Catalogue of Promising Practices for an indicator library for NCD monitoring (<i>monitoring framework</i>)
WP9	- Report on Good MHiAP Practices (<i>policy analysis</i>) - Policy Brief on Tobacco Industry Interference in FCTC Implementation (<i>policy brief</i>) - Report on commercial activities in food industry (<i>policy brief</i>) - Review of health considerations in impact assessments (<i>evidence review</i>) - Online Wellbeing Economy Toolbox (<i>implementation tool</i>)
WP10	- Toolkit for Citizen Engagement in Risk-Stratified Prevention (<i>practical guideline</i>) - Smoking Cessation Pilot Project End Report (<i>evidence review</i>) - Motivational Materials for Smoking Cessation During Pregnancy (<i>community training</i>)

The most common categories by output type were implementation tools and evidence reviews, followed by policy analyses, community training and monitoring frameworks. The least common categories were practical guidelines and policy briefs (Figure 6).

Figure 6: Number and type of KT outputs surveyed (N = 26).



By prevention focus, the most frequent outputs were related to the prevention of NCDs more broadly, rather than a specific risk factor or focus area (Figure 7). The next most common focus was social inequalities, followed by tobacco/nicotine use. Nine of the 26 outputs surveyed were categorised under more than one focus area.

Figure 7: Number of outputs categorised by prevention focus (N = 26; 9 outputs have >1 prevention focus).



3.3. Results

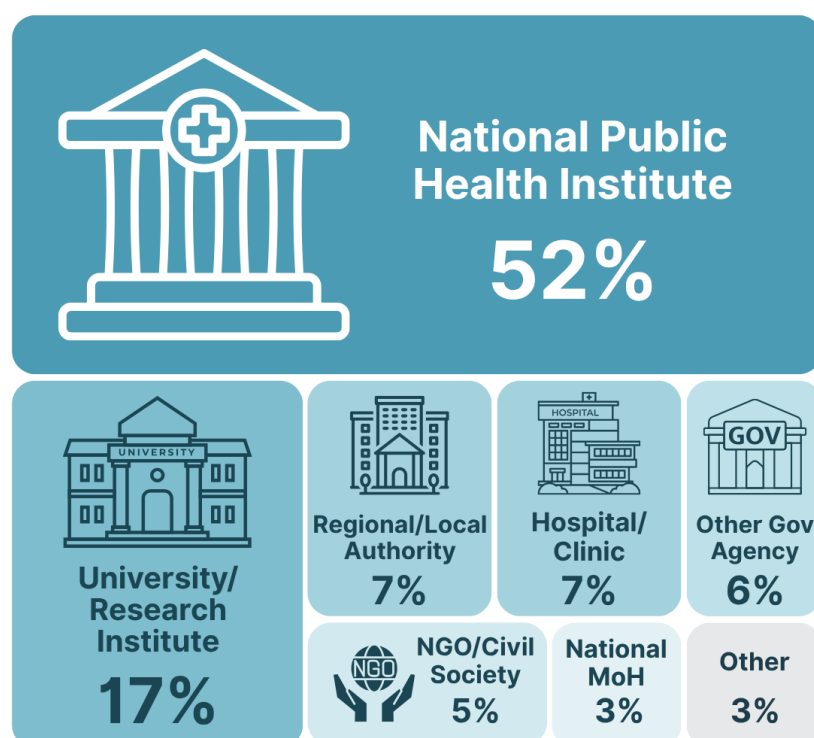
Respondent characteristics

The survey achieved an overall response rate of 43.6% (334/766 participants), ranging from approximately 25% to 50% across the individual WPs. However, the response rate should be regarded as an approximation. This is because contact lists used to compile the sample may not have been fully up to date. Furthermore, since no personally identifiable information was collected, it was not possible to determine how many respondents completed the survey for more than one WP (see Limitations, Section 3.4).

The following results distinguish between the total number of unique respondents (captured by “N”) and the number of responses (captured by “n”). This is because respondents answered the same questions for each output they were aware of. This means that one unique respondent could contribute up to five sets of responses, depending on their WP.

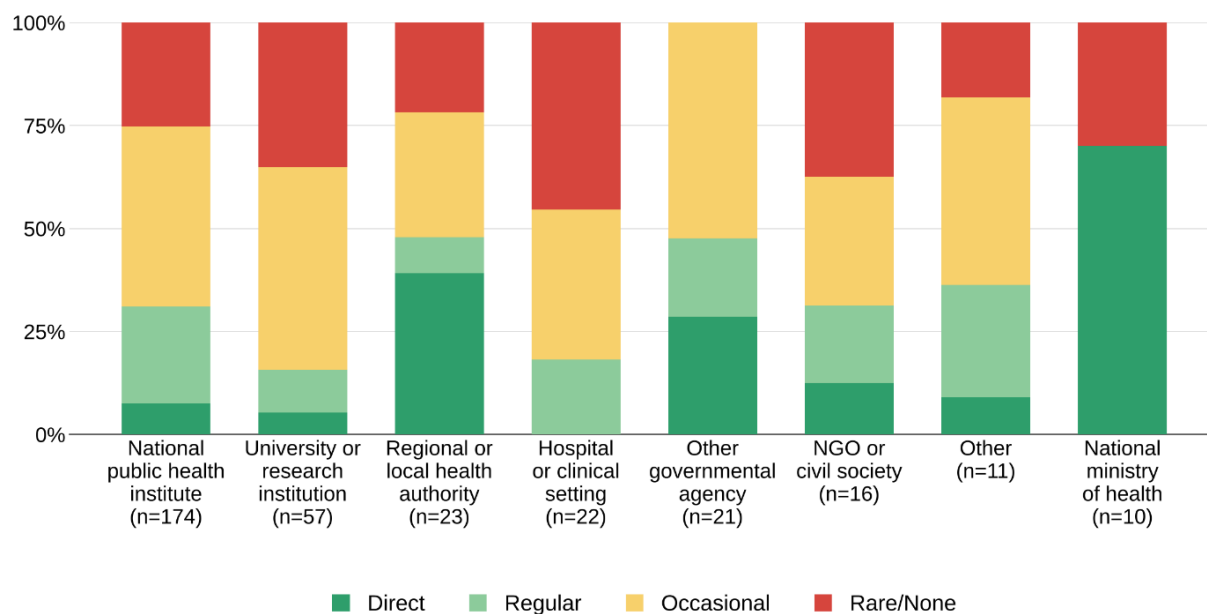
To help contextualise findings relating to the potential of outputs to reach decision-makers and end users, respondents were also asked what type of institution they work at. The majority of survey respondents work at national public health institutes. Figure 8 shows the other institution types.

Figure 8: Representation of what type of institutions the respondents work at (N = 334).



Although national public health institutes make up the largest proportion of survey respondents, this does not necessarily mean that their staff work closely with decision-makers. Overall, 31% of respondents reported having direct or regular contact with decision-makers or policymakers in their professional role (n = 104). This varied considerably by institution type (Figure 9). Among respondents from national public health institutes (n = 174), direct or regular contact with decision-makers was less common than occasional or no contact. By contrast, respondents from national ministries of health, regional or local health authorities, and other government agencies reported being in closer proximity to decision-makers.

Figure 9: Proximity to decision-makers/policymakers of respondents, by institution type (N = 334).



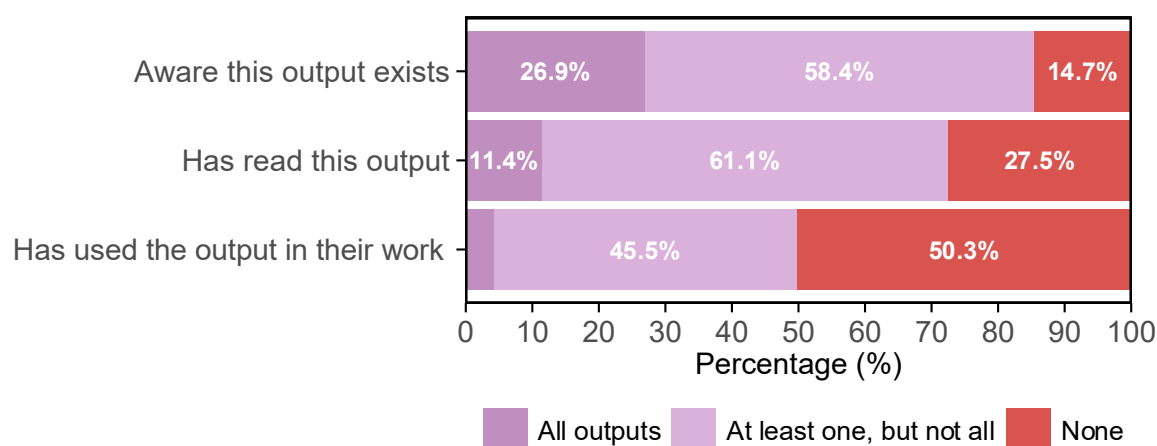
Are participants aware of the outputs from their WP?

For each output from their own WP included in the survey, respondents were first asked whether they were aware it existed. This served two purposes: firstly, it gauged how familiar WP participants were with the key outputs from their own WP; and secondly, it determined which follow-up questions they received. Respondents who were aware of a given output were then asked whether they had read or used it in their own work.

As the number of outputs surveyed varied between WPs (from three to five), the results are presented at an aggregate level here. To allow fair comparison across WPs, results on whether respondents are aware of, have read, and have used the outputs are grouped into three categories: none of the listed outputs; at least one, but not all; and all listed outputs.

The majority of respondents were aware of at least one of the outputs listed for their WP, but not all of them. More than a quarter were aware of all listed outputs, while 14.7% were unaware of any of them. Fewer respondents reported having read the outputs, and even fewer having used them (Figure 10).

Figure 10: Awareness, reading and use of outputs (N = 334).

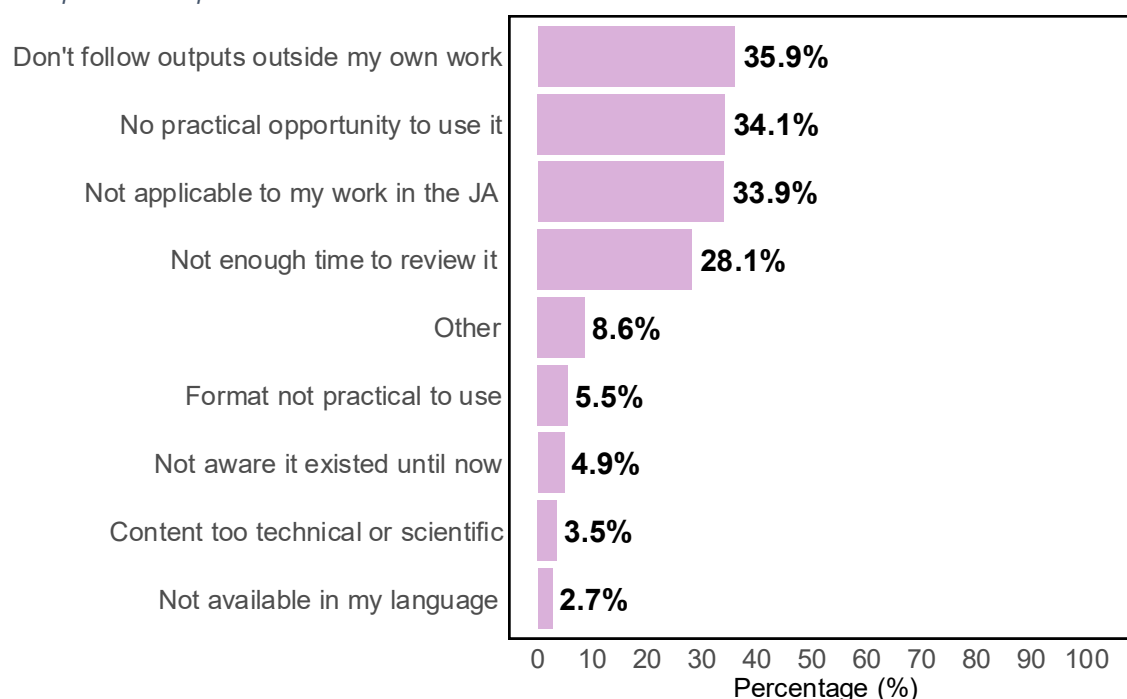


What are the reasons participants have not read or used outputs from their WP?

Reading or using an output is a necessary step before it can be shared with the relevant target groups and stakeholders. Therefore, understanding why some outputs are not read or used is an important part of this evaluation. This question was only shown to respondents who indicated that they were *aware* of a given output but had *not read* and/or *not used* it. Respondents who were not aware of an output were not asked any additional questions about it. Eligible respondents were asked to select their reasons from a predefined list, with the option to provide an open response, and could select more than one reason.

Figure 11 shows that there are four main reasons for deliberately not using the output. These reasons are related to the output's limited applicability to the respondent's work, the lack of an opportunity to use it yet, and the respondent's limited time to engage with the output. Each of these reasons was selected in 28–36% of cases. Barriers to usability, such as the format, technical or scientific content, or language, were cited less frequently.

Figure 11: Reasons why participants have not read or used KT outputs (N = 229 respondents; n = 1,016 responses). Multiple answers possible.



Respondents who selected 'Other' as the reason for non-use were required to provide an answer in an open-text field. The three main themes identified in these responses were:

- **Timing mismatch:** this was the most common theme among this subset of responses. Reasons given include the respondent joining the project (or their pilot/subtask) after the output was produced, or the output being released too late to inform work that was already underway.
- **Access or awareness gaps:** some respondents had only recently heard of the output, had not had access to the file or had missed the webinar/invitation where it was introduced.
- **Limited applicability or overlap:** a smaller group noted that the output was not directly relevant to their specific role, overlapped with existing outputs that they were already aware of, or (in one case) was considered too complex for practical local use.

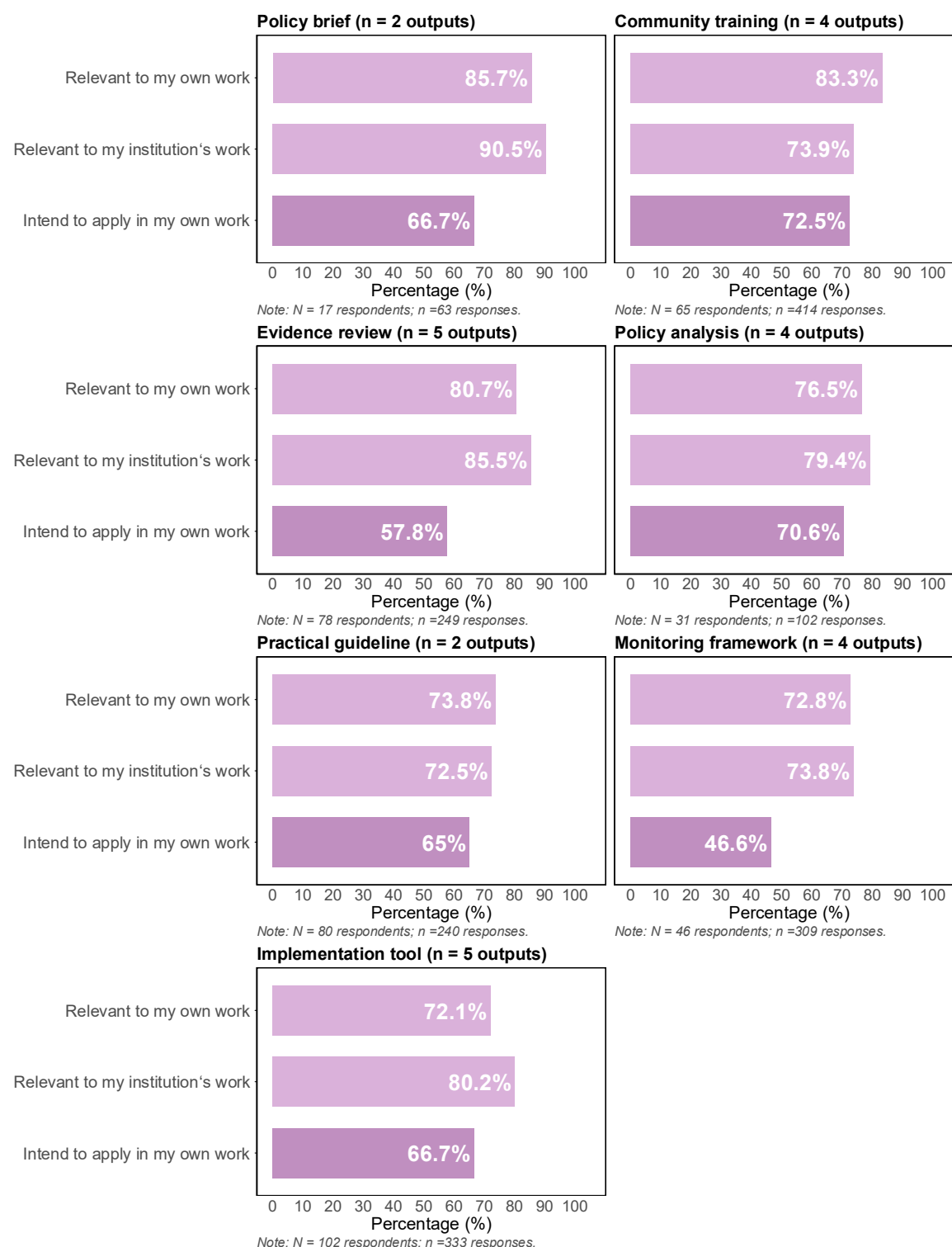
What outputs are perceived as most relevant?

For each output that they indicated they were aware of and had read and/or used, respondents were asked to assess its relevance to their own work and to the broader work of their institution, and to indicate whether they intended to apply any of its content to their own work.

In total, 334 respondents provided feedback on an average of 4.34 outputs each (range: 3–5), resulting in 1,450 output ratings in total (referred to as 'responses' and indicated using 'n' in the figures below). To provide actionable feedback at an aggregate level on certain categories of output, the responses were categorised and compared across output type (i.e. policy briefs, evidence reviews or implementation tools). Refer to Figure 6 for output types.

Overall, a clear majority of respondents' ratings (89.6%) considered the outputs relevant to either their own work or their institution's work more broadly across all output types (Figure 12). However, the stated intention to apply something from an output was markedly lower (63.7% on average). Community training scored highest on intention to apply. Policy briefs achieved the highest average rating across the three measures, driven by very high relevance scores, while monitoring frameworks scored lowest, mainly because fewer respondents intended to apply them in their own work.

Figure 12: Relevance of KT outputs for participants, by output type.

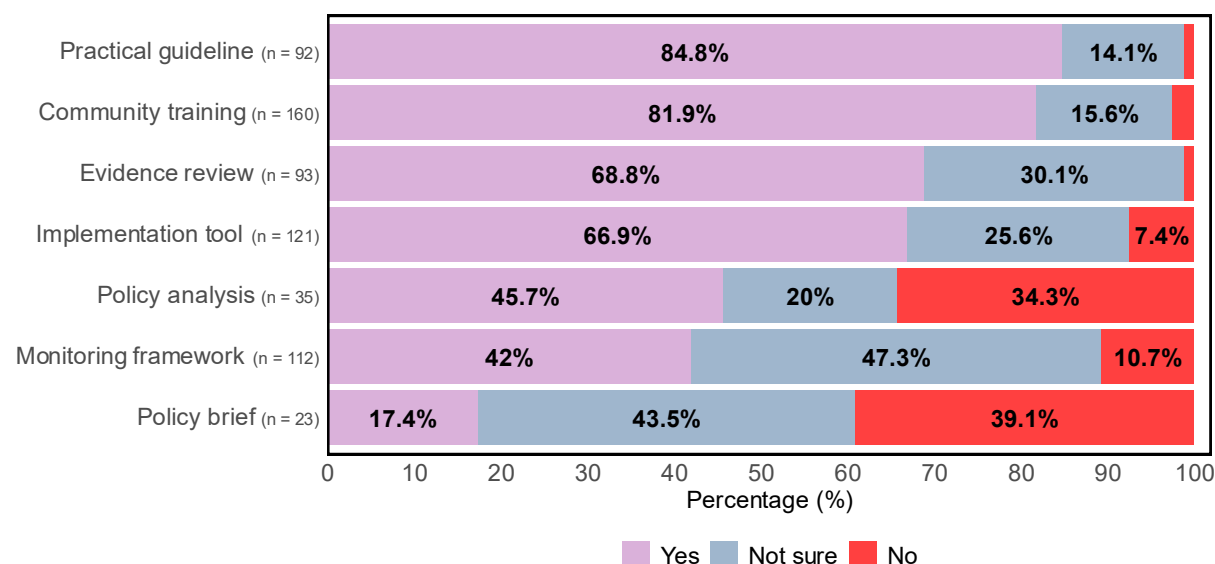


Do the outputs explicitly address social inequalities?

One of the JA's core objectives is to address social inequalities in cancer and NCD prevention. This survey does not independently assess whether outputs actually contribute to reducing inequalities in practice; rather, it captures respondents' perceptions of whether a given output considers this dimension. Respondents were asked whether a given output explicitly addressed health inequalities or the needs of vulnerable groups, such as those with a low socioeconomic status.

On average, 58.2% of ratings across output types indicated that the outputs explicitly addressed health inequalities (see Figure 13). Two output types performed particularly well: practical guidelines and community training. In contrast, policy briefs, monitoring frameworks, and policy analyses showed room for improvement, with many respondents either unsure or disagreeing as to whether these outputs addressed inequalities.

Figure 13: Does the KT output explicitly address health inequalities or the needs of vulnerable groups, by output type?



Note: The number (n) shown for each output type reflects number of responses. Figure 6 shows the number of outputs for each output type.

Are the outputs appropriate for their intended end users?

A key objective of creating KT outputs within the JA is to ensure that knowledge is accessible and actionable for the intended end users, including policymakers, practitioners and the general public. Respondents were asked whether they thought a given output had been developed appropriately for its intended end users.

The results were largely positive, showing little variation across output types. The proportion of respondents who rated the outputs as appropriate ranged from 66.7% to 78.3%. Policy briefs were rated the highest, followed by practical guidelines, with evidence reviews rated the lowest.

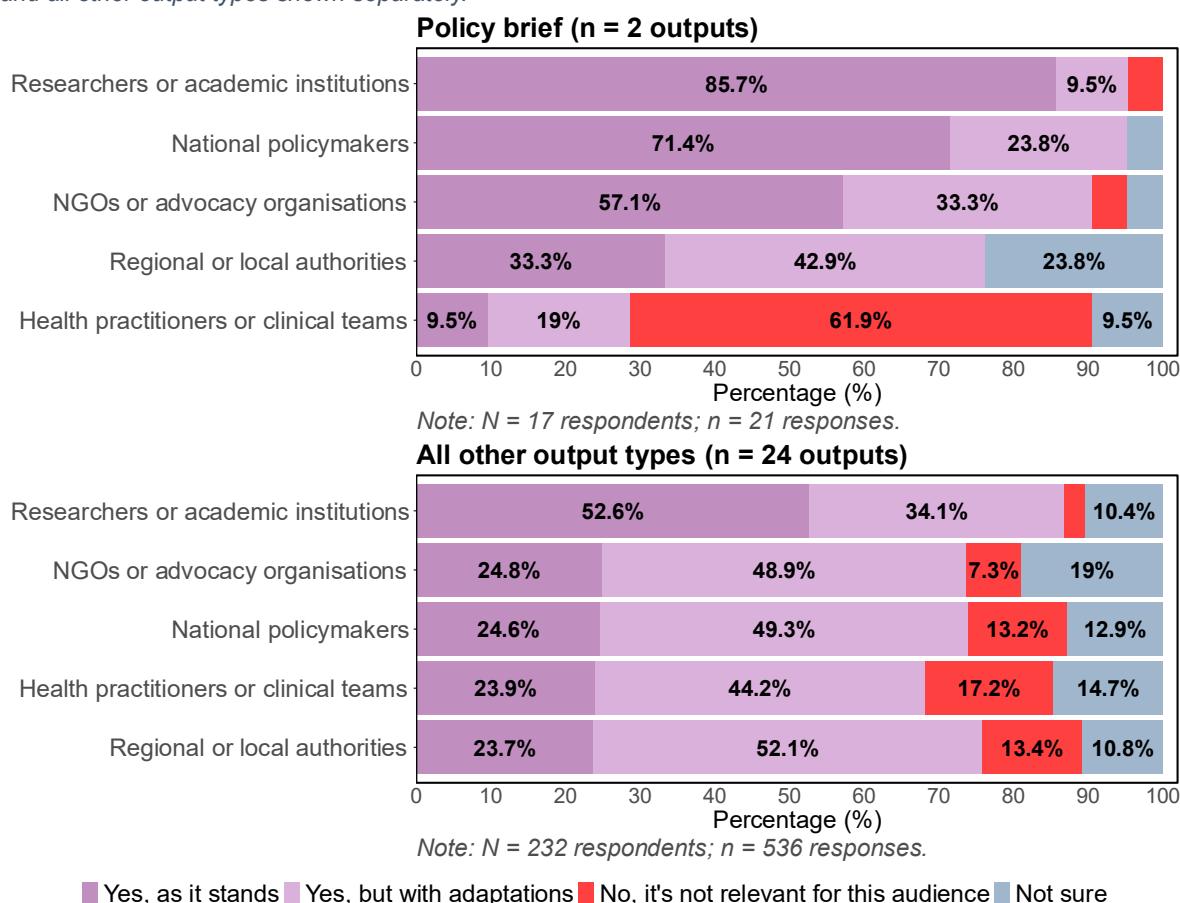
Could the outputs be adapted for use by key actors?

To better understand which key actors the JA's outputs are relevant to in respondents' national or regional contexts, respondents were asked, for each output, whether it was relevant to a given key actor group, and if so, whether it could be used as is or would first require adaptation.

Results are shown separately for policy briefs (which follow a different pattern because they are written for policy audiences) and for all other output types (Figure 14). Policy briefs were seen as ready to use as they stand by researchers (85.7%) and national policymakers (71.4%), but for regional or local authorities this was only one third of ratings. As these results are based on only two outputs and 17 respondents, they should be interpreted with caution.

Across all other output types, outputs were most often considered ready to use without changes by researchers and academic institutions (52.6%). For the four other groups, only about a quarter of ratings said an output could be used as it stands, while about half (45.7%) pointed to a need for adaptation, which means that outputs were mostly seen as relevant to these groups, but usually only after revision.

Figure 14: Could KT outputs be used by key actors, as they stand or with adaptation, by key actor? Policy briefs and all other output types shown separately.

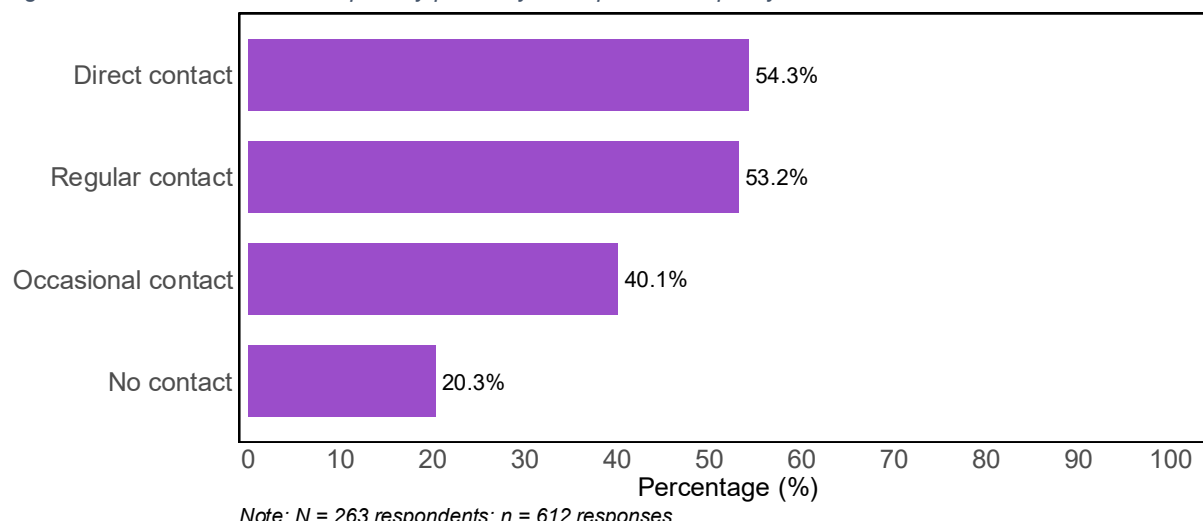


Do participants intend to share outputs with key actors?

For many KT outputs, achieving real-world impact depends in part on JA participants themselves acting as multipliers to share outputs with relevant decision-makers in their own national or regional context. As proximity to policymakers is likely to influence this intention, the results were analysed according to how closely respondents reported working with policymakers or decision-makers in their professional role.

A clear gradient emerged: around 53.8% of respondents who work directly with policymakers or have regular contact with them intended to share outputs. This proportion dropped to 30.2% among those with little or no contact with policymakers or decision-makers (Figure 15).

Figure 15: Intent to share KT outputs by proximity of respondent to policymakers or decision-makers.

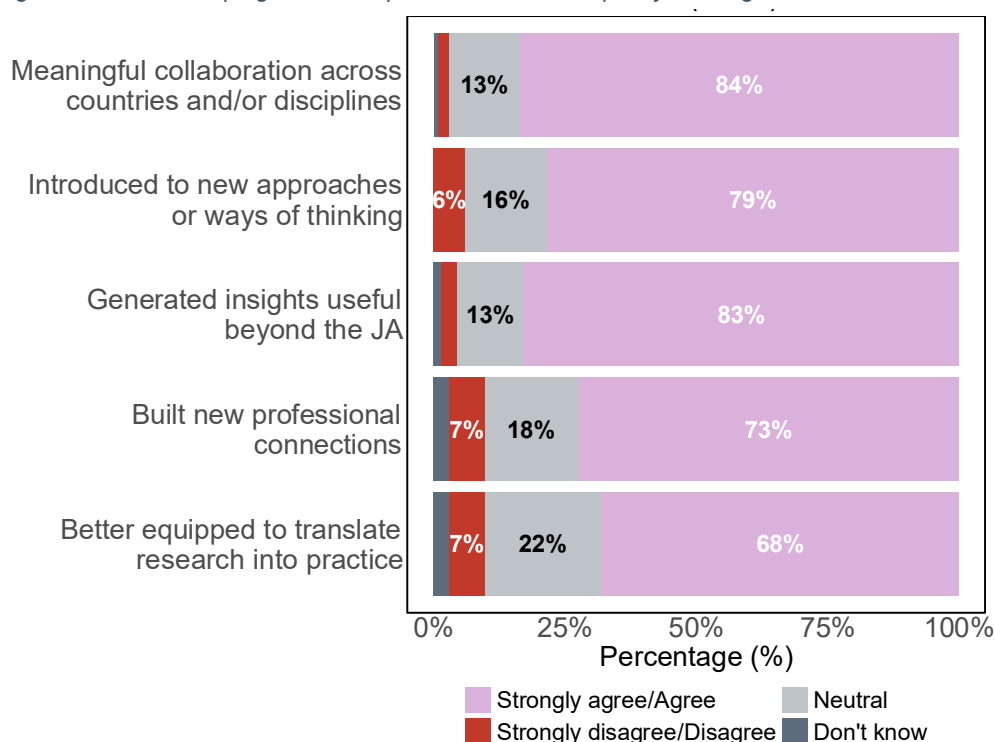


Did developing the outputs help build capacities?

The JA's broader goal is for participants and their institutions to build lasting capacities through their involvement, including the new knowledge and skills gained from developing outputs and the informal professional networks formed through international collaboration. To assess this, respondents who contributed to the development of a specific output were asked whether their involvement had contributed to one of five types of capacity building. Responses were collected on a five-point scale ranging from 'Strongly Agree' to 'Strongly Disagree'. For ease of interpretation, the responses "Strongly Agree" and "Agree" were combined, as were "Strongly Disagree" and "Disagree".

A clear majority of respondents agreed that contributing to the development of an output had been beneficial across all five capacity-building statements (Figure 16).

Figure 16: Did developing the KT outputs contribute to capacity building?



Note: N = 135 respondents; n = 675 responses.

3.4. Discussion

This peer assessment set out to answer three key evaluation questions: whether the project's KT outputs are relevant to participants' own work, whether they can be adapted for use by key actors, and whether developing them has contributed to capacity building. Answering these questions allows us to assess the extent to which the outputs are contributing to the JA's broader goals of building joint capacities, contributing to reducing social inequalities and engaging key actors. The findings offer a mixed but broadly encouraging picture, with clear implications for the remainder of the project.

Respondents had moderate awareness of outputs within their own WP: most knew of some, but not all, of the listed outputs, and 15% were unaware of any. This finding is worrisome given that we only asked about outputs from the respondent's own WP. It highlights the need for improved communication within WPs so that all participants are familiar with the products and tools developed. Where respondents were aware of an output, the ratings of its relevance were generally high, though the stated intention to apply it was consistently lower. Non-use was most commonly explained by limited time, no opportunity yet to use the output, or limited applicability to the respondent's own work, while usability barriers such as format, language or technical content were cited less often. This is a reassuring distinction as it suggests a challenge in dissemination and timing rather than a problem with the fundamental fit or design of the outputs. This aligns with the findings of WP3's first evaluation activity, in which task and subtask leads reported time constraints as the most common barrier to developing KT outputs. The same pressure appears to affect uptake as well [1].

Results on social inequalities varied more than those on end-user appropriateness. Practical guidelines and community training were rated strongly on addressing health inequalities and the needs of vulnerable groups, while policy briefs, monitoring frameworks and policy analyses lagged behind. As the question asked about explicit consideration, a possible explanation is that equity may not always be made visible in these shorter, policy-oriented or technical formats, even where it has been considered during development. Ratings of end-user appropriateness were more positive and varied little across output types, with between two thirds and three quarters of ratings considering outputs appropriate for their intended end users. As the project moves into its final phase and produces more practical, implementation-focused outputs, there is a clear opportunity to embed equity considerations and end-user appropriateness more explicitly and consistently across output types.

Outputs were most often seen as ready to use without changes by researchers and academic institutions. For the other key actor groups, only about a quarter of ratings on average said outputs could be used as they stand, and about half pointed to a need for adaptation. This is a sensible reflection of the JA's outputs to date, many of which are inherently academic in nature at this stage, and it suggests that most outputs will need adapting before they can be passed on to practitioners, policymakers and other key actors. Policy briefs, which are written for policy audiences, were an exception: they were seen as ready to use by national policymakers, but less so by regional and local authorities, which suggests that even policy-oriented outputs may need tailoring to regional contexts, although this rests on only two outputs.

Respondents' intention to share outputs with key actors was clearly linked to their proximity to policymakers in their day-to-day role. Interestingly, respondents from national public health institutes (the largest group in this survey) were not among those reporting the closest proximity to decision-makers. This suggests that being embedded within a public health institute does not guarantee direct access to policy or decision-making processes. This is an important consideration when assessing the pathways through which JA PreventNCD's outputs are likely

to influence decision-makers, and it suggests that influence depends not only on the quality of the outputs, but also on the ability of participants to act as multipliers.

Even when the final products are not yet fully relevant or usable for their intended audiences, the process of creating them appears to have been valuable. The majority of contributors reported meaningful collaboration across countries and disciplines, new insights, and exposure to different ways of thinking. This shows that the JA is creating value through the collaborative process itself, regardless of how far the outputs have progressed. This is a significant achievement for the JA to date.

Taken together, these findings suggest that JA PreventNCD is on a reasonable trajectory. The outputs produced so far have already built meaningful capacity among contributors, even though their reach and readiness for external audiences is still developing. Section 6 presents specific recommendations arising from these findings.

Limitations

This survey also has limitations worth noting. As no personally identifiable information was collected in line with privacy regulations, it was not possible to track individual responses, determine how many respondents completed the survey for more than one WP, or send targeted reminders to non-respondents. This was a genuine trade-off between privacy protection and ensuring evaluation precision.

Additionally, as this survey captured the perspectives of JA participants rather than external end users, findings on relevance and adaptability reflect anticipated rather than confirmed uptake in practice. This is a gap that WP3's upcoming evaluation activities, including stakeholder assessments planned for later project phases, are designed to address.

Finally, this assessment covers only a small selection of outputs and is not representative of the full body of work produced, or still to be produced, across the JA. Many WPs most significant outputs are expected toward the end of the project period and were therefore not captured in this survey. A follow-up peer assessment, or the incorporation of these later outputs into the planned stakeholder assessment, would help ensure the JA's most impactful outputs are also evaluated before the project concludes.

4. Implementation Case Studies

Another form of evidence used to evaluate the JA Prevent NCD's outputs and outcomes is the implementation case studies. These were included in the evaluation plan to identify promising examples of interventions early in the JA funding period, monitor them closely as they progress, and share them with partners as potential examples of good practice [2].

Given the scale of nearly 100 pilot projects across the JA, evaluating every intervention in depth is not feasible. Instead, this approach concentrates on a smaller, purposefully selected set of case studies capable of capturing contextual factors, implementation processes, and real-world outcomes across varied settings. This approach uses a mixed-methods, low-burden approach that avoids placing additional reporting demands on pilot and task teams [1, 2]. The case studies are complemented by WP4's assessment of pilot practices against the EU Commission Best Practice Portal criteria, which takes a broader, criteria-based view across the pilots and helps to fill gaps that in-depth case studies cannot cover.

The case studies aim to:

- Showcase diverse pilot models and their impact at local, national or EU level.
- Generate practical lessons to support replication, scale-up, and sustainability.
- Explain how and why implementation works in varying contexts.
- Produce in-depth, context-rich examples to foster scientific collaboration and future research.

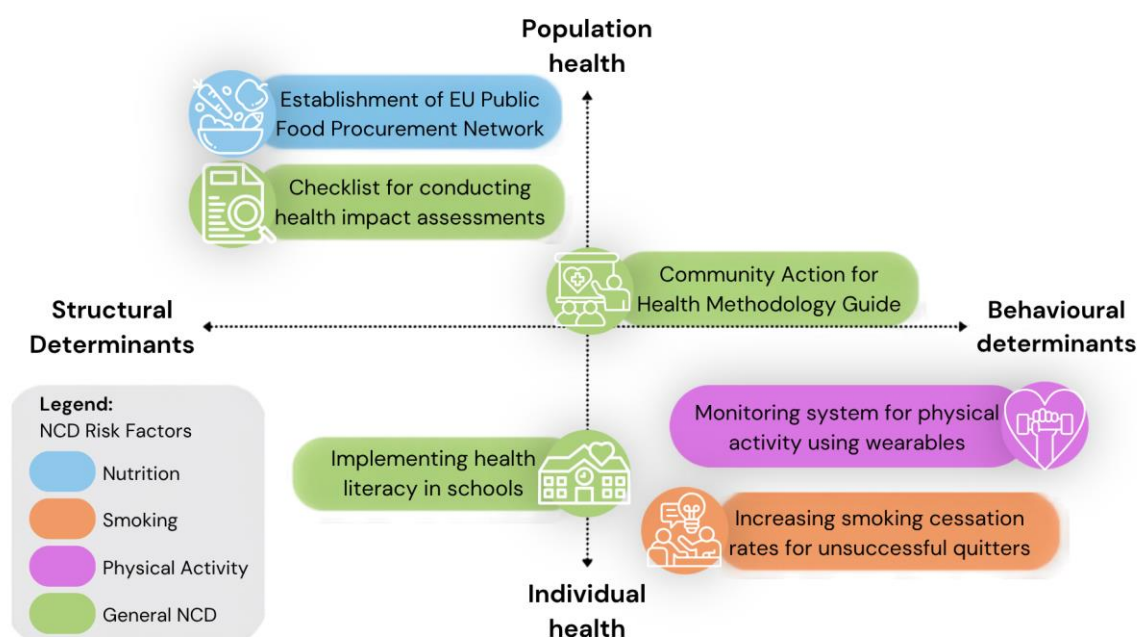
The rationale, selection criteria, and theoretical grounding for this work were set out in full in the first interim evaluation report, which introduced our use of Damschroder et al.'s Consolidated Framework for Implementation Research and Proctor et al.'s Implementation Outcomes Framework to guide data collection and analysis [24, 25]. This section builds on that foundation, reporting on the first insights generated since case study selection was finalised.

Overview and Approach

Case study identification began with WP leads proposing candidates, shortlisted against criteria including the inclusion of a diverse range of interventions at individual and population levels, coverage of key NCD risk factors, alignment with best practice frameworks and current priorities, likely progress within the funding period, and the availability of sufficient documentation to support meaningful development. Applying these criteria ensured a mix of interventions, target groups, and implementation contexts, reflecting the complexity and reach of JA PreventNCD [1, 2].

Implementation is tracked prospectively, following pilots as they progress rather than reconstructing their history retrospectively. Figure 17 maps the six selected case studies along two axes, whether they address structural or behavioural determinants of health, and whether their primary focus is population or individual health, illustrating the range of levels and mechanisms through which the JA aims to reduce NCD risk. Each case study is also colour-coded according to its primary focus on a risk factor: nutrition, smoking, physical activity, or NCDs more broadly. The remaining NCD risk factor, alcohol consumption, is not explicitly addressed by the selected case studies.

Figure 17: Selected implementation case studies, categorised by: NCD risk factor, structural/behavioural determinants, population/individual interventions.



As set out in the first interim evaluation report, the case studies draw on two established frameworks from implementation science. The Consolidated Framework for Implementation Research (CFIR) identifies the contextual factors, such as intervention characteristics, the inner and outer setting, and staff engagement and processes, that shape whether implementation succeeds [24, 26]. The Implementation Outcomes Framework then defines a set of specific, measurable outcomes for assessing implementation itself, including acceptability, appropriateness, feasibility, fidelity, adoption, cost, reach, and sustainability [25].

As most case studies are still in the process of implementation, our analysis at this stage focuses on two of these outcomes:

- **Feasibility:** Is the intervention practical to deliver with the staff, time, and resources available? What is working, what barriers have emerged, and how has the team responded?
- **Fidelity/Early adaptation:** Is the intervention being delivered in a way that is substantially consistent with its original design, with any adaptations reasonable and documented? What adaptations have been made, why, and what do they suggest for future practice?

Alongside these outcomes, we draw on CFIR to identify the contextual factors contributing to successes or challenges in each case, such as the policy environment, and staff engagement and processes. These were prioritised because they capture what is most observable and relevant in the early stages of a pilot's lifecycle: Later reporting stages will draw on additional outcomes from the framework, including adoption, appropriateness, and other contextual factors, as pilots mature and more evidence becomes available.

Together, these outcomes allow the case studies to move beyond describing activities, toward an honest account of what is and is not working, and why. Where adaptations have occurred, we present these as evidence of pilots responding constructively to local context, consistent with an implementation science perspective in which adaptation is both expected and, in many cases, a marker of successful implementation.

Each case study was developed using a light-touch, document-first approach. Drafts were primarily based on existing project documentation, such as milestone and deliverable reports, internal meeting minutes and monitoring data submitted by pilots as part of their reporting processes. These were supplemented by direct discussion with pilot leads during one or two bilateral meetings. Each draft was shared directly with the relevant leads for review before finalisation. The leads were asked to verify the accuracy of the problem definition, the description of the implementation, and the reported outcomes, and to reflect on and refine our interpretation of the findings. This ensured that the case studies reflected their own understanding of progress rather than an external assessment alone.

Each of the following case studies is structured consistently, beginning with a definition of the problem or opportunity being addressed, followed by a description of how the pilot or task responds to it. The next section contains findings on feasibility, fidelity, and early adaptation, and the final section summarises the main lessons and next steps.

One case study examining the pilot on monitoring physical activity through wearable devices is not included in this round of reporting. Delays in accessing the underlying pilot data meant that WP3 was unable to complete the document review necessary for developing a robust initial summary of insights within the reporting timeline. This case study is part of ongoing work and will be included in a future report once it is complete.

Building Implementation Capacity for Healthier Public Food Procurement



Task 5.4.3 EU Networks for Public Food Procurement

Lead: City of Copenhagen (KK). Partners: Austria (AGES); Estonia (TAI); Finland (THL); Greece (ICH); Hungary (NNGYK); Norway (HDIR); Poland (SUM); Slovenia (NIJZ).

Public institutions across Europe, such as schools, care homes and hospitals, serve millions of meals each day. This process, known as public food procurement (PFP), is an important but underused lever for improving population health. While policy ambitions for healthier and more sustainable diets exist in several Member States, implementation remains fragmented: responsibility is spread across ministries, procurement authorities, and local institutions, limiting coordinated action and knowledge exchange between countries.

To address this, Task 5.4.3 has established two complementary European networks: (1) a **PFP Officers Network** for procurement practitioners, and (2) a **Focal Point Network** for ministry representatives engaging with PFP across areas as varied as food, agriculture, climate, environment, and finance. The networks are led by the City of Copenhagen with support from the National Institute of Public Health in Slovenia. The City of Copenhagen has more than a decade of hands-on PFP experience from developing criteria to embedding nutritional and sustainability standards into large-scale public

meal systems, giving other countries a practical model to learn from.

Implementation Outcomes: First Insights

Feasibility

Early evidence suggests the network structure is feasible and generating genuine value. The EU PFP Officers Network, first established under the earlier JA Best-ReMAP, has grown to around 45 participants across 18 Member States under JA PreventNCD, a useful example of how outputs from one JA can be sustained and built upon in the next. Members of the network work primarily as PFP officers in municipal administrations or within national public procurement authorities. Participants range from countries with established national PFP structures, such as Finland and Denmark, to countries still building national coordination, such as Poland and Slovenia.

The EU Focal Point Network has grown from 8 Member States at launch in April 2025 to 10 Member States and around 18 participants. Members work across ministries including food,

agriculture, regional affairs, environment and climate, and finance. The EU Commission's DG SANTE and the Joint Research Centre (JRC)¹ also participate in meetings.

A key challenge has been identifying who should represent PFP at national level, since PFP is rarely owned by a single ministry and the participating institutions are themselves health bodies rather than procurement agencies. Experience from Greece illustrates this, where identifying appropriate representatives initially proved difficult, and meaningful change may still require legislative action.

Procurement officers and ministry representatives use the networks to exchange experience on topics including nutritional criteria, salt reduction, animal welfare, local sourcing, and food crisis preparedness. Finland has presented its publicly available procurement criteria tool as a model others could adapt, while Copenhagen has shared its salt reduction pilot as a case study in translating criteria into practice. Participants have consistently highlighted the practical value of this peer learning and understanding how other countries tackle shared implementation challenges.

The JRC's recently published Sustainable Public Procurement (SPP) criteria² for food and catering services has proven to be a significant policy enabler, giving the networks an EU-level framework to organise their work around. The Commission confirmed strong interest in PFP across multiple DGs and is considering a legal proposal to strengthen the role of public procurement in food systems. Building on this, participants began developing SPP criteria pilot projects with the JRC in February 2026, with an in-person workshop planned in Italy in November 2026. This marks a significant step from knowledge-sharing into active, coordinated implementation. Copenhagen's lead was also appointed to the Commission's Stakeholder Expert Group on Public Procurement in early 2025, creating a direct channel to Commission policy development and longer-term network sustainability.

Fidelity and Early Adaptation

The team has followed its planned approach, with adaptations driven by the complexity of national contexts. Bilateral meetings between the lead and partners quickly revealed that starting points vary substantially: Finland integrated the project into an existing national PFP network; Poland had a city-level network in Warsaw that could be scaled; Norway had several fragmented networks requiring consolidation; Estonia and Slovenia had no existing network structures.

To help countries identify and bring in the right people, given the difficulty of finding a single PFP contact in each country, the team has created simple guidance documents to help with recruitment. Several members originally recruited into the Officers Network have also been moved to the Focal Point Network once it became clear they were working at ministry level. Greece has since succeeded in establishing a national network with representation from multiple ministries, an encouraging early sign that this approach is working.

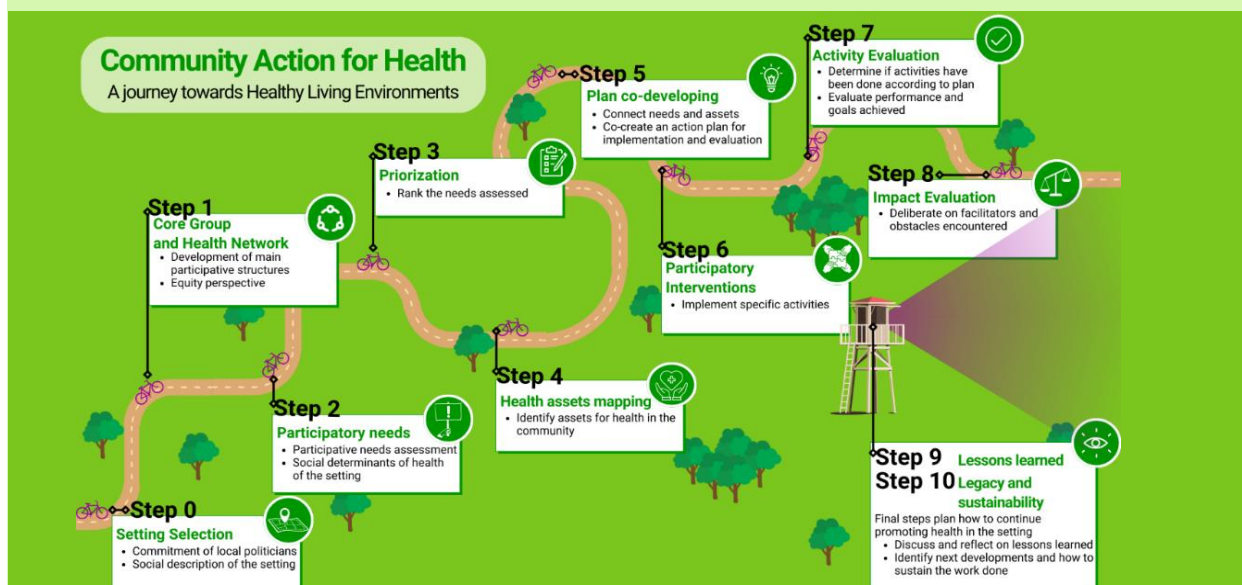
Early Lessons and Next Steps

Early implementation shows that meaningful change in procurement practices depends on first building the right relationships and structures, and that this takes time. It has also become clear that adapting the approach to each country's starting point matters more than applying one standard model everywhere. The planned SPP pilots will provide a concrete test of whether the network can translate dialogue into changed procurement practice. A final report consolidating network activities and lessons learned is due at the end of the project.

¹The JRC is the EU Commission's science and knowledge service. It functions as a Directorate-General (DG) of the Commission and supports EU policies by providing evidence and technical know-how independent of all private or national interests.

² The JRC's SPP (2025) provides voluntary guidance for public authorities seeking to embed environmental, nutritional, and social sustainability standards into food procurement.

One Methodology, 51 Contexts: Community Health Promotion Across Europe



Task 6.1: Community Action for Health Guide; Task 6.7: Building Infrastructure for Health Promotion at Supersetting Level; Task 6.6: Interactive Platform for Capacity Building.

Lead: Spain (DGSP). Co-leads: Croatia (CIPH); Poland (SUM; Task 6.6 Lead). Partners: Italy (UNITO); Germany (BiÖG; Task 6.7 lead).

Health promotion research regularly generates evidence on what works, but translating that evidence into consistent practice at local settings and community level remains a challenge: there is often no consensus on which methodology to use, and many proposed approaches are too complex for the infrastructure available in local settings. Task 6.1 addresses this challenge through the **Community Action for Health Methodology Guide**: an 11-step framework (pictured) applied across 51 pilots in 15 countries, spanning schools, workplaces, primary care, urban planning, municipalities, food environments, and green spaces. Rather than prescribing a single model, the guide aims to apply a shared methodology while remaining adaptable to each specific setting.

Each step is introduced through a dedicated workshop, staggered sequentially throughout the project period, and accompanied by a monitoring template for documenting progress. Task 6.7, led by Germany's Federal Institute of Public Health, supports pilots directly by identifying tools and methods for each step and delivering step-specific webinars and checklists.

It also provides intensive process support to seven selected pilots through 1:1 consultations and topic-specific webinars covering areas such as leadership, governance, and working with municipalities.

Implementation Outcomes: First Insights

Feasibility

Pilot engagement with the monitoring system has been strong, with 48 of 51 submitting Step 1 templates, and 48, 49 and 45 submitting Steps 2, 3, and 4 respectively. This shows sustained willingness across a large and diverse group to engage and report against the guide's framework.

Task 6.7's tool webinars have also been well attended (31 pilots for Step 3, 26 for Step 4). Pilots report the webinars are easy to understand, and value the cross-country exchange they created. Actual tool usage has been lower, however, has been lower than webinar attendance. Focus group discussions held during the WP6 Pula meeting in May 2026 found this was mainly down to timing relative to pilots' own processes, tool availability,

and limited time and workload. Pilots highlighted a need for clearer guidance, practical examples, and closer integration into project processes. Pilots who did use the tools reported real value, including increased confidence, better planning, and new ideas beyond their usual approaches.

Pilots that could connect the guide to existing institutional structures made faster progress. For example, a pilot connected with the WHO French Healthy Cities Network, and Estonia's workplace pilot building on an existing Health Promoting Employers Network, both established intersectoral core groups far more quickly than pilots starting from scratch.

Timing of the guide content was another challenge, which was released progressively between Month 4-18 of the JA and the complete guide finalised in June 2025. This was a product of the JA's timeline rather than a design decision, as the guide had to be developed in parallel with pilot implementation rather than in advance of it. Some pilots began implementation before later steps became available, meaning the guide functioned more as a retrospective reference than a live planning tool. Referring back to it still helped them recognise and incorporate essential groundwork, such as establishing a participatory, cross-sectoral working group, needed for successful and sustainable implementation.

Some pilots under time pressure also found the guide demanding to work through on its own. For instance, only 5 of 42 pilots rated it "very" or "extremely" useful at Step 0, against 21 "moderately" and 7 "not at all." Together with the tool-uptake gap above, this points to a clear lesson: a comprehensive methodology needs accompanying support structures to be genuinely usable, not just a well-written document. This is exactly the gap Task 6.1 and Task 6.7's webinars, checklists and workshops are designed to close. Task 6.6's development of an online platform to house this content will strengthen this further.

Fidelity and Early Adaptation

The guide is being used broadly as intended, and the central fidelity question is not whether pilots follow it exactly, but whether the team is learning from how pilots use it and adjusting accordingly. For example, a Croatian kindergarten pilot

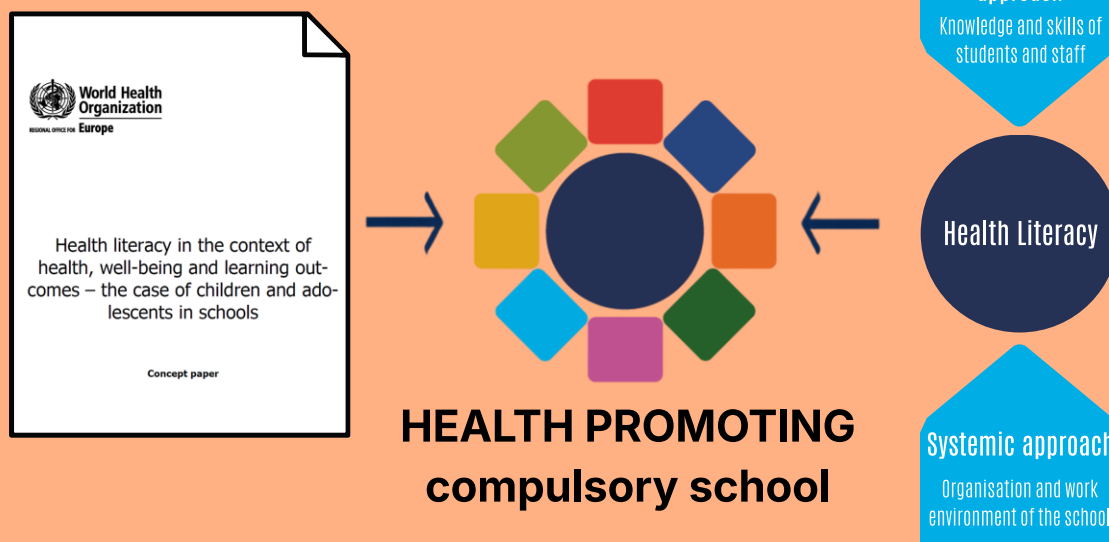
adjusted the sequential steps to its own rhythm, combining Steps 3, 4, and 5 to make best use of time when its core group was meeting. The Action Description Template provided in Step 6 was widely well received and prompted several pilots to revisit and revise earlier steps, suggesting the guide functions well as an iterative resource rather than a strict sequence. The guide's flexibility has also held up across the full range of settings it is applied in, from schools and neighbourhoods to urban planning and green spaces. Pilots are gradually recognising the value of a methodology that can be adapted to each specific context rather than applied uniformly. The guide is currently being revised to incorporate feedback from pilots.

Early Lessons and Next Steps

Several lessons have emerged from the implementation so far. First, using a consistent implementation methodology, while allowing genuine local adaptation, can strengthen health promotion in local settings and lead to more successful and sustainable outcomes. Second, a comprehensive methodology cannot succeed on its written content alone. Pilots have progressed furthest where they combined the guide with the active, ongoing support including the helpful webinars, checklists and exchange workshops. Deliberately pairing the guide with hands-on process support, rather than leaving pilots to implement it alone, has clearly been a valuable design choice. Valuable lessons were also learned from the minority of pilots that began implementing actions before establishing the groundwork needed to ensure long-term continuity, though it would have been preferable for the guide to be available from the very start of implementation.

The written guide is currently being validated and refined, and will be incorporated into an interactive online platform, that will pair each of the 11 steps with its methodological component, participatory tools, concrete examples from the pilots, and an overview of barriers that pilots encountered and how they were overcome. By transforming the guide into a simplified, easy-to-navigate format, this will directly address the accessibility issues raised by some pilots, and is expected to support broader dissemination and adoption by other settings wishing to launch health promotion projects and foster healthy public policies locally.

Promoting Health Literacy in Schools to Reduce Social Inequalities in Health



Pilot 7.5.19: Implementing Health Literacy in Schools (Iceland)

Lead: Iceland (DOHI).

Health literacy – the ability to find, understand and use health information and services – is increasingly recognised as a key determinant of health and a critical lever for NCD prevention. Building these skills early in life matters because attitudes toward food, physical activity and risk behaviours such as alcohol or nicotine use are largely formed during childhood and adolescence.

Health literacy also follows a social gradient: children from low-income households tend to have lower health literacy, contributing to wider health inequalities later in life. Schools offer an equalising platform, since attendance is close to universal, making them one of the few settings where it is possible to reach all children before this gap widens.

A pilot led by the Directorate of Health in Iceland explores schools as a setting for health literacy education, using the WHO's 2021 concept paper on health literacy in children and adolescents as its primary guide, alongside Germany's school health literacy model (*Gesundheitskompetente Schule*) and the Finnish national curriculum. In practice, the pilot has developed a practical guide for teaching health literacy in schools and is testing

it in two Icelandic "Health Promoting Schools" – a WHO-aligned status for schools that embed health promotion into daily practice. Testing involves teacher training workshops and pre- and post-intervention questionnaires for teachers and students aged 10 to 15. One of the schools chose to implement the intervention using one dedicated hour per week, following the guide and the Health Promoting Classes toolbox. Topics covered in this weekly hour include nutrition, physical activity, mental wellbeing, and substance prevention.

Implementation Outcomes: First Insights

Feasibility

Teachers at both schools completed pre-intervention questionnaires in October 2025, then attended a workshop in November where they saw a first draft of the guidelines and learned about the student questionnaires, which were completed shortly after. An updated version of the guidelines, ready for classroom use, was finalised in January 2026. One school began using the guidelines and completed post-intervention questionnaires; the other collected only pre-intervention data, but implementation has since stalled.

Each age group was assessed using an age-appropriate tool: teachers completed the 12-item Health Literacy Population Survey (HLS19-Q12), developed by M-POHL, the WHO's international health literacy network; students in grades 5-7 completed an adapted version of the Geko-T (*Gesundheitskompetenz von 9- bis 13-jährigen Kindern in Tirol*), an Austrian tool for measuring health literacy in 9 to 13-year-olds; and students in grades 8-10 completed the Health Literacy for School-Aged Children (HLSAC) scale, a widely used measure of adolescent health literacy.

Early results from the school that has implemented the intervention show meaningful improvements across a range of health literacy scores. Among teachers, the clearest gains were in navigating health information across healthcare, disease prevention, and health promotion, with improvements between 10.8 and 19.5 percentage points. Among students in grades 5-7, the share reporting difficulty finding answers, understanding recommendations, or making healthier food choices all fell to 0%. Among students in grades 8-10, the proportion who positively rated health literacy statements increased for most items, with the clearest gains in comparing information from different sources (73.9% to 95.6%) and finding easy-to-understand information (78.2% to 95.5%).

The rollout presents a mixed picture. At the school that has not progressed, implementation stalled before the guidelines could be put into practice, and withdrawal from the pilot is now being considered; the pilot team is reviewing the reasons behind this. At the other school, the rollout has been relatively smooth, helped presumably by a broader enabling condition: around 70% of compulsory schools in Iceland already hold Health Promoting School status, meaning they follow a health-promotion checklist that acts as an action plan for integrating health promotion into everyday school life, and have school nurses delivering preventive education and routine health checks. However, both pilot schools hold this status, suggesting that the Health Promoting School status alone does not guarantee smooth implementation.

Some important feasibility lessons have emerged during implementation so far. No single validated tool covered the full age range of students involved, making it harder to assess health literacy

consistently across younger and older schoolchildren. Health literacy is also not yet a formal part of the national education curriculum, so it currently competes for space with other topics within Health Promoting Schools' existing health education, and a recurring challenge has been finding ways to fit it into existing teaching time rather than adding to teachers' workload.

Fidelity and Early Adaptation

The core work of the pilot, developing and testing the guidelines in schools, is proceeding largely as planned, with two early adaptations. The Geko-T questionnaire proved difficult for younger children to understand, and the pilot team concluded that interviews would work better for this survey among this age group in future.

The school that completed the full process also requested more detailed, ready-to-use teaching materials, as teachers had limited time to develop lessons from a flexible framework requiring significant preparation. In response, the pilot team began a co-creation process with teachers from spring 2026, where teachers shared the materials and approaches they had actually used in the classroom. This material was reviewed by the pilot team and will be further developed in the 2026–2027 school year.

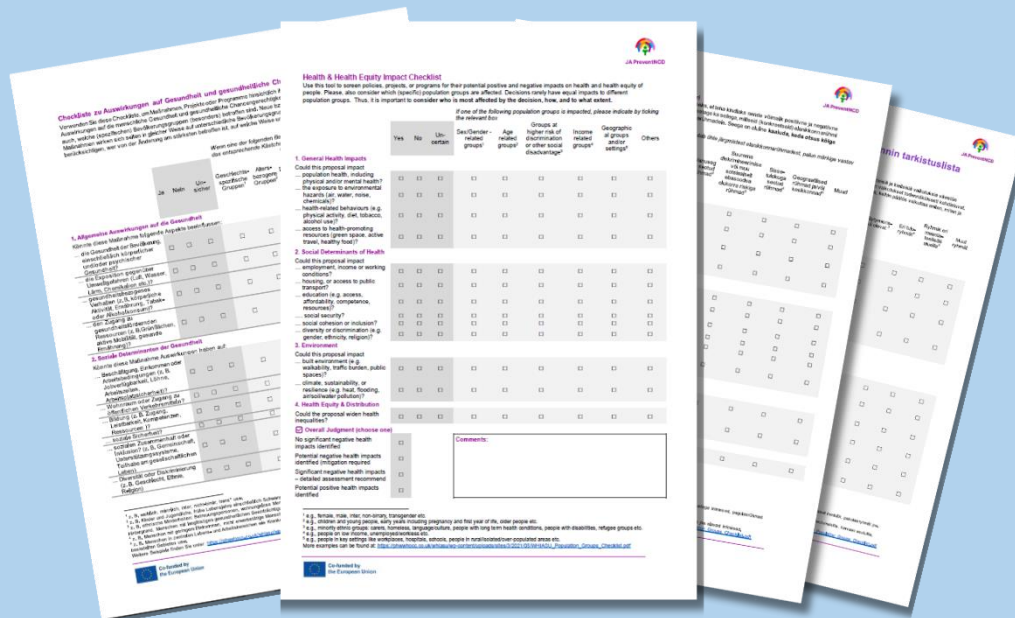
Early Lessons and Next Steps

The pilot has benefited considerably from Iceland's existing Health Promoting Schools framework. Building on a familiar and trusted structure lowered the barrier to engagement and provided a ready-made policy home for the work. The lesson for other pilots is that connecting a new topic to existing policy frameworks can be more effective than introducing it entirely from scratch.

A further lesson is that co-creating materials directly with teachers, rather than asking them to build lessons from a general framework, has also proven more effective and better accepted, though finding the right balance, meaningful involvement without adding to an already demanding workload, remains essential.

A symposium planned for later in 2026 will be used to share results and revise the guidelines, with further refinement continuing through 2026–2027 ahead of the final pilot report.

A Multi-Country Initiative to Embed Health and Health Equity in Impact Assessments



Task 9.5: Checklists for Health and Health Equity in Impact Assessments

Lead: Austria (GÖG). **Co-leads:** Belgium (Sciensano); Finland (THL). **Partners:** Estonia (TAI); Germany (RKI); Iceland (DOHI); Italy (INRCA); Spain (FISABIO).

Impact assessments (IA) are used across public administrations, including national, regional and local authorities, to evaluate the potential positive and negative consequences of proposed policies before adoption. However, health considerations are inconsistently integrated into existing IA frameworks across European countries, and health equity is rarely addressed. Task 9.5 confirmed this gap through a review of 60 IA frameworks, procedures and related guidance documents across eight partner countries and at the EU level.

The team addresses this gap by developing, piloting and disseminating a practical checklist to support public officials in considering health and health equity more systematically within existing IA processes. The tool is designed for use across public administration at all levels of governance, not just health departments. Two versions were developed for piloting: a concise checklist and a more comprehensive version.

The pilot examines their usability, perceived relevance and potential role within existing IA processes.

Implementation Outcomes: First Insights Feasibility

At this stage, feasibility evidence spans two elements: the collaborative process of developing the checklists, and their early acceptability and usability for the public officials testing them.

On the development process, the multi-country collaborative model has functioned well, sustained by strong leadership from the Austrian team and co-leads, whose structured facilitation and detailed documentation have kept partner countries aligned throughout. The mapping phase was completed across all countries despite the complexity of finding and categorising IA documents across very different legal and institutional contexts.

The team reached consensus on key tool design decisions through a collaborative process, including in-person meetings in Vienna. These sessions have proven important for building shared understanding and progress toward the team's goals.

On usability, the Finnish team gathered feedback from 21 officials across employment, education, health and social affairs, finance and planning – including the non-health specialists the tool is designed for. Officials found genuine value in both checklist versions. They also raised a concrete implementation risk: without clear framing as a screening tool rather than a standalone assessment, users risk completing it mechanically rather than with genuine analysis. This will directly inform the guidance and capacity building phase. Piloting is ongoing in the participating countries, and further usability evidence is expected as this progresses.

Austria's introduction of a mandatory climate check into its Regulatory Impact Assessment in January 2026 suggests that integrating new criteria into existing IA mechanisms is feasible when an enabling policy window emerges. In the Austrian case, Recovery and Resilience Facility (RRF) funding created such a window of opportunity by aligning political priorities, financial resources, and reform incentives.

Fidelity and Early Adaptation

The project team has adhered to its multi-phase approach. Piloting both a concise and a comprehensive checklist version was a deliberate decision to test which format best fits the everyday working reality of public officials. Some early feedback, particularly from Finland, has prompted reflection on how the two versions might work together in practice. As piloting continues across partner countries, these lessons will help identify the adaptations needed to ensure the checklist can integrate smoothly into existing IA processes used by public officials, rather than becoming an additional assessment that adds to their workload.

Early Lessons and Next Steps

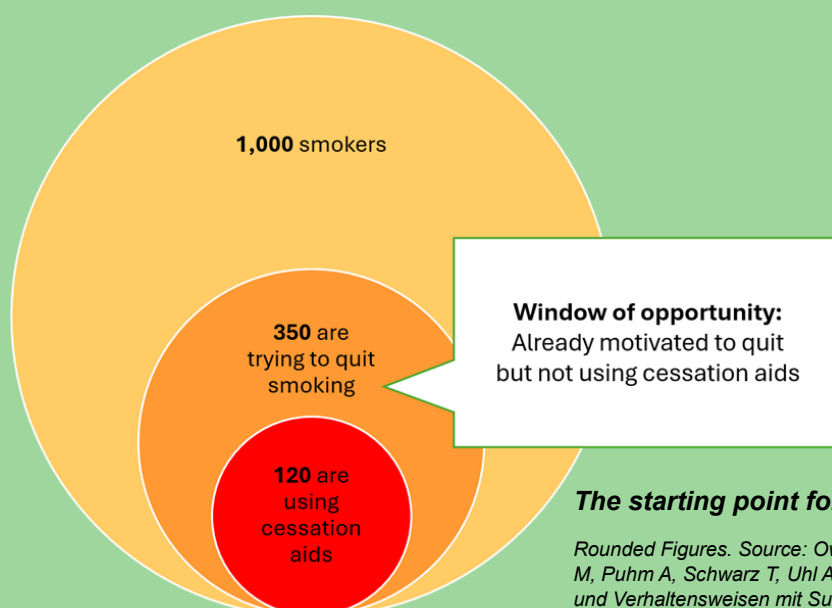
The diversity of IA systems across participating countries suggests that implementation is unlikely to follow a single model; the checklist may need to be embedded at different stages or within different procedures depending on national and institutional context.

While a broad research scope to map all IA types across partner countries demanded more from partners, it produced a stronger evidence base from which to develop the checklist. Designing the checklist for its intended non-health users also required additional effort and collaboration, as health and equity concepts often do not transfer easily into other policy settings. In both cases, this upfront investment has helped ensure the checklist better reflect the realities of its intended users.

Exchange with EuroHealthNet and the EUPHA Health Impact Assessment section has provided opportunities to discuss the approach with external experts and consider its relevance beyond the participating countries.

Next steps include completing piloting across all countries by September 2026, and an in-person meeting in Vienna in October 2026 to share feedback and discuss adaptations to the checklists. Preliminary results have already been shared with the JA Prevent NCD Sustainability Team and a subgroup of the WHO Healthy Cities Network, with further dissemination planned at the Policy Decision Makers Forum in Brussels in October 2026. A full report with country case studies is due in December 2026. The tools and lessons learned will be made available online by the end of the project to support longer-term dissemination.

Small but Impactful Activities to Support Tobacco and Nicotine Cessation Efforts in Austria



The starting point for Pilot 10.4.2.1

Rounded Figures. Source: Own representation based on Strizek J, Busch M, Puhm A, Schwarz T, Uhl A (2021). Repräsentativerhebung zu Konsum- und Verhaltensweisen mit Suchtpotenzial. Gesundheit Österreich, Vienna.

Pilot 10.4.2.1: Working Together Towards Better Access to Tobacco and Nicotine Cessation Services and Improved Quitting Rates

Lead: Austria (Addiction Competence Centre, GÖG). Partners: Finland (THL; FILHA) and Norway (NIPH).

Most attempts at tobacco and nicotine cessation end in relapse rather than lasting abstinence. The use of cessation services can greatly improve the chances of a successful quit attempt, yet many tobacco and nicotine users are not aware these services exist, and even those trying to quit often don't use them. Effective tobacco and nicotine cessation policy must therefore focus not just on delivering services, but on improving their reach. This means making them visible, accessible and responsive to user needs. Collaboration between different stakeholders is key to achieving this.

Pilot 10.4.2.1 addresses this in Austria by bringing together key actors in the field, such as health insurers, quitlines, pharmacists, hospitals, and self-help groups. Rather than delivering cessation programs directly, the pilot focuses on creating structured opportunities for stakeholders to share knowledge and collaborate to improve existing programs and interventions. Alongside this, the pilot assesses the availability and nature of tobacco and nicotine cessation services and related data in Austria, helping stakeholders identify priority areas for development.

Implementation Outcomes: First Insights

Feasibility

A stakeholder group has been successfully set up and has met multiple times, with members showing strong willingness to engage regularly. Initially limited to five organisations, the group has been expanded to ten organisations due to increased interest. This early commitment is in part thanks to the Austrian task lead's status as the national public health institute, with recognised expertise in tobacco and nicotine topics.

The pilot team organised a small national conference, "Tobacco and nicotine cessation in Austria - but how?", with the goal to bring awareness to existing good practices. The 27 participants represented cessation services, healthcare and health promotion organisations, and people with lived experience of cessation. Six invited speakers presented good practice examples, from referral pathways and opportunities to receive brief intervention training, to healthcare-based cessation projects and a mutual self-help group.

As a result of these activities, an opportunity arose to give input to guidelines on tobacco and nicotine cessation in pharmacies, being developed by the Austrian Chamber of Pharmacists. The pilot team facilitated a structured feedback process in which the stakeholder group helped align the new guidelines with existing recommendations for other settings.

The pilot team conducted a situation analysis, examining the Austrian tobacco and nicotine cessation landscape in line with Article 14 of the WHO Framework Convention for Tobacco Control, which has produced tangible outputs that extend beyond the pilot itself. The team compiled a comprehensive list of tobacco and nicotine cessation services, which has directly informed a chapter in Austria's national tobacco monitoring report, and an extended section of the *Suchthilfekompass* (Addiction Support Compass), Austria's online registry of addiction services. Subtask partners THL and FILHA (Finland) and NIPH (Norway) contributed to the assessment methodology, connecting the pilot to broader cross-country learning within the JA.

Mapping Austria's cessation landscape proved more difficult and resource-intensive than anticipated. Austria's federal structure, with nine provinces and multiple differently organised funders and service providers, added significant complexity. Regional web pages on cessation interventions were informative but often outdated, and routine monitoring and treatment-protocol data were not typically published by providers. One notable exception was the National Quitline's annual reports. As a result, the team supplemented desk research with interviews with service providers to build a more accurate picture – revealing not just what services exist, but also what data are easily accessible.

Fidelity and Early Adaptation

The core work of building a stakeholder group has proceeded largely as planned, with adjustments reflecting responsiveness to stakeholder needs. Stakeholders asked for virtual meetings to supplement planned in-person sessions, to allow for more frequent exchange. Three virtual meetings and two webinars have been held to date. The team revised its project plan in response to stakeholders' requests and introduced a structured format for each session, with a specific

topic and short opening presentation to focus discussion on what works, what doesn't, and the barriers and facilitators professionals encounter. Topics have included the accessibility of cessation services, and the role of the workplace in supporting cessation.

A second insight was that impact can be achieved more quickly and sustainably by utilising windows of opportunity and supporting existing projects rather than starting new ones – sometimes by connecting organisations, as with the pharmacy guidelines mentioned above, and sometimes by sharing expert knowledge. For example, the team helped their WP partner, Lillebaelt University Hospital (Southern Denmark), to find an Austrian participant organisation for a pilot that will also address tobacco/nicotine cessation. The team also supported the inclusion of tobacco/nicotine cessation in a provincial lung cancer screening pilot by compiling a small information pack, also showcasing similar projects in other EU countries.

A third adjustment concerned the involvement of people with lived experience of cessation. Originally, smokers and former smokers were to be interviewed as part of the situation analysis, but it became clear that such interviews would not yield the data required. The team decided instead to invite this group to the national conference, where they could share experiences in a more natural, informal setting.

Early Lessons and Next Steps

Early implementation points to two key lessons. First, remaining flexible has strengthened the pilot rather than compromised it: each adaptation has kept the work responsive to the needs of those it serves. Second, the situation analysis revealed as much about the gaps in Austria's cessation system as about the services themselves: the limited availability of public data on service monitoring and effectiveness is not just a practical obstacle, but a structural issue that key actors are now well placed to help address.

Next steps include publishing the situation analysis report and discussing its findings with the stakeholder group to agree on follow-up actions. The team will also prepare a national policy brief and plans to participate in two to three national conferences to raise the visibility of its work.

Common Implementation Lessons

While the pilots or tasks in each case study address different public health challenges, several patterns have emerged from this initial set of case studies. These patterns offer valuable, practical insights into the conditions that can determine the success of an intervention. These insights may be relevant for all pilots in the project. These are:

1. **Existing structures and open policy windows can accelerate implementation.** Case studies that built on established networks, policy frameworks, or moments of political opportunity, such as new funding or legislative change, made faster progress than those starting from scratch.
2. **Identifying the right people and navigating institutional complexity remain persistent barriers**, particularly where responsibility spans multiple sectors with no single clear owner, and where governance structures, legal frameworks, or data availability vary widely across and within countries.
3. **Flexibility, not strict adherence to an original plan, is generally what enables success.** Teams that adapted their sequencing, tools, or engagement methods to local context and real-world feedback made stronger progress than those attempting to apply a single model uniformly.
4. **Guidance and tools work best when paired with ongoing, hands-on support**, such as consultation, peer exchange, or co-creation with intended users, rather than left as standalone materials for people with limited time and capacity to interpret alone.

5. External Evaluation – First Phase Findings

The evaluation conducted by WP3 focuses on assessing the outputs, outcomes, and impact of the primary work of WP 5–10. As agreed at the outset of the project and outlined in the evaluation framework, an external evaluator was commissioned to evaluate the work of WP 1–4. The evaluator's role is to provide the coordination, communication, evaluation and sustainability structures that underpin the work of WP 5–10. This section reports on the first phase of the external evaluation, including a summary of the evaluator's key findings and proposed response actions.

Status and process

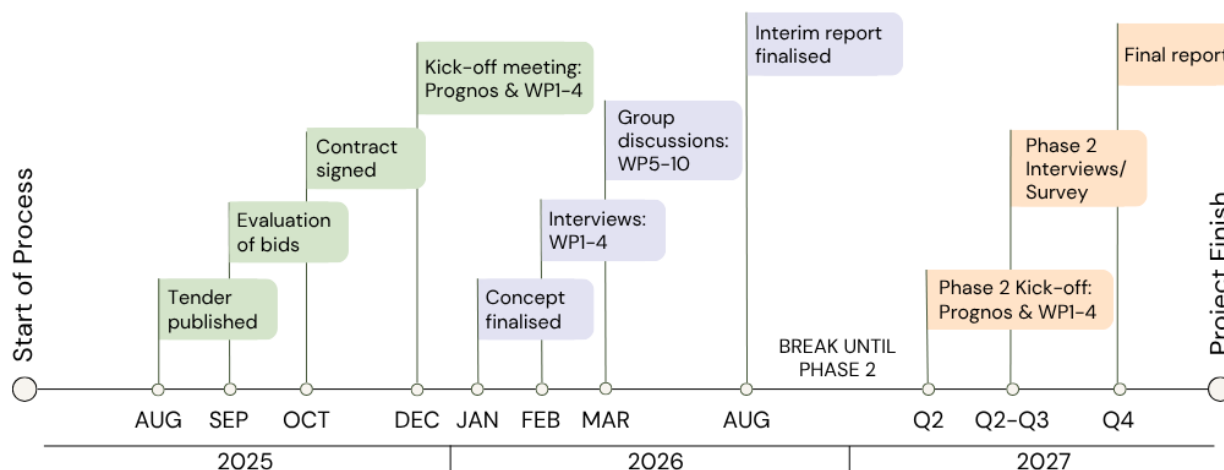
Following a competitive tender published in Germany in August 2025, Prognos AG was appointed as the external evaluator in September of that year. A kick-off meeting was held in December 2025 to begin the first phase of the evaluation. Figure 18 shows the full evaluation timeline.

Rather than developing a fixed list of indicators, Prognos structured the evaluation around an impact model based on the perspective of service providers. Work Packages (WPs) 1–4 are assessed as providers of services to WPs 5–10. The overarching evaluation question is:

To what extent do the structures and processes implemented by WPs 1–4 support, improve or potentially hinder the work of WPs 5–10?

For each of WP 1–4, the evaluator identified the specific services provided to WP 5–10 and derived tailored evaluation questions accordingly, covering the dimensions of input, activities and implementation, output, and outcome.

Figure 18: External evaluation timeline: main milestones and deliverables.



Summary of interim findings

The first phase of Prognos' evaluation involved document analysis and interviews with WP1–4, followed by group discussions with representatives of WP 5–10.

Overall, the evaluation concluded that the services provided by WP 1–4 are well-designed and provide a solid foundation for coordination, communication, evaluation and sustainability. The main challenge identified was not the design of these services, but rather their usability at scale. WP 5–10 reported difficulties in integrating, interpreting, and applying the inputs of WP 1–4 in their day-to-day work. A strong collaborative culture across the JA was identified as a key enabler throughout.

Prognos summarised the findings into two categories: structural findings that are relevant beyond the scope of this joint action (JA), and operational findings that can be addressed within the current project period.

Structural findings

The evaluation identified six structural findings, framed primarily as lessons for the design of future large-scale Joint Actions:

1. The importance of a sufficiently resourced preparatory phase to stabilise core service concepts before implementation begins.
2. The need for a coherent, jointly-defined service architecture across coordination, communication, evaluation and sustainability.
3. The importance of proportionate governance that balances stability and accountability with flexibility.
4. The need for explicit links connecting WP 1–4 service design to WP 5–10 implementation.
5. The role of working culture (accessible leadership, openness, trust-based collaboration) as a critical enabling factor alongside formal structures.
6. The importance of embedding sustainability into the everyday work of WP 5–10, not just establishing sustainability structures.

Given their relevance beyond this JA, these findings may be of particular interest to the European Commission in the design and setup of future Joint Actions.

Operational findings

The evaluation also identified seven operational, or short-term findings that can be addressed within the current JA, derived primarily from the perspective of WP 5–10:

1. Timing and sequencing of WP 1–4 inputs do not always align with WP 5–10 implementation cycles.
2. Operational expectations, including effort, timing, and decision routes, are not always clearly or consistently communicated.
3. The volume and structure of documents and channels make it difficult for WP 5–10 to identify what is relevant.
4. Services reach WP leads reliably, but reach to task, subtask and pilot level is less consistent.
5. Frameworks and guidance are well-regarded conceptually, but the practical "how-to" step for applying them is sometimes missing.
6. Cumulative, parallel requests from WP 1–4 create periods of high workload for WP 5–10, at times without WP 1–4 having advance visibility of the overlap.
7. Coordination between WP 1–4 themselves, in timing, communication and expectations, is not always fully aligned, contributing to the above workload burden.

WP 1–4's response to interim findings

Following the presentation of the results in May 2026, WP 1–4 discussed the findings jointly and agreed to prioritise five high-impact, low-resource actions that build on existing structures rather than introduce new processes. These action areas were discussed and agreed in the WP 1–4 meeting in September 2026, with responsibilities for implementation dedicated to each WP. These are:

- **Strengthen joint planning and coordination across WP 1–4**, through dedicated joint planning time in existing WP 1–4 meetings and a shared overview/calendar of upcoming WP 1–4 activities and deadlines.
- **Improve clarity and consistency of operational expectations**, including more direct engagement with pilot and subtask leads to identify specifically where expectations remain unclear.
- **Make information and resources easier to navigate**, through a "start here" overview on SharePoint and improved signposting of key activities and deadlines.
- **Strengthen how services and information reach task, subtask and pilot level**, through more direct engagement with WP 5–10, including participation in existing WP meetings.
- **Provide more practical "how-to" support** to translate existing frameworks into everyday work, following the model already used for reporting requirements.

Next steps – Phase 2

As outlined in Figure 18 above, Phase 2 of the external evaluation will commence in Q2 2027 and conclude in November 2027. It will assess the extent to which the developments described above have taken effect, through interviews with WP 1–4 on changes made in response to Phase 1 findings, and an online survey of WP 5–10 participants addressing both the Phase 1 findings and any changes observed since. The final report is expected in November 2027 and will be made available on the JA PreventNCD website.

6. Conclusion and Recommendations

JA PreventNCD enters its final phase largely on track. Of the 775 IM/ID due by M24, 82% were completed on time, and WP1's trackers and check-ins are in place to keep it that way. The outputs produced so far are considered relevant by the people who know them, and developing them has already built skills, networks and collaboration across countries.

The evaluation also shows where effort should go next. Outputs are not yet reaching everyone in the consortium: 15% of respondents knew none of the listed outputs from their own WP. Most outputs are best suited to researchers and would need adapting for other key actors, such as practitioners and policymakers, and equity considerations are not yet built in consistently. Early findings from the case studies show that pilots progress when they build on existing structures, adapt to local context and come with hands-on support. The external evaluation found WP 1–4's services well designed but hard for WP 5–10 to use at scale.

This matters most for the outputs still to come. Many of the JA's most significant outputs are due near the end of the project, when there will be little time or funding to evaluate their reach and usability. This is therefore the last checkpoint at which these findings can still shape their design, so that they are appropriate for their intended end users, address equity and reach the right audiences. Reviewing each output still in development against the findings on audience fit, equity and dissemination (Recommendations 1–4) would help, and sharing the list of late outputs with WP3 would allow them to be considered in the planned stakeholder assessment.

The following recommendations, based on these findings, set out how the consortium can strengthen delivery and contribute to reaching the goals of JA PreventNCD.

Recommendations

1. Strengthen the tailoring of outputs to their intended audiences and purposes.

Outputs are broadly seen as relevant but skew towards an academic audience. A sound scientific base is essential, but JA PreventNCD was launched as an implementation-focused project with a mandate to inform policy, and most outputs are not yet ready for direct use by key actors outside academia, such as policymakers, practitioners and NGOs, without adaptation. Keeping the intended audience in mind throughout development, and involving them in shaping the output where feasible, can help close this gap. Format, length, language and technical detail can then reflect their needs, and for outputs aimed at end users or policy, an accessible version that goes beyond standard reporting templates can support outreach and dissemination.

2. Embed equity considerations more explicitly in future practice-oriented outputs.

Equity is not yet embedded consistently across outputs, particularly in policy briefs, monitoring frameworks and policy analyses, which warrants attention given that reducing social inequalities is a core objective of the JA. Teams developing practice-oriented outputs can ask how their intervention affects different population groups and move from describing inequalities to proposing actionable responses. Applying a structured equity lens during development and review, with affected communities involved where feasible, helps ensure equity is built in rather than added as an afterthought.

3. Make better use of participants with policy contacts as multipliers.

Participants close to policy are the most willing and best placed to take outputs to decision-makers: 54% of those with direct or regular contact with policymakers intended to share outputs, compared with 30% of those with little or no contact. This is a significant and underused opportunity. Participants without direct access can draw on JA colleagues who work more closely with policy actors, and the same applies to other settings such as clinical

practice or community engagement. Considering this when planning the dissemination of each output makes it easier to reach the right people.

4. Strengthen awareness and dissemination of outputs within the consortium.

Awareness of outputs within a participant's own WP was only moderate, and low awareness is an avoidable barrier, since non-use was mostly linked to practical reasons such as limited time or opportunity rather than usability problems. Outputs need to be known inside the consortium before they can reach external groups. Making them accessible to all WP participants, not only contributors, with little extra effort helps: for example through WP meetings, using the results summary sheets, bilateral exchanges, and one easy-to-find list of finished key outputs per WP.

5. Document reasons for delay consistently.

No reason was recorded for 58% of delayed IM/ID, which limits insight into recurring bottlenecks. Recording a reason and a mitigation for each delay in future reporting rounds, including for items since delivered, would allow more informed monitoring and earlier corrective action.

6. Shift the focus of future case studies and pilot planning towards reach and sustainability.

Early case studies show promising signs of feasibility and fidelity. Collaboration and exchange between peers and countries are recurring strengths that are worth building on. As the pilots progress, questions regarding reach and how programmes will continue beyond the JA become more important. It may be useful for pilot and task teams to consider who will carry their work forward and what support they will need, and to share this with WP4 to inform the sustainability plan. The common lessons from the case studies (e.g. building on existing structures, maintaining flexibility, combining guidance with practical support) are relevant for all pilots.

7. Support and monitor implementation of WP 1–4's agreed priority actions.

In response to the external evaluation, WP 1–4 agreed on five actions to make their services easier to navigate and to reach task, subtask and pilot level. Their value depends on both sides: WP 1–4 following through, and WP 5–10 engaging with the new resources and flagging where expectations remain unclear or requests overlap. The effect of these changes will be assessed in Phase 2 of the external evaluation in 2027, where input from WP 5–10 will be important.

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8. Appendix

8.1. Progress monitoring definitions

Table 3: Definitions and examples for 'reasons for delay' categories.

Reasons for delay by category	Definition/examples
Resource-related causes	Lack of personnel, sick leave or absences, skills gap, team overload
Planning and coordination issues	Wrong time estimates, difficulties with coordination between partners, changes in priorities
Dependencies and external factors	Delays from external partners or suppliers, dependency on other delayed milestones, waiting for approvals or decisions, technical and system-related issues, IT or system failures, tools or platforms unavailable
Change in scope or requirements	New requirements or changes in deliverables, changes in regulations or framework, reprioritization.
Administrative issues	Missing documentation or procedures, lengthy internal approval processes, unclear roles and responsibilities, internal communication issues
Quality-driven adjustments	Extended time spent to improve quality, additional iterations to achieve better results, refinement of deliverables beyond initial scope
Other causes	If the reason doesn't fit any of the above categories.

Table 4: Definitions and examples for 'mitigation measure' categories.

Mitigation measure by category	Definition/examples
Coordination and administrative actions (<i>Coordination & admin</i>)	Actions to improve coordination, communication, or decision-making; additional partner meetings, responsibility clarification, closer coordination across teams.
Enhanced monitoring and implementation support (<i>Monitoring & support</i>)	Increased oversight, follow-up, or practical support to reduce impact of delays; development of alternative activities.
Scope and methodological adjustments (<i>Scope & method</i>)	Modified methodology, adapting scope of an activity, revising data collection procedures, simplification of tasks, or adapting outputs and approaches to fit circumstances.
Staffing and resource adjustments (<i>Staffing & resources</i>)	Changes in personnel, responsibilities, funding or other resources used to address capacity constraints, such as staff reallocation, hiring, or securing or reallocating budget.
Timeline and workplan adjustments (<i>Timeline & workplan</i>)	Shifts in timing of activities to accommodate delays and encourage completion; extending deadlines, rescheduling, or changing sequence of tasks.
No additional action	No specific mitigation measure was required, for example because the delay was reported to have no impact on work package progress.
Not reported	No mitigation measure was reported, or the response did not describe a measure.

8.2. Peer assessment concept

Table 5: KUUT outcome constructs assessed in the peer assessment survey.

KE Outcome	Description	KEQ	Source
Awareness	<i>The respondent knows the resource exists.</i> Awareness is the entry point of the KT continuum — without it, no further KT can occur.	KEQ1	[18, 20]
Reception	<i>The respondent has accessed or obtained the resource.</i> Reception captures whether the resource has been disseminated effectively enough to be in the hands of its intended audience.		
Cognition	<i>The respondent has read or intends to read the document.</i> Cognition is about whether the receiver of the resource has read, digested and understood the information.		
Discussion	<i>The respondent has shared or discussed the resource with others.</i> Discussion reflects the social dimension of KT — the extent to which a resource alters frames of reference and enters professional dialogue within and beyond organisations.		
Relevance and Adoption Intent	<i>The respondent perceives the resource as relevant and intends to use or adopt it.</i> This construct bridges cognition and full adoption — capturing perceived fit with the respondent's own work, institutional context, and end users, as well as equity considerations.	KEQ1	Adapted from [18]
Deliberate non-use	<i>The respondent has not adopted the resource, and the reasons are identifiable.</i> Deliberate non-use is distinguished from non-awareness — it reflects a considered decision shaped by organisational factors, environmental conditions, or individual characteristics. Analysing non-use is as important as understanding uptake.	KEQ1	[18, 23]
Transferability and Key Actor Engagement	<i>The respondent perceives the resource as adaptable and capable of engaging policy actors.</i> This construct captures the resource's potential reach beyond the Joint Action — whether it could be taken up by health ministries, policymakers, or practitioners at national level.	KEQ2	Own construct
Impact / Capacity Building through Development	<i>Participating in the development of the resource contributed to joint learning and capacity building.</i> This construct recognises that KT occurs not only through consumption of outputs but through their co-production — the development process itself as a knowledge exchange event.	KEQ3	Own construct; adapted from “Impact” in [18]

8.3. Descriptions and categories of outputs surveyed

Table 6: Descriptions and categorisations of outputs assessed in the peer assessment survey.

WP #	Output Title	Short description	Output Category	Risk Factor/Focus
5	State-of-the-art report on the promotion and reduction of portion sizes	Survey of 14 EU countries on portion-size policies and their role in NCD prevention. Concludes a multi-level approach is needed to tackle rising portion sizes and health inequalities.	Evidence review	Nutrition
	Narrative review of the literature on alcohol cancer warnings	Review of 51 studies on how alcohol cancer warning labels affect consumer attitudes and behaviour. Finds mixed reactions but concludes labels are a promising intervention tool.	Evidence review	Alcohol
	Alcohol and tobacco policy scales	Maps national alcohol and novel tobacco/nicotine regulations across the EU using two purpose-built policy scales. Finds wide variation in alcohol rules, more convergence on nicotine products, and shared gaps on online sales and digital marketing.	Implementation tool	Alcohol Smoking
	Overview of national and EU initiatives targeting air pollution and noise reduction	Reviews policies and interventions to reduce noise and air pollution exposure, combining a systematic literature review (173 publications) with expert questionnaires. Identifies the most effective measures and the need to align air/noise policy with urban development.	Policy analysis	Environment
	Analysis of the regulatory landscape concerning for per- and polyfluoroalkyl substances (PFAS) across Europe	Compares past and current national PFAS legislation against EU rules, focusing on maximum levels in drinking water and food. Highlights the need for further policy development, uniform regulation, and international collaboration.	Policy analysis	Environment
6	Community Action for Health Methodology Guide	An 11-step methodology for local health promotion and NCD prevention, covering intervention design, needs assessment, and building health networks. Supports WP6 pilots and public health professionals.	Practical guideline	General NCD
	Workshops/Webinars on the Methodology Guide	Workshops for WP6 pilots presenting the methodology guide step by step, with room for discussion and collaboration. Online workshops covering steps 1–5 held so far.	Community training	General NCD
	Workshops/Webinars on Tool Selection and Usage (Methodology Guide)	Workshops for WP6 pilots showcasing relevant published tools and how to use them at each step of the methodology guide. Steps 1–5 covered so far.	Community training	General NCD
	Checklists to Support Tool Selection (Methodology Guide)	Helps WP6 pilots identify the most suitable tools, with a question-based checklist for each step of the methodology guide. Available for steps 1–5 so far.	Implementation tool	General NCD

	BreatFEEDucation E-Learning Course for Students and Healthcare Professionals	A free, accessible e-learning course on breastfeeding support, adapted from the original Norwegian course and expanded for use across Europe under JA PreventNCD. Open to all students and healthcare professionals.	Community training	Nutrition Maternal/child health
7	Country-level mapping of digital health literacy (DHL) policies	Five country reports examining how digital health literacy (DHL) is defined, prioritised, and applied in France, Hungary, Italy, Norway, and Ukraine, covering infrastructure, institutional readiness, and workforce development. Identifies common gaps and country-specific approaches.	Policy analysis	Health literacy Social inequalities
	Reporting on Organisational Health Literacy (OHL) assessments	Four country reports assessing organisational health literacy (OHL) in primary care using the OHL-PHC tool, across Austria, France, Norway, and Ukraine. Access and communication scored highest; countries face similar structural challenges.	Implementation tool	Health literacy
	Systematic review of methods to assess environmental health inequalities in health impact assessments of local interventions	A systematic review of methods for assessing environmental health inequalities within Health Impact Assessments across urban planning, transport, and mining projects. Finds no standardised approach and proposes a practical framework for embedding equity throughout the HIA process.	Evidence review	Environment Social inequalities
	Equity Tool	A six-step tool helping teams embed equity into pilot interventions, covering assessment, implementation, and evaluation, with checklists and guidance on social determinants of health.	Implementation tool	Social inequalities
8	Country Fact Sheets	Reports from 16 countries covering risk factors, health determinants, monitoring systems, and stakeholders, verified by national experts. Provides an overview of NCD monitoring across EU states to support mutual learning and harmonisation.	Monitoring framework	General NCD
	Interim summary on mapped tools and methods	Data from multiple countries using the PROMAP template, covering existing and emerging tools for monitoring preventable NCD risk factors at individual and clinical levels. Further data collection is planned.	Monitoring framework	General NCD
	Mapping Data Sources to Monitoring Cancer Burden: Survey Results (Interim Report)	Maps data sources for monitoring the cost burden of cancer across seven countries, covering direct costs (e.g. patient care) and indirect costs (e.g. productivity loss).	Monitoring framework	General NCD
	Design of library indicators for NCD population monitoring (Catalogue of Promising Practices)	Documents development of a shared indicator library for population-level NCD risk factor monitoring, built with 14 partner organisations across 10 countries. Uses a standardised template to enable country comparison and harmonise EU-based methodology.	Monitoring framework	General NCD

9	Report on Good MHiAP Practices	Maps Mental Health in All Policies (MHiAP) implementation across 7 countries via literature review, questionnaires, and workshops, with case studies and recommendations on collaboration, policy, and evaluation.	Policy analysis	Social inequalities
	Policy Brief on Tobacco Industry Interference in FCTC Implementation	Policy brief on tobacco industry interference in WHO FCTC Article 5.3 implementation across the EU. Finds countries lack tools to detect interference, now evolving via novel nicotine products and digital tactics. Recommends national monitoring, transparency protocols, and civil society engagement.	Policy brief	Smoking Commercial determinants
	Report on commercial activities in food industry	Examines corporate political activity by food industry organisations in 4 European countries. Finds groups often present themselves as public health supporters while opposing evidence-based regulation through policymaker ties and self-regulation.	Policy brief	Nutrition Commercial determinants
	Review of health considerations in impact assessments	Reviews health and health equity considerations across 60 impact assessments in 8 countries and the EU. Finds physical health is commonly addressed but equity and intersectionality rarely are. Recommends intersectoral collaboration and better monitoring.	Evidence review	Social inequalities General NCD
	Online Wellbeing Economy Toolbox	An interactive platform helping policymakers and researchers build wellbeing into policy design, compiling policies, instruments, and case studies from across Europe.	Implementation tool	Social inequalities General NCD
10	Toolkit for Citizen Engagement in Risk-Stratified Prevention	A practical toolkit for designing citizen engagement in personalised risk-stratified prevention. Compares four engagement methods (citizens' assemblies, focus groups, interviews, surveys) used across France, Iceland, Norway, and Sweden. Concludes that meaningful engagement depends on genuinely centring citizens, more than the method chosen	Practical guideline	General NCD
	Smoking Cessation Pilot Project End Report	End report on a Norwegian pilot testing a publicly funded smoking cessation model (cost-covered medication plus structured counselling) across a hospital trust and 22 municipalities. Reached over 3,000 participants with a 28% quit rate. Documents challenges (COVID-19, medication shortage, admin hurdles) and recommends national scale-up.	Evidence review	Smoking
	Motivational Materials for Smoking Cessation During Pregnancy (Spanish)	Patient-facing materials for pregnant women, partners, and parents of young children in Cataluña and Cantabria, Spain. Part of a pilot combining motivational interviewing, cessation treatment, and healthcare professional training, with follow-up up to 18 months after birth. Produced in Spanish.	Community training	Smoking Maternal/child health

8.4. Peer assessment survey print out

Welcome to the JA PreventNCD Peer Assessment Survey

Developed by Work Package 3: Evaluation | Robert Koch Institute, Germany

Thank you for taking part. Your insights will help us evaluate a selection of knowledge translation (KT) outputs produced within the JA PreventNCD. The survey asks whether you are aware of the outputs, how relevant and useful they are for your work, and how adaptable they are for national use. This is not a quality assessment.

About the survey

You will be shown outputs from the work package (WP) you select in the first question. If you are involved in more than one WP, you are welcome to complete the survey separately for each. The survey takes approximately 15 minutes.

Your privacy

All responses are fully anonymous. We do not collect your name, task or subtask number, or any other identifying information. Results will be reported at WP level only. Details on how your data is handled can be found here: [Privacy policy](#)

Please note

The survey will time out after 30 minutes of inactivity and responses will not be saved. You may restart if needed.

Survey results will contribute to the WP3 interim and final evaluation reports. If you have any questions, please contact us at preventncd@rki.de

We appreciate your time and valuable input!

Meg, Simon and the WP3 Evaluation Team

Section 1: Background Information

To ensure we show you the relevant outputs from your work package (WP), please indicate which WP you are primarily involved in using the drop-down list below. We also ask for your institution type so that we can understand the range of professional settings represented in the survey.

1.1. Please select the number of the WP you are primarily involved in

Select an answer... ▼

1.2. What type of institution do you work for?

Select an answer... ▼

You indicated that you are primarily involved in work package [WP]. Is this correct? *Select 'Yes' if the WP number is correct. Select 'No' to re-enter the WP number.*

- ☐ Yes
☐ No

[If No] You have indicated that the number you entered is not correct.

Click "Next" to re-enter the correct task/sub-task number.

1.3. Proximity to policy- or decision-makers* for NCD prevention

Before answering the survey, we would like to understand your proximity to policymakers and decision-makers in your current role. This helps us contextualise responses across the survey. Please select one option from the list below. There are no right or wrong answers.

By ***policymakers and decision-makers**, we mean anyone with influence over health policy or practice, including staff at national or regional health ministries, local or regional government bodies, advocacy organisations working toward policy reform or advocating to government, and NGOs or other organisations that design and deliver public health programmes.

- ☐ I work directly with policymakers or decision-makers
- ☐ I have regular contact with policymakers or decision-makers
- ☐ I have occasional contact with policymakers or decision-makers
- ☐ I have no, or rarely any, contact with policymakers or decision-makers
- ☐ Not sure

Section 2: Reach and Awareness of Outputs

In this section, you will be asked to evaluate a selection of knowledge translation (KT) outputs* produced within your WP to date.

The selected outputs are outlined in the WP[#] Output Overview Document prepared by the WP3 evaluation team. This document provides a short description of, and direct link to, each output you will be asked about. It is a reference tool to help you navigate the survey. You can keep it open in a separate tab while completing the survey.

Before you begin:  [Open the WP\[#\] Output Overview Document](#)

What are KT outputs?

KT outputs are defined here as tangible outputs with practical recommendations or tools

intended to be used in practice, such as guidelines, toolkits, policy briefs, or lessons learned. Their purpose is to bridge the gap between what is known from research and what is actually done in practice, policy, or clinical settings, helping to translate evidence into real-world improvements.

Please note:

Each output will appear on a separate page. Please answer all questions for each output, even if you are not familiar with it.

Not all outputs produced in your WP are included here - a handful were selected in collaboration with WP leads to keep the survey manageable and to reflect the diversity of work being done within each WP.

2.1. This question asks about the "[Insert output name here – asked for every output in the indicated WP]"

	Yes	No
Are you aware this output exists?	☐	☐
Have you read this output?	☐	☐
Have you used this output in your work?	☐	☐
Did you contribute to the development of this output?	☐	☐

2.1.1. Why have you not read or used this output?

Note on survey design: Question 2.1.1. is shown if respondent answered “No” to “read” and/or “used” in the above question.

You indicated that you have not read or used "[Insert output name here]". We would like to understand why, as this helps us identify barriers to uptake across the JA PreventNCD. Please select all reasons that apply.

- ☐ I was not aware it existed until now
- ☐ I tend to focus on my own task or subtask and do not closely follow outputs from other parts of the JA
- ☐ It did not seem applicable to my work or role in the JA
- ☐ The content is too technical or scientific for my needs
- ☐ The format was not practical for me to use
- ☐ It is not available in a language I can use
- ☐ I have not had enough time to review it
- ☐ I have not yet found a practical opportunity to use it
- ☐ Other (open text)

[...]

Note on survey design: The above questions are repeated for each output surveyed in the indicated WP (3-5 outputs per WP). As described above, the non-use question shows only for respondents who indicated they have not read and/or used the output.

If a respondent indicated they were not "aware" of any of the outputs from their WP, the survey ended for them.

Section 3: Personal and Institutional Relevance

For each output you indicated you have read and/or used, this section asks for your opinion on its relevance for your own work and institutional context, and whether you think it contributes to the JA PreventNCD goal of reducing social inequalities in cancer and NCD prevention.

Please respond based on your current understanding of the output, even if you have not yet read it *in full*. There are no right or wrong answers - we are interested in your perspective to the best of your knowledge.

Select one response per item for each output shown.

Before answering, you may wish to remind yourself of the outputs:  [Open the WP\[#\] Output Overview Document](#)

Output 1: [Insert Output 1 name]

Output 2: [Insert Output 2 name]

Output 3: [Insert Output 3 name]

Output 4: [Insert Output 4 name]

Output 5: [Insert Output 5 name]

	Output 1			Output 2			Output 3			[...] (3-5 outputs per WP)
	Yes	No	Not sure	Yes	No	Not sure	Yes	No	Not sure	
Is this output relevant to your own work?	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Is it relevant to the broader work of your institution?	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Is it appropriate for its intended end users (<i>hover for examples</i>)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Does it explicitly address health inequalities or the needs of vulnerable groups (<i>hover for examples</i>)?	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Would you recommend it to colleagues or decision-makers in your institution?	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Do you intend to apply anything from this output in your own work?	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Section 4: Adaptability and Key Actor Engagement

The questions in this section will ask for your opinion on the potential of the outputs to be adapted and used by key actors, such as health ministries, policymakers, or practitioners at various levels. Engaging these actors in NCD prevention is a key goal of JA PreventNCD, and we would like to understand whether you see this potential in the outputs being developed.

4.1. Adaptability for key actors

Based on your experience and knowledge of your own national or regional context, please indicate whether you think each resource has potential for policy or practice use. If you have limited contact with policymakers or decision-makers, please answer to the best of your knowledge. Select one response per item.

This questions asks about the "[Insert output name here]"

	Yes, as it stands	Yes, but with adaptations (e.g. reformatting, translation, simplification)	No, it's not relevant for this audience	I'm not sure
National policymakers (e.g. health ministry, other sectors)	☐	☐	☐	☐
Regional or local authorities	☐	☐	☐	☐
Health practitioners or clinical teams	☐	☐	☐	☐
NGOs or, advocacy organisations	☐	☐	☐	☐
Researchers or academic institutions	☐	☐	☐	☐

4.2. Do you intend to share this resource with a policy- or decision-maker in your country/region?

- ☐ Yes
☐ No
☐ Not sure

[...]

Note on survey design: The above questions are repeated for each output in the WP that the respondent is aware of AND has read and/or used.

Section 5: Capacity Building

Note on survey design: This section is shown only to respondents who indicated they "contributed to this output" for one or more outputs in question 2.1.

You indicated that you contributed to the development of one or more of the outputs in this survey. The following questions ask whether your experience developing these outputs supported your own learning, collaboration, and capacity building.

5.1. Capacity building through development of outputs

Reflecting on your overall experience across all the outputs you indicated you contributed to, please rate your level of agreement with the following statements.

Use a scale from 1 to 5, where 1 = Strongly disagree and 5 = Strongly agree. Select one response per item.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	Don't know
I had prior specialised expertise on the topics covered in these outputs	☐	☐	☐	☐	☐	☐
Contributing to these outputs introduced me to new approaches or ways of thinking	☐	☐	☐	☐	☐	☐
I feel better equipped to translate research into practice as a result	☐	☐	☐	☐	☐	☐
The development of these outputs generated insights that would be useful beyond the joint Action	☐	☐	☐	☐	☐	☐
Contributing has strengthened professional connections I would not otherwise have made	☐	☐	☐	☐	☐	☐
The development process involved meaningful collaboration across countries and/or disciplines	☐	☐	☐	☐	☐	☐

5.2. Is there anything else you would like to share about your experience with the outputs presented in this survey?

For example, you may wish to comment on: their relevance for your work or national context; their potential for policy or practice use; your experience of working with or using these outputs; or what you gained from contributing to them.

We welcome any additional thoughts in your own words.

Please note: Do not include any personally identifying information in your response, such as personal names or institution names, in order to protect the anonymity of your response.

Survey complete

Thank you! You have completed the survey.

We appreciate your participation and valuable insights.

The results from this survey will be published in the second interim evaluation report.

For any questions, please contact us at preventncd@rki.de

Kind regards,

Meg, Simon and the Work Package 3 Team