Part B: technical description

A-Z-HEALTH – HEALTH IN GENERATIONS ALPHA TO ZOOMER

List of participants

No.	Participant organisation name	Short name	Country
1 (Coo.)	Imperial College of Science Technology & Medicine	ICL	UK
2	Istituto di Studi per l'Integrazione dei Sistemi	ISINNOVA	IT
3	Norwegian Institute of Public Health	NIPH	NO
4	EuroHealthNet ASBL	EHNet	BE
5	National Institute of Public Health Slovenia	NIJZ	SI
6	University of Cologne	UoC	DE
7	New York University	NYU	USA
8	University of Amsterdam	AUMC	NL
9	Ukraine Public Health Center	UPHC	UA
10	Choice Foundation	CHOICE	SE
11	Instituto de Investigación en Sistemas de Salud Biosistemak	Biosistemak	ES
12	Institute of Public Health of the Republic of Macedonia	IPH	MK
13	National Institute of Public Health NIH	PHZ	PL
14	Imperial College Health Partners	ICLHP	UK
15	European Medical Students' Association	EMSA	BE
16	International Youth Health Organisation	YHO	SI

1. Excellence

The A-Z-HEALTH project is designed to capture the core essence of the Horizon destination "Staying healthy in a rapidly changing society". It will do so by generating a comprehensive understanding of the rapidly changing determinants of young people's behaviours, which have been causing a concerning rise in conditions and precursors of non-communicable diseases (NCDs) emerging over the life course, typically rooted in habits acquired in young age. A-Z-HEALTH will focus on two key transitions in the age span from 12 to 25: from early to late adolescence, and from late adolescence to independent living. Each transition triggers new risk exposures for young people, often locking them gradually into unhealthy habits that typically lead to conditions most likely to persist into adult age. A-Z-HEALTH will devise, co-create with youth, culturally adapt, implement, and evaluate, multi-component intervention packages combining evidence-based and best practice actions to empower young people to take control of their environment and their health, and to achieve sustainable behaviour change. A-Z-HEALTH will uniquely combine scientific knowledge from world-leading academic research groups with the involvement of national Public Health Institutes that have the authority and legitimacy to convene local stakeholders, to intervene on key risk exposures affecting the behaviours and health of young people, and to ensure the future scalability and sustainability of behavioural interventions. Youth participation and co-creation will be at the centre of the A-Z-HEALTH approach, connecting partners and enabling the implementation of interventions designed to resonate with young people's needs, aspirations and preferences. The European Office of the World Health Organization, along with EuroHealthNet, will ensure that the knowledge, intervention approaches, and toolkits produced in A-Z-HEALTH reach their key audiences and generate lasting impacts on the prevention of NCDs in young people in Europe.

1.1. Objectives and ambition

Chronic NCDs are responsible for a very large share of disease burden in Europe, estimated at 84% in 2023 (66% if neoplasms are excluded) [ref IHME data]. The burden associated with mental health conditions has grown fastest, with an average increase of 1% per year since 2000. Individual behaviours and the environmental influences that trigger and shape those behaviours have been associated with an increasing incidence and a persistent prevalence of many NCDs. Behaviours are easily turned into habits, especially in vulnerable groups like young people experiencing critical transitions in their early lives, and adult lifestyles are deeply rooted into habits formed in young age. The health of young people in what is known today as Generation-Z is shaped by a combination of established trends and rapidly changing risk exposures in highly dynamic environments.

A-Z-HEALTH's ambition is to focus on three key areas of young people's health, accounting for a major component of the NCD burden experienced by young people in their youth as well as in their future adult lives. These areas are: (a) obesity and metabolic disorders; (b) mental health; and (c) addictions, broadly defined to include the use of tobacco and new nicotine products, alcohol beverages, illicit substances, gambling, screen addictions. A-Z-HEALTH's conceptual framework recognises that close connections exist between the above three areas of young people's health and adopts a coherent unifying approach on the behavioural determinants of NCDs across the three areas, leveraging a holistic representation of the habit formation process.

Aim and objectives

The overarching aim of A-Z-HEALTH is to provide a unifying framework for empowering young people to take control of their health through a combination of literacy, self-management, support tools and environmental nudges, designed to complement a supportive regulatory environment. The A-Z-HEALTH approach is aimed at preventing major NCDs in young people and throughout their future life course by enabling behaviours and habits conducive to healthier lives. A-Z-HEALTH will implement and evaluate interventions in European countries, will assess their impacts in diverse implementation settings, will explore the robustness of the project's findings to future scenarios in youth health, and will derive guidance and toolkits for the scale-up and sustainability of solutions in Europe.

The project will pursue the following 10 specific objectives:

1. To establish **trends over time in three critical NCD areas for youth health**, analyse **key drivers** of those trends, and scope intervention priorities
2. To **map the behavioural determinants of youth health** across the three NCD areas, and the environmental exposures (physical and digital environments) that shape youth behaviours
3. To identify **intervention entry points** along the habit formation process in **two critical transition periods** over the 12-25 age spectrum: from early to late adolescence and from late adolescence to independent living

4. To devise **multi-component intervention approaches** addressing the habit formation process holistically, with a view to empowering young people to take control of their health in each of the two critical transition periods
5. To implement an **equity-by-design** approach in the development of interventions, ensuring that the needs of the most vulnerable groups of young people are prioritised
6. To identify a suitable **real-world-data infrastructure** for supporting the design and implementation of interventions, and for monitoring and evaluating their impacts
7. To **assess intervention impacts** in a rigorous causal framework and across multiple dimensions of outcome
8. To **assess implementation outcomes** and identify key enablers and barriers to a successful implementation of interventions aimed at young people
9. To project the impacts of interventions observed over a 2.5 year implementation period into the future, over the entire life course of the young people involved, through a combination of **foresight and computer-based simulation approaches**
10. To produce **policy recommendations, guidance and toolkits** for scaling up and sustaining effective interventions in the EU, including recommendations for establishing a **regulatory framework that would enable and support the empowerment of young people** in taking control of their health

A-Z-HEALTH builds on one of the largest investments made by the EU in addressing NCDs, in the form of two major ongoing Joint Actions (JAs): PreventNCD and JACARDI (Joint Action on Cardiovascular Disease), which are establishing a robust infrastructure for interventions to address NCDs in Europe, without having a specific focus on young people. A-Z-HEALTH builds on those JAs through its unique partnership, which includes the coordinator of PreventNCD, several Competent Authorities and affiliated partners that have leading roles in both JAs, and brings together institutional participants with research and civil society organisations. Additionally, the project builds on several Research and Innovation actions funded within the EU Horizon programmes, which A-Z-HEALTH partners have been, or are currently coordinating.
Besides providing a wealth of findings, frameworks and capacity, the current EU JAs are piloting over 100 evidence-based interventions and programmes across European countries, which offers unprecedented insights into implementation outcomes, enablers and barriers in diverse country settings in Europe. A-Z-HEALTH will exploit this wealth of knowledge, apply and adapt it to the specific context of interventions aimed at young people experiencing two critical early life transitions.

Youth co-creation is central to the A-Z-HEALTH approach, as the foundation of a broader stakeholder engagement philosophy. A-Z-HEALTH will build on the leadership of the Norwegian Institute of Public Health (NIPH) in the area of youth co-creation, established with the coordination of the Horizon 2020 Co-Create project, which developed innovative tools, including a Dialogue Forum Tool [ref], alongside the youth organisation PRESS, also a partner in A-Z-HEALTH, to support structured youth involvement in policymaking. NIPH is also coordinating the Joint Action PreventNCD in the context of which a European Youth Advisory Group has been established, which is planned to be institutionalised and to serve the A-Z-HEALTH project in an advisory capacity. Youth co-creation will extend to co-delivery in A-Z-HEALTH, particularly in the context of health literacy training, delivered to a large extent through medical students using the CHOICE Foundation EU Best Practice approach.

A-Z-HEALTH adopts a novel conceptual framework that builds on established and validated behavioural science approaches, applying those approaches in critical transitions in young people's lives to mitigate health risks and prevent NCDs. The project's conceptual framework is embodied in a unifying logic model centred around a stylised habit formation pathway as follows:

The unifying nature of A-Z-HEALTH's logic model lies in the identification of consistent patterns of behaviour and habit formation across three NCD areas, recognising that obesity and metabolic disorders, mental health conditions, and various forms of addiction often starting in young age are closely intertwined and have common underlying behavioural determinants. This unifying approach makes A-Z-HEALTH stand out as one of the first projects to tackle holistically the behavioural determinants of health in young people, within a single causal model and intervention architecture. The shared habit-formation pathway means cross-disease interactions are theoretically predicted and empirically testable.

Interventions enter at different points in the habit formation pathway, allowing the conceptualisation of four complementary and mutually reinforcing intervention families, or groups (G1 to G4), as follows:
(G1) Exposure shaping interventions (typically requiring no or minimal agency on the part of the target group) — preventing habit formation by reducing harmful environmental cues;
(G2) Friction and interruption (low agency required) — preventing or slowing automatic repetition through barriers and 'speed bumps';
(G3) Agency scaffolding (moderate agency required) — rebuilding routines via self-regulation supports and feedback;
(G4) Identity and norm stabilisation (high agency required) — locking in gains through peer norms, co-created identities and autonomy-framed inoculation.

Departing from the dominant model in NCD intervention studies, A-Z-HEALTH will go beyond the state of the art by designing and implementing intervention packages embedding components drawn from multiple families, simultaneously within the same unifying theoretical framework, across multiple countries and NCD domains. Key components of the A-Z-HEALTH intervention packages include health and digital literacy (G3); self-management of risk exposures (G2); device-assisted monitoring and feedback (G3); environmental nudges (G1); and resources and services (G3-G4). The NCD prevention literature is divided between regulatory/structural interventions and individual empowerment interventions, often neglecting interactions and synergies between the two approaches, with the equity consequences of balancing low- and high-agency actions in different proportions remaining poorly understood.

A-Z-HEALTH will strive to adopt an equity-by-design approach in deploying behavioural interventions, relying on behavioural phenotyping to identify plasticity and predict responses to intervention in target individuals. This approach will ensure that actions are proportionate to needs, rather than to intrinsic motivation or baseline literacy, so as to redress rather than exacerbate inequalities.

The A-Z-HEALTH intervention packages are designed to exploit windows of opportunity for behaviour change and establishment of healthy habits, coinciding with two critical transitions in young age: from early to late adolescence and from late adolescence to independent living. These transitions are interpreted in A-Z-HEALTH both as causes of increased vulnerability for young people, and as opportunities for increased impact of behavioural interventions, as conceptualised in the habit discontinuity hypothesis literature[17] and demonstrated by evidence that durable habits can form over a short time period when appropriate conditions are created.[18]

Each spanning multiple domains, the A-Z-HEALTH intervention packages combine evidence-based actions that have been tested and validated in different settings either through peer-reviewed research or through institutional reviews of best/good practices by EU agencies, WHO, OECD, and national public health authorities. The value added of the A-Z-HEALTH approach lies in the combination of multiple intervention domains and components into comprehensive packages implemented in diverse country settings, to gauge unique insights on the scalability and sustainability of interventions within and across European countries.

Interventions will be rigorously evaluated in an observational causal inference framework that will enable the attribution of effects to interventions, net of the influence of observed and unobserved confounders. Intervention evaluations will be tailored to the specific characteristics of each country setting and implementation, and will be guided by a multi-dimensional evaluation framework developed under the leadership of the coordinator of A-Z-HEALTH in the context of the Joint Action JACARDI to become a gold standard for evaluating the implementation of public health interventions aimed at preventing and addressing NCDs.

Evaluations will be based on data, results and outcomes observed during a 2.5-year intervention delivery period within the duration of the project. However, the value of the interventions implemented in A-Z-HEALTH will be largely realised after the conclusion of the project, in terms of both future health and socio-economic outcomes that will manifest themselves over the lifetime of the young people concerned by A-Z-HEALTH interventions. In order to capture those outcomes, rarely assessed in the evaluation of public health interventions, A-Z-HEALTH will use a combination of simulation modelling and foresight approaches.

Strategic foresight is increasingly embedded in EU policymaking, notably through the European Commission's Strategic Foresight Reports and the JRC Foresight Framework, supporting anticipatory governance and policy design. International organisations (e.g. OECD, World Economic Forum) have further expanded foresight approaches to address technological, societal, and behavioural transformations. However, while foresight for policy design is well established, its application in public health—particularly for NCD prevention—remains limited. Existing initiatives rarely combine participatory approaches, behavioural science and intervention research in a

single analytical framework and only occasionally integrate youth perspectives and diverse socio-economic contexts in a systematic way.

A-Z-HEALTH addresses this gap by embedding participatory foresight within its research, implementation and policy transition framework. WP8 combines horizon scanning, social media analysis, youth participation, collective sense-making, and Delphi processes to identify emerging trends and uncertainties shaping youth health behaviours across diverse socio-economic contexts.

The project advances the state of the art by linking foresight outputs with intervention evaluation and quantitative simulations of future health and socio-economic outcomes, based on Imperial's open-source Health-GPS NCD microsimulation model. Scenario-based analyses will assess the robustness, scalability, and equity implications of behavioural interventions under alternative future conditions, supporting adaptive, evidence-based, and policy-relevant strategies for NCD prevention. This allows A-Z-HEALTH not only to evaluate what works today, but also to anticipate what may remain effective, acceptable, and fair in the youth health environments of the future.

Knowledge translation

1.2 Methodology

1.2.1 Overall methodology

Non-communicable diseases (NCDs) are the leading cause of death and disability in Europe, accounting for approximately 90% of all mortality. Among adults, NCD burden accumulates over decades — but the biological, behavioural, and social conditions that determine lifetime NCD risk are set during adolescence and early adulthood, between the ages of 12 and 25. Sawyer et al. established this window as the single most consequential period for long-term health trajectories.[1] It follows, therefore, that NCD prevention investments directed at this age group carry the highest potential return — and the longest window before harm is irreversible.

Europe is currently failing this generation across three interconnected disease domains. A-Z-HEALTH targets each one directly, starting from the disease — its burden, its biology, and its modifiable causes — and working backwards to the interventions that can change its course.

Obesity and metabolic disorders

Obesity (ICD-11 5B81) is a chronic, progressive, relapsing disease — not a risk factor, a lifestyle failing, or a side-effect of other conditions. The WHO recognises obesity as a disease in its own right, with distinct pathophysiology, defined diagnostic criteria, and independent attributable mortality. In European youth, the scale is now alarming: across 35 countries participating in the WHO COSI study, 29% of children and adolescents are overweight or obese,[2] with the highest rates in Southern and Eastern Europe exceeding 40%. Garrido-Miguel et al. (2019), in a systematic review and meta-analysis of 103 studies covering 636,933 European children aged 3–16, documented a monotonic increase in obesity prevalence from 1999 to 2016 in virtually every country studied.[3]

The consequences of adolescent obesity are severe and compound. Obesity in adolescence is associated with a 5-fold increase in the risk of adult obesity,[2] and directly predicts incident type 2 diabetes, cardiovascular disease, non-alcoholic fatty liver disease, hypertension, obstructive sleep apnoea, and several cancers in adulthood. Beyond physical comorbidity, adolescent obesity is strongly associated with depression, anxiety, and eating disorders — a bidirectional relationship that amplifies both conditions. The economic cost of obesity in the EU is estimated at over €70 billion annually in direct healthcare expenditure and productivity losses.

The primary behavioural driver in young people is dietary quality, specifically consumption of ultra-processed foods (UPFs) — industrially manufactured products containing additives, emulsifiers, and engineered palatability profiles that override normal satiety signalling. UPF now comprises over 50% of dietary energy intake among adolescents in the UK, and between 30–48% in France, Germany, and the Nordic countries.[4] Physical inactivity compounds this: fewer than 20% of European adolescents meet WHO guidelines for moderate-to-vigorous physical activity.

Mental health conditions

Mental disorders among young Europeans are not a homogeneous category — they are a family of distinct diseases with different aetiologies, different intervention targets, and different trajectories. A-Z-HEALTH focuses on three that dominate the burden in the 12–25 age group and share common digital environment exposure pathways.

Depression and anxiety (ICD-11 6A70–6B04) are the leading causes of disability-adjusted life years (DALYs) in European youth. Castelpietra et al. (2022), analysing Global Burden of Disease data for 30 European countries from 1990 to 2019, found that mental disorders, substance use disorders, and self-harm collectively accounted for

approximately 15% of all DALYs in the 10–24 age group.[5] The Lancet Psychiatry Commission on youth mental health (McGorry et al., 2024) identified a global youth mental health crisis, with 75% of adult mental disorders having their onset before age 25 and prevalence of anxiety and depression in European youth rising sharply from 2012 onwards — a rise that correlates temporally with the proliferation of smartphone social media.[6]

Sleep disorders (ICD-11 7A00–7A20) are insufficiently recognised as diseases in their own right, yet they carry substantial independent morbidity. Chronic sleep insufficiency in adolescence is associated with increased risk of depression, anxiety, obesity, type 2 diabetes, and cardiovascular disease. Carter et al. (2016) demonstrated in a systematic review and meta-analysis that portable screen-based media access was significantly associated with reduced sleep duration (OR 2.17) and poor sleep quality (OR 1.46).[7] European data show that 30–40% of adolescents report insufficient sleep, a proportion that has increased in parallel with smartphone adoption.

Eating disorders (ICD-11 6B80–6B84) — including anorexia nervosa, bulimia nervosa, and binge-eating disorder — have the highest mortality of any mental health condition, with standardised mortality ratios up to 6 times that of the general population. They disproportionately onset in the 12–20 age range, are exacerbated by social media-mediated body image exposure, and are increasingly comorbid with obesity as binge-eating disorder becomes the most prevalent eating disorder subtype.

Addictions

Addictions are diseases. Alcohol use disorder (ICD-11 6C40), nicotine/vaping dependence (6C4A), gambling disorder (6C50), and gaming disorder (6C51) are classified under ICD-11 Chapter 6C (Disorders due to substance use or addictive behaviours). They share a neurobiological substrate — dysregulation of dopaminergic reward circuitry — and a developmental vulnerability: the adolescent brain is disproportionately susceptible to addiction onset because prefrontal inhibitory control is not fully mature until age 25.

The scale of the problem in European youth is substantial. Hazardous alcohol use affects approximately 12–15% of young people aged 15–24, with binge drinking patterns established in adolescence predicting lifetime alcohol use disorder.[5] Vaping (nicotine/electronic cigarette use) has escalated sharply: the WHO European Regional Office reported in 2025 that the EU has the highest rate of youth e-cigarette use globally, with 32% of 13–15 year-olds in some countries having tried e-cigarettes.[8] Tarasenko et al. (2022), analysing Global Youth Tobacco Survey data across 17 European sites, found current e-cigarette use of 5–22% among adolescents depending on country.[9]

Problem gambling is emerging as a significant youth disorder: Calado et al. (2017), in a systematic review of 44 studies, found problem gambling prevalence of 0.2–12.3% among adolescents, with higher rates among males and digital/online gamblers.[10] All three addiction domains share a critical characteristic: digital environments are the primary contemporary vector for onset and escalation — through advertising, platform design, and the social normativisation of addictive products and behaviours in algorithmically curated feeds.

Analysis of trends over time in three critical NCD areas for youth health, and their drivers

Mapping of behavioural determinants of youth health and environmental exposures

Youth behaviours, environmental influences and the habit formation process

Critical transitions in young age and intervention entry points

A-Z-HEALTH will focus on two critical transitions during the age spectrum 12-25. In behavioural science, life transitions play a key role in behaviour change. On the one hand, they make individuals especially vulnerable to external influences, exposing them to new risks and potentially exacerbating old ones. For young people, this adds to an underlying vulnerability typical of young age, creating a double jeopardy that often leads to behaviours conducive to NCDs. However, transitions are also identified in behavioural science as entry points for behaviour change interventions, because they create unique, albeit temporary, states of behavioural plasticity in which new behavioural patterns and habits can be established, in line with the Habit Discontinuity Hypothesis [refs].

Two such critical transitions will be the focus of the behavioural interventions designed and implemented in A-Z-HEALTH. The **first transition** typically occurs during secondary school years and reflects the passage **from early adolescence to late adolescence**, often coinciding with the transition from lower to upper secondary school. This is a time when adolescents become more independent and change their relationships with those who have previously had authority on them, including parents and teachers. They face an expanded social context and stronger peer pressures, including pressures to experimenting with behaviours that are typically associated with the development of NCDs. Importantly, they gain increased access to digital media, which act as a multiplier of other exposures.

The **second transition** on which A-Z-HEALTH will focus is that **from late adolescence to independent living**, often coinciding with the transition from secondary school to tertiary education or work. This transition typically involves a significant leap into independence of choice and behaviour, and requires young people to take

responsibility for their own lives, with health being one dimension alongside others. Young people face yet more changes in their social context, and behavioural experimentation may continue. Digital media are increasingly used as tools, but their influence on behaviour and health remains strong.
A-Z-HEALTH will implement two intervention packages designed to exploit the windows of opportunity for behaviour change and habit discontinuity provided by the above two transitions.

The A-Z-HEALTH youth co-creation approach

Behavioural phenotyping to achieve equity by design

Intervention design

a. Health and digital/AI literacy

Health literacy is a critical condition for the empowerment of young people in taking control of their health, and the focus of substantial capacity building work in the context of the two EU JAs on NCDs. Like the two JAs, A-Z-HEALTH builds on the WHO Health Literacy Development Framework [ref], recognising the five key actions (Accessing, Understanding, Appraising, Remembering, Using) and the requirements for meaningful community engagement and local ownership to build locally fit-for-purpose and implementable actions [ref].

A-Z-HEALTH will adopt an EU best practice and award-winning approach to health literacy training for young people, developed by the CHOICE Foundation in Sweden, under the name of TUTCH (Teens Understanding and Taking Control of Health) approach. This is a structured health literacy programme targeting adolescents aged 12–18, as well as young adults up to 25. Its primary objective is to enhance knowledge and awareness of the effects of consuming addictive products such as alcohol, tobacco, and illicit substances, and of the mental health conditions linked with those behaviours, while strengthening young people's decision-making capacities, critical thinking, and resilience.

The programme is delivered through an interactive, peer-to-peer model in which trained medical students and medical doctors facilitate classroom-based sessions. It combines evidence-based health education with participatory methods, including group discussions, scenario-based exercises, and learning materials. This approach fosters engagement and encourages active reflection, while maintaining a structured pedagogical framework that can be adapted to different cultural and educational contexts.

A key feature of the TUTCH approach is its emphasis on high-quality implementation. Initial training is delivered on-site by certified CHOICE trainers in each participating country. This ensures consistency, methodological integrity, and a strong foundation for local delivery from the outset. Facilitators are certified following completion of the training and supervised initial sessions. Quality assurance is maintained through standardized curricula, detailed implementation guidelines, and continuous support from CHOICE. To enable sustainable scale-up, a train-the-trainer model may be considered in A-Z-HEALTH if more efficient. This would allow selected local coordinators to support ongoing delivery. However, CHOICE retains responsibility for initial training and certification to safeguard fidelity to the core methodology.

For international implementation, TUTCH places strong emphasis on co-creation with local stakeholders, including youth organisations, schools, and public health institutions. This collaborative process ensures cultural relevance and contextual adaptation, while preserving the programme's core content, structure, and educational principles.

A-Z-HEALTH will combine health and digital/AI literacy into a single literacy programme, with the latter component being delivered by specialists in digital media use. This will be aimed at bridging a major gap in the education that children, especially younger ones, should be receiving on digital media and their use. Arguably, digital media today have a larger influence on young people's lives and health than anything else they are exposed to, and yet young people learn what these tools are and how they can be used largely by themselves, with minimal support from parents, most of whom are no better equipped than their children, and from schools. The digital/AI literacy training will address questions ranging from general principles to the specific ways in which young people's health can be affected, and can be protected, when using digital media and AI tools. Those questions will centre around the dominant business models in the digital world, addressing issues of direct relevance to the health and wellbeing of young people, such as the use of personal data by providers of digital apps and advertisers, the algorithmic targeting of contents and advertising, the constant quest by digital providers to gain and retain the attention of young users for as long as possible, as many times a day as possible. The programme will also address

issues around misinformation and trustworthiness of sources and apps, and the risks associated with social interactions via digital media, including cyberbullying and harassment.

Literacy programmes will be differentiated for the two age groups, based on higher expected levels of information and agency in the 19-25 group. Both groups will receive training aimed at raising awareness of the risks young people are typically exposed to, and of the health conditions that may be linked to those. Training for the 19-25 group will include identifying thresholds at which young people should be seeking help, and ways in which they can access appropriate services.

Digital and AI literacy training for both age groups will focus on understanding the different ways in which contents accessed through digital media and AI tools may impact their health, and approaches to mitigate those impacts. This will include raising awareness of health risks arising from exposure to, for instance, targeted marketing based on data collected from their own use of digital devices, or to various forms of cyberbullying. Misinformation will also be a subject of digital/AI literacy training, especially for the age group 19-25, including ways in which this can be managed through pre-bunking and inoculation. Also, part of digital literacy training for the 19-25 groups, will empower young people who wish to seek help concerning health conditions from digital apps and devices to be able to appraise different commercially available options (app star rating approach).

b. Self-management of digital media use

This component is primarily intended for the age group 12-18. It is an individual-level intervention component, requiring children (and their families) to volunteer to modify their social media settings in ways that will limit their exposure to "attention grabbing" and potentially addictive features of digital media use. These interventions will include the following:

a) A unique digital media use-management tool, developed by researchers at NYU and tested in studies in the US [ref], will enable the replacemenet "infinite scroll" with a "pagination feature" so that when an adolescent scrolls past 10 posts, they will see an arrow that allows them to go to the next page of 10 posts. The rationale for this pagination feature is to disrupt mindless scrolling by placing a visual reminder of the amount of content being consumed. This feature will prevent children from excessive exposure to social media content and from spending exceeding amounts of time on screens and digital media, thereby reducing exposure to potentially harmful health-related content. There will also be benefits in terms of improved attention levels and improved sleep patterns.

b) A teen-targeted use-management tool, which would trigger a hard stop (not amenable to manipulation) on social media use at given times of the day and night. The use of the above tool by adolescents is expected to improve sleep duration and quality, and attention regulation.

c) Notification frequency reduction tool, which would reduce the frequency of notifications to once daily. Continuous notifications are another key "attention grabbing" feature of digital media use. The toll will operate by delivering notifications in batches, thereby reducing the frequency of device pick-up and time spent on digital devices, and improving attention regulation.

c. Device-assisted monitoring and feedback

This component is designed primarily for the 19-25 age group intervention, as it requires a higher level of literacy and agency. It is designed as an individual-level intervention component requiring young people to volunteer to use wearable devices for short periods of time or longer-term, to monitor aspects of their behaviour that can reflect or influence their health status. This behavioural intervention combines young people's empowerment from access to a wider and richer information set about their behaviours and health, with targeted and behaviourally inspired feedback delivered by the same devices based on the information gathered through monitoring. The feedback will be designed to include behavioural dimensions such as targets, commitments, peer comparisons, etc.

Behavioural monitoring dimensions may include the following:
a) Physical activity, from simple step counts to more detailed monitoring of physical activity patterns and intensity.
b) Sleep, rest and activity cycles monitoring, including duration and patterns of sleep, through actigraphy monitoring.
c) Eating patterns and diet monitoring, based on wearable cameras powered by AI image recognition software algorithms, developed and validated in the current Horizon project CoDiet (activity led by ICL).

This intervention component will build on a pilot implementation project that is currently been undertaken in the JA PreventNCD, involving seven countries and co-led by NIPH. This project provides a scalable and validated model for monitoring key behavioural risk factors for NCDs, corresponding to the behaviours listed in (a) and (b)

above, using actigraphy devices. A-Z-HEALTH will build on the data platform and standardised data collection methods developed in this PreventNCD pilot project, it will take stock of valuable insights on implementation challenges gathered in the seven-country pilot, and it will be able to re-use some of the monitoring devices purchased for the pilot.

d. Health-promoting environments and nudges

Applied primarily in the 12-18 intervention, this component is aimed at creating a health promoting environment within secondary schools. Interventions will aim at preventing conditions in all three health areas at the centre of the A-Z-HEALTH project (obesity, mental health, and addictions), as follows:

a) Evidence from STOP systematic reviews [ref], and WHO policy guidelines and recommendations [refs] developed with the contribution of the coordinator of A-Z-HEALTH, provide strong support for behavioural interventions in **school food environments**. WHO guidelines relate to nudges (portion size, nutrition information, food presentation and positioning), a well as direct food provision and nutrition standards. While not all schools will have canteens or directly provide full meals, there is scope for implementing food environment interventions that would have a meaningful impact on children's dietary intakes in all implementing countries.

b) Food environment interventions can be combined with **interventions to promote physical activity** in addressing obesity and metabolic disorders, but also with likely benefits in the other health areas. The feasibility of combining the two types of interventions will be assessed at the local level, depending on the sustainability of the infrastructural costs involved.

c) **Smartphone-free schools**, following an increasing number of jurisdictions preventing children from taking their smartphones to school or using them while at school. The A-Z-HEALTH framework is based on the premise that reducing exposure to digital media and digital content will have benefits in all of the project's three critical health areas.

After the end of secondary school, young people typically disperse into a variety of different environments, making it more challenging to design physical environment interventions that would have a sustained effect on the same individuals over a meaningful period of time. For this reason, behavioural interventions aimed at the 19-25 age group will focus mostly on digital environments (e.g. reminders, commitments, feedback) and on digital tools designed to help young people take control of specific domains of health risk (e.g. food choice apps).

e. Resources and services for young people

This intervention component is intended primarily for the 12-18 age group. It involves environmental interventions aimed at empowering children to request and obtain safe advice and counselling from trained staff on health issues they may be experiencing or may be concerned about.

The priority area in this domain is mental health, and the intervention may rely on transferring and adapting the NIJZ approach developed in Slovenia with the "To sem jaz" mental health counselling website to other countries. Potentially, an AI-assisted version of NIJZ's tool could be considered, for efficiency of deliver, while maintaining trained staff in control of the answers provided. The AI support algorithm could be trained using a database of questions asked and advice provided over the years (if available) in Slovenia.

Summary of intervention components and key design features

Implementation of intervention package for 12-18 year olds

- Germany
- North Macedonia
- Norway
- Slovenia
- Ukraine

Implementation of intervention package for 19-25 year olds

- Germany
- Poland
- Spain
- Ukraine

Real-world data infrastructure for monitoring and evaluation

Multi-dimensional assessment of intervention outcomes

The evidence gap: why effective intervention evidence does not yet exist at the required scale
Despite the scale of the problem, the evidence base for effective behavioural interventions targeting these three disease conditions in 12–25 year-olds, in European settings, at the scale required for population-level impact, remains critically underdeveloped. Four gaps are decisive.
Gap 1: Single-condition trials that miss shared pathways. Existing intervention research is siloed by disease. There are trials for obesity interventions, mental health interventions, and addiction interventions — but no project has simultaneously addressed all three conditions within a common theoretical framework, tested whether interventions targeting shared digital exposure pathways produce cross-condition benefits, or evaluated whether gains on one condition come at the cost of another. A-Z-HEALTH fills this gap.
Gap 2: Controlled settings that fail to demonstrate real-world scalability. Most existing behavioural intervention trials are conducted in highly controlled settings with atypical populations. They demonstrate proof-of-concept efficacy but not the real-world effectiveness across diverse European cultural, socioeconomic, and regulatory contexts that policymakers need. A-Z-HEALTH deploys interventions at scale across ≥5 European countries — spanning social-democratic, Mediterranean, and post-socialist welfare contexts — to generate the generalisable evidence the call requires.
Gap 3: No European evaluation of the digital regulatory experiments already underway. France (2023), the United Kingdom (2024), Australia (2024), and Norway have introduced or legislated restrictions on under-16 smartphone and social media access — the largest natural experiments in youth digital environment modification ever conducted. None has been rigorously evaluated for downstream effects on NCD outcomes. These policy experiments are creating staggered implementation timelines across A-Z-HEALTH consortium countries, providing a unique quasi-experimental platform. Without A-Z-HEALTH, this evidence opportunity will be lost.
Gap 4: No account of equity and the bundling problem. High-agency behavioural interventions — self-monitoring, goal-setting, digital therapeutics — tend to benefit young people who are already advantaged: those with higher health literacy, greater digital access, and more supportive environments. When deployed without structural protection (low-agency G1/G2 interventions), high-agency interventions can widen health inequalities rather than narrow them. This is the core equity hypothesis that Miraldo's bundling framework addresses — and it has never been tested in the context of digital environment interventions. A-Z-HEALTH tests it directly.

The future of young people's health: foresight and policy simulation

Foresight in A-Z-HEALTH is implemented as a structured, participatory, and policy-oriented process to anticipate how youth health behaviours and their relatedkey drivers may evolve over the next 10–20 years, and how behavioural interventions for NCD prevention may need to adapt in response. The approach builds on ISINNOVA's extensive expertise in EU policy-oriented foresight, including the Foresight on Demand (FOD) framework, and adapts a methodology tested in a previous EU project (EUARENAS), combining social media signal scanning, participatory sense-making, and Delphi-inspired foresight rounds.

The methodology is grounded in continuous engagement with youth and expert stakeholders. A Youth Advisory Committee ensures continuous engagement of diverse youth groups, contributing to the identification and interpretation of emerging trends, validation of findings, and assessment of intervention relevance and acceptability. These participatory inputs will be complemented by the involvement of multidisciplinary experts from public health, behavioural science, digital media, policy, education, and civil society. The foresight cycle includes: (i) systematic analysis of social media and other sources to detect emerging behaviours, attitudes, and inequalities; (ii) collective interpretation by a multidisciplinary panel to identify trends, mismatches with intervention assumptions, and early warning signals; and (iii) prioritisation of key uncertainties and assessment of intervention robustness across youth segments.

Foresight outputs feed into scenario development and subsequent modelling and policy simulation, enabling the project to assess the long-term effectiveness, equity, scalability, and robustness of interventions under alternative future conditions.
Towards scalable and sustainable intervention models: knowledge translation and institutionalisation

1.2.2 BACKGROUND
To be included

1.2.3. INTERDISCIPLINARITY APPROACH

The A-Z-HEALTH consortium brings together a interdisciplinary team that will collaborate closely throughout all stages of the project combining expertise from:

- Public health: XX
- Behavioural and social sciences: XX
- Youth engagement and communication: XX
- Digital technology and data science: XX
- Governance, policy, and economics:

Each partner contributes context-specific expertise, as described in Section 3.2, and each work package is implemented by partners with complementary skills and experience. This structured interdisciplinarity is designed to ensure that Z-GEN delivers evidence-based, context-sensitive interventions with strong potential for replication and transfer across Europe.

1.2.4 SOCIAL SCIENCES AND HUMANITIES

SSH approaches will play a key role in generating insights into the social determinants of health, including education, poverty, and inequality. Inequality will be addressed as a cross-cutting issue throughout the project, analysed in WP XX, and explicitly considered in the evaluation of the educational components and in the drafting of policy recommendations. By integrating these dimensions, A-Z-HEALTH will strengthen the relevance, acceptability, and effectiveness of its interventions across diverse European contexts.

A-Z-HEALTH will also draw on the expertise of its SSH-oriented partners to ensure that the needs, preferences, and perspectives of young people are reflected throughout the project and effectively communicated. This objective will be supported through activities on stakeholder engagement and participation (XX), capacity building (XX), behavioural research, social impact assessment (XX), and communication and dissemination.

Youth participation is a core design principle of A-Z-HEALTH. Young people will be involved from the outset through the Stakeholder Advisory Board in WP1 and throughout the project lifecycle, including the design phase (WP3), intervention development and implementation (WP4–WP6), and modelling, foresight, and policy transfer activities (WP8). In parallel, WP7 will assess the project's social impact and provide evidence on the behavioural and psychological factors that shape attitudes towards A-Z-HEALTH interventions, as well as the drivers of public acceptance and sustained uptake. Ethical issues will be addressed throughout the project by the Ethics Board, in close cooperation with the relevant Data Protection Officers and ethics committees at the pilot sites.

1.2.5 GENDER DIMENSION

A-Z-HEALTH integrates sex, gender, and intersectional factors across its research and innovation activities. These dimensions are considered in project design, implementation, evaluation, and dissemination. The project recognises that health behaviours, access, and outcomes are not gender neutral and may also differ by age, socioeconomic status, education, cultural background, and place of residence. By addressing these factors across the work plan, A-Z-HEALTH will strengthen the relevance, inclusiveness, and effectiveness of its interventions and favouring opportunities for upscaling and replication.

- **Project governance and research team:** A-Z-HEALTH will promote gender balance and equal opportunities in project governance, decision-making bodies, and research activities. The consortium will aim for balanced representation in project boards, advisory structures, and key tasks, while supporting the participation of researchers of all genders across the project. Partners are committed to equal opportunities and to fostering an inclusive working environment in line with European principles on gender equality.
- **Data collection and analysis (WP2-WP7):** A-Z-HEALTH will promote gender balance in data collection and will analyse possible differences linked to sex, gender, and other intersectional factors. These may include age, education, socioeconomic background, and place of residence. This analysis will help identify subgroup differences in perceptions, needs, and responses, and will strengthen the evidence base for intervention design.
- **Intervention design (WP3-WP4):** The gender dimension will be considered in the design and development of the intervention (WP3-WP4). A-Z-HEALTH will promote inclusive participation of practitioners, experts, educators, and young people, and will seek balanced involvement across

genders both as co-creators and users. This will support accessibility, usability, and relevance for diverse groups.

- **Pilot implementation and testing (WP5):** A-Z-HEALTH interventions will, where relevant and feasible, be tested in diverse and gender-balanced groups. Sex-disaggregated and gender-sensitive evaluation data will be collected when possible to assess differences in uptake, usability, and effectiveness. This will support more inclusive and responsive intervention refinement.
- **Modelling, foresight and policy (WP8):** Gender and intersectional considerations will be reflected in the interpretation of findings and in the development of policy recommendations. A-Z-HEALTH will assess whether differentiated approaches are needed to address the needs of different groups and to support inclusive uptake across contexts.
- **Communication and dissemination (WP9):** A-Z-HEALTH will use gender-inclusive language and balanced visual representation in all dissemination and exploitation materials. Communication activities will avoid gender bias and will pay attention to the different experiences, needs, and roles that may emerge from the project findings. Relevant gender stakeholders and participants from underrepresented or intersectional groups will be engaged as both contributors and target audiences. Public outputs will follow recognised guidance on inclusive and gender-neutral language.

1.2.6 OPEN SCIENCE

A-Z-HEALTH will embed **open science** as a core principle of its methodology, ensuring early, transparent, and inclusive sharing of knowledge, data, and tools. This will maximise scientific quality, reproducibility, and uptake, while fostering cross-sector collaboration and replication beyond the consortium. The approach combines FAIR data management, open access to outputs, and citizen participation in the research cycle. In addition, the project will make available all these types of results to the European research community in general and the Joint Action PreventNCD in particular. Overall, the project results will be made available based on the seven (6) practices:

1. **Early and open sharing of research**: key findings, methodologies, and intermediate results will be shared early through preprints, open repositories and presentations. Where relevant, preregistration and registered reports will be used to increase transparency in study design, e.g. behavioural and health impact assessments.
2. **Open access publication and research** Open access to all the peer reviewed scientific publications of the project will be provided. Selected publications will be made available with the highest standard (Gold Open Access). The rest publications will be made available in the project's web site, but also in OpenAIRE's Zenodo open access repository. Software, models, and algorithms (e.g.xx) will be released under open licences (MIT, GPL) with full documentation to enable reuse
3. **Open Research Europe Publishing Platform (OREPP)**: A-Z-HEALTH will publish a minimum of three (>=3) articles in the OREPP, including one project overview article at the beginning of the project and a concluding article providing a summary of the project's main research achievements at the end of the project.
4. **FAIR data management**: by month 6, the consortium will produce a **Data Management Plan (DMP)** compliant with Horizon Europe requirements, revised in M36. All research data generated or reused will be **Findable, Accessible, Interoperable, and Reusable**: metadata will follow EU standards (e.g. HL7/FHIR for health data), ensuring interoperability between datasets. Sensitive data will be pseudonymised or anonymised in compliance with **GDPR** and national regulations, with controlled access for qualified researchers.
5. **Reproducibility and quality assurance**: all code and workflows will be managed through open version-control systems (GitHub/GitLab). Analytical pipelines, modelling assumptions, and datasets will be linked to persistent identifiers (DOIs) to ensure transparency and traceability. Replication protocols will allow external validation.
6. **Citizen science and co-creation**: youth, youth groups, and civil society organisations will actively contribute to data generation (e.g.XX) and to the interpretation of results. This participatory approach will broaden the evidence base, strengthen local ownership, and increase societal uptake of project outcomes.

2. Impact

2.1 Project's pathways towards impact

The logic model in Figure X summarises how A-Z-HEALTH's ten project objectives translate, through specific work package activities and deliverables, into results, outcomes, and ultimately into sustained population-level impacts. This section provides the narrative underpinning that model, covering: (a) the unique contribution of A-Z-HEALTH results to the outcomes and wider impacts specified in the call destination; and (b) the requirements and potential barriers that will need to be navigated to realise those impacts.

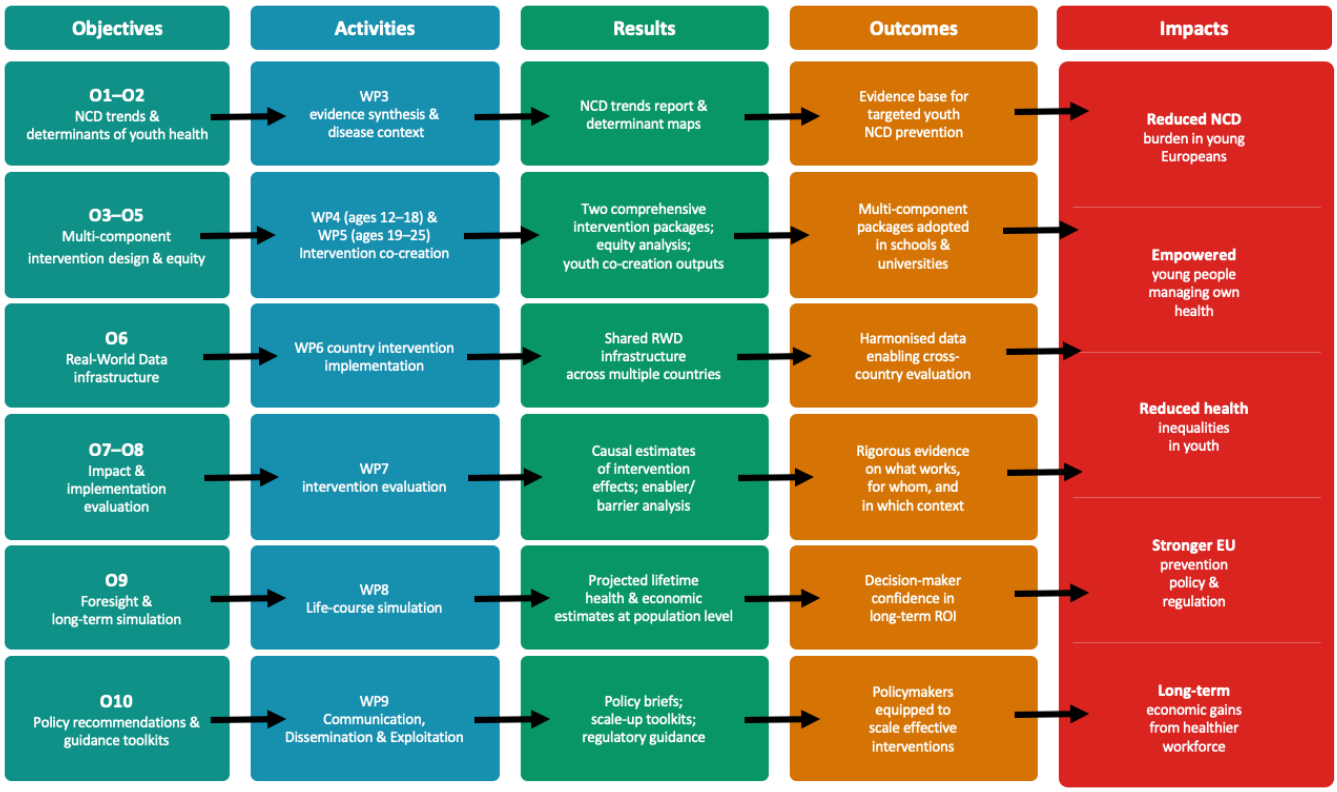

Fig X.

2.1.1 Unique contribution to expected outcomes and wider impacts

A-Z-HEALTH responds directly and comprehensively to the requirements of HORIZON-HLTH-2026-01-STAYHLTH-02. The call's focus on behavioural interventions for NCD prevention in young people aged 12–25, with emphasis on digital tools, self-monitoring, equity, gender-sensitive approaches, and real-world data, maps precisely to A-Z-HEALTH's design. The project's unique contribution is threefold: it generates the first multi-condition, multi-country, rigorous causal evidence base for youth NCD prevention in European settings; it produces validated, equity-tested intervention packages ready for national-scale adoption; and it delivers the policy tools, modelling outputs, and regulatory guidance that policymakers need to convert that evidence into sustainable action.

Target groups that will benefit from the project are:

Target group	Nature of benefit
Young people aged 12–18 (secondary school settings, ≥5 countries)	Direct beneficiaries of the WP4 intervention package. Multi-component interventions targeting obesity, mental health, and addictions are co-created with adolescents and embedded in school environments. The equity-by-design approach ensures that interventions actively prioritise young people from lower socioeconomic backgrounds, migration backgrounds, and those with limited digital access — those most at risk of NCD onset and least served by existing provision.

Young adults aged 19–25 (tertiary education and workplace settings)	Direct beneficiaries of the WP5 intervention package. This cohort — navigating the transition to independent living and early employment — is particularly underserved by health intervention evidence. Wearable-assisted monitoring, digital literacy components, and health-promoting environmental nudges are tailored to this age group's higher autonomy and digital fluency.
Healthcare professionals (GPs, school nurses, mental health practitioners, nutritionists)	Equipped with validated, contextually adapted toolkits for behavioural intervention in youth populations. By project end, structured training and access to resources will be available to health professionals across all partner countries, directly supporting the call's expected outcome on access to effective behavioural interventions.
Educators and school staff (secondary schools across Norway, Slovenia, and additional implementation sites)	Trained and supported to deliver health and digital literacy components of the WP4 intervention. School environments are reconfigured through nudge-based approaches and environmental modifications, creating a health-promoting institutional infrastructure that persists beyond the project period.
National public health institutes (NIPH/NASKO Norway, NIJZ Slovenia, and peers across implementing countries)	Strengthened institutional capacity in intervention delivery, evaluation, and data infrastructure. RWD platforms and evaluation frameworks established in WP6-WP7 create reusable national assets. Implementation science evidence from WP7 directly informs how interventions can be institutionalised within national health systems.
National and EU-level policymakers	Provided with the causal evidence, health-economic modelling, and policy toolkits (available in ≥4 EU languages) needed to make investment decisions on youth NCD prevention at scale. Foresight scenarios and Health-GPS microsimulation projections (WP8) will translate 2.5-year intervention findings into lifetime and population-level estimates that health ministries and EU institutions require.
Research and public health community	Benefits from a reusable FAIR-compliant data infrastructure, pre-registered protocols, open-access datasets, and a standardised evaluation framework adapted from JACARDI — raising methodological standards for future youth NCD intervention research across Europe.

The scale of potential impact is substantial. Young people aged 12–25 represent around 15% of the EU population — around 67 million individuals — yet account for a disproportionate share of modifiable NCD risk formation. Behavioural habits consolidated during this period are predictive of NCD outcomes across the entire life course. ICL's *Health-GPS* microsimulation outputs in WP8 will quantify projected reductions in obesity prevalence, mental health burden, and addiction-related harm attributable to A-Z-HEALTH interventions if scaled across EU Member States. Preliminary modelling from comparable interventions suggests that even modest effect sizes, replicated at population scale, will translate into material reductions in years of life lost and healthcare costs over a 20-year horizon.

The project's contribution to the wider expected impacts of the 'Staying Healthy in a Rapidly Changing Society' destination is equally direct. By targeting the behavioural and environmental determinants of NCDs at the two life-course windows where prevention has the greatest return — adolescence and the transition to independent living — A-Z-HEALTH advances the destination's vision of health-literate, empowered citizens capable of navigating rapidly changing digital environments. The equity-by-design approach and pre-specified subgroup analyses directly address the destination's emphasis on reducing health inequalities. The multi-sector consortium — spanning research institutions, national public health institutes, and civil society (EuroHealthNet) — embodies the cross-sectoral coordination that the destination identifies as essential to effective prevention.

A-Z-HEALTH also directly advances two flagship EU health initiatives. The project addresses three of the four disease areas prioritised under *Healthier Together* (cardiovascular disease and diabetes risk, mental health, and addictions). NIPH Norway coordinates Joint Action PreventNCD — the primary implementation vehicle for Healthier Together — meaning that A-Z-HEALTH evidence will flow directly into operational EU public health

infrastructure from the outset. NIJZ Slovenia leads JA PreventNCD's sustainability work package, providing a structured channel for A-Z-HEALTH tools and frameworks to achieve institutional permanence beyond the project's lifetime. Additionally, the FAIR-compliant, federated RWD infrastructure established in WP7 is designed for compatibility with the European Health Data Space (EHDS), contributing to the EU's digital health transformation agenda.

2.1.2 Requirements & Potential Barriers

HERE

2.1.1 Explanation of the project results

A-Z-HEALTH responds directly and comprehensively to the requirements of HORIZON-HLTH-2026-01-STAYHLTH-02. The call's central focus on behavioural interventions for NCD prevention in young people aged 12–25, with emphasis on digital tools, self-monitoring, equity, gender-sensitive approaches, and real-world data, maps precisely onto A-Z-HEALTH's design. Specifically:

Table 2.1.1: Expected outcomes based on the call and our feedback

Expected outcomes (based on the call)	*Planned A-Z-HEALTH outcomes*
*Healthcare professionals have **access to behavioural interventions** that can be used to establish and reinforce healthy habits and sustain behavioural changes.*	**NCD coverage:** A-Z-HEALTH will equip healthcare professionals — including general practitioners, nutritionists, and mental health practitioners — with a validated, evidence-based toolkit of behavioural interventions specifically designed for youth populations aged 12–18 and 19-25. Obesity (diet, physical activity), psychological wellbeing (social interaction, sleep) and addictions (nicotine/vaping, alcohol, online gambling) are among the leading modifiable NCD risk areas in the 12–25 age group. The toolkit will be structured around the intervention design (WP4-WP5) and implementation (WP6) and will enable professionals to tailor interventions to individual trajectories. By the end of the project, it is expected that at least **[X] healthcare professionals** across **[X] partner countries** will have received structured training and access to these resources.
*Health professionals and educators have **access to evidence-based strategies to mitigate risks of Non-Communicable Diseases (NCDs)** for youth, with clear metrics that can be used to assess health outcomes*	**Behavioural interventions at scale:** All A-Z-HEALTH interventions are evidence-based (≥TRL 5) and designed for implementation at scale, including clinical study designs as required by the call's clinical studies annex. The project will co-develop, together with educators and school health professionals, a set of school-based prevention modules targeting adolescents (12–18) and young adults (18–25) in transition phases (secondary school, higher education, early employment). These modules will include clear, validated metrics to monitor health outcomes over time — including BMI trajectories, psychological wellbeing indicators, and substance use patterns. An estimated **[X] educational institutions** will pilot and validate these tools, generating evidence on their effectiveness in diverse European contexts **[X] implementing countries**
*Youth have **increased individual responsibility** through targeted education, digital services, including easily accessible tools for self-monitoring, and community-based support, stemming from increased collaboration between healthcare professionals, educators and families.*	**Youth co-creation:** A-Z-HEALTH places youth at the centre of its approach fostering structured collaboration between healthcare professionals, educators, and families through community hubs piloted in **[N] local communities**. An estimated **[X] young people** aged 12–25 will be directly reached during the project lifetime. A-Z-HEALTH builds on the PreventNCD European Joint Action youth consultation infrastructure and the extensive co-creation experience of the NIPH (Co-Create coordinator) and ICL (STOP coordinator) to ensure genuine youth involvement throughout. **Digital tools and self-monitoring:** A-Z-HEALTH integrates wearables, biosensors and interoperable digital self-monitoring apps across all NCD areas, with AI-assisted personalisation, in line with call requirements (WPx).

*Researchers have **access to Real-World Data** (RWD), **existing health data infrastructure and digital tools**, including Artificial Intelligence (AI), which can contribute to the sustained success of behavioural health interventions.*	**RWD and existing data infrastructure:** A-Z-HEALTH will establish a federated Real-World Data (RWD) infrastructure, integrating data from clinical settings, schools, and digital platforms while fully complying with GDPR and relevant data governance frameworks. This infrastructure will support longitudinal analysis (WP7) of behavioural health trajectories (WP8) across different demographic and geographic contexts. AI-driven tools will be developed and validated to detect early risk patterns and personalise intervention pathways. All data assets, analytical tools, and AI models will be made available to the research community through open-access repositories, contributing to a shared European knowledge base on youth NCD prevention.
***Policymakers** at local, regional, national and EU levels **have new knowledge on behavioural interventions on NCDs** among youth, which they can use to improve interventions in diverse European contexts.*	**Equity and intersectionality:** A-Z-HEALTH explicitly targets socioeconomic, geographic and gender-based disparities in digital environment exposure and NCD risk, with a dedicated intersectional analysis framework (WP7). **Policy and multi-actor collaboration:** The project develops formats for collaboration between healthcare professionals, educators, families and policymakers, and directly feeds findings into EU and national regulatory processes. A-Z-HEALTH will produce a series of evidence-based policy briefs, addressed to local, regional, national, and EU-level policymakers, synthesising findings on the effectiveness and scalability of behavioural interventions across diverse European contexts. The involvement of **[N] countries** with different healthcare systems, educational structures, and cultural backgrounds will ensure that recommendations are genuinely transferable and adaptable. Results will be disseminated through dedicated policy dialogues and engagement with relevant EU bodies (WHO, EuroHealthnet, etc.).

Table 2.1.2: Expected outcomes based on the destination "Staying healthy in a rapidly changing society"

Expected outcomes (based on the programme destination)	*Planned A-Z-HEALTH outcomes*
*Its overarching goal is to **ensure that people of all ages in the EU remain healthy, resilient and independent,** despite rapid societal change, through healthier lifestyles and behaviours, supportive environments, evidence-informed health policies, and effective solutions for health promotion, disease prevention, monitoring and rehabilitation.*	A-Z-HEALTH directly advances this goal by generating evidence-based intervention packages for young people aged 12–25 — the generation most exposed to rapidly evolving digital risk environments. By targeting obesity, mental health diseases, and addictions through a shared digital habit-formation framework, A-Z-HEALTH addresses the behavioural and environmental determinants of future NCD burden at the point in the life course where intervention is most consequential. The project's multi-country implementation, equity-by-design and youth co-creation approach, and health system integration pathways directly support the Destination's vision of health-literate, empowered citizens and evidence-informed prevention policies across Europe.
The destination emphasises primary prevention, early detection and individual empowerment, placing health literacy and the ability of citizens to manage their own physical and mental health at the centre of future public health strategies.	Health literacy at the core: A-Z-HEALTH places health and digital literacy at the core of both intervention packages (WP4-5). All components are co-created with young people and explicitly build the capacity of 12–25 year-olds to navigate health information, critically evaluate digital content, and manage their own physical and mental health. The project embeds health literacy not as a standalone module but as a thread running through every intervention domain — from classroom-based literacy sessions and peer-led delivery models to wearable-assisted self-monitoring and resource/service access interventions. Primary prevention is the project's sole orientation: A-Z-HEALTH intervenes before disease onset, targeting modifiable behavioural and environmental determinants at the two life-course windows where prevention has the greatest return.

Research and Innovation actions are expected ***to strengthen coordination among healthcare, education, community and policy stakeholders, promote integration across care settings, and leverage real-world health data and digital technologies.***	Multi-sector by design: A-Z-HEALTH integrates national public health institutes (NIPH, NIJZ), universities (ICL, UoC, NYU, AUMC), civil society (EuroHealthNet, PRESS), and the WHO European Office into a unique operational consortium. WP6 explicitly coordinates implementation across healthcare, education, and community settings in six countries, with national PHIs convening local stakeholders and bridging institutional silos. WP7 establishes a shared RWD infrastructure integrating data from health registries, schools, and digital platforms, enabling cross-country pooled analyses. AI-assisted tools for personalised intervention delivery are validated across all implementation sites, directly demonstrating the call's vision of digital technology leveraged in integrated care settings.
Proposals under this destination should demonstrate a credible pathway to empowering citizens—especially young people and vulnerable groups—to adopt and maintain healthier lifestyles, reduce preventable disease and health inequalities, and support more effective, personalised and knowledge-based health promotion and prevention policies.	Youth empowerment as the central mechanism: The G1–G4 intervention architecture is explicitly designed to move young people from passive exposure to active agency over their health environments. G1/G2 interventions reduce structural barriers and harmful digital exposures; G3 scaffolds self-regulation and builds individual capacity; G4 stabilises gains through identity and peer norms. The pre-specified equity analysis tests whether this bundling approach narrows or widens inequalities by socioeconomic status, gender, and migration background — directly addressing the call's concern for vulnerable groups. WP8 modelling will project long-term disease burden reductions achievable through scale-up, producing the population-level estimates that health ministries require to make evidence-based investment decisions. Policy toolkits in ≥4 languages will translate findings for national and EU-level policymakers.
Funded projects should contribute to an interconnected European health data ecosystem, supporting initiatives such as the ***European Health Data Space (EHDS) and the European Open Science Cloud (EOSC),*** *and advancing the digital transformation of health and care in the EU.*	FAIR data infrastructure and open science: A-Z-HEALTH establishes a federated, FAIR-compliant RWD infrastructure (T7.1) built on the JACARDI common data model, enabling cross-country data linkage while fully complying with GDPR and national health data legislation. All study datasets are deposited in open-access repositories and made interoperable with EHDS standards. AI tools and analytical models are developed open-source. The project's data architecture is designed for compatibility with EOSC, contributing to a shared European knowledge base on youth NCD prevention. Pre-registration of all trials and publication of protocols and data in line with Horizon Europe open science requirements ensures reproducibility and supports the broader digital transformation of European health research.
The ***Healthier Together EU initiative***	A-Z-HEALTH addresses three of the four disease areas prioritised under the Healthier Together – EU Non-Communicable Diseases Initiative (cancer excluded): cardiovascular disease and diabetes risk (via obesity/metabolic health), mental health, and substance use/addiction. NIPH (Norway) coordinates JA PreventNCD — the flagship implementation vehicle for Healthier Together — and NIJZ (Slovenia) leads its sustainability work package. A-Z-HEALTH is designed to complement and accelerate PreventNCD's implementation work by generating the rigorous causal evidence on which intervention approaches are most effective for young people, feeding directly into the policy frameworks that Healthier Together aims to strengthen across Member States.

2.1.1. Requirements and potential barriers

Requirements

XXX:

Potential barriers and handling approaches

Several external factors may influence the degree to which the project's intended outcomes are achieved.

Potential Barrier 1 - *Adoption and behaviour change among professionals and educators*
The uptake of new behavioural intervention tools by healthcare professionals and educators depends heavily on existing workload pressures, institutional cultures, and the perceived relevance of new approaches. Resistance to change is a recognised barrier in health and education systems across Europe. A-Z-HEALTH will mitigate this through a participatory co-design process (WP4-WP5-WP8) that engages end-users from the earliest stages, ensuring that tools are practical, low-burden, and compatible with existing workflows. Continuous feedback loops and user testing will be embedded throughout the project lifecycle.

Potential Barrier 2 - *Youth engagement and digital equity*
The effectiveness of digital tools for youth depends on consistent engagement over time and on equitable access to technology. Dropout rates and engagement gaps between socioeconomic groups represent a realistic risk. The project will address this through multilingual interfaces and the active involvement of community mediators (x PHIs involved, x Youth association, etc.). A dedicated equity monitoring framework will track participation and outcomes across demographic subgroups throughout the project (WP7).

Potential Barrier 3 - *Regulatory and data governance environment*
Proposed Handling Approach: the collection, integration, and use of health-related data — particularly from minors — is subject to stringent and evolving regulatory frameworks across EU Member States. Differences in the transposition of GDPR and in national health data legislation may create barriers to cross-border data sharing. A-Z-HEALTH will address this by establishing a dedicated Data Management plan (Dx.x-) and an Ethic Avisory from the outset. Should regulatory conditions change during or after the project, the federated architecture of the data infrastructure will allow for country-specific adaptations without compromising the overall system.

Potential Barrier 4 - *Broader R&I landscape and duplication of effort*
A-Z-HEALTH will conduct a systematic mapping of ongoing European R&I activities in this field at the project's outset and establish formal liaisons with relevant initiatives, ensuring cross-fertilisation of findings and avoidance of duplication.

Potential Barrier 5 - *Sustainability beyond the project*
Ensuring that interventions, tools, and data infrastructures remain operational and institutionally embedded after the project ends is a critical long-term requirement. The project will develop a "Deliverable from WP8-WP9" from month **[X]** onwards, engaging national health authorities, school systems, and digital health industry partners in the definition of a long-term scenario analysis.

2.1.3. Scale and significance of the project's contribution to the expected outcomes and impact

WPs – activities	Indirectly	Directly
WP3 – NCD Evidence Framework & Disease Context	Provides the epidemiological and behavioural evidence base that justifies intervention priorities and informs study design	Generates systematic reviews and trend analyses documenting NCD burden in 12–25 year-olds across Europe; maps behavioural determinants and digital exposure pathways that policymakers and professionals can use directly
WP4 – Multi-component intervention package (16-18)	Develops the health and digital literacy, self-management, school environment, and resource/service components that are subsequently delivered in WP6	Produces validated, co-created intervention packages ready for implementation; generates evidence on youth involvement in intervention design; directly equips educators and school health professionals with tools and protocols
WP5 – Multi-component intervention package (18-25)	Develops the health literacy, device-assisted monitoring, and healthy environment/nudge components for the post-school transition cohort.	Produces validated intervention packages for higher education and early workplace settings; directly equips university health services and employers with scalable tools
WP6 – Implementation	Creates the real-world implementation infrastructure across ≥6 countries, embedding	Directly reaches ≥3,000 young people aged 12–25 across implementation sites; generates implementation science evidence on barriers,

	interventions within national public health systems	enablers, and scalability; trains national PHI staff in delivery
WP7 – Evaluation	Provides the methodological backbone (RWD infrastructure, pre-registered trial protocols, common data model) that enables valid causal inference	Generates valid causal estimates of intervention effectiveness across all three NCD domains; produces the evidence package that directly informs EU and national scale-up decisions; delivers equity analysis by SES, gender, and migration background
WP8 – Foresight & Modelling	Generates foresight scenarios and long-term projections that contextualise trial findings	Directly produces cost-effectiveness analyses and disease burden projections via Health-GPS microsimulation; delivers policy pathways and recommendations usable by health ministries and EU regulators; produces foresight storylines accessible to policymakers and the public
WP9 – Dissemination	Builds the stakeholder relationships, visibility, and brand recognition that amplify impact of all other WPs	Directly delivers the DEC plan, policy briefs, toolkits in ≥4 languages, and final exploitation/sustainability framework; ensures findings reach healthcare professionals, educators, policymakers, and young people via targeted channels; drives uptake through Joint Action networks, WHO European Office and other relevant stakeholders

2.2 Measures to maximise impact - Dissemination, exploitation and communication

A-Z-HEALTH's pathway to impact will be guided by a strategic **Dissemination, Exploitation and Communication (DEC)** plan, built on the following principles:

- **Collaboration:** All A-Z-HEALTH project partners will play a role in communication, dissemination, and exploitation activities. The DEC plan (D9.1, M6) will provide a common framework for coherent and consistent communication about the project and its results, while drawing on partners' complementary expertise, networks, and contextual knowledge relevant to reaching key audiences and supporting uptake of results. Alongside the project's other governance structures, a DEC coordination group bringing together one representative from each partner will meet regularly to support effective internal coordination and external communication of A-Z-HEALTH activities and findings. The A-Z-HEALTH consortium will also actively connect with other relevant EU-funded projects, initiatives and networks in related fields to maximise synergies, visibility and mutual learning. In particular, A-Z-HEALTH will build on the legacy structures of JA PreventNCD as a concrete pathway for dissemination, policy feedback, stakeholder exchange and sustainability planning. This includes drawing on its collaboration across 25+ participating countries, its public health authority and agency networks, its advisory and youth engagement structures, including the Youth Advisory Group and related engagement mechanisms, and its wider EU policy-facing interfaces, including the momentum created through the EU Health Policy Platform Thematic Network on youth engagement in NCD prevention.
- **Consultation and co-creation:** Relevant target groups (as further described below) will be consulted and involved in the design, refinement and validation of key project activities and outputs, including intervention-related materials, communication products, practice-oriented resources and policy messages. This is particularly important in a project working with older adolescents and young adults, where relevance, acceptability and accessibility of approaches and messages are essential to successful engagement and uptake. Consulting key stakeholders from the outset will strengthen ownership, applicability, relevance and potential for uptake and transfer of A-Z-HEALTH results. Where feasible, A-Z-HEALTH will support communication- and uptake-relevant youth engagement mechanisms at country level, including Youth Advisory Groups or equivalent structures, in order to strengthen sustained youth participation in dissemination, interpretation of findings and longer-term uptake planning.
- **Continuity and sustainability:** Communication, dissemination and exploitation planning and activities will take place throughout the project lifetime. The DEC plan will be routinely reviewed and updated to ensure the continuing relevance, quality and attractiveness of A-Z-HEALTH's communication and dissemination approaches and tools. Progress against the indicators set out in the plan will be monitored regularly and reviewed at least annually. Exploitation activities will increasingly come into focus in the later stages of the

project and will support the longer-term use, transferability and sustainability of A-Z-HEALTH findings, tools and recommendations beyond the funded period.

- **Targeted and tailored approaches:** Communication, dissemination and exploitation activities, including messaging, will be carefully tailored to ensure that they resonate with their respective audiences, such as researchers, policymakers, public health actors, practitioners, civil society organisations, youth-serving organisations, and representatives of older adolescents and young adults, including those in vulnerable situations or at greater risk of exclusion. Outreach will be grounded in stakeholder mapping, to be initiated at the start of the project, and in an understanding of the relevant policy, practice and implementation landscapes at European, national and where relevant local level. For adolescents and young adults, outreach will use digital-first approaches and formats suited to contemporary online environments, while ensuring accessibility, safety, inclusiveness and responsiveness to differing levels of digital literacy and vulnerability. As feasible, project outputs and messages will be adapted to different national contexts and made accessible in a range of relevant EU languages. To maximise impact, messages will be shared through a mix of channels and formats suited to different audiences, thereby increasing their reach, accessibility and potential use.

More details on specific communication, dissemination and exploitation activities, key target audiences, tools and channels are provided below, as well as in the WP9 description. This work package will follow a phased logic across the four-year project cycle: first establishing the foundations for project-wide communication, dissemination and stakeholder engagement during the design phase; then supporting dissemination, exchange and stakeholder interaction throughout the implementation phase; and finally intensifying exploitation, uptake, sustainability planning and policy translation in the final phase of the project. In line with the project's health equity orientation, A-Z-HEALTH will aim for inclusive, accessible and gender-balanced engagement across all communication, dissemination and exploitation activities, while remaining responsive to the diversity of young people's circumstances and the changing demographic realities of European societies.

Target groups: A-Z-HEALTH will focus on two broad and interlinked target groups, aligned with the project's objectives. The first includes stakeholders who can generate, apply, support or scale up the project's results, such as researchers, policymakers, public health actors, practitioners, education and community organisations, and other relevant intermediaries. The second includes the wider public, with a particular focus on older adolescents and young adults, including those in vulnerable situations or at greater risk of exclusion, who are both a key audience for and, where relevant, contributors to the project.
These stakeholder groups can be further differentiated:

- Research and scientific communities are important for ensuring the visibility, credibility and further development of A-Z-HEALTH findings. This includes experts in areas such as youth health, public health, mental health, health behaviours, nutrition and obesity, substance use, prevention, implementation science, and health equity.
- Decision-makers and policymakers are a key target group for supporting the uptake of A-Z-HEALTH results in policy and systems change. These actors operate at local, regional, national and European levels and include public authorities and other bodies with responsibility for youth health, wellbeing, prevention and related services.
- Practice and implementation stakeholders are also central. These include health and care professionals, education and training providers, youth workers, community organisations, social services and civil society actors working with older adolescents and young adults. Their engagement is essential to ensure that A-Z-HEALTH results are practical, relevant and usable in real-world settings.
- Older adolescents and young adults themselves, including those in vulnerable situations, are a particularly important target group. A-Z-HEALTH will seek to involve their perspectives, where appropriate, in communication, dissemination and engagement activities, to strengthen the relevance, accessibility and longer-term uptake of project results.

Communication

Communication – Aims, Measures, and Performance Indicators (M&PI)		
Overall aim	To communicate and disseminate A-Z-HEALTH's work effectively, engage relevant stakeholders, and support the uptake of effective, health-equity-sensitive interventions for older adolescents and young adults.	
Overall M&PI	A shared visual identity for A-Z-HEALTH, including logo, templates and core communication materials	KPI: Branding package in place by M6

	A project website with public information on A-Z-HEALTH, news and updates, and a section for key outputs and resources	KPI: Website launched by M6
	Project-level communication channels used regularly to share activities, milestones and results	KPI: Regular communication activity throughout M1–M48, with intensified dissemination, exploitation and uptake-oriented communication in M40–M48
	A Dissemination, Exploitation and Communication (DEC) plan to guide messages, audiences, tools and monitoring	KPI: DEC plan completed by M6 and updated as needed
	An initial stakeholder mapping and engagement framework to support targeted outreach at EU, national and local levels	KPI: Stakeholder mapping completed by M9
Research and scientific communities		
Aim	To ensure visibility and credibility of A-Z-HEALTH within the scientific community and support further development and uptake of project findings.	
M&PI	Present A-Z-HEALTH concepts, methods and findings at relevant scientific conferences and expert events	KPI: 6–10 conference presentations across the project lifetime
	Disseminate scientific outputs, including methodological papers, protocols and key findings, where relevant	KPI: Scientific dissemination targets to be refined in line with the final research design
	Engage with related EU-funded projects and research initiatives in relevant fields to exchange knowledge and maximise synergies (for instance, reaching out through the EuroHealthNet Partnership of public health authorities across Europe)	KPI: At least 2–4 structured exchanges during the project lifetime
	Use partners' academic and professional networks to broaden the reach of project findings	KPI: Ongoing outreach through consortium networks across M1–M48, with increasing focus on uptake, scale-up and sustainability in the final project phase
Decision-makers and policymakers		
Aim	To position A-Z-HEALTH as a relevant source of evidence and practical insight for decision-makers and policymakers working on youth health, wellbeing, prevention and health equity.	
M&PI	Develop and share policy-oriented messages and outputs tailored to European, national and, where relevant, local audiences	KPI: At least 3–5 policy-facing outputs across the project lifetime
	Present A-Z-HEALTH findings in policy dialogues, roundtables, stakeholder briefings and relevant events	KPI: Regular participation in policy-relevant events from Year 1 onwards
	Contribute, where feasible, to relevant policy discussions, consultations and strategic processes at EU and national levels	KPI: Strategic policy engagement opportunities identified and acted upon throughout the project
	Build links with relevant EU and national initiatives, frameworks and networks to support visibility and uptake of A-Z-HEALTH results	KPI: Collaboration and alignment activities maintained across the project period
Practice and implementation stakeholders		
Aim	To engage actors who can help apply, adapt and support the implementation of A-Z-HEALTH approaches and findings in real-world settings.	
M&PI	Develop and disseminate practice-oriented materials tailored to relevant implementation settings and intermediaries	KPI: Practice-oriented outputs produced at key project stages
	Engage practitioners and intermediaries through webinars, workshops, peer-learning activities and targeted events	KPI: At least 3–6 stakeholder engagement activities across the project lifetime
	Use consortium and stakeholder networks to reach relevant health, education, youth, social and community-based actors	KPI: Multi-sectoral outreach implemented across participating countries and at EU level

	Gather feedback from practice stakeholders to improve the relevance and usability of outputs	KPI: Stakeholder feedback mechanisms integrated into project activities by mid-project
Older adolescents and young adults, including those in vulnerable situations		
Aim	To ensure that A-Z-HEALTH is visible, relevant and accessible to older adolescents and young adults, including those in vulnerable situations, and that their perspectives help inform project outreach and uptake.	
M&PI	Develop accessible, audience-appropriate messages and materials tailored to older adolescents and young adults	KPI: Youth-oriented communication materials developed during the project
	Involve relevant youth-facing organisations, networks and, where appropriate, representatives of young people in communication and engagement activities	KPI: Youth engagement mechanisms, including country-level Youth Advisory Groups or equivalent structures where feasible, established by M12
	Use digital-first and other appropriate channels to share project messages in formats suited to contemporary online environments used by adolescents and young adults	KPI: Youth-relevant outreach activities implemented throughout M1–M48, including stronger digital engagement during implementation and youth-informed dissemination of findings in the final phase

	Ensure communication approaches reflect health equity, inclusion and accessibility principles	KPI: Equity-sensitive communication principles embedded across project outputs and outreach
General public		
Aim	To make A-Z-HEALTH, its objectives, activities and key findings known to the wider public, and to raise awareness of the importance of effective and equitable approaches to improving health and wellbeing among older adolescents and young adults.	
M&PI	Share project updates and major results through media outreach, partner channels, press materials and public-facing digital communication	KPI: Public communication activities delivered at major project milestones
	Produce clear and accessible public-facing messages on the relevance and findings of the project	KPI: Public-facing outputs published throughout the project lifetime
	Support visibility of A-Z-HEALTH through partner organisations' events, channels and networks	KPI: Consortium-wide amplification of key messages across M1–M48

Dissemination

A-Z-HEALTH will implement a targeted dissemination strategy to ensure that project findings, methods, tools and recommendations reach those actors most able to apply, adapt, support or scale them. Dissemination will focus in particular on scientific communities, policymakers and public authorities, public health actors, practitioners, education and youth-serving organisations, civil society and relevant intermediary networks at European, national and, where relevant, local level. Measures will include scientific publications and conference presentations; policy-oriented outputs such as briefs, summaries and stakeholder notes; practice-oriented resources and implementation-relevant materials; webinars, workshops and peer-learning exchanges; and dissemination through consortium and partner networks. Dissemination activities will be phased in line with project progress, beginning with the positioning of A-Z-HEALTH and its approach, and increasingly focusing on emerging findings, implementation lessons, evaluation results and policy-relevant insights as these become available. Outputs and messages will be tailored to the needs, language and decision contexts of different audiences, with attention to accessibility, usability and health equity.

Exploitation

A-Z-HEALTH will pursue exploitation pathways that support the uptake and practical use of its key results beyond the consortium. Exploitable results may include evidence and evaluation findings, intervention approaches and related materials, methodological tools, practice-oriented resources, implementation insights, and policy-relevant outputs arising from modelling, policy simulation and foresight work. Exploitation will focus primarily on non-commercial uptake through policy, practice, service, education and community settings, while also supporting transferability, adaptation and wider use by relevant actors across Europe. Potential pathways will be assessed during the project in relation to relevance, feasibility, ownership, transferability, scalability and added value. Particular attention will be paid to how exploitation can support equitable reach and benefit, including for older adolescents and young adults in vulnerable situations or at greater risk of exclusion. Exploitation planning will be closely linked to stakeholder engagement, dissemination and the final project event, which will help identify realistic opportunities for uptake, continuation and embedding of results.

Sustainability beyond the duration of A-Z-HEALTH

From the outset, A-Z-HEALTH will consider how its most valuable results, resources and partnerships can continue beyond the funded period. Sustainability will be pursued through several complementary routes: embedding relevant outputs in the work of consortium partners and their networks; supporting the continued use and adaptation of tools, materials and approaches in policy, practice and implementation settings; linking project outputs to ongoing European, national and local initiatives; and identifying follow-up opportunities for further research, implementation and scale-up. Particular importance will be given to sustaining those outputs with the greatest potential to inform policy and practice, strengthen prevention efforts, and contribute to fairer health outcomes for older adolescents and young adults. A final exploitation and sustainability framework will identify concrete options for continuation, ownership, stewardship and longer-term use of key project results.

Policy feedback

A-Z-HEALTH will also generate feedback relevant to policy design, implementation, monitoring and review. Through its work on implementation, evaluation, modelling, policy simulation and foresight, the project will provide evidence and practical insight that can inform existing and emerging policy and programmatic measures relating to youth health, prevention, health equity and related service and community systems. Policy feedback will be channelled through tailored policy-oriented outputs, stakeholder dialogues, targeted briefings, and the project's engagement with relevant European and national policy and professional networks. This will help position A-Z-HEALTH not only as a research project, but also as a source of actionable intelligence for more effective and equitable policy and practice.

Intellectual property, ownership and access rights

A-Z-HEALTH will develop an appropriate approach to intellectual property, ownership and access rights in line with Horizon Europe requirements and the future consortium agreement. Given the nature of the project, exploitation is expected to rely primarily on uptake, adaptation and use of knowledge, tools, methods and resources in public-interest, policy, service and community settings rather than on commercialisation. Where relevant, suitable protection and management measures, including copyright, licensing arrangements, access rights, data governance and recognition of background and foreground knowledge, will be applied to support appropriate use and longer-term exploitation of project results. Ownership and access conditions for key results will be clarified by the consortium in order to enable both collective and partner-specific uptake opportunities.

Taken together, these measures will help ensure that A-Z-HEALTH is not only visible during its lifetime, but also that its results are disseminated effectively, used meaningfully, and positioned for longer-term uptake and impact in research, policy, practice and community contexts.

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3. Quality and efficiency of the implementation

3.1 Work plan and resources

OVERALL STRUCTURE OF THE WORK PLAN

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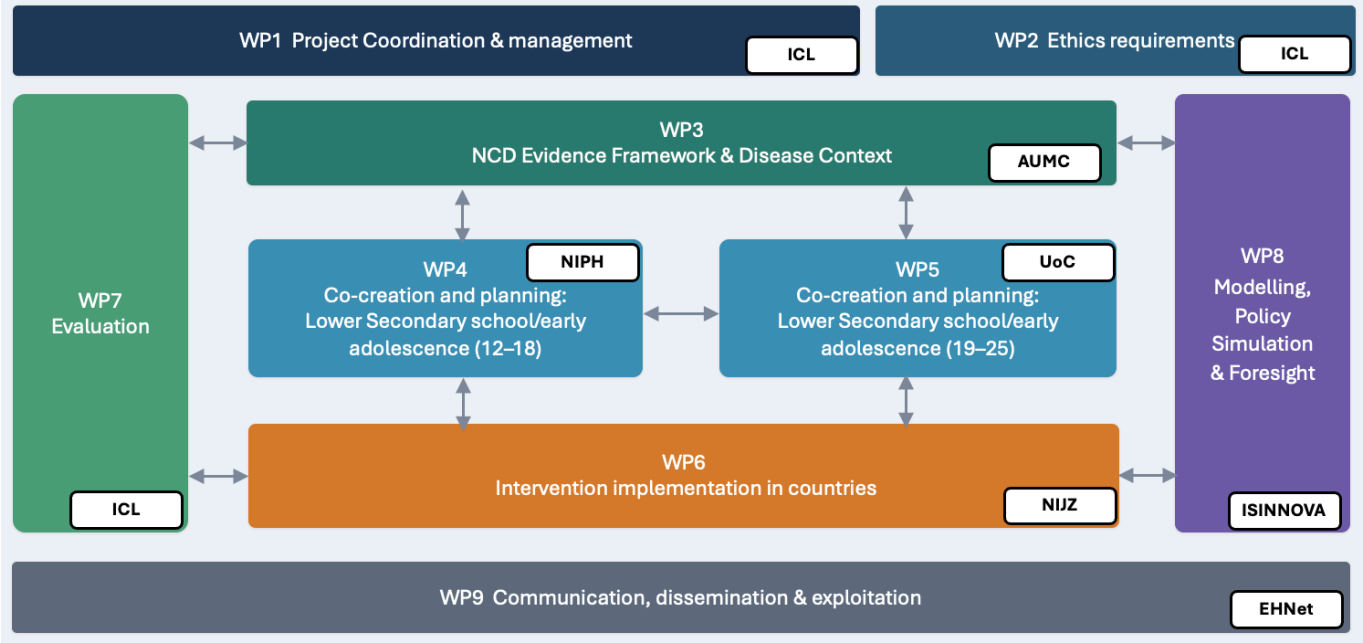


DETAILED WORK DESCRIPTION

WP	WP Title	Part. n.	Lead	PM	Start	End
1	Project Coordination & Management	1	ICL		1	48
2	Ethics requirements	1	ICL		1	48
3	NCD Evidence Framework & Disease Context	8	AUMC		1	10
4	Co-creation and planning: lower secondary school/early adolescence (age 12-18)	3	NIPH		1	18
5	Co-creation and planning: upper secondary school/late adolescence (age 19-25)	6	UoC		1	18
6	Intervention implementation in countries	5	NIJZ		10	39
7	Evaluation	1	ICL		1	48
8	Modelling, Policy simulation & Foresight	2	ISINNOVA		6	48
9	Communication, dissemination & exploitation	4	EHNet		1	48

Work package description .

Work package number	1
Work package title	**Project Coordination & Management**
Objectives. (1) to conduct project coordination; (2) to lead production of the consortium agreement and project implementation plan; (3) to facilitate WP connections and external cooperation with regular meetings; (4) to conduct central planning and management of sensitive topics (AI, privacy, gender, data, service design); (5) to conduct financial and regular reporting to EC.	

Description of work

T1.1 Scientific & Technical management (Lead: ICL; Participants: ALL PARTNERS)
This task coordinates interactions between WPs and it is responsible for the supervision of the overall progress of the project, pursuing the conformance with deadlines and technical objectives. Specific documentation (presentations and procedures) will be prepared by the project coordinator and presented in a specific meeting to all the WP leaders within the kick-off meeting. WP leaders will be in charge of transferring this information to all the task leaders of their WP, having a 3-month cycle sprint meeting, helping the task leaders overcome impediments and establishing contingency plans for deviations, planning the review meetings at the end of each sprint and transfer results and information to other WP in the project progress meetings. Activities within this task, including detection of errors and deviations in the project's life cycle and corrective actions or contingency plans, will be reported in the periodic reports. Enforce the quality assurance procedures, which is joint responsibility of all partners applied at all levels of the project's activities.

T1.2 Administrative and Operative management (Lead: ICL, Participant: ISINNOVA)
Formal & legal relationship between Partners & the various constitutive components of the Consortium & the CE. It includes the maintenance and enactment of the provisions of the Consortium Agreement and the creation and maintenance of the various operational structures and communication tools. It will also monitor the implementation of the planned work, deadlines and milestones, follow-up of progress based on the DoA, financial & resource monitoring of the project, controlling schedule & consistency of deliverables. Planning (six-monthly Steering Committee and annual General Assembly) meetings to ensure information exchange and joint work execution. Remote and in-person meetings. Deal with the preparation of any modifications to the Description of Action (DoA) required by the results of annual reviews, partnership changes, or external factors. Periodic Reports. Ensuring that all contractual, society and gender equality issues related to the project research are properly considered and any relevant conventions are respected.

T1.3 Quality and Risk management (Lead: ISINNOVA, Participants: WP LEADERS) This task will create a plan for the identification of risks and definition of procedures for their mitigation and resolution. This will be included in D1.1. This task will guarantee that the scientific and technical results of the project have been produced based on high quality standards. It will implement and maintain a quality assurance plan that will provide a single point of reference on the quality that will be governed during the project. Moreover, this task will deal with any potential risks and perform and evaluated within the whole project duration. The methodology to be followed for risk management consists of four steps: a) risk identification where areas of potential risk will be identified and classified, b) risk quantification where the probability of events will be determined and the consequences associated with their occurrence will be examined, c) risk response where methods will be produced to reduce or control the risk, and d) risk control and report where lessons learnt will be documented.

T1.4 Data management (Lead: ICL, Participants: WP LEADERS)
A data management plan (D1.2) will be developed, maintained, and implemented, outlining which data will be generated and how they will be managed during research and piloting; metadata, standards and quality assurance measures; plans for sharing data; copyright and IPR of data; data storage and back-up measures; data management roles and responsibilities as well as and ensure comparability and consistency of the collected data across the groups of interest; monitoring project activities (especially activities related to tenure of user-generated content) strictly follow legal, ethical and security procedures dictated by National and EU regulations. This will include a consideration of the GDPR, as well as issues such as privacy, human rights, gender, and cultural implications; Ensuring that Social Science Humanities (SSH) is embedded in the project as an enabler of Responsible Research Innovation (RRI).

DELIVERABLES

- D1.1 Project Management Handbook – M3 (Definition of the meetings, representatives of each partner and WP leaders, internal communication strategy and risk and contingency plan)
- D1.2 Data and knowledge Management plan – M6 (Definition of the items that are subjected to intellectual property and the procedures to exchange information among the partners. Updates will be informed during project reports)
- D1.3 Intermediate Progress report M12 – M24 – M36 (Report of the scientific and technical activities carried out in the project)

- D1.4 Final report M42

MILESTONES

- M1 Kick off meeting organised M2
- M2 Project management handbook submitted M3
- M3 Data management plan submitted M6

Work package number	2
Work package title	Ethics requirements

Objectives: to ensure compliance with the 'ethics requirements' set out in this work package.

Description of work

T2.1 Participant protection & ethical governance (Lead: ICL; Participant: Ethical Management officer)
This task establishes the ethical framework for the involvement of human participants across all research activities. It covers recruitment procedures, informed consent and assent protocols adapted for minors, safeguarding measures, and — where applicable — the ethical management of biological samples. An Ethical Management officer will be appointed to oversee compliance throughout the project lifetime and liaise with national IRBs across partner countries. To include references to the national ethical consensus

T2.2 Data protection & regulatory compliance (Lead: ICL; Participants: ALL PARTNERS)
This task ensures full compliance with data protection legislation (GDPR and national equivalents) across all partner countries. It includes the development of a Data Protection Impact Assessment (DPIA), the designation of a project Data Protection Officer, and the establishment of data sharing agreements among consortium members. Where non-EU partners are involved, this task verifies the equivalence of ethical standards and secures the necessary regulatory approvals in those jurisdictions.

T2.3 Equity, gender & ethical quality of interventions (Lead: ICL; Participants: ALL PARTNERS)
This task integrates gender and intersectionality analysis into the design, implementation, and evaluation of all behavioural interventions. It examines how interventions may affect participants differently across gender, socioeconomic status, and cultural background, ensuring that no group is systematically disadvantaged. The task also includes a substantive ethical review of the nudging techniques employed, addressing the tension between autonomy and paternalism when behavioural interventions are directed at young people.

DELIVERABLES

- D2.1 POPD – Requirement No. 3 (ICL – Ethics – Confidential – M1)
- D2.2 NEC – Requirement No. 4 (ICL – Ethics – Confidential – M1)
- D2.3 AI – Requirements No. 5 (ICL –Ethics Confidential – M1)
- D2.4 H – Requirement No. 1 (ICL – Ethics – Confidential – M3)
- D2.5 HCT – Requirement No. 2 (ICL – Ethics – Confidential – M3)
- D2.6 GEN – Requirement No. 6 (ICL – Ethics – Confidential – M3)

Work package number	3
Work package title	NCD Evidence framework and disease context

Objectives

To generate a comprehensive evidence framework on the trends and modifiable drivers of NCD risk in youth in Europe, focusing on two key transition ages: from early to late adolescence (12-18 years) and late adolescence to independent adulthood (19-25 years).

This WP comprises four interlinked tasks employing meta-reviews and original epidemiological modeling to analyze trends and determinants across three key health domains in youth: obesity/metabolic health, mental health, and addictions. We will evaluate how these conditions have evolved over time in EU countries, considering factors such as dietary shifts toward processed foods, increased sedentary behaviour linked to screen time, rising rates of youth mental illness, and transitions from traditional tobacco to novel nicotine products. A flexible mixed-methods approach will be employed, combining systematic reviews and syntheses with secondary analyses of surveys and longitudinal multi-cohort data. Behavioural determinants and environmental exposures

influencing young people's habits will be systematically examined across two pivotal life-stage transitions: early to late adolescence (12–18 years) and late adolescence to independent adulthood (19–25 years). The findings will populate the A-Z-HEALTH habit-formation model and directly inform the design of four intervention families (G1–G4) developed in WP4 and WP5 and implemented in WP6.

Description of work

T3.1 Obesity and metabolic health (Lead: AUMC)

This task will combines systematic literature reviewing (including global evidence) with epidemiological analyses of European datasets such as from the EU Child Cohort Network (ECCN), GBD, HBSC, and EHIS; covering youth aged 12–25, stratified by sex, socioeconomic position and by age groups (12–18, and 19–25 years). Additionally, existing evidence from the NCD Risk Factor Collaboration (NCD-RisC) will be incorporated to contextualize trends in obesity and metabolic health. The task will focus on identifying key behavioral and environmental drivers, including food and physical activity environments, that influence habit formation.

T3.2 Mental health (lead: NIJZ)

Through systematic reviews and secondary data analyses of WHO, HBSC, and cohort studies, this task will document trends in adolescent depression, anxiety, and well-being across age groups. It will explore how school and social stressors, among other determinants, have evolved and influenced habit pathways, providing evidence for interventions G2 and G4.

T3.3 Addictions (Lead: NYU)

This task will systematically review and analyze European data sources (GBD, EMCDDA, HBSC) and cohort studies on smoking, alcohol, drug use, and emerging behavioural addictions (e.g., gambling, screen addictions) in youth aged 12–25. It will assess how these behaviours have changed over time, examining exposures such as advertising and accessibility that shape habit formation, guiding intervention development.

T3.4 Mapping of behavioural determinants across disease areas (Lead: ICL)

This task will synthesize evidence on social and digital influences (including parental, peer, school, and media determinants) across all NCD domains through literature reviews. It will explicitly examine changes by age, such as increasing autonomy after 18, and how these factors interact with behavioral and environmental exposures to influence habits.

Deliverables

- D3.1 Evidence meta review – M10 – description: a set of systematic reviews on burden and drivers of NCDs across the three disease domains in youth at transitions ages from early to late adolescence and from late adolescence to independent adulthood. will identify key behavioural and environmental exposures shaping habit formation. This deliverable will provide a robust evidence base to inform epidemiological modeling in subsequent Tasks, and intervention design in subsequent WPs.
- D3.2 Integrated A-Z-HEALTH evidence framework on modifiable drivers of NCD risk (M10 – ICL). Description: A comprehensive, flexible framework integrating findings from systematic reviews and epidemiological analyses across obesity/metabolic health, mental health, and addictions domains in youth. This Deliverable guide A-Z-HEALTH's intervention design and implementation.

Milestones

M3.1 Protocols of systematic literature reviews ready (M4).

M3.2 Data analyses plans for secondary data analyses ready and submitted to repository (M12).

Critical risks

Heterogeneity across data sources and limited availability of data on emerging determinants (e.g. vaping, social media use and content).

Work package number	4
Work package title	Co-creation and planning: lower secondary school/early adolescence (age 12-18)
Objectives	

(1) To identify, select and adapt multi-component interventions targeting obesity, mental health diseases and addictions; (2) To explore to what extent meaningful youth involvement and co-creative processes with educators, health professionals and parents influence the successful or unsuccessful implementation of such interventions

Description of work

T4.1 Identification and selection of evidence-based intervention elements (Lead: NIPH)

A-Z-HEALTH will implement multi-component interventions targeting adolescents aged 12–18 across four policy domains: (i) health and digital literacy; (ii) self-management of digital media use; (iii) healthy school environments and behavioural "nudges"; and (iv) resource- and service-oriented interventions. A review of interventions addressing the three target disease areas will be conducted using scientific and grey literature. Interventions will be appraised for effectiveness, quality and certainty of evidence, and relevance across the G1–G4 framework, with particular attention to scalability, contextual adaptability, and their potential to reduce social inequalities.

T4.2 Co-creation and involvement process at intervention sites (Lead: NIPH)

Adolescents will be actively involved across all intervention packages to ensure relevance of content and delivery. In each country, Group Model Building (GMB) sessions will be conducted with adolescents, educators, parents, and health professionals, recruited via youth networks to ensure diversity and gender balance. These sessions will generate shared models of NCD risk behaviours and inform intervention adaptation. Given limited evidence on youth involvement, adolescents' experiences of participation will be systematically documented.

T4.3 Developing intervention packages and implementation plans (Lead: NIPH – Participants: ICL, NYC, EHNet, NIJZ).

Interventions will be described in terms of theoretical foundations, core concepts, and underlying assumptions, and analysed using a systems perspective to identify mechanisms and leverage points for change. They will be iteratively adapted based on GMB outputs and youth engagement and adapted to the specific contexts of the participating sites to ensure that the interventions are contextually relevant, culturally appropriate, and responsive to the needs and preferences of the target population. A dedicated implementation plan based on specific needs assessment will be developed for each intervention (tasks 4.3.1-4.3.4 below).

Subtask 4.3.1 The health and digital literacy intervention (ICL, NIPH) **–** A co-created health and digital literacy programme with youth and relevant local stakeholders. Involvement of school health services and community nurses (where relevant). Components may include the following: a) TUTCH (Teenagers understanding and taking control of their health) educational approach, developed by the CHOICE Foundation (SE) based on training medical students to deliver health literacy sessions to adolescents on mental health and addictions. b) Digital literacy sessions, focusing on access to health information through digital media. Understanding how AI algorithms affect the health-related information young people access. Managing exposure to misinformation through pre-bunking and inoculation. A component of the digital literacy programme will be designed to support domain no. 2 in the intervention package, described below.

Subtask 4.3.2 Self-management of digital media use intervention (NYU) – An individual-level intervention component, requiring children (and their families) to volunteer to modify their social media settings in ways that will limit their exposure to "attention grabbing" and potentially addictive features of digital media use. These interventions will include the following: a) Content access management tool, hindering "infinite scrolling" which will prevent children from excessive exposure to social media content and from spending exceeding amounts of time on screens and digital media, thereby reducing exposure to potentially harmful health-related content. b) Sleep duration and attention controls, which would trigger a hard stop (not amenable to manipulation) on social media use at given times of the day and night. c) Notification frequency reduction tool, which would reduce the frequency of notifications, another key "attention grabbing" feature of digital media use, by delivering them in batches, thereby reducing the frequency of device pick-up and time spent on digital devices.

Subtask 4.3.3 Healthy school environment and behavioural "nudge" interventions (EHNet, ICL) **-** School-level intervention component aimed at creating a health promoting environment. The interventions will consist of a) Alignment with WHO policy guidelines and recommendations for school food environments related to direct food provision; nutrition standards; and nudges (portion size, nutrition information, food presentation and positioning). While not all schools would have canteens or directly provide full meals, there is probably sufficient scope for implementing food environment interventions that would have a meaningful impact on children's dietary intakes. b) Food environment interventions that can be combined with physical activity interventions in addressing the first critical health area (overweight and obesity), provided that the required infrastructure investment is affordable and

sustainable. c) Smartphone-free schools, following an increasing number of jurisdictions preventing children from taking their smartphones to school or using them while at school.
Subtask 4.3.4 Resources and services intervention (NIJZ) - Environmental interventions aimed at empowering children to request and obtain safe advice and counselling from trained staff on health issues they may be experiencing or may be concerned about. The priority area in this domain will be mental health, and the intervention may rely on transferring and adapting the NIJZ approach developed in Slovenia with the "To sem jaz" mental health counselling website or similar resources in the other countries. Potentially, an AI-assisted version of NIJZ's tool could be considered, for efficiency of deliver, while maintaining trained staff in control of the answers provided. The AI support algorithm could be trained using a database of questions asked and advice provided over the years (if available) in Slovenia.

Deliverables
D4.1 Systematic review M6 (Lead: NIPH?)
D4.2 Health and digital literacy intervention description M10 (Lead: ICL?)
D4.3 Self-management of digital media use intervention description M10 (Lead: NYU?)
D4.4 Healthy school environments and nudges intervention description M10 (Lead: EHNet?)
D4.5 Resource- and service-oriented intervention description M10 (Lead: NIJZ?)
D4.6 Report on youth involvement in intervention development M18 (Lead: NIPH?)

Milestones
M4.1 Intervention packages and implementation plans finalized M18

Critical risks
Individual-oriented interventions are typically designed on the implicit premise that individuals possess a sufficient degree of agency to modify their behaviours in response to health-promoting initiatives. However, this assumption may not hold uniformly across populations. Such interventions risk disproportionately benefiting individuals who already possess the requisite social, economic, and environmental resources to enact healthier choices, as well as those residing in contexts where such choices are more readily accessible. Consequently, a critical concern is that individual-oriented approaches may inadvertently exacerbate existing social inequalities in health by systematically privileging more advantaged groups.

Work package number	5
Work package title	Co-creation and planning: upper secondary school/late adolescence (age 18-25)

Objectives
(1) To identify, select and adapt multi-component interventions targeting obesity, mental health diseases and addictions for young adults aged 19 to 25 accounting for individual characteristics
(2) To explore to what extent meaningful young adult involvement and co-creative processes with educators, health professionals, and community partners influence the implementation of interventions

Description of work
T5.1 Identification and selection of evidence-based intervention elements (Lead: UoC)
A-Z-HEALTH will implement multi-component interventions targeting young adults aged 19 to 25 across three domains: (i) health and digital literacy; (ii) device-assisted monitoring and feedback; and (iii) health-promoting environments and behavioural economic nudges. A systematic review of behavioural-economics informed interventions addressing the three target areas will be conducted using scientific and grey literature. Interventions will be appraised for their effectiveness, quality and certainty of evidence, and relevance across the G1-G4 framework, with a strong focus on methodological rigour, scalability, and contextual adaptability while considering their potential to reduce social inequalities among young adults.

T5.2 Co-creation and involvement process at intervention sites (Lead: UoC).
Young adults will be actively involved across all intervention packages to ensure relevance of content and delivery. In each country, Group Model Building sessions will be conducted with young adults, university and vocational school educators, community health professionals, and peer representatives, recruited via higher education and youth networks to ensure diversity and gender balance. These sessions will generate shared models of NCD risk behaviours and inform intervention adaptation. Given limited evidence on young adult involvement in health intervention design, participants' experiences of co-creation will be systematically documented.

T5.3 Developing intervention packages and implementation plans (Lead: UoC – Participants: ICL, NYU, EHNet, NIJZ).
Building on the co-creation process in T5.2, each intervention package will be grounded in an explicit theory of change, drawing on behavioural and systems science frameworks suited to the contexts of higher education and early working life. Packages will be iteratively refined and shaped by site-specific needs assessments to ensure contextual relevance, cultural appropriateness, and fit with the routines and preferences of this age group. A dedicated implementation plan will be developed for each of the three intervention domains (tasks 5.3.1 to 5.3.3 below).

Subtask 5.3.1 The health and digital literacy intervention (ICL, UoC). For young adults navigating higher education and early working life, health and digital literacy take on new dimensions as formal school structures give way to greater individual autonomy and more complex information environments. The intervention will thus be co-created with students, young professionals, university staff, and community health partners. It will draw, for example, on peer-based delivery models in which medical and health science students facilitate sessions on mental health and addictions for their fellow students. Digital literacy components will address specific challenges of this age group, including, for example, critical appraisal of health information encountered on social media and professional networks, understanding how algorithmic personalisation shapes health-related content exposure, and building resilience to misinformation through pre-bunking strategies. Besides aiming at enhancing young adults' health and digital literacy, the intervention also aims at educating young adults about behavioural biases (e.g., present bias, probability overweighting) and limited self-control important for health behaviours while also highlighting self-centred benefits. A dedicated module will explore the links between digital media habits and health behaviours, feeding directly into the monitoring and feedback approach described below.

Subtask 5.3.2 Device-assisted monitoring and feedback intervention (UoC, NYU). An individual-level intervention leveraging smartphone applications and potentially wearable devices to provide young adults with real-time monitoring and personalised feedback on health-related behaviours, including physical activity, sleep, dietary patterns, and screen time. Components may include: (a) use of validated wearable sensors and linked apps to track daily health behaviours and generate tailored feedback reports, supporting self-awareness and behavioural self-regulation; (b) structured goal-setting and reflection modules, enabling users to set personal health targets and review progress over time, with optional sharing with peers and/or professional support; and (c) nudges delivered via app notifications, prompting timely behaviour change based on individually tracked patterns, for example, encouraging physical activity or signalling screen-time thresholds to support sleep hygiene.

Subtask 5.3.3 Health-promoting environments and nudges intervention (EHNet, ICL). Universities and workplaces offer underexplored but promising leverage points for shaping the health behaviours of young adults. Unlike the school setting, these environments are characterised by greater individual autonomy and a more complex mix of commercial, social, and institutional influences on food choice, physical activity, and digital habits. The intervention will work across three interconnected levers: (a) food environments in universities and community settings will be mapped against WHO and EU policy benchmarks, with targeted changes to provision, nutrition standards, and choice architecture (e.g., food and calorie labels, presentation and positioning of healthier food options); (b) where campus infrastructure allows, food environment improvements will be paired with measures to support physical activity, such as accessible recreational facilities, addressing overweight and obesity through combined behavioural pathways; and (c) digital environment nudges, distinctive to this age group, will include designated screen-free zones for study and socialising, default opt-out from social media notifications during scheduled academic periods, and awareness initiatives connecting screen time, sleep quality, and mental wellbeing.

Deliverables
D5.1 Systematic review M6 (Lead: UoC?)
D5.3 Health and digital literacy intervention description M10 (Lead: ICL?)
D5.4 Device-assisted monitoring and feedback intervention description M10 (Lead: NYU?)
D5.5 Health-promoting environments and nudges intervention description M10 (Lead: EHNet?)
D5.2 Report on intervention development and young adult involvement M18 (Lead: UoC?)

Milestones
M5.1 Intervention packages and implementation plans finalized

Critical risks
Individual-oriented interventions rest on the implicit premise that people possess sufficient agency to modify their behaviour in response to health-promoting initiatives. However, this assumption does not hold uniformly across populations. Such approaches risk disproportionately benefiting those who already possess the social, economic, and environmental resources to enact healthier choices, potentially exacerbating existing health inequalities by systematically privileging more advantaged groups. This concern is particularly acute among young adults aged 19 to 25, given the considerable diversity in their living situations, financial circumstances, and access to education or community support.

Work package number	6
Work package title	Intervention implementation in countries

Objectives
(1) to ensure that proposed interventions are not only theoretically sound innovations but would be also effectively translated and implemented at the national and possibly regional and local levels by national institutes of public health in six (>5) participating countries.
This work package addresses three key dimensions:
1. Common denominators of interventions: Identification of the shared mechanisms and principles across all interventions to enable harmonization and standardized approaches where feasible.
2. National implementation feasibility: Assess whether each intervention can be scaled up and institutionalized and integrated into the national context. This includes identifying necessary adaptations, relevant national stakeholders and right-holders to support, vulnerable groups and groups at risk (addressing inequalities), and assessing sustainability. Implementation science principles will guide the analysis to ensure that the interventions follow evidence-based, structured pathways from pilot to nationwide application.
3. Alignment of the proposed outcomes and recommendations with EU regulatory frameworks: Analyze how interventions relate to European legislation, such as the Digital Services Act (DSA), AVMSD, Healthier together, EU Beating Cancer plan and Safe Hearts Plan, Child Guarantee of EPSR and others.
Final aim is to understand which principles can be harmonized and operationalized within the interventions, providing a clear framework for implementation.

Description of work
T6.1 Contextual analysis and implementation capacities addressing digital environment influences on youth NCD risk, in six EU countries (represented by the national public health institutes) (Lead: XX – Participants: xx)
Lead partner, together with partners from participating NIPHs will provide the baseline assessment of the key capacities in partners organizations, especially in the aspect of digitalization, important for the successful and long term implementation of the interventions: staff capacities, knowledge capacities, financial capacities, institutional and leadership capacities.
Exploratory contextual analyses will be provided, to increase the understanding of the national contexts, priorities, and strategic/political environment at the national and EU level – to increase the understanding of the conditions for the implementation of the interventions and provide inputs for finetuning or adapting the implementation processes in participating countries. Structure – agency interplay, equity aspects (gender and geographical equity) and migration background would be specifically addressed.
To improve the implementation potential, project relevant capacity building activities would be developed and provided to the implementation teams in six countries.
In the last year of the project, follow-up assessment of the institutional capacities will be provided and lessons learnt for the implementation of the interventions will support the development of the final recommendations.
In stakeholder mapping[1] process, relevant national and EU stakeholders and right-holders for the individual interventions would be identified, by their demography (public – private, profit-nonprofit, formal-nonformal, type, orientation, power, others). Basic stakeholder network analysis will be provided, to better understand the alliances and relationships among project stakeholders, including their power and direction of influence. Special interest will be paid to the possible conflicts of interest and influences in the individual interventions.

[1] https://cdn.who.int/media/docs/default-source/reproductive-health/contraception-family-planning/stakeholder-mapping-tool.pdf;

Alignment with the relevant existing intersectoral groups or support to the establishment of the new intersectoral groups would be highly encouraged in the national context. Intersectoral groups could increase multidisciplinary competences of the national intervention teams and thus increase the opportunities for successful implementation of different types of intervention. Each of the partners will be establishing collaboration the up-mentioned collaboration and actions aligned with the national contexts.
Meaningful engagement of youth is the key principle of the project and youth engagement would be elaborated specifically.

T6.2 Core implementation science activities (lead partner – role of participants)
Implementation science principles and frameworks will be applied to support the implementation of the interventions, to assess critical steps, target groups, and sustainability of each intervention. Understanding of the accountability cycle step three (holding to the account), linked to the effectiveness of the intervention, will be especially targeted by the implementation science approaches during the intervention, hopefully giving good insights into the nature of the intervention. Models such as Knowledge-to-Action Model (Graham s sod., 2006) or Quality Implementation Framework (Meyers s sod., 2012) would be explored for relevance for actions in the A-Z-HEALTH project.
Interventions will be clustered using common denominators (existence of the strategic grounding (legislative) document to increase the legacy of the intervention; level of implementation - nat., reg-local; (gender) equity addressed; available capacities for implementation; transferability addressed; proportion of the population included in the intervention; addressed health determinants / NCDs / mental health; right-holders, vulnerable groups, migrants, youth engaged, rural /urban location; …and possible others, to be decided during the course of the project) and compared among themselves in that regard.
Sustainability elements of the interventions will be explored in addition, to assure higher probability of long-term implementation of interventions and to increase the understanding what are the institutional characteristics influencing successfulness and effectiveness of the implementation of interventions.

T6.3 Implementation of health and digital literacy programme and digital media self-management

T6.4 Implementation of device-assisted monitoring and feedback

T6.5 Implementation of resources and services

Deliverables
D6.n name – short description – Delivery date

Milestones
Milestone name – Delivery date

Critical risks
Any plausible event or issue that could have a high adverse impact on the ability of achieve the objectives.

Work package number	7
Work package title	Evaluation

Objectives
(1) To establish a harmonised, FAIR-compliant data infrastructure across implementation countries that integrates real-world data (RWD) sources; (2) To develop an evaluation framework specifying study designs, counterfactuals, and outcome measurement instruments for each implementing country; (3) To generate valid causal estimates of intervention effectiveness across all three NCD domains; (4) To synthesise primary study results into a standardised evidence package and develop actionable recommendations for national and EU-level scale-up.

Description of work
T7.1 Real world data infrastructure (Lead: ICL; Participants: NIPH, NIJZ, EHNet)
A harmonised data governance framework will be developed and maintained in compliance with GDPR and FAIR data principles, coordinating data management plans across all experimental WPs. Building on data linkage

approaches developed in the Joint Action on CVD and Diabetes (JACARDI #101126953), A-Z-HEALTH will establish a common data model to enable cross-country pooled analyses. ICL will maintain a living data dictionary and ensure all study datasets are deposited in line with open science requirements. Country-specific sub-tasks (T7.1a–n) cover national registry linkage and data access agreements in each implementing country.

T7.2 Evaluation design (Lead: ICL; Participants: NIPH, NIJZ, UoC, EHNet)
Drawing on the methodological framework for pilot project assessment developed for JACARDI, this task supports each implementing country in identifying an appropriate study design and counterfactual before implementation begins. Where feasible, randomised controlled trials will be used; where randomisation is not possible, quasi-experimental designs will be applied, including difference-in-differences and regression discontinuity methods. A standardised assessment planning template, completed by each intervention country, will specify the counterfactual definition, participant selection approach, and outcome measurement instruments. All primary studies will be pre-registered via OSF or ClinicalTrials.gov.

T7.3 Country-Level Impact assessment (Lead: NIJZ; Participants: ICL, all implementation partners)
Each implementing country will conduct an in-depth assessment of their intervention(s) using the standardised framework developed in T7.2, covering causal inference analysis, economic evaluation, equity analysis, and sustainability/scalability. Country-level assessments are coordinated by NIJZ, with ICL providing methodological oversight. A minimum requirement for all studies is demonstration that the primary outcome changed significantly relative to counterfactual, supported by appropriate regression analysis and pre-specified heterogeneity testing by sociodemographic subgroup. Country-specific sub-tasks (T7.3a–n) are led by respective national partners.

T7.4 Synthesis, evidence packaging and recommendations (Lead: NIJZ; Participants: ICL, all implementation partners)
Study results will be synthesised into a standardised evidence package to inform WP8 modelling work, including intervention-level summaries specifying effect size estimates, study design quality, implementation fidelity, equity profile, and scalability. ICL will coordinate sensitivity analyses for WP8 Health-GPS inputs. Actionable recommendations for national and EU-level scale-up will be developed, embedded in relevant EU and national policy frameworks covering NCDs, mental health, and digital environments.

Deliverables
D7.1 Data Management Plan — M6 (TO DECIDE IF WP1 or WP7)
D7.2 Evaluation Protocol and Assessment Planning Templates — M12
D7.3 Assessment Reports — M42
D7.4 Final evaluation and scale-up recommendations report — M48

Milestones
Mx All studies pre-registered; data governance agreements signed — M6
Mx - Assessment templates completed — M12
Mx – Primary outcome data collection complete — M42

Critical risks
Registry linkage failure. *Mitigation:* Applications initiated M3; registry data supplements rather than replaces prospectively collected primary outcomes.
Follow-up attrition. *Mitigation:* Digital-first protocols; power calculations assume ≥25% dropout; NIPH retention expertise applied across sites.
R3: Policy delay disrupting natural experiments. *Mitigation:* EuroHealthNet monitors implementation timelines in real time; multiple staggered quasi-experimental sites provide redundancy.
Measurement non-equivalence across countries. *Mitigation:* Validated cross-culturally adapted instruments specified in D7.2; measurement invariance tested before pooled analyses.

Work package number	8
Work package title	Sustainable implementation, Policy simulation & Foresight
Objectives	

(1) to identify emerging behavioural, social, and technological trends shaping youth health behaviours and NCD risk factors; (2) To explore plausible future scenarios to 2050 affecting the effectiveness, scalability and equity of behavioural interventions in different youth segments and contexts; (3) To integrate foresight and modelling to assess the long-term robustness, adaptability and policy relevance of intervention strategies under alternative future conditions; (4) To generate forward-looking policy recommendations, adaptation pathways and communication outputs to support sustainable implementation and uptake.

Description of work

T8.1 Horizon scanning, prioritisation of drivers and participatory sense-making (Lead: ISINNOVA)

This task initiates the foresight cycle through a structured horizon scanning and sense-making process aimed at identifying critical drivers of change, emerging trends, weak signals, and potential disruptions shaping youth health behaviours,NCD risk factors and exposure pathways linked to NCD prevention. The task combines: (i) systematic desk research and rieview of scientific, grey and foresight literature; (ii) social media signal scanning across platforms and online spaces relevant to diverse youth segments, in order to to detect evolving behaviours, attitudes, narratives, motivations, barriers and inequalities; (iii) stakeholder-informed inputs, including semi-structured interviews with multidisciplinary experts, to refine and contextualise emerging insights; and (iv) collective and participatory sense-making exercises with a multidisciplinary panel (including youth representatives) to identify key trends, potential mismatches with intervention assumptions, and early warning signals of unintended consequences or exclusion.

A Delphi-inspired survey process will then be used to assess the relevance and uncertainty of identified drivers and to prioritise key trends and critical uncertainties. The main outputs of this phased task will be a validated evidence base for scenario development (T8.3) and for assessing the future robustness and equity implications of A-Z-HEALTH interventions (T8.4).

T8.2 Policy simulation and modelling of long-term impacts (Lead: ICL – Participants: xx)

This task will model the long-term health and policy implications of scaling A-Z-HEALTH interventions under alternative implementation and policy conditions. Building on intervention evidence generated by the project and informed by the outputs of Task 8.1, the modelling work will estimate the potential long-term effects of selected intervention strategies on youth health trajectories and NCD-related outcomes.

The task will develop **policy simulation scenarios** to assess the likely impacts, cost-effectiveness, and distributional implications of intervention uptake across different socio-economic and national contexts. It will also identify the parameters and indicators most relevant for linking foresight outputs to modelling assumptions, ensuring that scenario narratives developed in WP8 can inform quantitative projections. The task will work in close interaction with the evaluation and intervention WPs to ensure methodological alignment and consistency of assumptions. This task will generate the **modelling backbone for the integrated policy pathways** developed later in WP8.

T8.3 Scenario development and stress testing of interventions (Lead: ISINNOVA)

Building on the prioritised trends and uncertainties identified in T8.1,, this task will develop a coherent scenario space and a set of 3–4 plausible future scenarios (to 2040) describing how youth health behaviours and key drivers of Non-Communicable Diseases (NCDs) may evolve. The scenarios will be co-developed through participatory foresight methods involving youth representatives, researchers, and stakeholders, ensuring diversity of perspectives and analytical relevance. The process will include a **scenario consolidation workshop** to collaboratively define key axes of uncertainty derived from the prioritised drivers and construct contrasting scenario logics capturing alternative evolutions of behavioural dynamics, social norms, and structural determinants affecting youth. Scenario narratives will then be elaborated and validated through structured consistency checks and expert validation to ensure analytical rigour, coherence, and plausability.

Particular attention will be paid to how emerging trends in digital platforms, social norms, commercial exposure patterns, institutional trust, and regulatory conditions may reshape behavioural dynamics and intervention contexts across socio-economic and cultural settings.

The scenarios will subsequently be used as a **framework to stress test behavioural interventions** targeting NCD prevention and associated policy approaches. This will assess:

- robustness and fragility of intervention mechanisms under different future conditions
- scalability and transferability across youth segments and countries
- potential equity implications, including risks of exclusion or widening inequalities
- needs for policy adjustment, complementary measures, or safeguarding mechanisms

This task will provide the strategic bridge between qualitative foresight and quantitative modelling, and will support the development of future-proof intervention and policy pathways in T8.4.

T8.4 Evaluation of integrated pathways, policy recommendations and foresight uptake (Lead: ICL – Participant: ISINNOVA)
This task will synthesise the findings from modelling and foresight into actionable policy pathways and recommendations to support the sustainable implementation of A-Z-HEALTH interventions. It will identify how interventions may need to be adapted, combined, or sequenced under different future conditions, and which regulatory, educational, communicative, and infrastructural levers are needed to support their implementation and scale-up.
The task will translate the integrated outputs of Tasks 8.2 and 8.3 into policy-relevant recommendations for EU, national, and local actors, with attention to intervention effectiveness, equity, and long-term resilience. [EXPAND ON RECOMMENDATION ACTIVITIES AND APPROACH]
It will also generate a communication-oriented output stream, including open-access **web-based foresight storylines and visual narratives**, developed in coordination with WP9, to support dissemination, strengthen stakeholder engagement, and increase the long-term impact of foresight visions.
The storylines will translate trends, uncertainties, scenarios, and policy insights into accessible and visually engaging narratives for policymakers, practitioners, educators, youth organisations and the wider public.
Structured around two main sections, *Challenges* and *Visions*, the platform will combine concise texts, infographics, and interactive elements to illustrate how youth health behaviours and intervention conditions may evolve towards 2040. Youth participants will contribute to the co-creation and validation of the storylines, ensuring relevance, credibility, and communication value.

Deliverables
D8.1 – Horizon scanning and participatory sense-making report (LEAD: X – M: X)
D8.2 - Policy simulation framework and modelling report (LEAD: X – M: X)
D8.3 – Foresight scenarios report on future drivers of youth health behaviours (LEAD: X – M: X)
D8.4 – Policy pathways and recommendations report (integrating foresight and modelling) (LEAD: X – M: X)
D8.5 - Web-based foresight storylines

Milestones
MS8.X – Completion of horizon scanning and validation of key trends/uncertainties (LEAD: X – M: X)
MS8.X Set of future scenarios (2035–2040) developed and validated through stakeholder and youth workshops, ensuring relevance, diversity of perspectives, and policy applicability. (LEAD: X – M: X)

Critical risks

Limited or biased participation of youth and stakeholders	Medium	High	Targeted stakeholder recruitment; collaboration with youth organisations; inclusive and hybrid engagement formats; attention to diversity across age, gender, socio-economic background, and cultural context.
Weak integration of foresight outputs with modelling and policy tasks	Medium	High	Early alignment with modelling team; joint workshops; iterative feedback loops; co-development of policy-relevant indicators

Work package number	9
Work package title	Communication, Stakeholder engagement, dissemination and exploitation

Objectives
(1) To establish and implement the project's dissemination, exploitation and communication plan; (2) To ensure effective, targeted and inclusive communication and dissemination of A-Z-HEALTH activities, findings and outputs to relevant stakeholder groups; (3) To engage stakeholders and multiplier networks throughout the project to strengthen relevance, visibility, ownership and uptake of results; (4) To translate evaluation findings, implementation experience, and modelling and foresight outputs into accessible policy- and practice-relevant

products; (5) To prepare pathways for exploitation, transferability and sustainability of key project results beyond the funded period.

Description of work

T9.1 Dissemination, exploitation and communication plan (DEC Plan) (Lead: EHNet; Participants: WP1 (ICL), WP7 leaders, WP8 leaders, WP6 implementation partners, relevant digital and web support partners)
This task will develop the project's dissemination, exploitation and communication plan within the first 6 months of the project and update it as needed during implementation. It will define target audiences, key messages, communication channels, dissemination formats, stakeholder groups, exploitation routes, partner responsibilities and indicators for monitoring outreach and uptake. The task will ensure alignment with the overall project governance under WP1 and coherence with the evidence, implementation, evaluation and modelling work across the project.

T9.2 Communication and project visibility (Lead: EHNet; Participants: WP1 (ICL), WP3 leaders, WP6 implementation partners, all partners)
This task will implement the project's communication activities and support a clear, coherent and accessible external profile for A-Z-HEALTH. It will cover core messaging, communication materials, website and digital channels, promotion of key milestones, and support to partners' outreach and visibility activities. Communication will be tailored to different audiences and aligned with the project's equity objectives, including attention to vulnerable, underserved and less-heard groups. Where relevant, communication approaches and messages will be informed through co-design and participatory mechanisms involving people with lived experience and relevant advisory or engagement structures, including youth and community networks.

T9.3 Stakeholder engagement and targeted dissemination (Lead: EHNet; Participants: WP1 (ICL), WP4, WP5, WP6 implementation partners, WP7 and WP8 leaders, stakeholder-facing partners)
This task will engage relevant stakeholders and multiplier networks at European, national and local levels and support the targeted dissemination of project findings and outputs to policy, practice, research and community audiences. It will include stakeholder mapping, tailored outreach, participatory and deliberative engagement approaches, and dissemination through partner networks. Particular attention will be paid to communication- and uptake-relevant engagement of vulnerable, underserved and less-heard groups, including through people with lived experience and, where relevant, youth and community advisory structures. The task will also prepare and deliver the final project event to present and discuss key findings, implementation lessons, and policy- and practice-relevant messages with relevant stakeholder audiences.

T9.4 Exploitation, uptake and sustainability of project results (Lead: EHNet; Participants: WP1 (ICL), WP4, WP5, WP6 implementation partners, WP7 and WP8 leaders, partners owning key tools or interventions)
This task will prepare the exploitation, uptake and sustainability of key A-Z-HEALTH results beyond the project period. It will identify exploitable outputs, assess their transferability and scale-up potential, and develop pathways for their use in policy, practice, service and community settings. Building on evaluation findings, implementation experience, and modelling and foresight outputs, the task will support exploitation approaches that are credible, context-sensitive and relevant to end users. It will in particular explore uptake and sustainability routes through relevant legacy and policy-facing structures, including JA PreventNCD and associated public health institute, authority, advisory and youth engagement networks at national and European level. In close link with T9.3, the task will contribute to the final project event as a platform to showcase key results and stimulate dialogue on uptake, transferability, scale-up potential and sustainability beyond the project period. The task will culminate in a final exploitation and sustainability framework.

Deliverables

D9.1 - Dissemination, exploitation and communication plan (DEC Plan) - M6
Project plan for communication, dissemination, stakeholder engagement and exploitation, including target audiences, key messages, channels, roles, timeline, monitoring indicators, and links to relevant legacy and policy-facing structures; Type: R/DEC; Dissemination level: SEN

D9.2 - Inclusive communication and stakeholder engagement toolkit – M12
Practical package including project narrative and messaging, visual identity, communication templates, website and digital content approach, and guidance for accessible, equity-sensitive and youth-oriented communication and engagement; Type: other/DEC; Dissemination level: SEN

D9.3 - Stakeholder engagement and dissemination activities – **M30**
Report on stakeholder mapping, outreach, engagement and dissemination activities undertaken, including channels, products, networks and engagement mechanisms used, and lessons for subsequent project outreach; Type: R; Dissemination level: SEN
D9.4 - Final exploitation and sustainability framework – M48
Framework identifying exploitable outputs, transferability and scale-up potential, pathways for uptake and longer-term use, and follow-up opportunities through relevant policy, stakeholder and legacy structures; Type: R; Dissemination level: SEN

Milestones
MS9.1 DEC plan approved – M6
Means of verification: DEC plan submitted and approved by the consortium/project governance bodies.
MS9.2 Communication and engagement toolkit operational – M12
Means of verification: Toolkit completed; website launched; core communication materials and templates in use.
MS9.3 Stakeholder engagement and dissemination activities underway – M24
Means of verification: Stakeholder mapping completed; first dissemination and engagement activities implemented and documented.
MS9.4 Exploitation and sustainability framework completed – M48
Means of verification: Final framework submitted; final project event delivered; follow-up and uptake pathways documented.

Critical risks
R9.1 - Limited reach and engagement of key target audiences - Project communication and dissemination activities may not reach or sufficiently engage priority audiences, including policymakers, practitioners, multiplier organisations, and adolescents and young adults, thereby reducing visibility, relevance and uptake of project results.
Likelihood: Medium. Severity: High.
Mitigation: The DEC plan will define target audiences, tailored messages, channels and engagement formats from the outset. Stakeholder mapping will be completed early and updated during the project. Dissemination and engagement approaches will be adapted to different target groups, including digital-first formats for adolescents and young adults, and will build on consortium networks and relevant external platforms.
R9.2 - Weak stakeholder uptake of project findings and outputs - Relevant stakeholders may show limited interest in or capacity for using project outputs, particularly where findings emerge late, are insufficiently tailored to decision contexts, or are not aligned with policy, practice or implementation needs.
Likelihood: Medium. Severity: High.
Mitigation: WP9 will engage stakeholders throughout the project rather than only at the end, using targeted dissemination, participatory and deliberative formats, and early testing of messages and products. Particular attention will be given to policy- and practice-relevant packaging of results, links with WP6–WP8, and use of established networks and legacy structures, including JA PreventNCD, to support uptake and continuity.
R9.3 - Weak youth-facing communication and engagement - Communication products and channels may not be sufficiently relevant, accessible or appealing to adolescents and young adults, especially those in vulnerable or less-heard groups, limiting the quality of outreach and reducing the project's ability to support meaningful youth-facing dissemination and uptake.
Likelihood: Medium. Severity: Medium/High.
Mitigation: Youth-oriented communication will use digital-first approaches and formats suited to contemporary online environments. Where relevant, communication approaches and materials will be informed by co-design, lived experience, and youth and community engagement mechanisms. Accessibility, inclusiveness and contextual adaptation will be built into the toolkit and reviewed during implementation.

Critical risks for implementation (To be completed based on WP description)

Risks related to the horizontal aspects: Management and dissemination		
Description of risk	**WP**	**Proposed risk-mitigation measures**
1. Withdrawal of partner(s)		The PC prepares a proposal for replacement / swap of activities, including partial or total reallocation to

A partner could decide to discontinue the collaboration and leave the consortium. Likelihood: **Low.** Severity: **High**		existing partners. A contract amendment is agreed with the consortium and proposed to the EC
2. Communication Misunderstandings, resulting from poor communication, can cause delay in the workplan and/or reduce the clarity of project functioning. Likelihood: **Low.** Severity: **High**		The PC reviews the communication procedures and channels, and design the necessary adjustments (additional meetings, revised formats, more detailed minutes, etc.). WP leaders will organise regular on-line meetings to ensure to a good coordination.
3. Coordination problems within WP Roles and duties within a WP are not clearly assigned and causes delay to the WP activities Likelihood: **Low.** Severity: **Medium**		PC contacts WP leader to identify a solution, including (i) reallocation of responsibilities and resources, (ii) rescheduling of milestones and deliverables, (iii) identification of alternative courses of action.
4. Delayed or unsatisfactory deliverable A deliverable not produced by the due date or with a satisfactory quality could delay i) the linked activities and/or ii) approval of periodic activity reports. Likelihood: **Low.** Severity: **Medium**		In case of prolonged delay or constant low quality of the deliverable, the PC will assign the task to another team/researcher, and modify the allocation of the EC contribution accordingly, in line with the provisions that will be set out in the Consortium Agreement
Risks related to the scientific aspects		
Description of risk (indicate level of (i) likelihood, and (ii) severity: Low/Medium/High)	**WP**	**Proposed risk-mitigation measures**

Summary of staff effort (To be completed based on budget)

Participant n./name	*WP1*	*WP2*	*WP3*	*WP4*	*WP5*	*WP6*	*WP7*	*WP8*	*WP9*	*Total PMs*
1. ICL										
TOTAL										

'Subcontracting costs' items (To be completed based on budget)

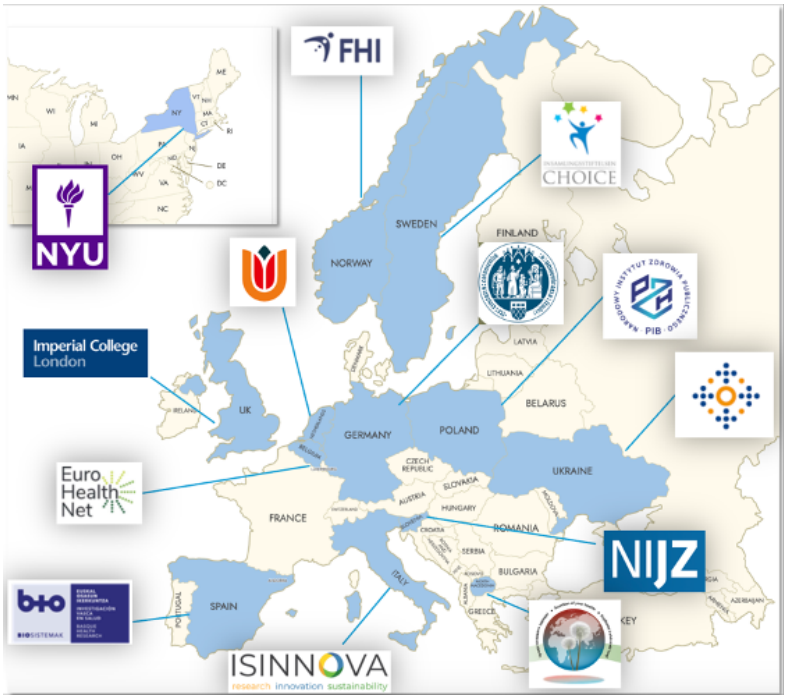
Participant Number/Short Name		
	Cost (€)	**Description of tasks and justification**
Subcontracting		

'Purchase costs' items (To be completed based on budget)

1. ICL	Cost (€)	Justification
Travel and subsistence		

Other goods, works and services		•
Total		
2. xxx		
Travel and subsistence		
Other goods, works and services		•
Total	**x€**	

3.2 Capacity of participants and consortium as a whole



A-Z-HEALTH relies on consortium of 18 partners from 12 EU countries and 1 from USA. The partners have been carefully chosen to ensure the successful completion of the project activities and achievement of the objectives providing for both methodological soundness and operational leadership. Altogether the group gathers organisations with an outstanding reputation in the research, engagement, innovation and communication arena. ICL, as **Project Coordinator**, will be the sole intermediary between the Partners and the European Commission retaining all formal/contractual responsibilities. The partnership assembles a coalition of experts well reflecting the backbone components of the key tasks of the project and for their respective fields of competence, in particular:

- 4 Universities based in Europe and USA (Imperial College of London, University of Cologne, New York University and University of Amsterdam) covering …
- 7 National Public Health Institutes from Norway, Slovenia, Ukraine, Spain, North Macedonia and Poland in charge of …
- 4 Networks (EuroHealthNet, European Medical Students' Association, International Youth Health Organisation, PRESS)
- An independent research institute (ISINNOVA) that supports sustainable visions and policies
- A specialized training center (Choice)
- BGF institute

A-Z-HEALTH project team form a cohesive and complementary group capable of conducting the activities planned in the workplan. In the table below are summarised the specific expertise in the consortium and their role:

Type	Partner	Core expertise and knowledge	Role in the consortium
Universities	ICL		**Project coordinator** Leader of **WP2** and **WP7** Contribution to: Tx.x
	UOC		Leader of **WP5** Contribution to: Tx.x

	NYU		Contribution to: T3.x
	AUMC		Leader of **WP3** Contribution to: Tx.x
National Public Health Institutes	NIPH		Lead: **WP4** Contribution to: Tx.x
	NIJZ		Lead: **WP6** Contribution to: Tx.x
	PHCU		Contribution to: Tx.x
	BIOSISTEMAK		Contribution to: Tx.x
	IPH		Contribution to: Tx.x
	NIH		Contribution to: Tx.x
Others	ISINNOVA		Lead: **WP8** Contribution to: Tx.x
	CHOICE		Contribution to: Tx.x
Network	EHNet		Lead: **WP9** Contribution to: Tx.x
	EMSA		Contribution to: Tx.x
	YHO		Contribution to: Tx.x
	PRESS		Contribution to: Tx.x
tbcd	BGF BE		Contribution to: Tx.x
	WHO		Contribution to: Tx.x

The Project Partners will be pivotal in nurturing the cultural and political debate maintaining a constant dialogue with the outside experts and stakeholders' communities all along the project. In addition, A-Z-HEALTH has created a **Stakeholder Advisory Board (SAB)** consisting to xx youth representatives. The SAB will contribute to reach the project objectives by i) ensuring the scientific debate of the main issues developed within A-Z-HEALTH, and ii) ensuring that the advances achieved by the project are widely and promptly disseminated within the scientific world. Below is provided a preliminary list of experts who confirmed the interest and availability to be part of the committee. XXX