JA PreventNCD
T8.3 & T8.4 Meeting

Rome, 5th November, 2024

Co-funded by
The European Union

SESSION I: T8.3

8:45-10:45	Session I: Task 8.3 "Gathering and further exploiting population-based monitoring systems"	Task 8.3 leaders
8:45-9.00	Brief introduction to Task breakdown (subtasks)	Task leaders: Valentina Possenti (ISS, Italy)
9:00-9:30	Subtask 8.3.1: methods cross-fertilisation, and harmonization Pilot 8.3.a: pooling health surveys	Subtask leaders: Valentina Minardi (ISS, Italy) Pilot leaders: Sanna Heikkinen (CSF, Finland)
9:30-10:00	Subtask 8.3.3: data visualization and foresight modelling. Pilot 8.3.b: Risk assessment and risk-based projection for NCDs	Subtask leaders: Benedetta Contoli (ISS, Italy) Pilot leaders: Vanessa Gorasso, Sarah Croes (Sciensano, Belgium)
10:00-10:45	Round Presentation on Partner Organization contribution to the Task	All Task 8.3 Partners

JA PreventNCD
Joint Action Prevent Non-Communicable Diseases

Gathering and further exploiting population-based monitoring systems
to address data driven decision making
for efficient and effective health-related policies

WP1 Executive Committee

LEAD GROUP
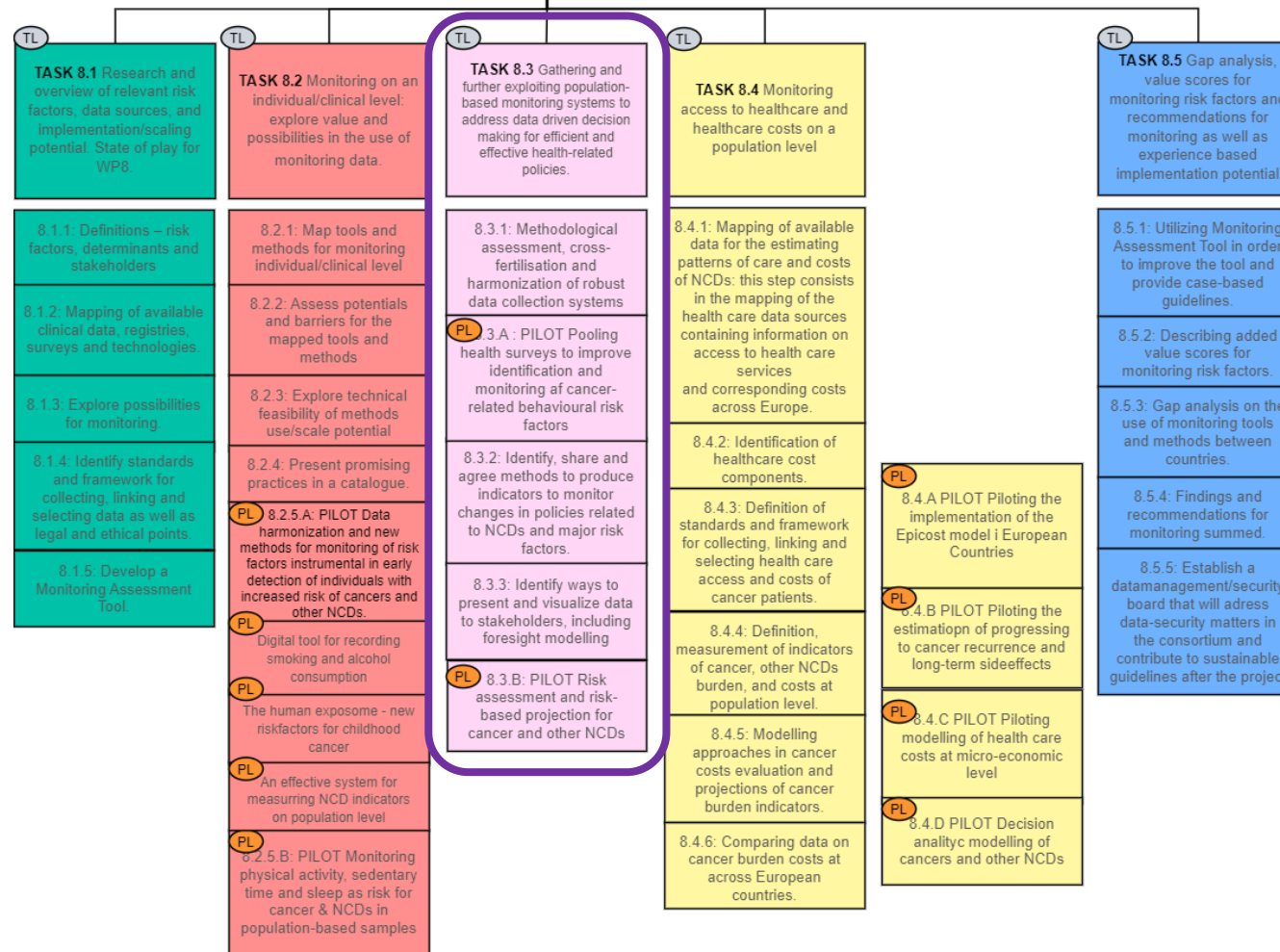LEAD: DK , CO LEAD: IT
Lead and organisation

TL = Task Lead
PL = Pilot Lead

TASK 8.1 Research and overview of relevant risk factors, data sources, and implementation/scaling potential. State of play for WP8.

TASK 8.2 Monitoring on an individual/clinical level: explore value and possibilities in the use of monitoring data.

TASK 8.3 Gathering and further exploiting population-based monitoring systems to address data driven decision making for efficient and effective health-related policies.

TASK 8.4 Monitoring access to healthcare and healthcare costs on a population level

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

8.1.1: Definitions – risk factors, determinants and stakeholders

8.1.2: Mapping of available clinical data, registries, surveys and technologies.

8.1.3: Explore possibilities for monitoring.

8.1.4: Identify standards and framework for collecting, linking and selecting data as well as legal and ethical points.

8.1.5: Develop a Monitoring Assessment Tool.

8.2.1: Map tools and methods for monitoring individual/clinical level

8.2.2: Assess potentials and barriers for the mapped tools and methods

8.2.3: Explore technical feasibility of methods use/scale potential

8.2.4: Present promising practices in a catalogue.

PL 8.2.5.A: PILOT Data harmonization and new methods for monitoring of risk factors instrumental in early detection of individuals with increased risk of cancers and other NCDs.

PL Digital tool for recording smoking and alcohol consumption

PL The human exposome - new riskfactors for childhood cancer

PL An effective system for measurring NCD indicators on population level

PL 8.2.5.B: PILOT Monitoring physical activity, sedentary time and sleep as risk for cancer & NCDs in population-based samples

8.3.1: Methodological assessment, cross-fertilisation and harmonization of robust data collection systems

PL .3.A : PILOT Pooling health surveys to improve identification and monitoring af cancer-related behavioural risk factors

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

8.3.3: Identify ways to present and visualize data to stakeholders, including foresight modelling

PL 8.3.B: PILOT Risk assessment and risk-based projection for cancer and other NCDs

8.4.1: Mapping of available data for the estimating patterns of care and costs of NCDs: this step consists in the mapping of the health care data sources containing information on access to health care services and corresponding costs across Europe.

8.4.2: Identification of healthcare cost components.

8.4.3: Definition of standards and framework for collecting, linking and selecting health care access and costs of cancer patients.

8.4.4: Definition, measurement of indicators of cancer, other NCDs burden, and costs at population level.

8.4.5: Modelling approaches in cancer costs evaluation and projections of cancer burden indicators.

8.4.6: Comparing data on cancer burden costs at across European countries.

PL 8.4.A PILOT Piloting the implementation of the Epicost model i European Countries

PL 8.4.B PILOT Piloting the estimatiopn of progressing to cancer recurrence and long-term sideeffects

PL 8.4.C PILOT Piloting modelling of health care costs at micro-economic level

PL 8.4.D PILOT Decision analityc modelling of cancers and other NCDs

8.5.1: Utilizing Monitoring Assessment Tool in order to improve the tool and provide case-based guidelines.

8.5.2: Describing added value scores for monitoring risk factors.

8.5.3: Gap analysis on the use of monitoring tools and methods between countries.

8.5.4: Findings and recommendations for monitoring summed.

8.5.5: Establish a datamanagement/security board that will adress data-security matters in the consortium and contribute to sustainable guidelines after the project

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From the Detailed Protocol (pp. 50-62)

⚠️

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DETAILED PROTOCOL FOR WORK PACKAGE 8 – Monitoring

Content

⚠️ *This lastly circulated version refers to the part describing T8.3 only and needs further update as requested by the Coordinators*

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In brief

- builds on the **existing population-based monitoring systems** and explores possible implementation options for **extension, cross-over and/or upscale**, with reference to data for different levels (country, subnational or even subregional) not working as "greatest common divisor" but "least common multiple"

- enlarges the study of risk factors, determinants and other relevant issues in cancer and other NCD prevention policies or public health campaigns, even including information about the role played by **health professionals** (i.e., advice provided to citizens or patients)

- encompasses also the **measurement of geographic, temporal and social variations both in exposure** and in health impact (e.g., according to GBD metrics)

- develops an **assessment of the actual and expected risks** under different scenarios.

TL

TASK 8.3 Gathering and further exploiting population-based monitoring systems to address data driven decision making for efficient and effective health-related policies.

8.3.1: Methodological assessment, cross-fertilisation and harmonization of robust data collection systems

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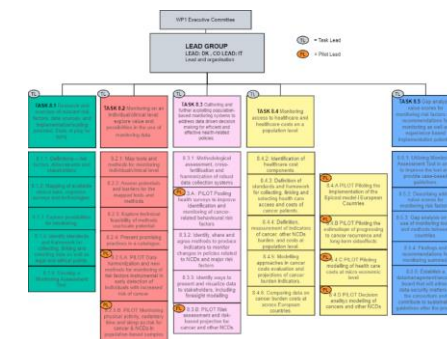
8.3.3: Identify ways to present and visualize data to stakeholders, including foresight modelling

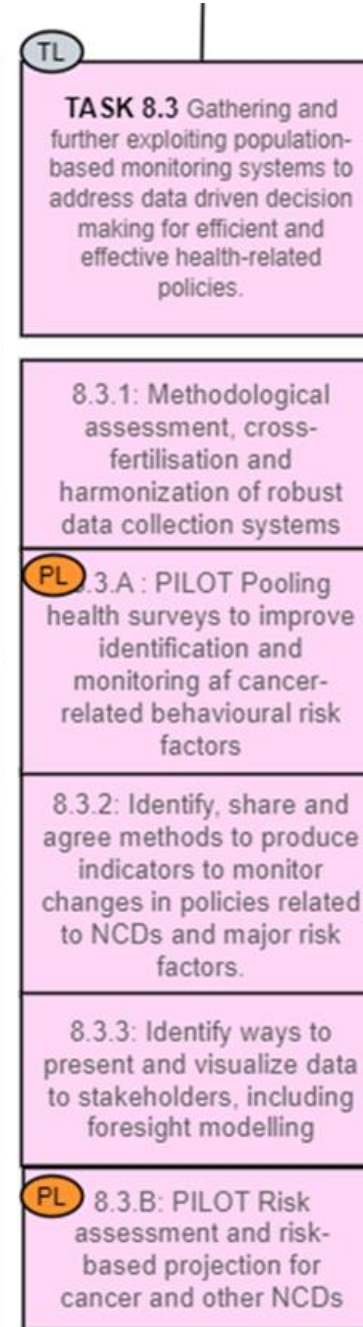**PL** 8.3.B: PILOT Risk assessment and risk-based projection for cancer and other NCDs
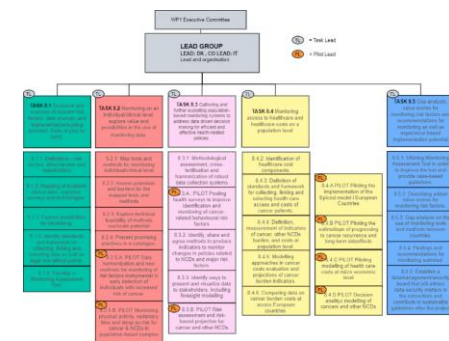
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In brief

- **Building on T8.1** - in terms of indicator definitions (8.1.1), mapping existing data sources and tools (8.1.2), exploring other monitoring possibilities (8.1.3), describing legal and ethical standards for data management (8.1.4) and developing common methodological frameworks

- T8.3 as a whole represents an attempt to go beyond what is already available, by inverting the scheme (**pooling country efforts in the field of population monitoring systems and comparing to EU-level data**).

- It will also link to data from other existing surveys, disease registries and administrative sources in the EU, ranging **from the local level to greater aggregations, such as regional or national extent**.

- The two pilots included, 8.3.a and 8.3.b, will address the **development of specific methodological aspects** such as, respectively, data harmonisation and risk projection scenarios.

Acting Partners in T8.3

Gathering and further exploiting population-based monitoring systems to address data driven decision making for efficient and effective health-related policies

Country	CA	AE	Name	Mail	Note	PM in WP8 as GA	PM in T8.3	PM in ST8.3.1	PM in Pilot 8.3.a	PM in ST8.3.2	PM in ST8.3.3	PM in Pilot 8.3.b
Belgium	Sciensano		Federica Rossetti	Federica.Rossetti@sciensano.be	Reference Person for Sciensano	135	56	6	0	0	20	30
			Robby De Pauw	Robby.DePauw@sciensano.be	Pilot 3.8.b Leader							
			Brecht Devleesschauwer	brecht.devleesschauwer@sciensano.be								
			Vanessa Gorasso	Vanessa.Gorasso@sciensano.be	Pilot 3.8.b co-Leader							
			Sarah Croes	Sarah.Croes@sciensano.be								
Denmark	RSYD		Emil Høstrup	emil.hostrup@rsyd.dk		378	6	2	0	2	2	0
			Linda Justi	linda.justi@rsyd.dk								
			Trine Mosbæk Sørensen	tmos@rsyd.dk								
			Morten Sønderskov Frydensberg	MSF@rsyd.dk								
			Emilie Brysting	Emilie.Brysting@rsyd.dk								
Estonia	TAI		Jane Idavain	jane.idavain@tai.ee	ST8.3.1 and 8.3.2	118	33	2	17	2	0	12
			Aleksei Baburin	alex.baburin@tai.ee	Pilot 8.3.a Pooling surveys pilot							
			Rainer Reile	rainer.reile@tai.ee	Pilot 8.3.a Pooling surveys pilot							
			Mall Leinsalu	mall.leinsalu@tai.ee	Pilots 8.3.a Pooling surveys pilot and T8.3.b risk assesment							
			Kaisa Usberg	kaisa.usberg@tai.ee								
			Johann Saavaste	johann.saavaste@tai.ee	Pilot 8.3.b Risk assessment pilot							
			Maria Lepnurm	maria.lepnurm@tai.ee	Pilot 8.3.b Risk assessment pilot							
			Aire Mill	aire.mill@tai.ee	Pilot 8.3.b Risk assessment pilot							
Finland	THL		Hanna Tolonen	hanna.tolonen@thl.fi		44,6	35,6	3	12,8	2	5	12,8
			Jaakko Reinikainen	Jaakko.Reinikainen@thl.fi								
			Jukka Kontto	jukka.kontto@thl.fi								
			Tommi Härkänen	tommi.harkanen@thl.fi								
		CSF	Sanna Heikkinen	Sanna.Heikkinen@cancer.fi	T8.3=26 PM, ST8.3.1 linked to pilot 8.3.a, ST8.3.3 linked to pilot 8.3.b	89	81	13	25	0	13	30
			Sirpa Heinavaara	Sirpa.Heinavaara@cancer.fi	T8.3=26 PM, ST8.3.1 linked to pilot 8.3.a, ST8.3.3 linked to pilot 8.3.b							
			Maarit Lamminmäki	Maarit.Lamminmaki@cancer.fi	T8.3=26 PM, ST8.3.1 linked to pilot 8.3.a, ST8.3.3 linked to pilot 8.3.b							
Germany	BZGA		Patricia Tollmann	Patricia.Tollmann@bzga.de	Originally not supposed to contribute to T8.3 but expressed voluntarily	10	3,6	0	0	1,8	1,8	0
			PreventNCD@BZgA	preventncd@bzga.de								
		RKI	Julika Loss	LossJ@rki.de	They need to better understand the extent of their involvement in T8.3	58	30	3	12	2	3	10
			Kristin Manz	ManzK@rki.de								
			Giselle Sarganas Margolis	Sarganas-MargolisG@rki.de								
			Hannelore Neuhauser	NeuhauserH@rki.de								
			Christa Scheidt-Nave	Scheidt-NaveC@rki.de								
			Alexander Rommel	RommelA@rki.de								
			Elena von der Lippe	vonderLippeE@rki.de								
			Martin Thißen	ThissenM@rki.de								
		BIPS	Yvonne Kaiser	kaiser@leibniz-bips.de	Agreement reached on September 30th	45	25	10	0	5	10	0
			Ulrike Haug	haug@leibniz-bips.de								

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Country	Code	Partner	Name	Email	Notes							
Greece		IDIKA	Sofia Terzi	s.terzi@idika.gr		6,65	1	0,3	0	0,3	0,3	0
		HUA	Yannis Manios	manios@hua.gr		7	1	0	0	1	0	0
			Niki Mourouti	nmourouti@hua.gr								
			Eva Karaglani	ekaragl@hua.gr								
			Christina Patmiou	cpatmiou@hua.gr								
		NKUA	Vasiliki Benetou	vbenetou@med.uoa.gr		7	1	0,3	0	0,3	0,3	0
Iceland	DOHI		Johanna Torfadottir	johanna.e.torfadottir@landlaeknir.is		28	12	1	8	0	1	2
			Hildur Guðny Asgeirsdottir	hildur.gudny.asgeirsdottir@landlaeknir.is								
Italy	ISS		TASK LEADER			169	0	30	6	14	12	0
			Valentina Possenti	valentina.possenti@iss.it								
			Giovanni Capelli	giovanni.capelli@iss.it								
			Eva C. Appelgren	eva.appelgren@iss..it								
			Benedetta Contoli	benedetta.contoli@iss.it								
			Maria Masocco	maria.masocco@iss.it								
			Valentina Minardi	valentina.minardi@iss.it								
			Paola Nardone	paola.nardone@iss.it								
			Enrica Pizzi	enrica.pizzi@iss.it								
			Temporary contract	(about to be activated)								
		MAR	Roberta Papa	roberta.papa@regione.marche.it		8	8	0	8	0	0	0
		RM2	Massimo Trinito	massimo.trinito@aslroma2.it		10	10	2	8	0	0	0
			Rosaria Gallo	rosaria.gallo@aslroma2.it								
			Daniela Marotta	daniela.marotta@aslroma2.it								
			Valentina Pettinicchio	valentina.pettinicchio@aslroma2.it								
		CPO	Cristiano Piccinelli	cristiano.piccinelli@cpo.it		1	1	0	0	0	1	5
Norway	NDOH		Else Karin Groholt	elsekarin.groholt@helsedir.no	Originnaly 12 PM assigned to NIPH, then split between NIPH and NDOH	136,5	6	1	0	1,5	3,5	0
			Heidi Lyshol	Heidi Lyshol <heidi.lyshol@helsedir.no>								
		NIPH	Lars Kjerpeseth	lars.kjerpeseth@fhi.no			6	0	0	0	6	0
			Fredrik Aaeng Kristiansen	FredrikAaeng.Kristiansen@fhi.no								
			Eli Margrethe Walseth	EliMargrethe.Walseth@fhi.no								
Portugal	ISPUP		Henrique Barros	henrique.barros@ispup.up.pt		9	3	1	0	1	1	0
			Julia Nadine Doetsch	julia.nadine.doetsch@gmail.com								
Slovenia	NIJZ		PreventNCD@NIJZ	prevent.ncd@nijz.si	ST8.3.1 Eva Murko (3,5PM) , Petra Ožbolt (4PM); ST8.3.2 Petra Ožbolt (4PM), Lea Raztresen (4,5PM); ST8.3.3 Petra Ožbolt (4PM); Pilot 8.3a Pia Vračko (9PM), Lea Raztresen (6PM); Pilot 8.3.b Pia Vračko (8,5PM), Eva Murko (1,5)	60	45	7,5	9	8,5	10	10
			Petra Ozbolt	Petra.Ozbolt@nijz.si	ST8.3.1 (4PM); ST8.3.2 (4PM); ST8.3.3 (4PM)							
			Lea Raztresen	Lea.Raztresen@nijz.si	ST8.3.2 (4,5PM); ST8.3.3 (6PM)							
			Eva Murko	eva.murko@nijz.si	ST8.3.1 (3,5PM); Pilot 8.3.b (1,5)							
			Pia Vračko (from 2025 on)	pia.vracko@nijz.si	Pilot 8.3a (9PM); Pilot 8.3.b (8,5PM)							
countries	CA	AE										
11	9	11				364	82,1	105,8	39,4	91,9	111,8	

Acting Partners in T8.3

Gathering and further exploiting population-based monitoring systems to address data driven decision making for efficient and effective health-related policies

Sub-actions: three subtasks, two pilots

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TL

TASK 8.3 Gathering and further exploiting population-based monitoring systems to address data driven decision making for efficient and effective health-related policies.

8.3.1: Methodological assessment, cross-fertilisation and harmonization of robust data collection systems

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

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PL 8.3.B: PILOT Risk assessment and risk-based projection for cancer and other NCDs

Task/Deliverable/Milestone	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Gathering and further exploiting population-based monitoring systems to address data driven decision making for efficient and effective health-related policies																
ST8.3.1																
ID8.3.1															X	
IM8.3.1a					X											
IM8.3.1b							X									
Pilot 8.3.a															X	
IM8.3.a1										X						
IM8.3.a2													X			
ST8.3.2																
ID8.3.2													X			
IM8.3.2a												X				
IM8.3.2b												X				
ST8.3.3																
ID8.3.3															X	
IM8.3.3a					X											
IM8.3.3b							X									
Pilot 8.3.b															X	
IM8.3.b1										X						
IM8.3.b2													X			

A quick look at ST8.3.2 (2026)

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Participants	PMs	Responsibilities and contributions
ISS (Italy)	14	Desk search and data collection on the contribution of monitoring systems to prevention policies at different levels. Coordinating international Partners.
NIJZ (Slovenia)	8,5	Data collection on the contribution of monitoring systems to prevention policies at different levels
BIPS (Germany)	5	Data collection on the contribution of monitoring systems to prevention policies at different levels, data collection to exemplify the potential of combining primary and secondary data
RKI (Germany)	2	Data collection on the contribution of monitoring systems to prevention policies at different levels
RSYD (Denmark)	2	Data collection on the contribution of monitoring systems to prevention policies at different levels
TAI (Estonia)	2	Data collection on the contribution of monitoring systems to prevention policies at different levels
THL (Finland)	2	Data collection on the contribution of monitoring systems to prevention policies at different levels
BZgA (Germany)	1,8	Further feedback on Country experience
NDOH (Norway)	1.5	Data collection on the contribution of monitoring systems to prevention policies at different levels
HUA (Greece)	1	Further feedback on Country experience
ISPUP (Portugal)	1	Further feedback on Country experience
NKUA (Greece)	0.3	Further feedback on Country experience on the contribution of monitoring systems to prevention policies at different levels
Idika (Greece)	0.3	Further feedback on Country experience

Deliverables and milestones:

ID8.3.2	Report on effective use cases of monitoring indicators in the cancer and NCD prevention plans and policies	M39
IM8.3.2a	Understanding of how monitoring data on cancer and NCD risk factors and determinants contribute to country prevention by planning informing or evaluating policies.	M30
IM8.3.2b	Data collected on how/to what extent monitoring data on cancer and NCD risk factors and determinants contribute to country prevention by planning informing or evaluating policies.	M36

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

Subtask leaders: Maria Masocco, Valentina Possenti, ISS, Italy

Participants (13): Denmark (RSYD), Estonia (TAI), Finland (THL), Germany (BZgA, RKI, BIPS), Greece (Idika, HUA, NKUA), Italy (ISS), Norway (NDOH), Portugal (ISPUP), Slovenia (NIJZ)

Further exploitation/upscale on the extent and use of indicators delivered by the population monitoring systems to inform cancer and NCD prevention policies and intervention planning, orienting effective decisions on public health campaigns and initiatives.
As per ST8.3.1, with reference to this action a strong connection will be built with some tools and experiences developed by WHO, such as:
- the "Annex 3: Country Profile of Capacity and Response to Noncommunicable Diseases (NCDs)" included in the WHO Periodic Report "Assessing national capacity for the prevention and control of noncommunicable diseases: report of the 2021 global survey";
- the SCORE or Health Data Technical Package for strengthening country data systems and capacity to monitor progress towards public health objectives, the S stands for "Survey populations and health risks" that includes regular population-based surveys, surveillance of public health threats, regular population census.

The perspectives to assume could be diverse such as for the behavioural risk monitoring:
-topic/field covered (firstly the WHO best buys but also compliance with the main prevention programs such as cancer screening and vaccination, safety-related issues, mental health, quality of life and others),
-temporal trends and within particular emergency timeframes (such as the flexibility and resilience shown by the systems in gathering data during the occurred pandemics, i.e. A/H1N1 and COVID-19),
-geographical areas or analysing by rural vs urban dimensions,
-target-population subgroups (healthy or people who received a cancer diagnosis in their lifetime) or specific-age group needs such as difficulties met by elderly in accessing basic health and social services,
-or even including information about the role of health professionals in cancer and other NCD prevention (i.e., advice provided to citizens or patients).
Health planning documents informed by monitoring systems to investigate will range from the national/regional/local Prevention or other Plans up to collaboration with supranational networks, for instance the behavioural system PASSI in Italy provides data also to the Italian WHO Healthy Cities Network. Furthermore, in terms of tools, the possibility of using

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

Connection to WP5, WP9

Subtask 8.3.1 Methodological assessment, cross-fertilisation, and harmonisation of robust data collection systems

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9:30-10:00	Subtask 8.3.3: data visualization and foresight modelling. Pilot 8.3.b: Risk assessment and risk-based projection for NCDs	Subtask leaders: Benedetta Contoli (ISS, Italy) Pilot leaders: Vanessa Gorasso, Sarah Croes (Sciensano, Belgium)
10:00-10:45	Round Presentation on Partner Organization contribution to the Task	All Task 8.3 Partners

ST8.3.1 Starting points of interest/ challenges

- Data harmonization and availability: defining a data standard is theoretically straight-forward, but real world is different

- Overview of available data generated from relevant population monitoring systems is complex because the heterogeneous sources (health information/examination surveys, registries, secondary/health claims data)

- Finding the right people for the right projects: matching among different working groups (not necessarily same Organizations same people)

- Sharing indicator definitions, standard and vocabularies for variables

ST8.3.1 and WP8 basis

- Linked to the work under development in **T8.1** and its major output, the **Country Factsheets**, for the overview on existing systems and methods that monitor the key cross-cutting risk factors (e.g., smoking, harmful alcohol consumption, obesity and lack of physical activity) and known health determinants such as education, socio-economic status, gender, age, and employment relevant across cancer and other NCDs as explicitly mentioned in the Europe's Beating Cancer Plan.

JA PreventNCD
Mapping of Monitoring and Surveillance Practices for Cancer and other NCDs
Country Factsheet: ITALY
Version: 0.1

62 **DEFINING RISK FACTORS AND MAPPING MONITORING AND SURVEILLANCE**
63 **SYSTEMS OF CANCER AND THE THREE OTHER NCDs IN #INSERT COUNTRY NAME#**
64
65   1. **DEFINITION OF COMMON RISK FACTORS FOR CANCER AND OTHER NCDs**
66
67 **EXPLANATION:** The WHO has published the European Code Against Cancer, which describes relevant risk- and preventive factors for cancer. Amongst these there
68 are, tobacco use, second-hand smoking, healthy body weight, physical activity, diet, alcohol, sun-/UV exposure, pollutants, radiation, breastfeeding and hormonal
69 therapy (for women), vaccination and infections, screening and others[1]. It further illustrates 12 preventive ways to reduce the risk for cancer, as in the following:

1   *Tobacco.* Do not smoke. Do not use any form of tobacco.
2   *Second-hand smoking.* Make your home smoke free. Support smoke-free policies in your workplace.
3   *Healthy body weight.* Take action to be a healthy body weight.
4   *Physical activity.* Be physically active in everyday life. Limit the time you spend sitting.
5   *Healthy eating.* Have a healthy diet: Eat plenty of whole grains, pulses, vegetables and fruits. Limit high-calorie foods (foods high in sugar or fat) and avoid
    sugary drinks. Avoid processed meat; limit red meat and foods high in salt.
6   *Alcohol.* If you drink alcohol of any type, limit your intake. Not drinking alcohol is better for cancer prevention.
7   *Sun exposure.* Avoid too much sun, especially for children. Use sun protection. Do not use sunbeds.
8   *Pollutants.* In the workplace, protect yourself against cancer-causing substances by following health and safety instructions.
9   *Radiation.* Find out if you are exposed to radiation from naturally high radon levels in your home. Take action to reduce high radon levels.

...er's cancer risk. If you can, breastfeed your baby.
...(HRT) increases the risk of certain cancers. Limit use of HRT.
...on programmes for: Hepatitis B (for newborns), Human papillomavirus (HPV) (for girls).[2]
...mmes for: Bowel cancer (men and women), Breast cancer (women), Cervical cancer (women).[3]

[3] Exa...

Connection to WP7

ST8.3.1 aims

- Building on these grounding frameworks, in ST8.3.1, the issue of **capacity building** is aimed to develop, strengthen and homogenise the competencies, processes and resources that the different monitoring systems apply to data collection, considering the potential of local/regional/national current data sources or surveillances in the EU participating countries.

- The goal of this action is the development of a joint effort to **harmonise and implement different-sized integration of the monitoring systems** for collecting data on health determinants/risk factors of NCDs and cancer.

- One of the first action will be about obtaining **ethical approvals**, identification and quality assessment of the relevant data needed from each participant.

ST8.3.1 actions to develop

- Development of a context analysis of available data sources on cancer/NCD-related health determinants in the participating countries

- Delivery of a feasibility/opportunity study on applying population-based surveillance (sample survey) in participating countries sharing a common health system organization

- Exploratory analysis on adding up specific questionnaire modules to existing health surveys

Relevant indicator definition frameworks – WHO, 2021

Risk factor

| Unmodified definition, updated commentary |

Social, economic or biological status, behaviours or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury.

The identification of behavioural, social and physical environmental risk factors is commonly used to explain variations in *healthy life expectancy* and *health outcomes*. Understanding the causes and consequences of these risk factors provides an entry point or focus for application of health promotion strategies and actions.

Burden of disease

◆ Modified

The burden of disease is a measurement of the gap between a population's current health and the optimal state where all people attain full life expectancy without suffering major ill-health.

Burden of disease analysis is an important and widely used tool that enables decision-makers to identify the most serious health problems facing a population currently and the likely burden in the future. It may be expressed as lost healthy life years (HeaLYs), disability-adjusted life years (DALYs), quality-adjusted life years (QALYs), or adjusted combinations of these measures. Burden of disease data also provide a basis for determining the relative contribution of various *risk factors* and can be useful in identifying the relative importance of the broader determinants of health to overall population health. Burden of disease data can be applied to make explicit the unequal impact of risk factors and determinants of health and can be used to highlight the actions required to achieve greater *health equity*. These data and analyses can be used to determine priorities for health promotion action within countries.

Source:
The Global Burden of Disease 2000 project: aims, methods and data sources. WHO Global Programme on Evidence for Health Policy Discussion Paper No. 36. Geneva World Health Organization; 2001 (https://www.who.int/healthinfo/paper36.pdf, accessed 8 July 2021).

Health behaviour

◆ Modified

Any activity undertaken by an individual for the purpose of promoting, protecting, maintaining or regaining health, whether or not such behaviour is objectively effective towards that end.

Behaviour remains a critical determinant of health. Changes to behaviour may either directly benefit health, or enable increased control over the determinants of health. As such, behaviour change remains an important element to health promotion. Health behaviours are influenced by emotional, cognitive and interpersonal factors as well as individual *skills for health;* and are fundamentally shaped by the social, cultural, commercial and physical environments in which people live and work. Health behaviours are often related in clusters and in groups of people that form a complex set of interdependent relationships. In health promotion, behaviour change can be supported through approaches that combine policy instruments such as legislation or regulation with *community mobilisation* to influence social norms and practices, and behaviour change interventions that address the complex realities shaping people's health.

Source:
Van den Broucke S. Needs, norms and nudges: the place of behaviour change in health promotion. Health Promotion International. 2014; 29(4):597–600.

Social determinants of health

✚ New term

The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life.

The social determinants of health influence a person's opportunity to be healthy, their risk of illness, health behaviours and *healthy life expectancy*. Health inequities result from the uneven distribution of these social determinants.

Approaches to address the social determinants of health include specific socioeconomic and public policies addressing living conditions or access to power, money and resources; multisectoral collaboration across policy sectors, such as the Health in all policies approach, and improved health governance; community empowerment and participation for health; improved monitoring of health inequalities; and improved health social and environmental health workforce capacities to recognize important social determinants of health and local actions of redress.

Sources:
Social determinants of health. Geneva: World Health Organization; 2020 (https://www.who.int/social_determinants/sdh_definition/en/, accessed 8 July 2021).
Social determinants. World health Organization Regional Office for Europe; 2016 (http://www.euro.who.int/en/health-topics/health-determinants/social-determinants, accessed 8 July 2021).
Promoting health: Guide to national implementation of the Shanghai Declaration. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/handle/10665/260172, accessed 8 July 2021).

Life course

✚ New term

A culturally defined sequence of stages that people typically pass through as they progress from birth to death. Health across the lifespan reflects a complex interplay of biological, behavioural, psychological, and social protective and risk factors that contribute to health outcomes across the span of a person's life.

A life course approach provides a holistic view of people's health and *well-being* at all stages in life, as well as interlinkages with sustainable development. A person's health and well-being are shaped by many different individual, social and environmental factors throughout life. Risk exposures in early life can affect health, well-being and socioeconomic participation decades later. Risk and *resilience* are accumulated throughout the life course.

Health Promotion Glossary of Terms 2021   25

The life course approach encompasses actions that are taken early, appropriately to transitions in life and together as a whole society. This approach confers benefits to the whole population across the lifespan, as well as accruing to the next generations. A life course approach to health promotion can increase the effectiveness of interventions throughout a person's life by focusing on a healthy start to life and targeting the needs of people at critical periods throughout their lifetime.

Sources:
A life course approach to health, human capital and sustainable development. Geneva: World Health Organization; 2019 (https://www.who.int/life-course/publications/life-course-brief-20190220.pdf, accessed 8 July 2021).
The Minsk Declaration. The life-course approach in the context of Health 2020. Copenhagen: World Health Organization Regional Office for Europe; 2020 (https://www.euro.who.int/__data/assets/pdf_file/0009/289962/The-Minsk-Declaration-EN-rev1.pdf, accessed 8 July 2021).
Life-course approach. Copenhagen: World Health Organization Regional Office for Europe (http://www.euro.who.int/en/health-topics/Life-stages, accessed 8 July 2021).
Glossary of life-course terms. Copenhagen: World Health Organization Regional Office for Europe; 2015 (https://www.euro.who.int/__data/assets/pdf_file/0009/289539/Glossary-Life-course-Terms.pdf, accessed 8 July 2021).

Relevant indicator measuring frameworks – WHO, 2013

WHO's Noncommunicable Diseases Global Monitoring Framework: Indicator Definitions and Specifications

- Behavioural RFs (1-10)

- Biological RFs (11-17)

Behavioural Risk Factors:

    3. Harmful use of alcohol: Adult Per Capita Consumption

    4. Harmful use of alcohol: heavy episodic drinking

    5. Harmful use of alcohol: alcohol-related morbidity and mortality

    6. Physical inactivity in adolescents

    7. Physical inactivity in adults

    8. Salt intake

    9. Tobacco use in adolescents

    10. Tobacco use in adults

Biological Risk Factors:

    11. a) Blood pressure: raised blood pressure

    11.b) Blood pressure: mean blood pressure

    12. Raised blood glucose/diabetes

    13. Overweight and obesity in adolescents

    14. Overweight and obesity in adults

    15. Saturated fat

    16. Low fruit and vegetable consumption

    17. a) Total Cholesterol: raised

    17.b) Total Cholesterol: mean

National Systems Response:

    18. Drug therapy and counselling to prevent heart attacks and stroke

    19. Essential medicines and technologies for NCD

    20. Palliative care

    21. Elimination of trans-fats

    22. Vaccination for HPV

    23. Marketing to children

    24. Vaccination for Hepatitis B

    25. Cervical cancer screening

Relevant indicator measuring frameworks – WHO, 2013

Global monitoring framework

Mortality & morbidity

Unconditional probability of dying between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases

Cancer incidence by type of cancer

Risk factors

Harmful use of alcohol (3)
Low fruit and vegetable intake
Physical inactivity (2)
Salt intake
Saturated fat intake
Tobacco use (2)
Raised blood glucose/diabetes
Raised blood pressure
Overweight and obesity (2)
Raised total cholesterol

National systems response

Cervical cancer screening
Drug therapy and counselling
Essential NCD medicines & technologies
Hepatitis B vaccine
Human papilloma virus vaccine
Marketing to children
Access to palliative care
Policies to limit saturated fats and virtually eliminate *trans* fats

Total number of related indicators in brackets

25 Indicators

World Health Organization

Relevant indicator measuring frameworks – WHO, 2013

Set of 9 voluntary global NCD targets for 2025

- Premature mortality from NCDs 25% reduction
- Harmful use of alcohol 20% reduction[1]
- Essential NCD medicines and technologies 80% coverage
- Physical inacitvity 15% reduction[2]
- Drug therapy and counselling 50% coverage
- Salt/sodium intake 30% reduction
- Tobacco use 30% reduction
- Diabetes/obesity halt the rise
- Raised blood pressure 25% reduction
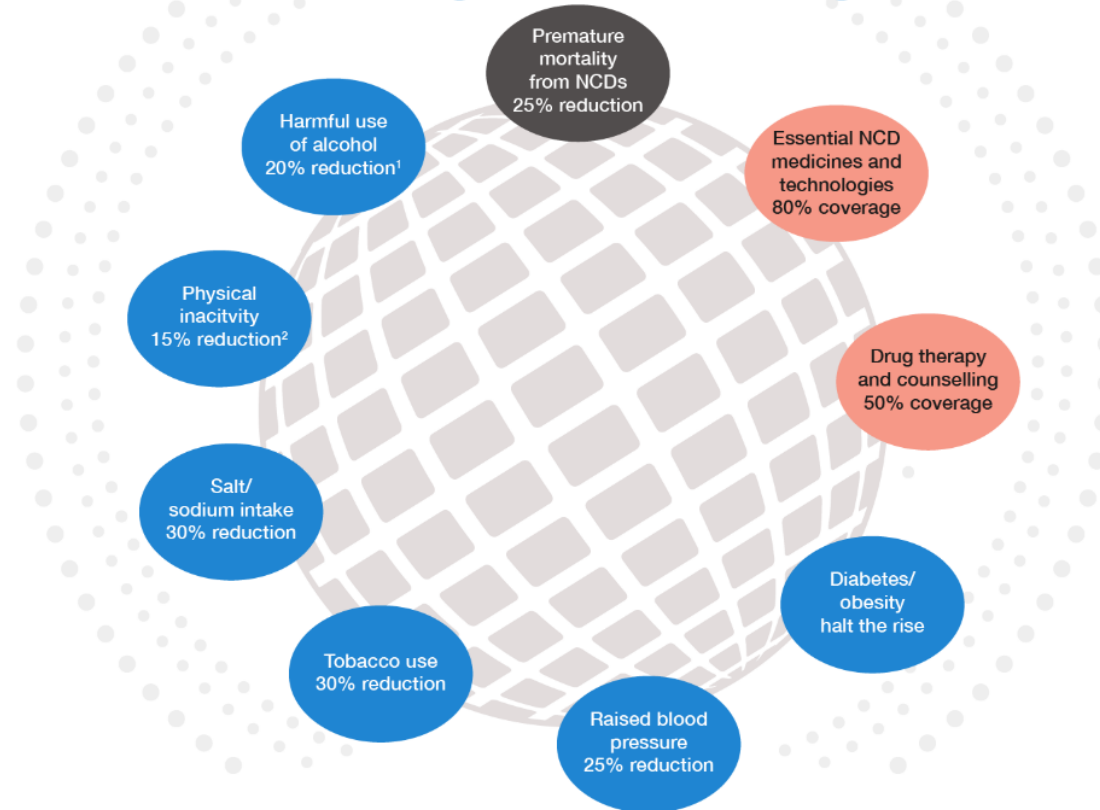
[1] By 2030. Target updated in 2022 (https://apps.who.int/gb/ebwha/pdf_files/EB150/B150_7Add1-en.pdf)
[2] By 2030. Target updated in 2018 (https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_R6-en.pdf)

- Mortality and morbidity
- Risk factors for NCDs
- National systems response
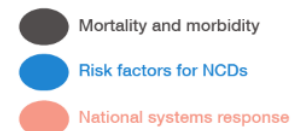
Relevant indicator measuring frameworks – EU, 2023

JA PreventNCD

Mapping metrics of health promotion and disease prevention for health system performance assessment

Annex 2 to the report "Mapping metrics of health promotion and disease prevention for health system performance assessment": Full list of indicators as reported by participating countries, in alphabetical order

CHALLENGES OF MEASURING AND INTERPRETING METRICS OF HEALTH PROMOTION AND DISEASE PREVENTION

Based on HSPA Expert group discussion, there was a recognised need to include health promotion and disease prevention indicators in HSPA, but what the Expert group discussions and case studies have showcased is that it is less clear which indicators should be used. Indicators that are more straightforward to interpret, are widely available and comparable are often derived from EU-wide initiatives.[61] Few countries make direct links to HSPA or use indicators to inform health policy-making that incorporate information on wider determinants of health to interpret health systems performance. In countries that do (such as Chapter 3 showcase of Austria's Health Promotion Strategy), these indicators can provide important information on the effects of broader policies on population health and well-being.

One initiative developed to aid in comparable data collection, under the Second Programme of Community Action in the Field of Health 2008-2013, the EU funded Joint Action (JA) on European Community Health Indicators Monitoring (ECHIM), has defined core health indicators and consolidated data collection tool which aims to move toward a sustainable health monitoring system in Europe supporting the EU Health Strategy. In June 2012, a shortlist of 88 health indicators was completed and a tool created which has assisted in processes such as structuring of National Health Information systems, stabilization of new indicators and foster cross-country benchmarking.[62] While indicators were not categorized specifically as health promotion and disease prevention, indicators were categorized into chapters (see Box 11) as well as by policy area. As one example, prevention is captured in the policy area of health determinants as preventable health risks and lifestyle health behavior (which included population below poverty line and income inequality, drug, smoking or alcohol related deaths) or within the chapter health interventions: health promotion which captures data on policies on environmental tobacco smoke (ETS) exposure, policies on healthy nutrition, policies and practices on healthy lifestyle and integrated programmes in setting, including workplace, schools, hospital. Despite the existence of many indicators related to health promotion and disease prevention, their use in the context of HSPA remains limited and insufficient or incomplete data, as well as gaps in comparability, remain a concern across the EU.[63]

There are also limitations in the extent to which indicators capture health inequities. The 2019 European Union Companion Report[64] highlights that standard health promotion and disease prevention data routinely used across the EU tend not to capture the multi-dimensional features of health promotion and disease prevention. Even where good data availability exists, for example regarding vaccination coverage, inequities (beyond geographic ones) are rarely captured.
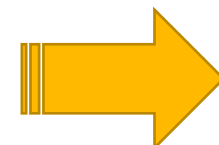
Relevant indicator measuring frameworks – EU, 2013

JA PreventNCD

[European Core Health Indicators (ECHI) - European Commission (europa.eu)](#)

- [88 indicators](#)

The European Core Health Indicators (ECHI) shortlist of 88 health indicators identified by policy area

		Relevant policy areas*												
		Health services and health care			Ageing and population			Health determinants		Diseases and Mental Health			HIAP
ECHI Chapters	ECHI Indicators	Sustainable health care systems	Health system performance, Quality of care, Efficiency of care, patient safety	(Planning of) health care resources and health care cost	Healthy ageing, Ageing population	Maternal & perin. health	Child health	Health inequalities (including accessibility of care)	Preventable health risks and lifestyle health behavior (including young adults)	Non-Communicable diseases (NCD), Chronic Diseases	(Preventable) Burden of Disease (BoD) and health threats, communicable diseases	Mental health	Health in All Policies (HIAP) including occupational and environmental health

European Core Health Indicators (ECHI)

PAGE CONTENTS

ECHI data tool

References

Latest updates

Documents

The European Core Health Indicators (ECHI), formerly known as European Community Health Indicators, is the result of long-term cooperation between EU countries and the European Commission.

Three ECHI projects (1998-2001, 2001-2004, 2005-2008) funded under the EU Health Programmes established the first lists of ECHI indicators, aiming to provide comparable health information and knowledge system to monitor health at EU level.

The [Joint Action (JA) on European Community Health Indicators Monitoring (ECHIM)](#) resulted in a shortlist of [88 health indicators](#) ⊕, classified by policy area, which were revised in 2017 under the [BRIDGE-Health project](#) (Bridging Information and Data Generation for Evidence-based Health Policy and Research). Of these, definitions and data collection mechanisms are [in place for over 60](#) ⊕, and where appropriate, data is disaggregated by sex, age, socio-economic status, and region.

Heading	Examples
Demographic and socio-economic situation	Population, birth rate, total unemployment
Health status	Infant mortality, HIV/AIDS, road traffic injuries
Health determinants	Regular smokers, consumption/availability of fruit
Health interventions: health services	Vaccination of children, hospital beds, health expenditure
Health interventions: health promotion	Policies on healthy nutrition

Indicators are at the crossroads of policy questions and data sets. They reflect a policy interest as well as a select set of possibilities in terms of what can be calculated. For these reasons, the European Commission also presents other European health indicators that are not part of the ECHI system but are still useful to health stakeholders.

ECHI data tool

The [ECHI data tool](#) provides data on both ECHI indicators and other European health indicators, which are available in different formats ranging from line or bar charts, to maps or tables. It can be converted into an image or downloaded as a data file. The tool allows the multiple-selection of indicators.

References

Evaluation of the use and impact of the European Community Health Indicators ECHI by Member States (August 2013):

- [Executive summary](#) ⊕
- [Final report](#) ⊕.

Box 12: European Core Health Indicators (ECHI) data tool[65]

The ECHI is an interactive application using a graphics tool to present relevant and comparable information on health at EU level. The tool presents a list of indicators, grouped in five chapters:

- demographic and socio-economic factors (9)*,

- health status (32),

- determinants of health (14),

- health interventions: health services (29),

- health interventions: health promotion (4)

Following on from a shortlist of 88 indicators, definitions and data collection mechanisms are now in place for more than 60 indicators and these are available on the ECHI platform. The aim of the ECHI indicators is to provide the shortest meaningful list of indicators that gives a reliable overview of health and health systems across Europe. In addition, other health indicators are also presented in the graphics tool to provide additional information on various health topics. Where considered useful or appropriate, stratification by gender and age is applied. In the tool, breakdowns by socio-economic or regional level are provided when available.

Most of the data is provided by Eurostat, but many indicators are drawn from other sources, such as WHO, OECD, specific programmes and specialised databases.

*denotes number of indicators within each chapter

Note: The ECHI data tool will have a new interface and updated information at the end of 2023.

JA PreventNCD

Relevant international frameworks of interest – ECAC

9 out of 12 European Code against Cancer indicators are considered in the required action-level indicators

Number of gap analysis per risk factor (according with the European Code against Cancer) to **define needs.**	WP8	Tobacco: 5 Second-hand smoke: 5 Overweight/obesity: 5 Physical activity: 5 Diet: 5 Alcohol use: 5 Pollutants: 5 Breastfeeding: 5 Screening: 5
Number of gap analysis per risk factor (according with the European Code against Cancer) in vulnerable categories.	WP8	Tobacco: 5 Second-hand smoke: 5 Overweight/obesity: 5 Physical activity: 5 Diet: 5 Alcohol use: 5 Pollutants: 5 Breastfeeding: 5 Screening: 5

Large population-sample behavioural multirisk monitoring systems

In Italy, relevant tools for planning and evaluating health interventions and policies in the fields of disease prevention and public health promotion

JA PreventNCD

Population surveillances

Children aged 0-2 years
The surveillance of children aged 0-2 years investigates the determinants of health in early childhood

Children aged 6-10 years
OKkio alla Salute focuses on health promotion and healthy growth in children

Adolescents aged 11-15 years
HBSC provides a snapshot of young people's health and social context

Adolescents aged 13-15 years
La Global Youth Tobacco Survey (Gyts) indaga l'uso del tabacco fra i giovani

Adults aged 18-69 years
The PASSI surveillance monitors health in the adult population across Italy

Elderly aged 65+ years
The Passi d'Argento surveillance monitors health in the elderly population across Italy

Behavioural surveillance systems

Developed locally, jointly carried out by the Italian Local Health Units (LHUs) and regions, and **centrally coordinated** by the *National Centre for disease prevention and health promotion* of the Italian National Institute of Health (ISS)

Population surveillances

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Large population-sample behavioural multirisk monitoring systems

JA PreventNCD

Surveillance system for the main determinants of health in children aged 0-2 years

- on **breastfeeding and other relevant determinants of the first 1000 days** needs to be strengthened and grow up nationwide as per coverage or representativeness;

- next data collection: 2025

Connection to T6.5 on Baby friendly community

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Large population-sample behavioural multirisk monitoring systems

JA PreventNCD

- **Surveillance system for overweight, obesity and related risk factors in primary schoolchildren** (6-10 years of age; OKkio alla Salute is part of the *Childhood Obesity Surveillance Initiative*, **COSI** established by the WHO Europe; next data collection: 2027)

•COSI, HBSC, GYTS are internationally based networks and in these cases some new and innovative experiences of youth involvement and co-creation could be tested

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Large population-sample behavioural multirisk monitoring systems

- **Health Behaviour in School-aged Children (HBSC)**, international multicentric study conducted in over 40 countries across Europe and North America, in partnership with the WHO Europe; next data collection: 2026

- **Global Youth Tobacco Survey (GYTS)**, in conjunction with HBSC, promoted by the WHO Europe; next data collection: 2026

- COSI, HBSC, GYTS are internationally based networks and in these cases some new and innovative experiences of youth involvement and co-creation could tested

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JA PreventNCD

Large population-sample behavioural multirisk monitoring systems

- **BRFSS adults** (18-69 yy)

- **BRFSS elderly** (65+ yy)

- In Italy, the two systems providing **continuous data collection** allow the delivery of public health profiles as tools for decision-makers to plan, evaluate and re-orient health services, and this model – partly or fully – will be studied for implementation or adaptation in other European countries.

- After almost two decades of life, in the coming soon national conference (Rome, December 10th), they have been defined as **"high-resolution tools for action in Public Health"**

PASSI e PASSI d'Argento strumenti ad alta risoluzione per l'azione in Sanità Pubblica

10 dicembre 2024

organizzato da

ISTITUTO SUPERIORE DI SANITÀ
Centro Nazionale per la Prevenzione delle malattie e la Promozione della Salute (CNaPPS)

Main sessions:
- **_Prevention_** _as key for future health_
- **_Health_** _as universal right: challenges in a transforming society_
- **_Local_** _practices and experiences_
- **_Surveillances_** _as tools for action_

PASSI and PASSI d'Argento

- Developed under mandate of the **Italian Ministry of Health**, since 2006, in order to orient, monitor, and evaluate interventions for the prevention of chronic diseases

- **PASSI** (Progressi delle Aziende Sanitarie per la Salute in Italia - Progresses of Local Health Units for Health in Italy) and **PASSI d'Argento** are two ongoing nationwide surveillance systems, which collect information about:

- **health status, behavioral risk factors for non-communicable chronic diseases** (i.e. smoking, alcohol consumption, physical activity, diet, obesity)

- **adherence to some important preventive measures** (i.e. participation in cancer screening)

- **Active and Healthy Ageing** indicators among adults (18-69 year olds) and elderly (64 years and over)

Origins and evolution

as per the National Prevention Plan, the Italian Ministry of Health mandated the National Health Institute (ISS) to develop two pilot studies to monitor major behavioural risk factors and preventive measures among the adult population living in Italy. The project was named **PASSI** (**P**rogressi delle **A**ziende **S**anitarie per la **S**alute in **I**talia - *Progresses of Local Health Units for Health in Italy*)

The PASSI surveillance starts the systematic and continuous data collection in subjects aged 18-69 years

A first experimental sampling on the population aged over 65 takes place: since the methodology is similar to PASSI, it takes the name of **PASSI d'Argento** («Silvery» PASSI)

PASSI d'Argento starts to realize surveys every other year

also PASSI d'Argento data collection becomes systematic and continuous

| 2005-2006 | 2007-2008 | 2009-2010 | 2012 | 2016 |

PASSI and PASSI d'Argento

- Data are collected on age-gender representative samples of non-institutionalized citizens, by telephone interviews which specifically trained staff of the Local Health Units (LHUs) administer using a standardized questionnaire.

- Records collected during a 11-month calendar year are aggregated in an annual data set.

- LHUs' data are merged and analyzed to obtain regional and national estimates.

- **Study design** - cross-sectional with continuous data collection; the units of data collection are the Local Health Units (LHUs),
- **Sampling design -** proportional by sex and age monthly sample extracted from the list of each participating LHU
- **Data collection -** Specifically trained LHU professionals interview sampled individuals by administering a standardized questionnaire on the phone (face-to-face interview in elderly people who expressly ask for)
- **About 35,000 subjects aged 18-69 years** are interviewed every year in PASSI **About 13,000 subjects aged over 65s** are interviewed every year in PASSI d'Argento

Main topics under study

PASSI (18-69yy)

- **Lifestyles and behavioral risk factors** (alcohol consumption, smoking, physical inactivity, obesity and overweight, inadequate fruit and vegetable consumption, use of salt)
- Prevalence of the major **Non Communicable Diseases** (diabetes, BPCO, stroke, ecc.)
- **Cardiovascular risk factors** (such as hypertension)
- Perceived **physical and psychological well-being**, some aspects indicating the quality of life, and **depressive symptoms**
- Advice and **counselling** provided by general practitioners or other healthcare professionals about promoting healthy habits
- Anti-flu vaccination

- Compliance with the three main **cancer screenings** (cervical, breast, colorectal)
- **rubella vaccination uptake**
- **road safety measures** or **home injuries**
- health-related issues about **pregnancy and breastfeeding**

PASSI d'Argento (65+yy)

- **Falls**
- Use of **drugs** and **medicaments**
- **Sight**, **hearing** and **chewing** problems
- **Social isolation** signs, participation in social life
- **Access** to health care
- Level of **autonomy** (using the Katz Index of Independence in Activities of Daily Living (**ADL**))
- Lawton Instrumental Activities of Daily living (**IADL**) assessment

Themes investigated in s...

PASSI (18-69 years old)

HEALTH
- Perceived health
- Health-related quality of life (unhealthy days)
- Symptoms of depression (PHQ-2 Patient Health Q...
- Chronic conditions
- Insight into diabetes and hypertension

HEALTH-RELATED BEHAVIORAL RISK FA...
- Smoking, Secondhand smoke, Alcohol, Physical ac... iodized salt
- Cardiovascular risk factors (hypertension, hyperch...

Adherence to PREVENTION PRO...AMS
- Cancer screening (mammography, ...cal, colore...
- Vaccinations (anti-flu and anti-...a)
- Home Safety, Road Safety

SOCIO-DEMOGRAPH... CHARACTERISTI...

Age, Gender, Marital status, Cohabitation, Citizenship...

OPTIONAL MODULES

Active mobility, Pregnancy and Lactation, Environme...
Health literacy, Home safety, Antibiotic misuse, COVID module

Optional modules of regional and/or national interest

PASSI	PASSI d'Argento
COVID Module (→ core 2020-22)	COVID Module (→ core 2020-22)
Environment and Health (→ core 2023)	Breast screening in 70-74 years old women
Active mobility (→ core)	Local interventions (walking groups)
Pregnancy and breastfeeding (→ core)	Adapted Physical Activity
Home safety/injuries prevention (→ core)	Home safety/injuries prevention (→ core)
Health literacy	Falls in previous 12 months (→ core)
Stroke Symptom Awareness	Healthcare renunciation (→ core)
Antibiotics misuse	Antibiotics misuse
Physical activity prescription	Need of aids for vision/hearing/chewing)
Module naz A/H1N1	Diabetes
L'Aquila Earthquake Module (2009)	Vitamin D use / Osteoporosis

Adapted Physical Activity, Falls, Home safety, Antibiotic misuse, COVID module

CDC Behavioral Risk Factor Surveillance

JA PreventNCD

Behavioral Risk Factor Surveillance System

Print

The Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world. See More.

2023 BRFSS Data Now Available
View the latest 2023 BRFSS Annual Data

Prevalence Data & Data Analysis Tools

BRFSS Questionnaires

Publications & Resources

Survey Data & Documentation

Spotlight

Working with Module Data? BRFSS Statistical Briefs help guide research on many topics.

https://www.cdc.gov/brfss/index.html

- Survey mode: *population sample*
- Data collection periodicity: *continuous*
- Data collection method: *telephone interviews*
- Standardized questions
  - Single questions -> Indicators
  - Structured interview form (*Core modules + local/optional modules*)

- Timeliness results
- Performance ….?

Table 6. Response Rates for Landline and Cell Phone Samples

State	Landline Response Rate	Cell Phone Response Rate	Combined Response Rate
PR	56.9	59.8	58.5
VI	56.6	58.1	57.5
Minimum	10.4	34.2	22.8
Maximum	78.1	64.0	66.8
Mean	47.3	45.8	45.9
Median	46.3	44.7	45.1

US BRFSS ->

IT PASSI ->   Response Rate **~ 80-85%** / Rejection Rate **~ 10%**

ST8.3.1 Deliverables and milestones

D8.3.1	**Report on possible methodological cross-over for risk factor monitoring systems and results from the piloting action**	M45
M8.3.1a	Methodological framework/questionnaire design for data harmonisation, set up the pilot study testing the pooling health surveys has been defined	M15
M8.3.1b	Data collection implemented and procedures for the pilot study established	M21

Responsibilities and contributions of participating countries

Participants	Responsibilities and contributions
ISS (Italy)	Development of the methodological framework to assess the level of cross over among monitoring systems and coordination of Partners.
CSF (Finland)	Design of pilot studies and data collection to assess the level of cross over among monitoring systems.
Other participating countries	Support in the development of the methodological framework Feedback on the national application of the methods proposed

Pilot 8.3.a

Pooling health surveys to improve identification and monitoring of cancer-related behavioural risk factors

- How to better optimize harmonization and cross-fertilization of all monitoring methods considered will be particularly exploited in **Pilot 8.3.a** Pooling health surveys to improve identification and monitoring of cancer-related behavioural risk factors.

Pilot leader by name, institution, country	**Sanna Heikkinen, CSF, Finland**
Other participating countries (minimum 3 countries per pilot)	TAI-Estonia, NIJZ-Slovenia, THL-Finland, RKI-Germany, DOI-Iceland, ISS-Italy, RM2-Italy, MaR-Italy
Rationale	Heterogeneous monitoring systems on health determinants and major risk factors for cancer and NCDs.

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Pilot 8.3.a

Objective
- to capitalize on the scalability potential of nationwide health surveys and behavioural surveillance systems -possibly linked to cancer registry data -for monitoring the prevalence of lifestyle and other, modifiable or environmental, risk factors for cancer and the associated cancer and NCD burden.

Methodology
The work is going to be developed according the following three sub-actions:
- Data identification, ethical approval and permissions in pilot countries.
- Development of harmonization process of the data
- Analyses and subgroup analysis of the pooled, harmonized data

Main expected outcomes
- strengthened existing monitoring systems on cancer and other NCDs, their determinants and risk factors
- identification of limits and gaps in population-level monitoring of health determinants and risk factors for cancer and NCDs
- further newly generated evidence to inform European prevention policies to tackle NCDs including cancer.

Intervention
- Eligible health surveys modules used in the different countries will be identified and pooled. Possible strategies and protocols to link harmonised risk factors and behavioural data to cancer registry data will be proposed.
- The most applications would be the harmonisation of a pool of key cancer risk factors measurement modules to be used in health surveys and behavioural surveillance systems and the exploitation of cross-sectional health surveys by developing call-back to people who have been diagnosed with cancer in their lifetime.

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Pilot 8.3.a

Type of data: quantitative/qualitative	Quantitative (and qualitative?) data on lifestyle and environmental factors associated with cancer outcomes
Demographics – gender/age groups to be covered	All age and gender groups
Approximate sample size(s)	300,000 (Finland)
Short description of innovative elements	These identified piloting options relate not only to methodological data collection issues but also to ethical and legal procedures, e.g., acquiring informed consent.

The proposed methods to harmonise data to collect will also be used to assess cancer burden in the population. |

Pilot 8.3.a

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Evaluation, possibility for scaling up & sustainability

Such pilot actions apply to diverse monitoring-related aspects. Some examples:

- extending the territorial coverage or focus
- translating, validating and piloting thematic module(s) already implemented in other countries
- expanding to broader area or oversampling at local level
- adding a longitudinal dimension to risk factor population surveys
- cause-effects evaluation opportunities through linkage to cancer or disease registries.

By the possibility to update/repeat data analysis regularly, the persons in the study cohort(s) can be follow up further to estimate their cancer incidence, cancer mortality and cancer survival.

The obtained results from this piloting actions will be disseminated by publication in peer-reviewed scientific journals.

Pilot 8.3.a Some practical options

- One example could be represented by the "*call-back surveys*" to interviewees who reported ever being diagnosed with cancer or other NCDs

Pilot 8.3.a Deliverables and milestones

D8.3.1	Report on possible methodological cross-over for risk factor monitoring systems and results from the piloting action	M45
M8.3.a1	Procedure of the pilot study conducted, and data collection started	M30
M8.3.a2	Data collection terminated, preparation of result elaboration	M39

ST8.3.1 & Pilot 8.3.a

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Task/Deliverable/Milestone	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Gathering and further exploiting population-based monitoring systems to address data driven decision making for efficient and effective health-related policies																
ST8.3.1																
D8.3.1														X		
M8.3.1a					X											
M8.3.1b							X									
Pilot 8.3.a															X	
M8.3.a1										X						
M8.3.a2														X		

Jun 25 Dec 25

Mar 25 Sep 25 Jun 26 Mar 27

Sep 27
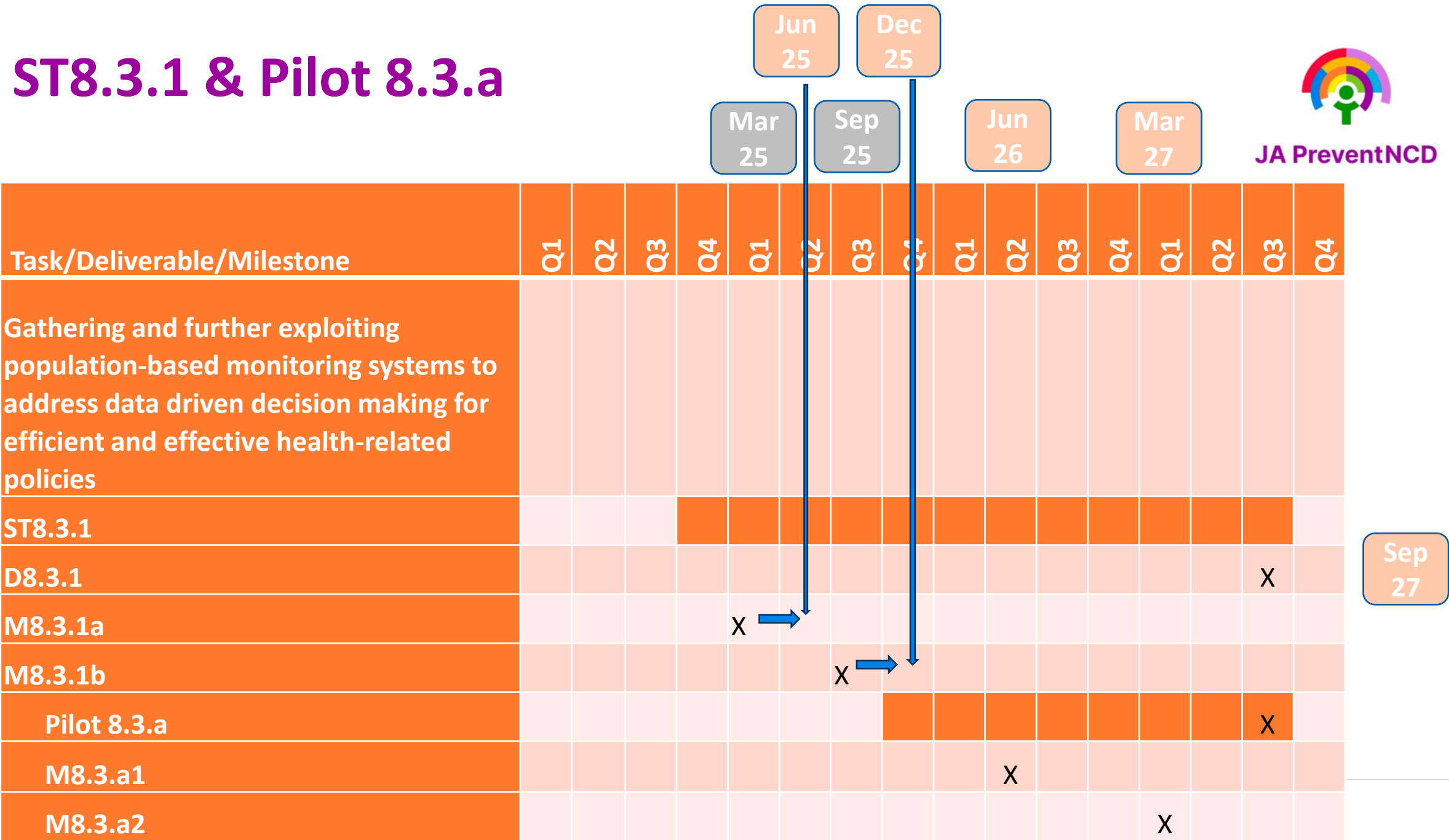
Subtask 8.3.3 Identify ways to present and visualize data to stakeholders, including foresight modelling

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8:45-10:45	Session I: Task 8.3 "Gathering and further exploiting population-based monitoring systems"	Task 8.3 leaders
8:45-9.00	Brief introduction to Task breakdown (subtasks)	Task leaders: Valentina Possenti (ISS, Italy)
9:00-9:30	Subtask 8.3.1: methods cross-fertilisation, and harmonization Pilot 8.3.a: pooling health surveys	Subtask leaders: Valentina Minardi (ISS, Italy) Pilot leaders: Sanna Heikkinen (CSF, Finland)
9:30-10:00	Subtask 8.3.3: data visualization and foresight modelling. Pilot 8.3.b: Risk assessment and risk-based projection for NCDs	Subtask leaders: Benedetta Contoli (ISS, Italy) Pilot leaders: Vanessa Gorasso, Sarah Croes (Sciensano, Belgium)
10:00-10:45	Round Presentation on Partner Organization contribution to the Task	All Task 8.3 Partners

ST8.3.3 Inputs from the population surveillances

- Surveillance systems such as PASSI and PASSI d'Argento aim to establish a specific database at **local level**, continuously updated, in order to monitor trends of risk factors and preventive measures

- The shift from cross-sectional surveys to **ongoing monitoring** entails different ways of collecting and interpreting data.

- **Continuous data collection** allows to grasp aspects which could not be perceived otherwise (such as trends or rapid changes of some variables in association with public health actions, natural events, etc).

- The results of PASSI and PASSI d'Argento surveillances confirm the idea that the progress of a health care system requires **greater interaction between service supply and care providers on one side and demand from users on the other**.

- PASSI and PASSI d'Argento are a real opportunity of **empowerment** for the health system especially at community level.

Indicators for NCDs

Indicators for NCDs

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- sovrappeso e obesità
- consumi di frutta e verdura
- consumo di alcol
- abitudine al fumo
- fumo passivo
- smettere di fumare
- consumo di sale
- rischio cardiovascolare
- diabete
- dispositivi per la sicurezza stradale
- guida sotto l'effetto dell'alcol
- sicurezza domestica
- screening cervicale
- screening mammografico
- screening colorettale
- vaccinazione per l'influenza stagionale
- vaccinazione antirosolia
- percezione dello stato di salute
- depressione
- patologie croniche
- caratteristiche socio-anagrafiche
- focus tematici

Definizioni operative

1. **Non fumatore** è una persona che dichiara di aver fumato nella sua vita meno di 100 sigarette (5 pacchetti da 20) e di non essere attualmente fumatore.
2. **Fumatore, secondo la definizione dell'Oms**, è una persona che dichiara di aver fumato nella sua vita almeno 100 sigarette (5 pacchetti da 20) e di essere fumatore al momento dell'intervista o di aver smesso di fumare da meno di 6 mesi.
3. **Fumatore occasionale** è un fumatore che dichiara di non fumare tutti i giorni.
4. **Fumatore quotidiano** è una persona che dichiara di fumare almeno una sigaretta ogni giorno.
5. **Tentativo di cessazione** riguarda coloro che negli ultimi 12 mesi hanno tentato almeno una volta di smettere di fumare.
6. **Ex fumatore** è una persona che dichiara di aver fumato nella sua vita almeno 100 sigarette (5 pacchetti da 20), di NON essere fumatore al momento dell'intervista e di aver smesso di fumare da più di 6 mesi.
7. **Fumatore in astensione** è una persona che dichiara di aver smesso di fumare da meno di 6 mesi.

Consulta anche le informazioni generali con le caratteristiche degli indicatori Passi, e gli approfondimenti dedicati.

Scheda indicatore: prevalenza di non fumatori

Popolazione di riferimento	Residenti in un Comune della Asl e iscritti all'anagrafe assistiti della Asl, in età 18-69 anni.
Numeratore	Persone di età 18-69 anni che nella loro vita hanno fumato meno di 100 sigarette (5 pacchetti da 20) o hanno risposto "non so/non ricordo".
Denominatore	Intervistati che hanno fornito una risposta (qualunque essa sia) alla domanda sull'abitudine al fumo esclusi, i valori mancanti; il denominatore corrisponde in pratica all'intero campione.
Misure di frequenza	Prevalenza annuale (sulla popolazione di 18-69 anni), con intervalli di confidenza al 95%.
Intervallo temporale di riferimento per la definizione di caso	Il periodo temporale di riferimento sono gli anni di vita dell'intervistato.
Significato per la salute pubblica	Rispetto ai fumatori, chi non fuma ha un'aspettativa di vita di ben 10 anni superiore e una qualità di vita di gran lunga migliore. Chi vive libero dal fumo infatti respira meglio, riesce più facilmente a evitare faringiti e laringiti, bronchite cronica ed enfisema polmonare, il rischio di patologie circolatorie e cardiache, il pericolo di ictus o di ostruzione delle arterie. Senza il fumo, migliorano anche il sonno, la prontezza dei riflessi, i tassi di fecondità sia negli uomini che nelle donne.
Limiti dell'indicatore	L'indicatore misura un comportamento riferito dall'intervistato ed è in teoria soggetto a distorsione legata alla desiderabilità sociale del comportamento, che può essere considerato sconveniente e soggetto a stigmatizzazione. In teoria, ciò può spingere il rispondente a dichiarare di non aver mai fumato, e ciò determina una sovrastima della prevalenza. Questo effetto è stato valutato e gli studi di migliore qualità mostrano che si attesta comunque su valori modesti.
Validità dell'indicatore	In altri contesti di studio, quando i dati dichiarati sono confrontati con quelli misurati obiettivamente (mediante l'analisi dei livelli di cotinina, un metabolita della nicotina, nei liquidi biologici: saliva, urine o sangue), l'indicatore circa la frequenza di coloro che conducono una vita libera dal fumo mostra una sovrastima, ma anche una buona correlazione con le misure oggettive, che lo rende utile per valutare le differenze territoriali e i trend temporali.

* Vedi anche: Behavioral Risk Factor Surveillance System (Brfss)

From data collection to data visualization

What is PASSI

PASSI is a public health surveillance system based on the model of the *Behavioural Risk Factor Surveillance* adopted by many countries. Since 2008, PASSI has been continuously collecting information on lifestyles and behavioural risk factors associated with the development of chronic non-communicable diseases among adults aged 18-69 years living in Italy, as well as information on the target population's knowledge and participation in the relevant prevention programmes.

Coordinated by the Istituto Superiore di Sanità, PASSI is an essential tool of the National Health System for creating regional health profiles. Information is produced in a timely and continuous manner, at regional level and at the level of local health units (LHUs), so as to guide prevention activities and regularly assess their effectiveness towards achieving the health objectives set out in the National and Regional Prevention Plans.

Topics investigated by the PASSI surveillance include: tobacco use, physical activity, overweight, alcohol consumption, fruit and vegetable consumption, salt intake, cardiovascular risk, participation in cancer screening programmes, flu vaccination coverage among vulnerable groups and rubella vaccination coverage among women of childbearing age, adoption of safety measures to prevent road and domestic accidents, physical and mental health (Patient Health Questionnaire-2) [6,7], health-related quality of life (unhealthy days), symptoms of depression and chronic conditions. Thanks to their flexibility, these systems can be adapted to meet new national or regional needs. In addition to the topics above, areas of specific interest to the Regions or the country as a whole can be investigated, also in emergency situations: for example, during the influenza A/H1N1 pandemic and the earthquake in L'Aquila, in 2009, but also during the ongoing COVID-19 pandemic, to assess its health, economic, social and cultural impact. Areas investigated during the COVID-19 pandemic include: perceived risk and consequences of infection, willingness to get vaccinated against SARS-CoV-2, confidence in public institutions and compliance with infection containment measures, impact on the population's emotional state, economic and working conditions and demand for care.

The availability of additional social and personal information makes it possible to identify and analyze social inequalities in health and prevention. The data collected by PASSI also allow exploring the attention given by doctors and healthcare workers to their patients' behavioural determinants of health, as perceived by service users themselves.
Data are collected throughout the year using a standardized questionnaire, which is administered over the phone by properly trained LHU workers to a representative sample (by age and sex) of the 18-69 year old population in their respective catchment areas.

Since 2008, about 35,000 interviews have been conducted each year. The collected data are transferred online to a national database, which can be accessed by LHU and regional coordinators.
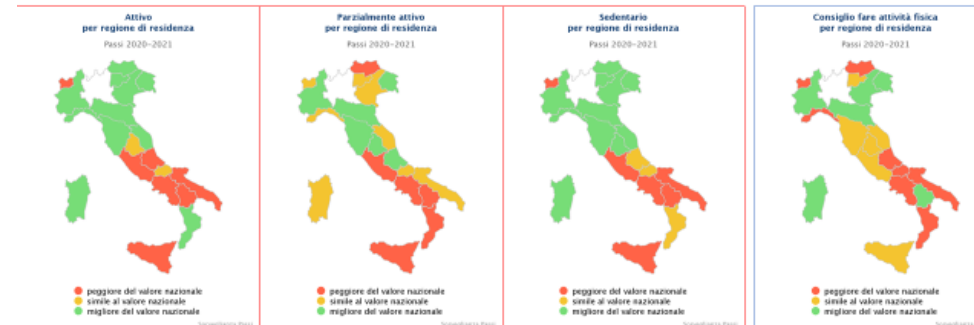Every year, over 90% of the LHUs operating across Italy take part in the surveillance, providing information on over 90% of the country's resident population. The response rate is consistently above 85%, while the refusal rate never exceeds 10%.

Serie storica Sedentari per area geografica
Passi 2008–2021
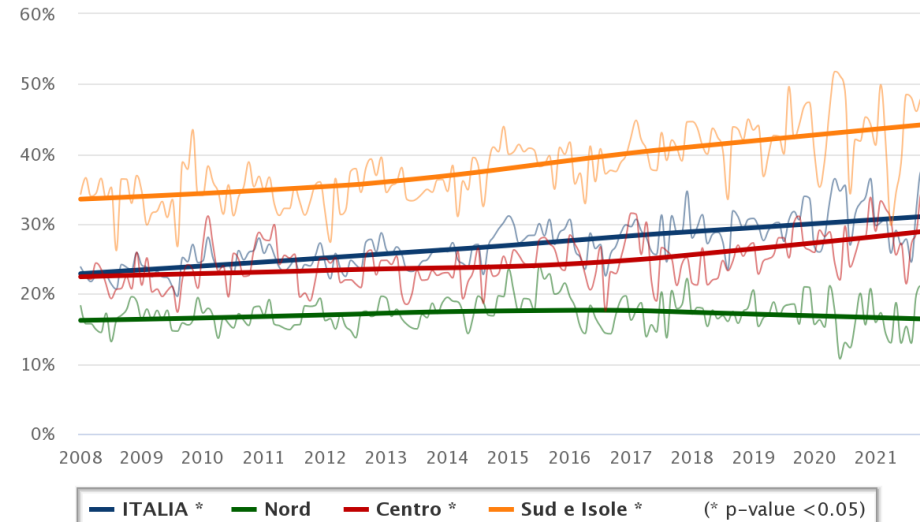
From data collection to data visualization

What is PASSI D'Argento

PASSI d'Argento is a surveillance system focused on the elderly population (people aged 65 years and over) and, as such, complements the PASSI surveillance.

Like PASSI, PASSI d'Argento is a public health surveillance system that collects information on health and behavioural risk factors associated with the development and complications of chronic non-communicable diseases in the country's resident population.

PASSI d'Argento also collects information on some conditions specific to people over 65 years for the purpose of describing quality of life and treatment and care needs in this age group, while bearing in mind the concept of "healthy and active ageing", as defined by the WHO.

PASSI d'Argento investigates several topics that allow outlining a profile of the over 65 population based on the three pillars of active ageing identified by WHO's Active Ageing strategy: health, participation and security. Information regarding health and prevention includes: perceived health, satisfaction with life, health-related quality of life (unhealthy days), symptoms of depression (Patient Health Questionnaire-2) [6,7], chronic conditions and independence in performing basic and instrumental activities of daily living (ADLs and IADLs) [8,9], sensory impairments (e.g. sight, hearing, chewing), falls, use of medications, flu vaccination, behavioural risk factors such as smoking, alcohol use, fruit/vegetable consumption, overweight or unintentional weight loss and physical activity (measured using the PASE instrument [10,11]).

Since 2016, about 14,000 interviews have been conducted each year. The response rate is above 85%, while the refusal rate is 11%.

Uso dei farmaci

	Italia n = 24401		
	%	IC95% inf	IC95% sup
Nessun farmaco *	13.7	13.1	14.4
Uso di farmaci **			
1 farmaco	12.9	12.2	13.6
2 farmaci diversi	18.1	17.4	18.8
3 farmaci diversi	16.7	16.0	17.4
4 o più farmaci diversi	38.6	37.7	39.6

* Persone che dichiarano di non aver assunto farmaci nella settimana precedente l'intervista
** Persone che dichiarano di aver assunto uno o più farmaci diversi nella settimana precedente l'intervista

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Periodo 2021-2022

Percentuali per Regione

Indicatore: Copertura vaccinale negli ultra65enni   ● Dati standardizzati ○ Dati grezzi
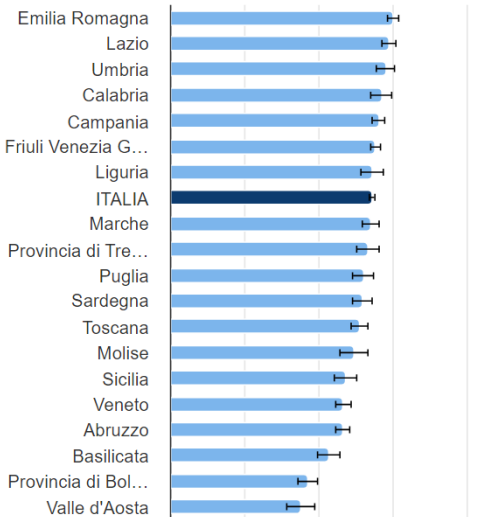
Dati standardizzati

Copertura vaccinale negli ultra65enni per regione di residenza
Passi d'Argento 2021-2022

● peggiore del valore nazionale
● simile al valore nazionale
● migliore del valore nazionale

Sorveglianza Passi d'Argento

Copertura vaccinale negli ultra65enni per regione di residenza
Passi d'Argento 2021-2022

Emilia Romagna, Lazio, Umbria, Calabria, Campania, Friuli Venezia G..., Liguria, ITALIA, Marche, Provincia di Tre..., Puglia, Sardegna, Toscana, Molise, Sicilia, Veneto, Abruzzo, Basilicata, Provincia di Bol..., Valle d'Aosta

0% 25% 50% 75% 100%

Sorveglianza Passi d'Argento

☐ Mostra valori

Chronic patients among adults
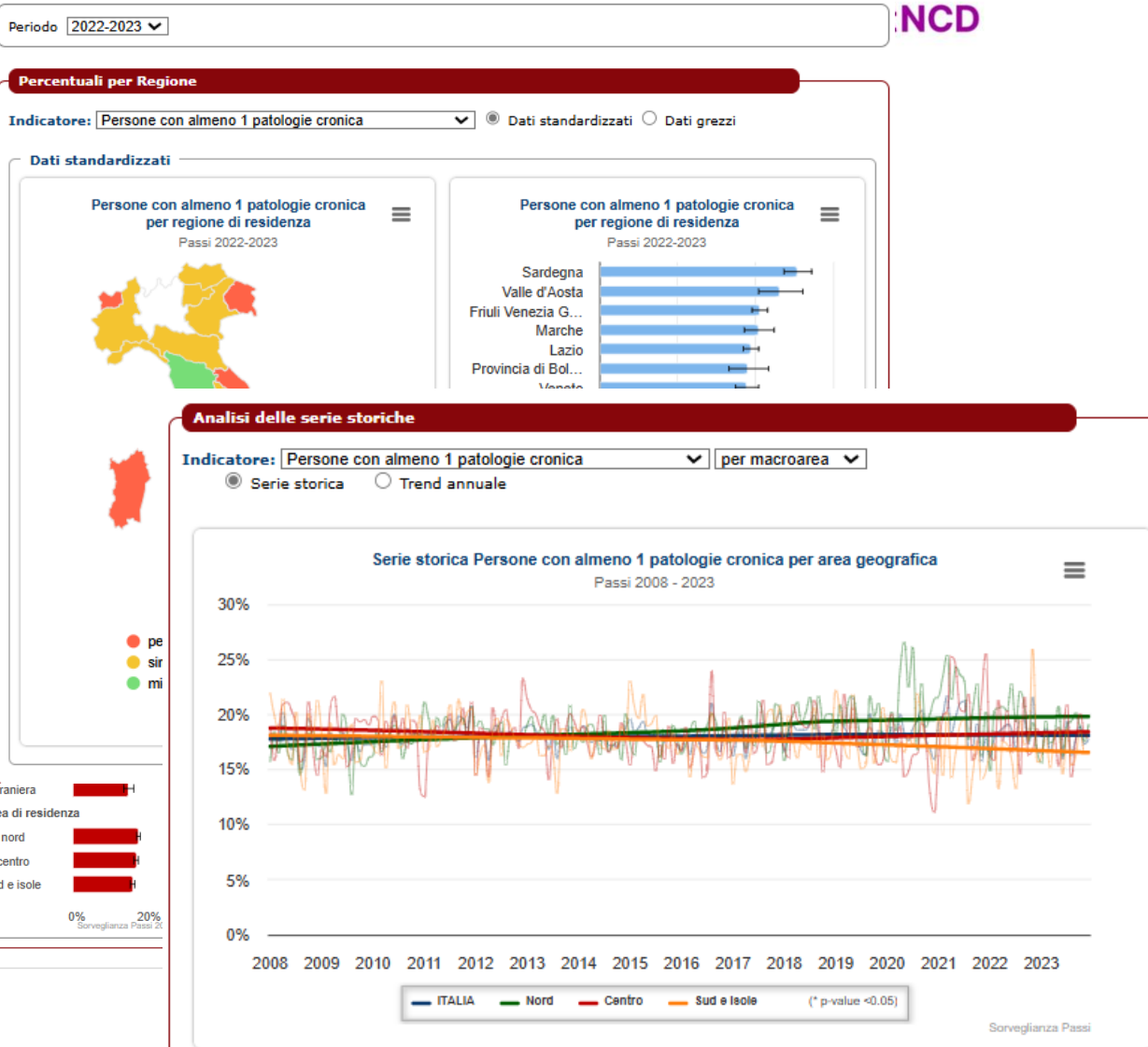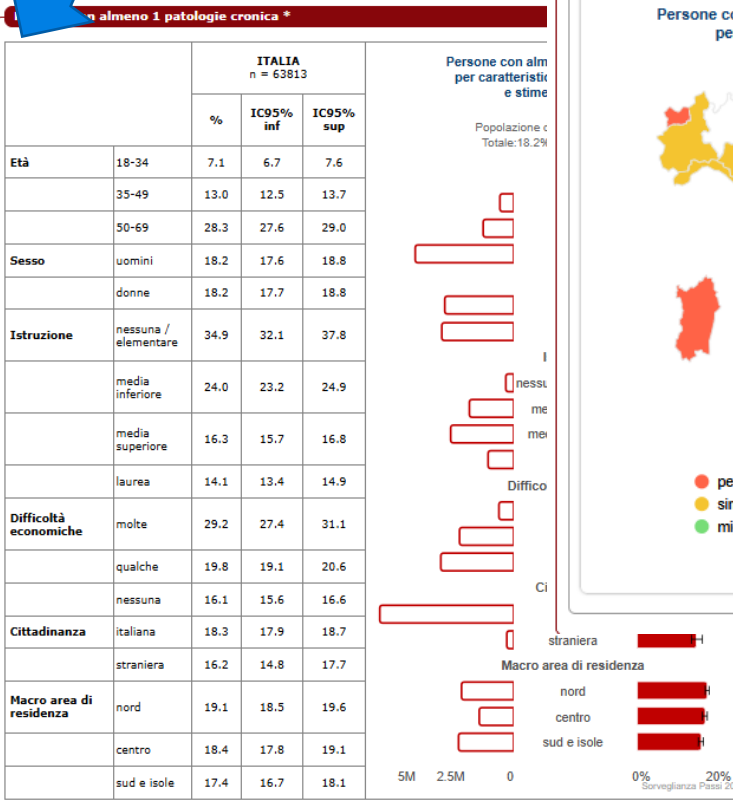
Overweight among older individuals

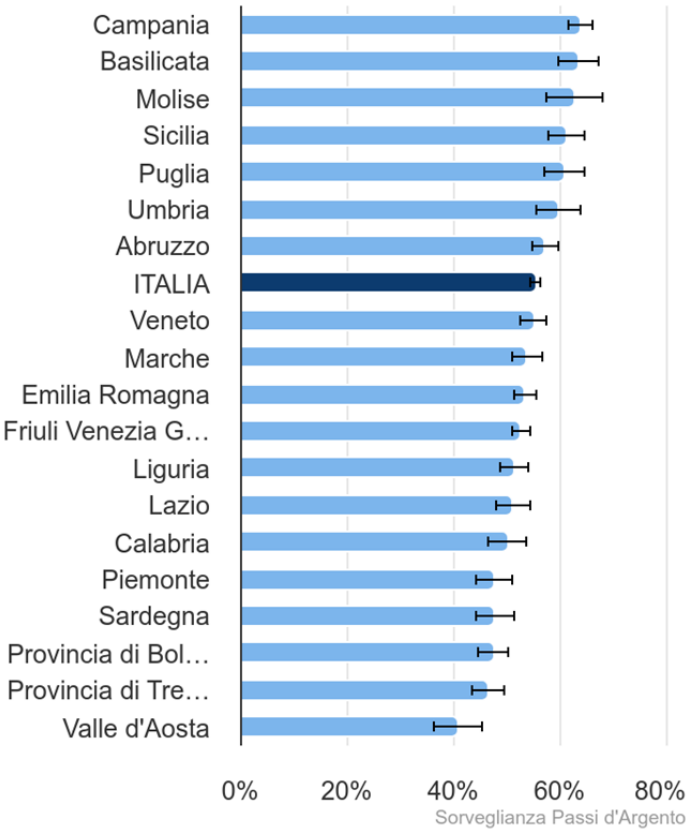

Overweight + Obese
By Region (>65 y)
Passi d'Argento 2022-2023

worse than the national average
on the national average
better than the national average

Sorveglianza Passi d'Argento

Overweight + Obese
By Region (>65 y)
Passi d'Argento 2022-2023

Campania
Basilicata
Molise
Sicilia
Puglia
Umbria
Abruzzo
ITALIA
Veneto
Marche
Emilia Romagna
Friuli Venezia G…
Liguria
Lazio
Calabria
Piemonte
Sardegna
Provincia di Bol…
Provincia di Tre…
Valle d'Aosta

0% 20% 40% 60% 80%

Sorveglianza Passi d'Argento

Estimates from the PASSI d'Argento surveillance data (2016-2023)

55.94   54.85

Italy (average)
Italian Regions

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The European Union

PASSI
d'Argento
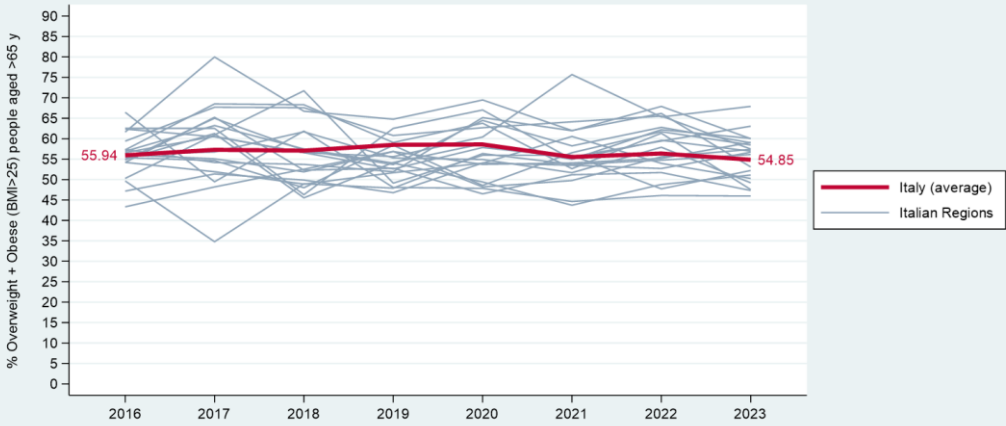
Data presentation to stakeholders

Graphical excellence consists of complex ideas communicated with clarity, precision and efficiency. **Graphical elegance** is often found in simplicity of design and complexity of data.

E.R.Tufte, The visual display of quantitative information, Graphics Press, 1983

Three types of poducts covered

- Scientific articles
- Abstracts (incl. posters, infographics, videoabstracts etc.)
- Policy briefs

Guidance on content

- Manuscripts and abstracts
- Policy briefs (including templates)

Connection to WP2

Data use case: Italian factsheet on PA

- The six-page **WHO factsheet 2024 on Physical Activity** includes several information on the extent for promoting PA in Italy, prevalence data in the different age groups are from the population surveillance systems (OKkio alla Salute, HBSC, PASSI and PASSI d'Argento)
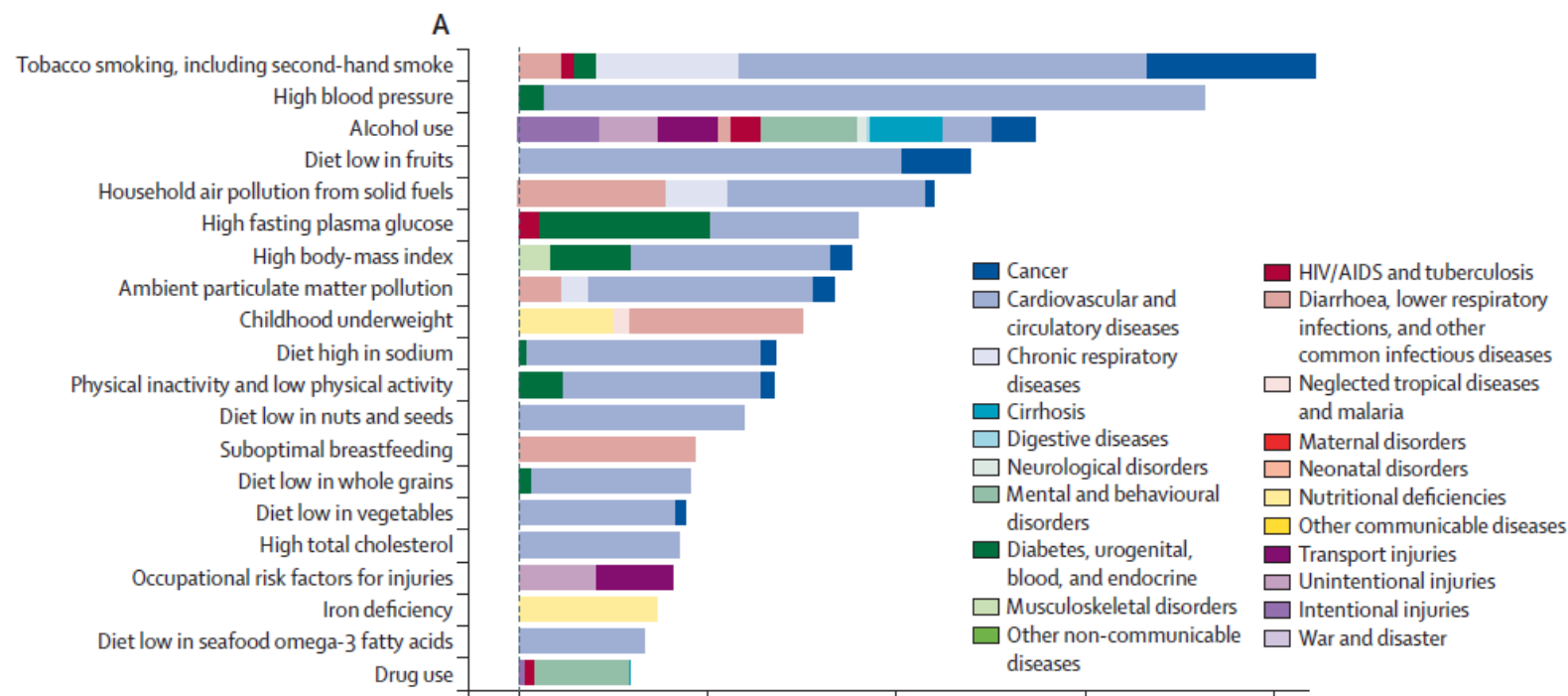
Linking to Pilot 8.3.b

Comparative risk assesment

ST8.3.3 Deliverables and milestones

D8.3.3	**Report on risk assessment and risk-based projection for cancer and other NCDs and results from the piloting action**	**M45**
M8.3.3a	Methodological framework/design to support the cancer risk assessment and set up the pilot study testing the tool has been defined	M15
M8.3.3b	Data collection implemented and procedures for the pilot study established	M21

Pilot 8.3.b

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Risk assessment and risk-based projection for cancer and other NCDs

- ST8.3.3 on foresight modelling includes the GBD-metric exploitation by **Pilot 8.3.b** Risk assessment and risk-based projection for cancer and other NCDs.

Pilot leader by name, institution, country	Robby De Pauw and Vanessa Gorasso, Sciensano, Belgium
Other participating countries (minimum 3 countries per pilot)	THL-Finland, CSF-Finland, TAI-Estonia, DOI-Iceland, CPO-Italy, RKI-Germany, NIJZ-Slovenia
Rationale	A proper understanding of projections for cancer and NCD determinants and risk factors is crucial for sustainable and equitable prevention policies and interventions.

Organization

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The work is going to be divided in the following subtasks:

- Data permissions and access in pilot countries

- Assessing and comparing projections

- Conducting scenario-based analysis

Participants	PMs	Sub-task responsibilities and contributions
Sciensano	30	Coordinator and participating in sub-acions i), ii), iii)
CSF-Finland	30	Participating with major contribution in sub-acions i), ii), iii)
THL-Finland	12.8	Participating with medium contribution in sub-acions i), ii), iii)
TAI-Estonia	12	Participating with medium contribution in sub-acions i), ii), iii)
RKI-Germany	10	Participating with medium contribution in sub-acions i), ii), iii)
NIJZ-Slovenia	10	Participating with medium contribution in sub-acions i), ii), iii)
CPO-Italy	5	Participating with medium contribution in sub-acions i), ii), iii)
DOHI-Iceland	2	Participating with low contribution in sub-acions i), ii), iii)

Two tools

- Risk assessment tool – identifying risk profiles

- Risk-based projections
    - Predict future burden of risk factors
    - Policy planning
    - Resources allocation

Any specific requirements/needs for these tools?

Inputs

Risk assessment tool

- Use of cancer registry data

- Cancer Risk Assessment Tool

- designed for common cancers with high absolute risks and well-known risk factors
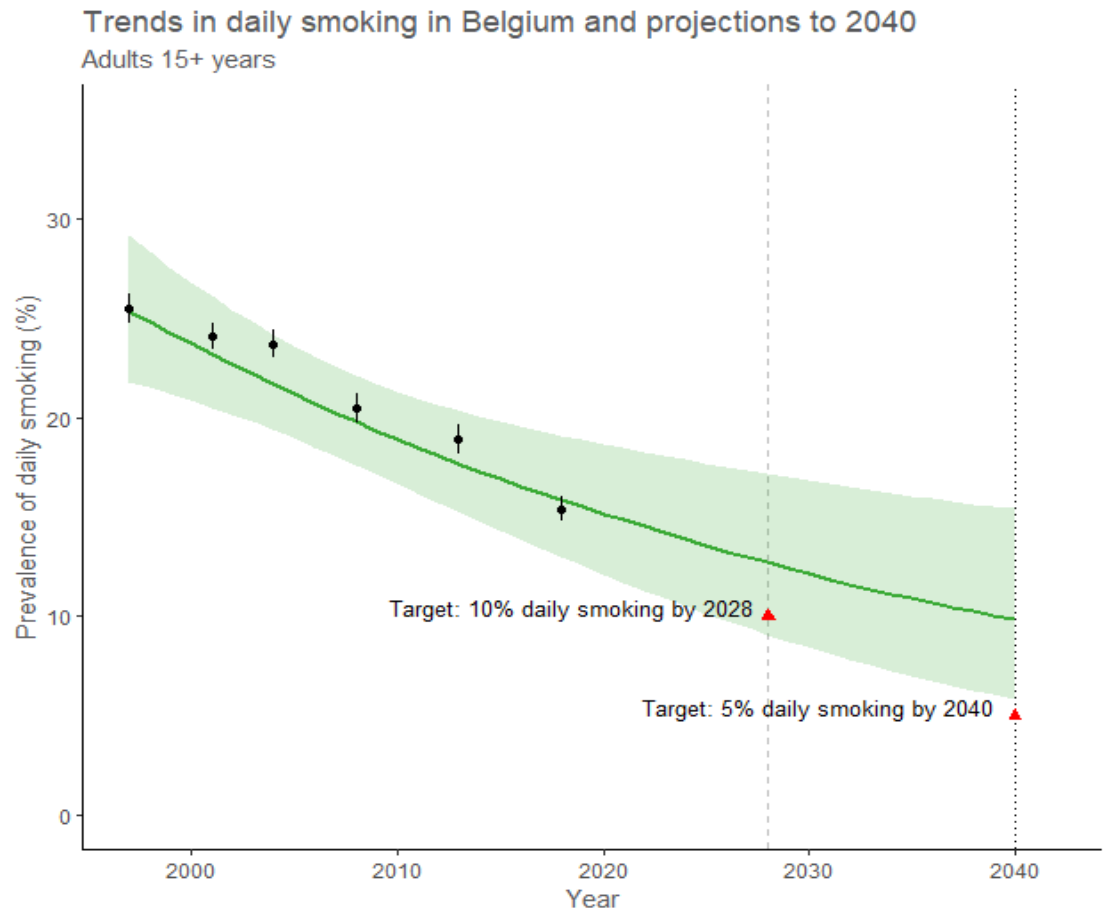
Risk-based projections

- Use of existing data on disease burden

- predefined set of risk factors

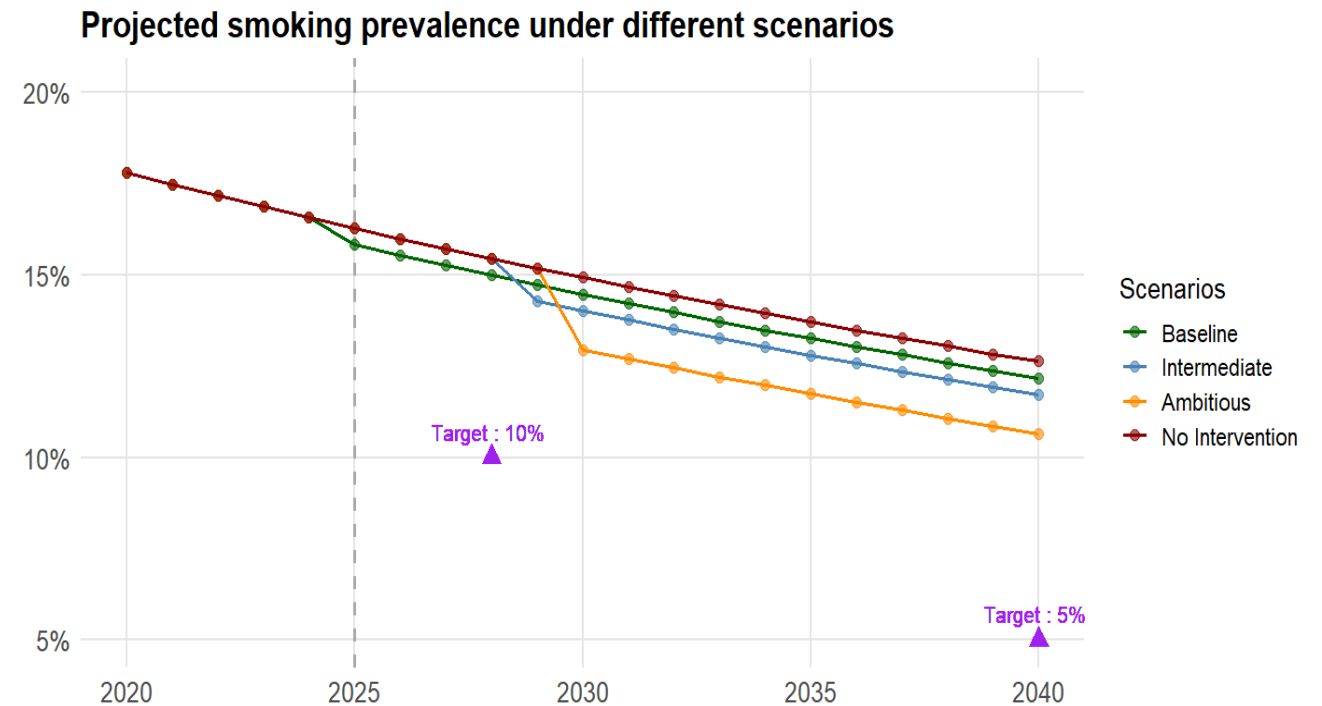- results compared against existing open-source tools

Example : Risk-based projections

- How will smoking prevalence evolve over time in Belgium?
  - HIS data : 1997-2018
  - Population projections
  - Bayesian inference model (nested Laplace approximation)

Trends in daily smoking in Belgium and projections to 2040
Adults 15+ years

Target: 10% daily smoking by 2028

Target: 5% daily smoking by 2040

Example : Risk-based projections

- How does smoking prevalence evolve over time in Belgium?
  - HIS data : 1997-2018
  - Population projections
  - Bayesian inference model (nested Laplace approximation)
- What is impact of policy?
  - Effect size
  - Scenarios
  - Targets

Projected smoking prevalence under different scenarios

Scenarios
- Baseline
- Intermediate
- Ambitious
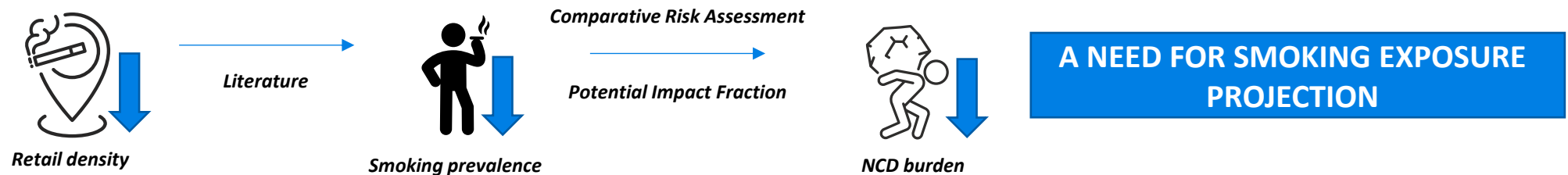- No Intervention

Target : 10%
Target : 5%

Example : Tobacco exposure projections

- Context
  - Health Impact Assessment (HIA)
    - Predicting impact of health intervention
    - How much burden can be averted due to policy?
  - Belgian 'tobacco plan'
  - Impact policy on smoking exposure

- Method : decrease in tobacco availability will lead to decrease in exposure

Retail density → Literature → Smoking prevalence → Comparative Risk Assessment / Potential Impact Fraction → NCD burden → A NEED FOR SMOKING EXPOSURE PROJECTION

Example : Comparative Risk Assesment

- Population Impact Fraction (PIF) → %
  - Percentage of the burden of a disease that could be avoided with the implementation of a policy targeting the exposure

- Avoidable burden
  - Disease burden that could be prevented with the implementation of policy

Tobacco Exposure

Relative Risk

$$\text{Burden} \quad X \quad \text{PIF} \quad = \quad \frac{\int_{x=0}^{n} P(x)RR(x)dx - P'(x)RR(x)dx}{\int_{x=0}^{n} P(x)RR(x)dx}$$

= **Avoidable Burden**

Pilot 8.3.b Deliverables and milestones

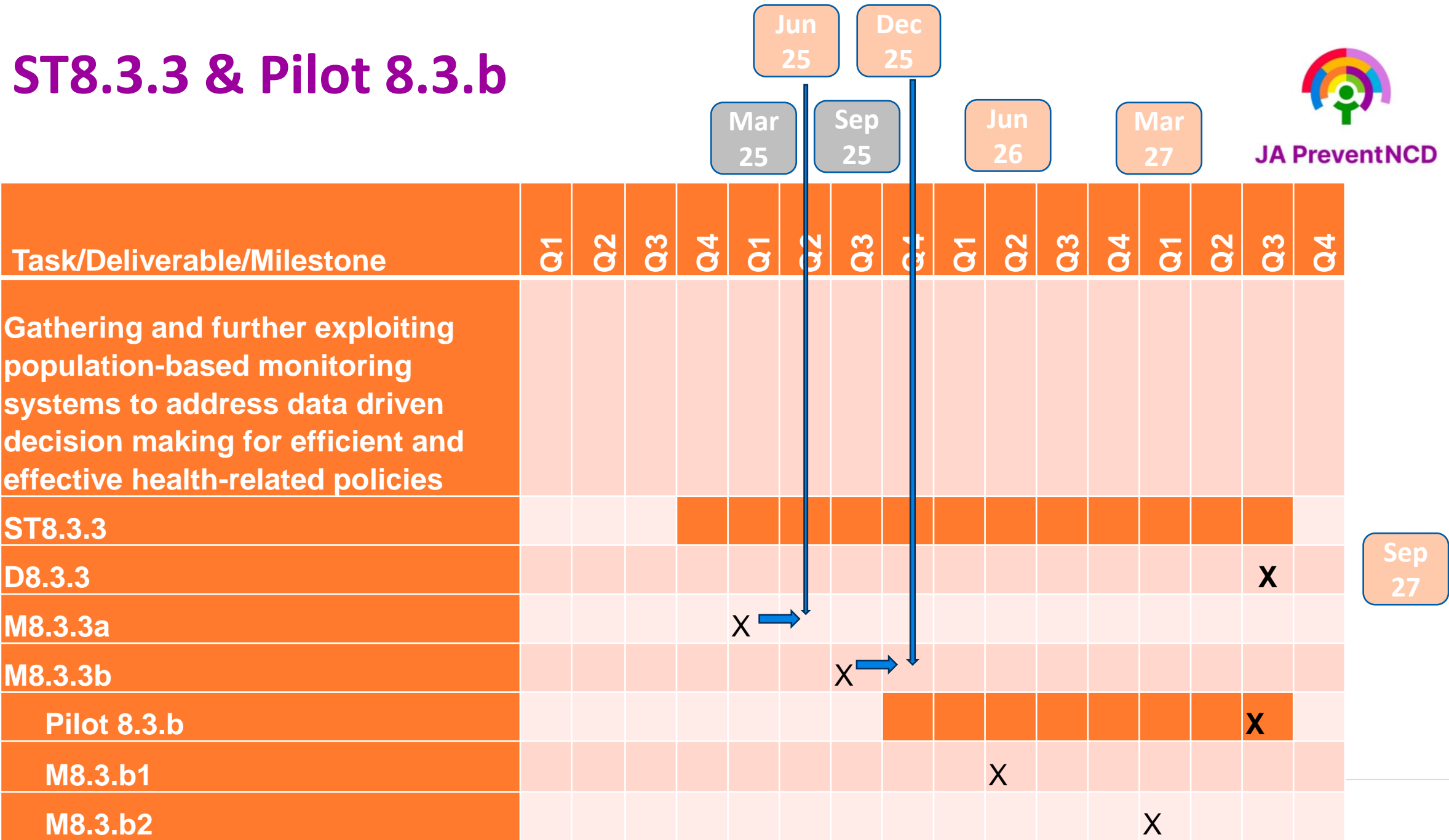| D8.3.3	**Report on risk assessment and risk-based projection for cancer and other NCDs and results from the piloting action**	**M45**
M8.3.b1	Procedure of the pilot study conducted, and data collection started	M30
M8.3.b2	Data collection terminated, preparation of result elaboration	M39

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Joint Action Prevent Non-Communicable Diseases

Thank you all for your commitment!
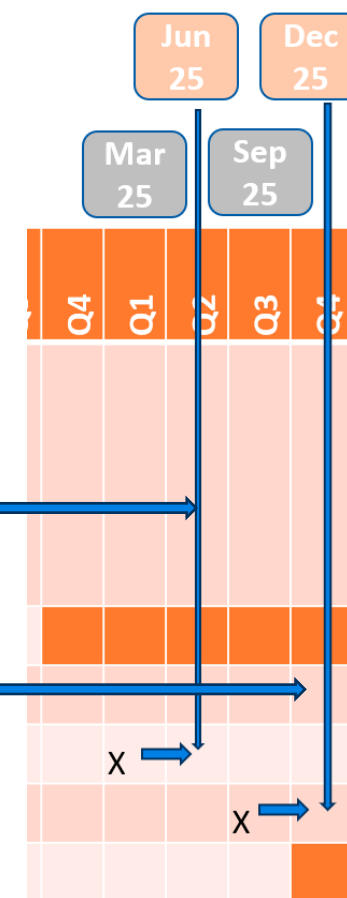
Co-funded by
The European Union

Afternoon session

13:45-14:45	Session III: Operational Working Procedures	WP8 and task leaders
13:45-14:15	Task 8.3 and Task 8.4: due timelines for effort, milestones, deliverables	Task leaders
14:15-14:45	Overall Recap and take-home messages	All Participants

What's next

CHALLENGE/RISK	ACTION
Several Partners	Known country working groups
Rigid scheduling	Flexible and shared working flows/methods T8.3
Crowded calendar	In T8.3 one virtual meeting every two months, sending a Doodle at least one month before

Overlapping	Ideas for T8.3 appointments as updating, ST8.3.1 and ST8.3.3:
	- December 2024
	- February 2025
	- April 2025
	- **June 2025 (two internal milestones)**
	- August-September 2025
	- October 2025
	- **December 2025 (two internal milestones)**
	   - Two **pilots** start
	   - Possible **joint meeting** with T8.4 (t_1) and anolther December 2026 (t_2)