



## D3.1 Engagement through Learning methodology Report

**Deliverable Lead:** University of Maribor

**Deliverable due date:** 31 March 2026

**Actual submission date:** 31 March 2026

**Version:** v1.0



Funded by  
the European Union

This project has received funding from the European Union's Horizon Europe Research and Innovation Programme under the call HORIZON-WIDERA-2024-ERA-02 and the Grant Agreement No 101217136.

| <b>Deliverable</b> D3.1 Engagement through Learning methodology Report |                                             |
|------------------------------------------------------------------------|---------------------------------------------|
| <b>Work Package(s)</b>                                                 | WP3                                         |
| <b>Task(s)</b>                                                         | T3.1                                        |
| <b>Dissemination Level</b>                                             | Public                                      |
| <b>Due Date</b>                                                        | 31 March 2026                               |
| <b>Actual Submission Date</b>                                          | 31 March 2026                               |
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| <b>Document History</b> |             |                    |                                              |                                    |
|-------------------------|-------------|--------------------|----------------------------------------------|------------------------------------|
| <b>Version</b>          | <b>Date</b> | <b>Description</b> | <b>Comments</b>                              | <b>Editor(s)</b>                   |
| <b>v0.1</b>             | 7. 1. 2026  | ToC                | Approved                                     | Izidor Mlakar (UMA)                |
| <b>v0.2</b>             | 25. 2. 2026 | Initial draft      | Updated ToC                                  | Tanja Zdolsek Draksler (UMA)       |
| <b>V0.3</b>             | 20. 3. 2026 | Final draft        | Prepared with contribution from all partners | Tanja Zdolsek Draksler (UMA)       |
| <b>V0.4</b>             | 24. 3. 2026 | Reviewed document  | Review report prepared separately; QA done   | Eleni-Vasiliki Provopoulou (INTRA) |
| <b>V1.0</b>             | 30. 3. 2026 | Final document     | Updated based on the review report and QA    | Tanja Zdolsek Draksler (INTRA)     |

## Executive Summary

This deliverable presents the work undertaken under **Work Package 3 (WP3): Knowledge Generation and Capacity Building**, with a specific focus on **Task 3.1 (T3.1): Engagement through Learning Methodology**. WP3 aims to identify gaps in existing knowledge, develop innovative research methodologies, and provide the resources necessary to strengthen the skills and competencies of all project participants.

Within this framework, T3.1 establishes the methodological foundation for subsequent activities under WP3. It is guided by two main objectives: first, to identify existing knowledge, methodologies, and best practices in wellbeing research and knowledge valorisation; and second, to analyse and integrate the project's methodological building blocks (MBBs) into a coherent and unified toolset. Following the first objective of identifying existing knowledge a three-level analysis was used:

- **state-of-the-art identification**: uncovering current state of the field, including successful approaches and established standards;
- **gap analysis**: identifying gaps, challenges, and opportunities within the existing literature to guide the project's research focus
- **best practice synthesis**: extracting evidence-based methodologies, frameworks, and strategies that work.

The outcomes of T3.1 are expected to inform the design of the capacity-building programme under T3.2 and support the implementation of training activities under T3.3. More broadly, the task contributes to the overall project by ensuring that activities are grounded in current best practices, responsive to stakeholder needs, and aligned with the ERA Policy Agenda on Knowledge Valorisation.

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## Abbreviations

| Abbreviations |                                                                                                               |
|---------------|---------------------------------------------------------------------------------------------------------------|
| AIM           | Acceptability of Intervention Measure                                                                         |
| CAM           | Complementary and integrative medicine                                                                        |
| CBPR          | Community based participatory research                                                                        |
| CFIR          | Consolidated Framework for Implementation Research                                                            |
| COM-B         | Capability, Opportunity, Motivation – Behaviour                                                               |
| CoP           | Communities of Practice                                                                                       |
| EIC           | European Innovation Council                                                                                   |
| ENoLL         | European Network of Living Labs                                                                               |
| ERA           | European Research Area                                                                                        |
| ERIC          | Expert Recommendations for Implementing Change (taxonomy)                                                     |
| EU            | European Union                                                                                                |
| FRAME         | Framework for Reporting Adaptations and Modifications-Enhanced                                                |
| GDP           | Gross Domestic Product                                                                                        |
| HiAP          | Health in All Policies                                                                                        |
| IAM           | Intervention Appropriateness Measure                                                                          |
| IP            | Intellectual Property                                                                                         |
| IRLM          | Implementation Research Logic Model                                                                           |
| KPI           | Key Performance Indicator                                                                                     |
| KTA           | Knowledge-to-Action framework                                                                                 |
| MBB           | Methodological Building Block                                                                                 |
| MEDSPACE      | MEDVIEW's digital collaboration environment (working name)                                                    |
| OECD          | Organisation for Economic Co-operation and Development                                                        |
| PARIHS        | Promoting Action on Research Implementation in Health Services (also i-PARIHS, where i stands for integrated) |
| QA            | Quality Assurance                                                                                             |
| PDSA          | Plan-Do-Study-Act                                                                                             |
| PPI           | Patient and Public Involvement                                                                                |
| PoC           | Proof of Concept                                                                                              |
| RIA           | Regulatory impact assessment                                                                                  |
| RE-AIM        | Reach, Effectiveness, Adoption, Implementation, and Maintenance                                               |
| QOL           | Quality of Life                                                                                               |
| QH            | Quadruple Helix                                                                                               |
| SOPs          | Standard operating procedures                                                                                 |
| SME           | Small and Medium-sized Enterprise                                                                             |
| SROI          | Social Return on Investment                                                                                   |
| VSD           | Value-Sensitive Design                                                                                        |

# 1. Introduction

This report constitutes **Deliverable D3.1: Engagement through Learning Methodology**. It describes the rationale, objectives, scope, work done and contribution of **Task 3.1 (T3.1)** within **WP3: Knowledge Generation and Capacity Building**.

WP3 addresses the need to strengthen knowledge generation processes and build capacities across the consortium and relevant stakeholder groups. In this context, T3.1 plays a foundational role by consolidating knowledge on existing research methodologies and best practices, and by integrating the project's methodological building blocks into a structured framework that can support subsequent tasks.

## 1.1 Purpose and scope

The purpose of T3.1 is to provide a robust methodological basis for the project's work on wellbeing research and knowledge valorisation. The task focuses on reviewing and systematizing existing knowledge, identifying methodological strengths and weaknesses in the field, and translating these insights into a coherent methodological toolset for project use.

The scope of T3.1 includes:

- mapping the current state of knowledge in wellbeing research and knowledge valorisation;
- identifying relevant methodologies, standards, and best practices;
- analysing gaps, challenges, and opportunities in the existing literature and practice;
- integrating the project's methodological building blocks into a unified and operational framework.

Through these activities, T3.1 ensures that the project is equipped with an evidence-based methodological foundation that supports both research and implementation.

## 1.2 Objectives

T3.1 is guided by the following objectives:

**Objective 1:** To identify and assess existing knowledge, methodologies, and best practices in the fields of wellbeing research and knowledge valorisation.

**Objective 2:** To analyse and integrate the project's methodological building blocks (MBBs) into a coherent methodological toolset that can be applied across project activities.

These objectives are designed to ensure both analytical depth and practical applicability, thereby linking knowledge review with methodological development.

## 1.3 Main Results and Expected Outputs

Task 3.1 delivers several key results that are essential for the implementation of WP3 and the project as a whole. First, it provides a structured overview of the **current state of the art** in the field, including successful approaches, recognised standards, and existing methodological practices relevant to wellbeing research and knowledge valorisation. Second, it identifies **gaps, challenges, and opportunities** within the

existing literature and practice. This analysis supports the refinement of the project's research direction and highlights areas where additional methodological innovation or stakeholder-oriented adaptation may be required. Third, T3.1 produces a **coherent methodological toolset** based on the integration of the project's methodological building blocks. This toolset serves as a practical reference framework for the design and implementation of subsequent project activities. Finally, the task helps define and guide the **project's research focus and capacity-building activities**, ensuring that these are informed by evidence and aligned with stakeholder needs. The outputs of T3.1 are intended to provide direct support to other tasks under WP3, which is in detail described in the following subchapters.

### 1.3.1 Contribution to T3.2 Design & Development of Capacity Building Programs

T3.1 provides the unified methodological toolset that constitutes the basis for the design of the **capacity-building programs** under T3.2. By establishing a common methodological framework, T3.1 ensures consistency and coherence in the development of the program content, structure, and delivery approach.

### 1.3.2 Contribution to T3.3 Implementation of Training and Capacity Building Activities

T3.1 also supports T3.3 by enabling the effective implementation of training activities. In particular, it contributes through:

- evidence-based engagement guidelines; and
- stakeholder needs assessment.

These elements help ensure that training activities are relevant, targeted, and responsive to the specific contexts and expectations of the intended participants.

## 1.4 Broader Project Impact

Beyond its immediate contribution to WP3, T3.1 has broader significance for the overall project. It establishes the methodological foundation for knowledge valorisation across all work packages, thereby promoting coherence and facilitating cross-work-package integration. In addition, it ensures that project activities are grounded in current best practices and remain responsive to identified stakeholder needs. This strengthens both the relevance and the potential uptake of project results. T3.1 also supports alignment with European policy priorities, in particular the ERA Policy Agenda Action 7 on Knowledge Valorisation, by embedding knowledge valorisation principles into the project's methodological framework from the outset.

## 2. Methodology

As a starting point, a methodological foundation was established, consisting of three steps:

- **Identifying** state-of-the-art approaches and best practices.
- **Detecting** gaps, challenges, and opportunities in existing literature.
- **Synthesizing** findings into a unified methodological framework for capacity building.

Building on this three-step foundation, we structured the literature review and subsequent analyses around eleven thematic domains (D01–D11), each reflecting a critical stage or enabling condition in the transformation of wellbeing research into practice. This domain structure ensured that the review did not focus solely on generating evidence, but also systematically addressed policy integration, knowledge

valorisation methodologies, evaluation and impact assessment, digital and IP-related enablers, and the translation of research into real-world settings. Dedicated domains on capacity building, stakeholder engagement, and co-creation and participatory design further aligned the methodology with contemporary European approaches to responsible, impact-oriented research and innovation. Finally, an explicit “Gaps & Opportunities” domain (D11) was included to synthesise cross-cutting insights and highlight areas where further methodological development and capacity building are needed. The 10 MEDViEW domains (plus the synthetic “Gaps & Opportunities” domain) mirror the main stages and enablers of transforming wellbeing research into real-world impact in current EU and international practice (European Commission, n.d.-a)

## 2.1 Overall logic for the domains

Recent EU guidance frames knowledge valorisation as a cycle: generating high-quality research, integrating it into policy, enabling uptake through platforms and IP management, co-creating solutions with stakeholders, and building capacity to sustain impact. MEDViEW’s domains D01–D10 map systematically to these steps and to cross-cutting enablers (stakeholder engagement, co-creation, capacity building, evaluation), while D11 ensures explicit identification of gaps and future opportunities (European Commission, n.d.-a; European Commission. Directorate General for Research and Innovation., 2024). Domain-by-domain justification is presented in Table 1.

*Table 1: Domain-by-domain justification*

| Domain                                   | Why it is needed in the framework                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| D01 Wellbeing Research                   | A dedicated domain on wellbeing research is essential because robust, context-sensitive evidence on determinants of wellbeing, inequalities and effective interventions underpins all later valorisation steps. Reviews of co-created public health and community-based health services show that problem definition and outcome selection grounded in wellbeing concepts strongly influence the success and sustainability of interventions. |
| D02 Policy Integration                   | EU knowledge valorisation policy explicitly highlights the need to use research results for designing and implementing public policies and standards, not just for commercial outputs. Without an explicit policy integration domain, evidence on wellbeing risks remaining fragmented, with limited influence on health, social, and regional policies.                                                                                      |
| D03 Knowledge Valorisation Methodologies | The EU Guiding Principles define knowledge valorisation as transforming research results into social and economic value through tailored methods, mechanisms and partnerships. A specific domain on valorisation methodologies allows MEDViEW to identify, compare and adapt tools such as living labs, industry–academia co-creation, citizen engagement models and intermediaries to wellbeing-focused use cases.                           |

| Domain                                | Why it is needed in the framework                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| D04 Evaluation & Impact Assessment    | Literature on co-created and participatory health research stresses that demonstrating impact (on wellbeing outcomes, equity, service quality or policy change) is critical for legitimacy, scaling and funding. Evaluation and impact assessment as a separate domain allows systematic treatment of indicators, methodologies and standards, aligning with EU calls to adopt common metrics and indicators for knowledge valorisation.                                                                      |
| D05 Digital Platform Enablement       | Many contemporary engagement and valorisation practices rely on digital platforms for data sharing, stakeholder interaction, co-creation processes and dissemination of research and innovation. EU reports on knowledge valorisation emphasise using digital infrastructures, networks and platforms to connect actors and scale practices across regions and sectors. A dedicated domain allows MEDViEW to examine usability, inclusiveness, data governance and their effects on engagement and wellbeing. |
| D06 IP Protection & Commercialization | Intellectual asset management and support for IP protection and commercialisation are explicitly identified as pillars of EU knowledge valorisation, complementing social and policy impacts. Including this domain ensures that MEDViEW addresses how wellbeing-related innovations (e.g., tools, digital services, interventions) can be protected, licensed and brought to market ethically and efficiently.                                                                                               |
| D07 Research-to-Practice Translation  | Numerous studies describe a persistent “research-implementation gap” in health and social care, where evidence-based interventions fail to reach practice or are poorly adapted to local contexts. A specific domain on research-to-practice translation allows analysis of implementation frameworks, intermediary roles and conditions for successful scaling of wellbeing interventions beyond pilot projects.                                                                                             |
| D08 Capacity Building Approaches      | EU guidance stresses that developing skills and competences for researchers, practitioners, policy-makers and citizens is indispensable for effective knowledge valorisation and co-creation. Public health co-creation literature similarly highlights training, facilitation skills and reflexive learning as prerequisites for meaningful participation and shared. This justifies a dedicated domain on capacity building, aligned with MEDViEW WP3’s focus.                                              |
| D09 Stakeholder Engagement Practices  | Stakeholder engagement is recognised as a core foundation of value co-creation and of impactful knowledge valorisation in multi-stakeholder settings. EU reports on citizen engagement for knowledge valorisation show that structured, inclusive engagement practices enhance relevance, legitimacy and uptake                                                                                                                                                                                               |

| Domain                                                                                                                                                       | Why it is needed in the framework                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                              | of research results. A separate domain allows MEDViEW to systematise methods for engaging communities, practitioners, policy-makers, industry and other actors in wellbeing research.                                                                                                                                                                                                                                                                                                                                                     |
| D10 Co-Creation & Participatory Design                                                                                                                       | Co-creation and participatory design are increasingly promoted in EU R&I policy as ways to align research and innovation with societal needs and values, particularly in health and wellbeing. Reviews of co-creation methods in public health show that participatory approaches can enhance emotional wellbeing, agency and satisfaction, and lead to more valid and contextually appropriate solutions. This domain focuses on concrete co-creation and participatory design tools, complementing broader engagement practices in D09. |
| D11 Gaps & Opportunities                                                                                                                                     | EU knowledge valorisation guidance encourages partnerships to identify unmet needs, knowledge gaps and opportunities for new approaches, including interdisciplinary collaboration and experimentation with co-creation. A dedicated domain on gaps and opportunities allows MEDViEW to synthesise cross-cutting findings from D01–D10, highlight under-researched areas (e.g., specific vulnerable groups, digital exclusion, long-term wellbeing impacts) and propose future methodological innovations and policy actions.             |
| Summarization made based on literature sources (Agnello et al., 2025; European Commission 2014; European Commission n.d.-a, n.d.-b; Greenhalgh et al., 2016) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

Taken together, D01–D10 correspond to the main components of a unified methodological toolset for “engagement through learning” in wellbeing research and knowledge valorisation: from knowledge generation (D01) and policy/valorisation mechanisms (D02–D04, D06–D07), through enabling infrastructures and capabilities (D05, D08), to participatory processes that ensure legitimacy and relevance (D09–D10). D11 then consolidates evidence from all domains to explicitly map remaining gaps, challenges and opportunities, providing a structured bridge between the state of the art and MEDViEW’s own methodological innovations.

The three stages and the domains are graphically presented in Figure 1. For facilitation of work, domains were further explained with specific thematic areas defined.

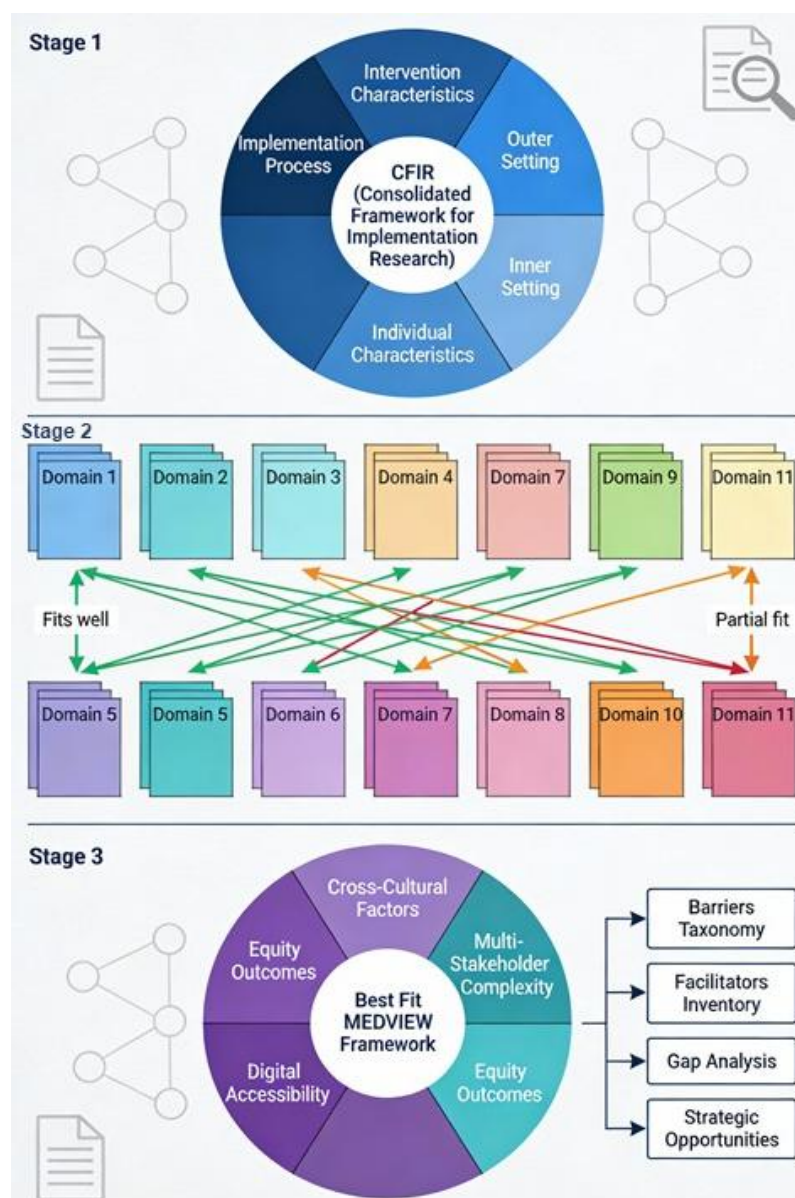


Figure 1: Methodology: identifying - detecting – synthesizing (AI generated)

Based on the expertise of partners, domains were mapped to partners and presented to them as a plan (Table 2).

Table 2: Domains per partners with thematic areas defined (plan from partner UMA)

| Partner | Domain 1                                                                                                                             | Domain 2                                                                                                   |
|---------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| MITERA  | <b>Wellbeing Research Domains:</b><br>Healthcare, psychology, economics perspectives; multidimensional health; post-COVID challenges | <b>Policy Integration:</b> Policy-research interfaces, regulatory frameworks, health policy implementation |

| Partner     | Domain 1                                                                                                                                           | Domain 2                                                                                                                 |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| KINNO/METIS | <b>Knowledge Valorisation Methodologies:</b> Action Learning, Communities of Practice, Value-Sensitive Design, Behavioural Change, Open Innovation | <b>Evaluation and Impact Assessment:</b> Valorisation metrics, capacity building evaluation, outcome measures, KPIs      |
| INTRA       | <b>Digital Platform Enablement:</b> Digital collaboration tools, online engagement platforms, hybrid delivery models                               | <b>IP Protection and Commercialization:</b> IP management, proof-of-concept support, SME uptake pathways                 |
| UM          | <b>Research-to-Practice Translation:</b> Knowledge transfer frameworks, implementation science, innovation diffusion                               | <b>Capacity Building Approaches:</b> Training methodologies, skill development, cross-sector collaboration, competencies |
| EUROCAM     | <b>Stakeholder Engagement Practices:</b> Citizen participation, multi-stakeholder co-creation, Quadruple Helix engagement                          | <b>Co-Creation and Participatory Design:</b> User-centered design, Living Lab implementations, participatory tools       |
| KINNO       | <b>Gaps and Opportunities:</b> Unmet needs, challenges in knowledge valorisation, barriers to engagement, innovation opportunities                 |                                                                                                                          |

Key flexibility note: domain leaders could customise this framework to match needs, expertise and context. This ensured guidance, not prescription, with integration maintained through regular progress meetings.

## 2.2 General methodology proposed from lead partner UMA to partners to perform

As only one project partner is an academia partner (WP3 leader and T3.1 lead: UMA), well experienced in scientific research and having scientific expertise, the next steps was to transfer knowledge to other partners to teach them how to perform (scientific) literature review. This was done with specific internal workshops/webinars and designing guided steps for partners. All partners were trained in the shared review approach and agreed the following process: define research questions and search strings; select databases; execute searches; conduct title/abstract screening; conduct full-text screening; perform data extraction and quality assessment; and synthesize findings into domain reports.

The search process was organized in 6 steps:

- ❑ **Step 1:** Define search string combinations and database selection.
- ❑ **Step 2:** Execute searches across primary databases with detailed documentation.
- ❑ **Step 3:** Apply initial title/abstract screening with inclusion/exclusion criteria.
- ❑ **Step 4:** Retrieve full texts and conduct detailed screening.
- ❑ **Step 5:** Extract data and assess quality of included studies.
- ❑ **Step 6:** Synthesize findings and identify research gaps.

Detailed steps were presented to partners, which describe a standard and widely accepted process for conducting a literature review in scientific research, aligned with

best practices (steps 1-3 were performed by partner UMA, while other steps were taken from all partners with support of partner UMA):

1. Define the research question
2. Define inclusion and exclusion criteria
3. Develop the search string
4. Search databases
5. Remove duplicates
6. First screening (titles and abstracts)
7. Second screening (full texts)
8. Final list of included studies
9. Perform the grading of the literature and divide literature into groups: high, medium, low quality
10. Data extraction and synthesis

Moreover, key challenges and mitigation strategies were taken into account (Table 3).

*Table 3: Key challenges defined & mitigation strategies*

| Challenge                                                            | Mitigation                                                                                                                       |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| <b>Volume of literature</b><br>across domains                        | Narrow focus to specific inclusion criteria; use structured screening; consider domain-specific expertise                        |
| <b>Language diversity</b><br>(need translations)                     | Use team language resources; prioritize English; note where translation needed; consider machine translation tools               |
| <b>Gray literature access</b><br>(policy docs, EU reports)           | Contact EC directly; use official government sites; leverage partner networks                                                    |
| <b>Quality heterogeneity</b><br>(different rigor across domains)     | Develop domain-specific quality assessment tools; transparent reporting; leverage domain expertise to adjust criteria            |
| <b>Time pressure</b>                                                 | Launch searches immediately; distribute workload; weekly progress check-ins; domain leaders can adapt timeline if justified      |
| <b>Integration complexity</b><br>(11 domains + synthesis)            | Clear framework for synthesis; regular partner coordination; cross-domain workshops; domain leaders customize approach as needed |
| <b>Domain customization</b><br>(balancing guidance with flexibility) | Encourage domain leaders to adapt framework to context; share modifications in progress meetings; maintain integration alignment |

The timeline of activities was spanning from November 2025 till March 2026, as follows:

- 18 November 2025: Presentation from partner UMA of the overall plan at the project meeting.
- 16 December 2025: Internal workshop (UMA) on literature review; search aims, research questions, inclusion/exclusion criteria and search strings prepared for all domains and presented to partners.
- 23 December 2025: Initial deadline for partners to finalise/update the outline (research questions, search strings, inclusion/exclusion criteria), launch initial

searches (at least 3–4 databases per domain), and start screening; deadline later extended to January.

- 12 January 2026: Internal webinar “Where are we? Data Extraction & Evidence Synthesis”.
- 16 January 2026: Initial deadline for  $\geq 50\%$  of screening completed, data extraction commenced.
- 31 January 2026: Initial deadline for full-text screening, quality assessment and synthesis completed (deadline extended to Feb 17).
- 12 February 2026: Internal webinar providing an overview and status update of literature review activities.
- 17 February 2026: Final deadline for partners to submit the final list of scientific literature for all domains.
- 25 February 2026: Final deadline for partners to complete data extraction and submit domain summaries.

For each domain, partner UMA defined specific aims, expected outcomes and research questions, accompanied with search keywords, inclusion criteria and content focus, to ease the process for the involved partners. Details are presented in Annex A, C and D.

Furthermore, for coordinated work, a shared document (Excel) was prepared, serving as a data extraction template with instructions (consisting of an overview, how to use the template-step by step guide, key features and quality appraisal). An overview is showed in Figure 2.

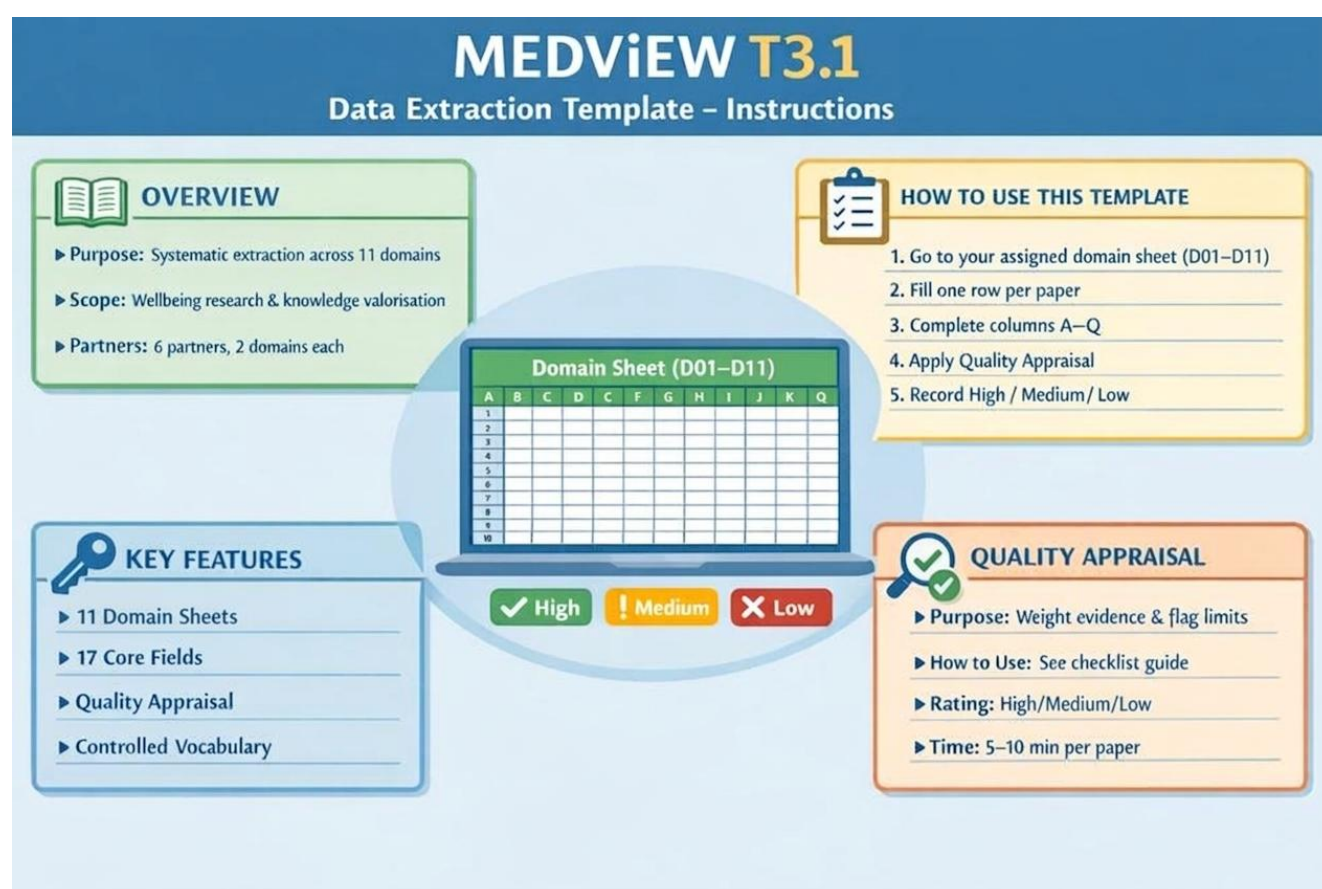


Figure 2: Overview of the Data extraction template (AI generated)

A list of databases for literature search was also provided, roughly outlined in Table 4.

*Table 4: Databases for literature search*

|                                                                  |                                                                                                                                                      |
|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Scholarly databases</b>                                       | Scopus                                                                                                                                               |
|                                                                  | Web of Science                                                                                                                                       |
|                                                                  | PubMed/MEDLINE                                                                                                                                       |
| <b>Domain-specific additions (pick based on specific domain)</b> | PsycINFO for mental health / behavioural science.                                                                                                    |
|                                                                  | CINAHL for nursing, allied health, and practice-oriented evidence.                                                                                   |
|                                                                  | Cochrane Library for systematic reviews and evidence syntheses.                                                                                      |
|                                                                  | Implementation Science Journal                                                                                                                       |
| <b>Policy, EU, and grey literature</b>                           | Publications Office of the European Union (op.europa.eu) to retrieve EU publications and institutional outputs.                                      |
|                                                                  | CORDIS to identify outputs and results from EU-funded projects.                                                                                      |
|                                                                  | WHO IRIS for WHO/WHO-Europe reports and policy-relevant evidence.                                                                                    |
|                                                                  | OpenAIRE/ Zenodo as supplementary sources; capture EU project communities, EU reports, white papers, project deliverables, and non-journal evidence. |
| <b>Other</b>                                                     | Google Scholar as a supplementary source.                                                                                                            |

### 3. Literature Review Results

This chapter involves a report on the conducted literature review and synthesizes the review into summaries per specific domain area. Table 5 presents an overview of work done, highlighting the final number of literatures per domain, with the quality appraisal (high, medium or low-quality literature in numbers).

*Table 5: Literature review results – quantitative overview*

| Domain                                   | Partner in charge | Volume of literature used | Quality of literature |        |     |
|------------------------------------------|-------------------|---------------------------|-----------------------|--------|-----|
|                                          |                   |                           | High                  | Medium | Low |
| D01_Wellbeing Research                   | MITERA            | 21                        | 21                    | 0      | 0   |
| D02_Policy integration                   | MITERA            | 53                        | 45                    | 6      | 2   |
| D03_Knowledge Valorisation Methodologies | KINNO             | 18                        | 10                    | 8      | 0   |
| D04_Evaluation & Impact Assessment       | METIS             | 26                        | 20                    | 6      | 0   |
| D05_Digital Platform Enablement          | INTRA             | 11                        | 8                     | 3      | 0   |
| D06_IP Protection & Commercialization    | INTRA             | 6                         | 3                     | 1      | 2   |

| Domain                                 | Partner in charge | Volume of literature used | Quality of literature |        |     |
|----------------------------------------|-------------------|---------------------------|-----------------------|--------|-----|
|                                        |                   |                           | High                  | Medium | Low |
| D07_Research-to-Practice Translation   | UMA               | 942                       | 26                    | 182    | 734 |
| D08_Capacity Building Approaches       | UMA               | 197                       | 0                     | 24     | 173 |
| D09_Stakeholder Engagement Practices   | EUROCAM           | 138                       | 10                    | 128    | 0   |
| D10_Co-Creation & Participatory Design | EUROCAM           | 51                        | 40                    | 11     | 0   |
| D11_Gaps & Opportunities               | KINNO             | 4                         | 4                     | 0      | 0   |
| Total:                                 |                   | 1467                      | 187                   | 369    | 911 |

All literature review work was guided through the Data extraction template document mentioned in previous chapter and Figure 2. This document includes the whole list of the literature used in the literature review process, that is presented in a summative /quantitative way in Table 5. The document Data extraction template is an extensive file, that's why it is available upon request, and not directly included in the deliverable. To ease the process of summarization of literature review content, partners used different AI tools to generate a summary of literature review results. In the following text, each subchapter first presents in short, the methodology used, followed by the results presentation in a form of a literature review summary. As a note, due to different styles of narrative and format of the prepared summary per partner, partner UM tried to re-shape all of the contributions in a more uniform style.

### 3.1 Wellbeing Research Domains (MITERA)

**Methodology:** This literature review synthesizes multidisciplinary perspectives on wellbeing across healthcare, psychology, economics, and public policy, with emphasis on the post-COVID-19 period (2020–2025). The review addresses four research questions: (RQ1.1) conceptualizations of wellbeing across disciplines; (RQ1.2) documented impacts of COVID-19 across population groups; (RQ1.3) multidimensional wellbeing frameworks; and (RQ1.4) the integration of the One Health approach in contemporary research and governance. Sources include peer-reviewed articles, systematic and narrative reviews, WHO/EU policy documents, and European Observatory reports. Databases used: PubMed; Google Scholar.

#### Results:

**Conceptualising wellbeing across disciplines (RQ1.1):** Across healthcare, psychology and economics, wellbeing is increasingly conceptualised as a dynamic, adaptive and multidimensional construct, rather than merely the absence of disease. The literature converges around several shared elements: the capacity to adapt and self-manage in the face of physical, mental and social challenges; functional ability and participation in meaningful life roles; subjective quality of life and perceived wellbeing; and the influence of social, economic and environmental conditions. Healthcare and public health literatures build on the biopsychosocial model and on broad understandings of health, emphasising how physical and mental functioning, social relationships and environmental exposures together shape wellbeing.

Psychological research focuses on emotional wellbeing (positive affect, absence of distress), eudaimonic wellbeing (meaning, purpose, personal growth), resilience and coping. Economic and “beyond GDP (Gross Domestic Product)” work extends wellbeing to include income, employment security, housing, social protection and inequality, as well as environmental quality and sustainability, reflecting the shift toward wellbeing-oriented and wellbeing-economy frameworks. Recent work, particularly in European policy debates, increasingly frames wellbeing as a system-level outcome emerging from interactions between individuals, communities, institutions and ecosystems. This orientation underpins calls for wellbeing to be embedded in macro-governance and for health to be addressed in all policies rather than solely in the health sector. For MEDViEW, this convergence supports defining wellbeing as the dynamic capacity of individuals and communities to adapt, self-manage and thrive physically, mentally and socially within changing environmental and societal conditions.

**Wellbeing impacts of COVID-19 (RQ1.2):** The COVID-19 pandemic is widely recognised as a major inflection point in wellbeing research. Multiple reviews and empirical studies document substantial deterioration in mental health in the general population, including increased symptoms of anxiety, depression, psychological distress and loneliness, with some persistence of effects beyond the acute crisis. Healthcare workers experienced unprecedented levels of stress, burnout, moral injury and intention to leave, driven by workload, staffing shortages, exposure to death and perceived lack of support or recognition. Evidence consistently identifies youth and young adults as particularly vulnerable, owing to school closures, disrupted education and training, reduced social contact and uncertain labour market prospects. Gendered impacts are observed, with women more likely to bear additional unpaid care burdens, experience financial insecurity and show higher levels of distress. People with pre-existing mental or physical health conditions faced exacerbated risks due to disrupted services, delayed care and increased isolation. Studies emphasise that these impacts are patterned by structural inequalities: factors such as low income, precarious work, minority status and crowded or unsafe housing interact to amplify mental health risks. The notion of “permacrisis” has been used to describe the cumulative strain of overlapping crises (pandemic, cost-of-living, climate, geopolitical tensions) on wellbeing, highlighting the need for resilient systems that can buffer shocks. For MEDViEW, this evidence underscores the importance of focusing on mental health, vulnerable groups (including youth, women and people with chronic conditions), and workforce resilience as core elements of wellbeing.

**Multidimensional wellbeing frameworks (RQ1.3):** Contemporary frameworks increasingly conceptualise wellbeing as multidimensional, typically incorporating at least physical health, mental health and social wellbeing, and in some cases spiritual or existential dimensions. International and regional guidelines on wellbeing measurement emphasise that robust frameworks should capture material conditions (such as income, housing, employment), quality of life (health, education, social connections, personal security) and environmental aspects (air quality, green space, climate risks), while distinguishing between current and future wellbeing. There is a clear shift toward combining subjective and objective indicators, in line with broader “measuring what matters” agendas. European initiatives advocate for integrated indicator systems that support Health in All Policies and link health, social, economic and environmental data, moving beyond disease-specific metrics. Some frameworks

explicitly adopt resilience-oriented or systems-based perspectives, treating wellbeing as an emergent property of complex socio-ecological systems rather than an aggregation of individual scores. However, several gaps remain. While many conceptual frameworks integrate physical, mental and social dimensions, fewer provide validated, multidimensional measurement systems that are routinely used in policy and practice. Governance-related dimensions—such as institutional capacity, policy coherence and trust—are increasingly recognised as determinants of wellbeing but are not yet consistently operationalised in indicator sets. These gaps are directly relevant for MEDViEW's ambition to connect research, governance and citizen engagement.

**One Health and systemic integration (RQ1.4):** The One Health approach, understood as an integrated paradigm that aims to balance and optimise the health of people, animals and ecosystems, has gained prominence in the post-COVID-19 period and in connection with climate and biodiversity crises. Recent analyses emphasise that One Health governance requires multisectoral, transdisciplinary collaboration across human, animal and environmental health sectors, supported by integrated surveillance, interoperable data systems and cross-cutting policies. While early One Health work focused mainly on zoonoses and food safety, more recent contributions underscore its relevance for broader wellbeing and planetary health. Evidence highlights that environmental conditions (air quality, climate-related events, biodiversity loss, access to green and blue spaces) are tightly linked to mental and physical wellbeing, and that policies in agriculture, transport, urban planning and energy can have profound, often indirect, impacts on health. This has led to stronger calls for One Health principles to be embedded into strategies on climate, environment and sustainable development. Citizen and stakeholder engagement are recognised as critical for operationalising One Health, especially in managing trade-offs and ensuring legitimacy of cross-sector decisions. Deliberative and participatory processes are recommended to negotiate values, address ethical questions and co-design interventions that affect communities and ecosystems. For MEDViEW, this supports linking wellbeing research to environmental determinants, One Health governance and participatory engagement methods.

**Gaps, challenges and implications for MEDViEW:** Across the reviewed literature, several gaps and challenges are evident. First, research remains fragmented across medical, psychological, economic and environmental traditions, with relatively few truly interdisciplinary studies that integrate data and methods across these domains. Second, while multidimensional wellbeing frameworks are conceptually well-developed, operational integration—through robust, routinely used indicator sets that span sectors—remains limited. Third, governance metrics capturing policy integration, institutional capacity, participation and trust are underdeveloped despite their recognised importance for wellbeing outcomes and One Health governance. Fourth, longitudinal and intersectional analyses of vulnerable populations, particularly those facing overlapping inequalities, are still comparatively scarce. For MEDViEW, the Domain 1 findings provide a conceptual anchor for the project's engagement and capacity-building activities. The evidence base justifies four engagement priorities: (1) mental health, given the documented and unequal psychological impacts of COVID-19 and other crises; (2) metabolic and chronic disease challenges, including cancer and diabetes, which remain major determinants of quality of life; (3) environmental determinants of health, aligned with One Health and planetary wellbeing agendas; and

(4) institutional and governance resilience, reflecting the need for systems capable of embedding wellbeing in policy and managing “permacrisis” conditions.

Taken together, the literature shows a clear evolution toward systemic, multidisciplinary and policy-integrated models of wellbeing. Wellbeing is now widely understood as multidimensional, adaptive and socially embedded, with strong arguments for integrated measurement, cross-sector collaboration and governance mechanisms that place wellbeing at the core of health and public policy systems.

### 3.2 Policy Integration (MITERA)

**Methodology:** Domain 2 examined how research on health and wellbeing is integrated into European policymaking and governance, in order to inform MEDViEW’s approach to policy-relevant knowledge valorisation. Four research questions guided the review: RQ2.1 (mechanisms and interfaces that connect research evidence with policy development and implementation in health and wellbeing); RQ2.2 (how regulatory frameworks across EU Member States facilitate or create barriers to knowledge valorisation in healthcare); RQ2.3 (models that successfully implement HiAP (*Health in All Policies*) and integrate wellbeing across policy domains); and RQ2.4 (ways to engage policymakers effectively in co-creation with researchers, citizens and industry for policy-relevant valorisation). Google Scholar was the main database where the search has been conducted.

#### **Results:**

**Mechanisms connecting research evidence to policy (RQ2.1):** The literature identifies several structured interfaces that facilitate the uptake of research into health and wellbeing policymaking. A first group are institutionalised knowledge translation platforms, including national and regional mechanisms that support the preparation of evidence briefs for policy, organisation of policy dialogues, rapid response syntheses and capacity-building for policymakers. These platforms embed standardised evidence-to-policy processes within ministries and public administrations and help stabilise the research–policy interface over time. A second group of mechanisms are evidence advisory systems and scientific committees. These include formal advisory bodies, regulatory impact assessment systems and structured science–policy interfaces that provide procedural routes for evidence input into legislative or regulatory decisions. By clarifying mandates, transparency rules and consultation procedures, they contribute to the legitimacy and predictability of evidence use in policymaking. A third type of interface consists of monitoring and indicator frameworks that measure the degree of evidence-informed policymaking capacity across institutions. Recent initiatives highlight benchmarking tools and institutional indicators (e.g. presence of evidence units, use of regulatory impact assessments, participation in knowledge networks) as a way to assess and strengthen policy integration. Across these mechanisms, common features of effectiveness include institutional anchoring, structured dialogue formats, attention to political feasibility and sustained capacity-building on both the research and policy sides.

**EU regulatory frameworks and knowledge valorisation (RQ2.2):** The EU regulatory and governance landscape both enables and constrains knowledge valorisation in health and wellbeing. On the enabling side, European Health Union initiatives strengthen cross-border coordination, crisis preparedness and joint action in public health, thereby creating demand for integrated evidence and cross-country comparison. The ERA Policy Agenda and innovation frameworks promote research

uptake and valorisation by supporting networks, mission-oriented approaches and open science practices. Regulatory impact assessment procedures, when systematically applied, institutionalise the expectation that policy proposals be informed by evidence and explicit consideration of impacts. EU funding instruments such as Horizon Europe and the Recovery and Resilience Facility provide financial and strategic incentives for Member States to develop evidence-based reforms. At the same time, several structural barriers persist. Administrative complexity and fragmentation across Member States, including differing legal traditions and governance structures, complicate harmonised implementation. Misalignment between research timelines and policy cycles, as well as variability in national implementation capacity and analytical resources, can impede timely use of evidence. Legal and governance constraints related to data protection, interoperability and digital infrastructure can limit data sharing and digital innovation, especially in cross-border contexts. Overall, regulatory frameworks tend to facilitate knowledge valorisation when they are accompanied by technical assistance, inter-ministerial coordination and clear accountability structures for implementation, rather than relying on formal rules alone.

**Health in All Policies and cross-sector governance (RQ2.3):** HiAP implementation models increasingly move from rhetorical commitments to more structured governance approaches. The literature describes intersectoral evaluation processes that embed health and wellbeing objectives into policies in non-health sectors, such as transport, housing, employment or environment. Whole-of-government strategies aligned with the Sustainable Development Goals provide an overarching frame for integrating health, social and environmental goals, while “Health for All Policies” and co-benefit framing emphasise that health gains often coincide with economic and ecological benefits. Governance tools used in this context include frameworks that assess transparency, accountability, participation, integrity and policy capacity, as well as diagnostic approaches that identify institutional strengths and weaknesses. Successful HiAP and cross-sector models share several features: high-level political commitment and clear mandates; cross-sector coordination mechanisms (e.g. interministerial committees, joint units, shared budgets); defined accountability and monitoring arrangements; and the integration of health and wellbeing metrics into standard policy planning and review cycles. Nonetheless, the literature stresses that siloed administrative structures and sector-specific incentive systems remain major obstacles. Maintaining intersectoral collaboration over time is challenging, especially when political priorities shift, resources are scarce or coordination is seen as an additional burden rather than a core governance function. HiAP practices often depend on a small group of champions and can be vulnerable to turnover or changes of government.

**Co-creation and multi-stakeholder engagement (RQ2.4):** Contemporary approaches to policy integration increasingly emphasise co-creation models involving policymakers, researchers, citizens, civil society and industry. Key mechanisms include structured policy dialogues that bring diverse stakeholders together around evidence briefs or scenario analyses; participatory evidence synthesis processes where stakeholders help formulate questions, interpret evidence and assess implications; co-production methodologies for designing and testing interventions; digital platforms that facilitate ongoing stakeholder input; and “living labs” or pilot policy environments that allow experimentation under controlled conditions.

These approaches can enhance the contextual relevance, legitimacy and acceptability of policies, particularly when dealing with complex wellbeing challenges that cut across sectors. Co-creation supports mutual understanding of constraints and opportunities on all sides and can generate more implementable and socially robust policy solutions. However, the literature also notes that co-creation requires skilled facilitation, sustained trust-building and clarity about roles and expectations to avoid tokenism or consultation fatigue. Empirical evidence suggests that co-creation has greatest impact when embedded within institutional routines and formal processes (e.g. regular advisory forums, participatory budgeting, standing multi-stakeholder committees), rather than as ad hoc or one-off projects.

**Gaps, challenges and implications for MEDViEW:** Across the reviewed materials, several research and governance gaps are visible. There is limited longitudinal evaluation of policy integration outcomes, making it difficult to determine which interfaces and governance models have the strongest and most durable impacts on health and wellbeing. Metrics for measuring institutional evidence-informed policymaking capacity are still underdeveloped and unevenly applied. Political economy analysis is insufficiently integrated into knowledge translation strategies, meaning that power, interests and incentives are not always explicitly considered. Digital governance readiness, including data infrastructure and analytical capacity, varies widely across Member States, creating asymmetries in the ability to participate in and benefit from EU-level initiatives. Structural challenges include policy fragmentation across sectors and levels of governance, resource and capacity asymmetries among Member States, the complexity of EU regulatory instruments and political volatility that can undermine continuity of integration efforts. At the same time, the post-COVID-19 period opens strategic opportunities: there is a stronger policy window for institutionalising resilience and evidence use, renewed momentum under the European Health Union for cross-border coordination, expansion of One Health and sustainability-oriented governance, and rapid advancements in digital governance and AI-supported decision systems. For MEDViEW, the Domain 2 findings support the development of a policy integration framework structured around four pillars: (1) institutionalised research–policy interfaces (knowledge translation platforms, advisory systems, indicator frameworks); (2) regulatory alignment and strengthened use of regulatory impact assessment; (3) HiAP-inspired governance models with clear cross-sector accountability; and (4) structured co-creation and stakeholder engagement mechanisms. Such a framework connects research production, knowledge translation, regulatory embedding, policy implementation and monitoring/feedback, and aligns with the broader evolution of EU health governance toward more structured, measurable and participatory models.

### 3.3 Knowledge Valorisation Methodologies (KINNO)

**Methodology:** Domain 3 examined methodological approaches that enable the systematic conversion of research evidence into practice, policy and societal benefit in health and wellbeing contexts. The domain was structured around four methodological building blocks (MBBs): (1) action learning and Communities of Practice; (2) value-sensitive design and ethical co-creation; (3) behavioural change theories and Living Lab methodologies; and (4) open innovation frameworks (including Open Innovation 2.0 and quadruple helix models). The specific aims were to: (1) review and synthesise the four MBBs that form MEDViEW’s methodological core; (2) identify integration strategies that combine these approaches into a unified, coherent

methodological toolset; and (3) document successful applications in health and wellbeing that demonstrate practical effectiveness and conditions for success. Expected outcomes included an integrated methodological framework synthesising all four MBBs with implementation pathways, evidence-based validation of each approach's contribution to knowledge valorisation, strategies to address complementarities between MBBs, and a compendium of best practices from health, wellbeing and related sectors.

Four research questions guided the review: RQ3.1 (how action learning approaches foster Communities of Practice in health and wellbeing and what conditions enable sustained engagement and osmosis); RQ3.2 (how value-sensitive design embeds ethical values such as fairness, transparency, inclusivity and sustainability into co-creation, and what outcomes are documented); RQ3.3 (which behavioural change theories and Living Lab methodologies effectively promote adoption of evidence-based wellbeing practices); and RQ3.4 (how Open Innovation 2.0 frameworks engage SMEs in health valorisation while addressing barriers such as costs, IP complexity and risk). Searches were conducted in Scopus, Web of Science, Google Scholar and the Publications Office of the European Union. Screening followed a narrative review logic; data extraction captured methodological features, application contexts, reported outcomes, and enablers and barriers relevant to each research question.

## **Results:**

**Action learning and Communities of Practice (RQ3.1):** Across the literature, action learning and Communities of Practice (CoPs) emerge as powerful vehicles for knowledge valorisation in health and wellbeing settings. Action learning approaches typically bring together small groups of practitioners, managers, community representatives and sometimes researchers to work on real problems in cycles of planning, action, reflection and learning. When these processes are sustained and structured, they frequently evolve into or deliberately form CoPs, where members regularly share experiences, tools and reflections, and gradually build a shared repertoire of practices. Reports describe several outcomes of these arrangements: enhanced capacity to apply evidence in context; increased confidence and motivation to implement changes; diffusion of tacit knowledge among participants; and small-scale but concrete practice changes in services, programs or local policies. CoPs also function as “social infrastructure” for valorisation, enabling knowledge to flow beyond the original research team through peer-to-peer exchange and mentoring. Conditions that enable sustained engagement and osmosis include clear purpose and shared focus, skilled facilitation, psychological safety, recognition and support from organisations, stable communication channels (often digital), and sufficient time and resources for participants to engage. Where these conditions are weak, CoPs risk becoming information-sharing forums without deeper learning or implementation. In sum, the evidence suggests that action learning CoPs can effectively translate research into practice when they are problem-focused, participatory, supported by leadership and connected to organisational decision-making processes. They provide a methodological backbone for continuous, practice-based valorisation within MEDVIEW.

**Value-Sensitive Design and ethical co-creation (RQ3.2):** Value-sensitive design (VSD) and related ethical co-design approaches are increasingly applied in health, digital health and AI-enabled care. These methodologies explicitly foreground human

values—such as fairness, justice, autonomy, inclusion, privacy, transparency, accessibility, equity and sustainability—throughout the design and implementation lifecycle. In practice, VSD typically combines conceptual analysis of relevant values, empirical engagement with affected stakeholders and technical design work that embeds value considerations into features, interfaces and workflows. Applications in health and wellbeing include the design of digital tools, AI decision-support systems, care robots, patient portals and public health platforms. Documented outcomes point to several benefits: improved alignment between technological solutions and users' needs and constraints; increased trust and acceptance; better anticipation of ethical risks and harms; and design features that promote accessibility, safety and fairness. VSD-inspired methods also help surface value tensions (for example, between efficiency and equity, or privacy and data-driven innovation) and provide structured processes for negotiating trade-offs transparently. At the same time, challenges are reported. These include the complexity of balancing plural and sometimes conflicting values, the need for sustained stakeholder engagement, and the risk of treating values as checklists rather than as ongoing, contested issues. Nevertheless, the literature indicates that when thoughtfully applied, value-sensitive and participatory design approaches can embed ethical considerations into co-creation and thereby support socially robust knowledge valorisation. For MEDViEW, VSD provides a methodological lens for ensuring that co-created interventions and tools reflect fairness, transparency, inclusivity and sustainability.

**Behavioural change theories and Living Lab methodologies (RQ3.3):** Behavioural change theories provide the conceptual underpinnings for many health promotion, prevention and self-management interventions, and are central to the design of effective wellbeing strategies. The reviewed literature stresses that interventions grounded in explicit theories—such as health behaviour models, self-determination theory, social cognitive theory, a behaviour change model COM-B (Capability, Opportunity, Motivation – Behaviour) and related frameworks—are better able to specify mechanisms of action, target specific determinants (e.g., capability, opportunity, motivation) and guide measurement. Theory-based programmes in areas such as physical activity, diet, mental health and adherence show improved clarity about intervention components and more systematic evaluation of outcomes. Living Lab methodologies complement behavioural theories by offering real-world, user-centred environments where innovations can be co-designed, tested and iteratively refined with end-users and other stakeholders. In health and wellbeing, Living Labs often operate as open innovation ecosystems involving citizens, patients, clinicians, researchers, SMEs and public authorities. They support co-creation of solutions in real-life contexts (homes, communities, services), rapid prototyping and feedback, and multi-stakeholder evaluation of feasibility, usability and impact. The literature indicates that combining behavioural change frameworks with Living Lab methodologies can be particularly effective: theory guides what should change and why, while Living Labs provide the context and processes for how change can be implemented, adapted and scaled. Documented benefits include higher user engagement, better fit with local practices and constraints, and more robust evidence on implementation barriers and facilitators. However, Living Labs require significant coordination, governance and resources, and their effectiveness depends on sustained participation and clear value propositions for all partners. For MEDViEW, this combined approach offers a structured path from behavioural insight to co-created, real-world adoption of wellbeing practices.

**Open Innovation 2.0 and SME engagement (RQ3.4):** Open Innovation 2.0 (OI2.0) frameworks and quadruple helix models extend traditional innovation paradigms by emphasising co-creation among four main actor groups: government, academia, industry (including SMEs) and citizens/civil society. In health and wellbeing contexts, these frameworks are applied to create innovation ecosystems where SMEs collaborate with research institutions, health services, policy bodies and user communities to develop and scale solutions. The literature highlights several mechanisms through which OI2.0 frameworks engage SMEs in health valorisation: Living Labs and testbeds that lower entry barriers for SMEs to trial innovations in real-world settings; co-creation workshops and design sprints with end-users and clinicians; innovation hubs and accelerators linked to universities and hospitals; and digital platforms that connect SMEs to data, expertise and networks. These environments can help address common SME barriers such as limited resources, uncertainty about regulatory and IP issues, and lack of access to clinical partners or end-user feedback. However, challenges remain. SMEs often face high transaction costs in participating in complex multi-stakeholder initiatives, and may struggle with legal and IP arrangements, data governance requirements and differing timelines between innovation and procurement cycles. Effective OI2.0 ecosystems therefore rely on clear governance, supportive regulatory and funding frameworks, transparent IP and data-sharing models, and intermediary organisations that broker relationships and build trust. For MEDVIEW, open innovation approaches provide a way to systematically involve SMEs in knowledge valorisation while explicitly addressing costs, risk and IP complexity.

**Cross-cutting insights and implications for MEDVIEW:** Taken together, the Domain 3 findings show that knowledge valorisation in healthcare and wellbeing is inherently multi-method and relational. Action learning and Communities of Practice provide ongoing, practice-based structures for implementing and adapting research findings. Value-sensitive design ensures that ethical and social values are embedded into co-created solutions. Behavioural change theories and Living Lab methodologies combine to design, test and refine interventions that are both theoretically grounded and context-appropriate. Open Innovation 2.0 frameworks, finally, extend the innovation space by integrating SMEs and broader quadruple-helix actors into co-creation and scaling processes. For MEDVIEW, this evidence supports the development of an integrated methodological framework that: (1) uses action learning CoPs as a core engine for engagement and iterative learning; (2) applies value-sensitive and participatory design to safeguard fairness, transparency, inclusivity and sustainability; (3) anchors interventions in behavioural theory and tests them in Living Lab-type environments; and (4) situates these activities within open innovation ecosystems that actively involve SMEs and other stakeholders. Such a framework can help bridge the evidence–practice gap and guide the design of MEDVIEW’s methodological toolset and capacity-building activities.

### 3.4 Evaluation and Impact Assessment (METIS)

**Methodology:** Domain 4 examined how knowledge valorisation and capacity building can be measured across social, economic and scientific dimensions in health and wellbeing contexts. The domain was structured around four main themes: valorisation metrics, capacity-building evaluation, outcome measures and key performance indicators (KPIs). The specific aims were to synthesise state-of-the-art frameworks for

measuring knowledge valorisation, analyse European Commission (EC) evaluation approaches aligned with Horizon Europe and the ERA Policy Agenda, map KPIs and metrics for capacity-building effectiveness across heterogeneous stakeholders, and identify social and economic value-creation mechanisms such as societal wellbeing, health equity, SME innovation, cost-effectiveness and return on investment (ROI). Six research questions guided the work: RQ4.1 (which evaluation frameworks integrate multiple impact dimensions – social, economic, scientific), RQ4.2 (how EC frameworks define valorisation success and which KPIs they prioritise), RQ4.3 (how social impact can be measured, including health outcomes, equity, empowerment, behavioural change and quality of life), RQ4.4 (which indicators capture the value of citizen–researcher collaboration beyond traditional outputs), RQ4.5 (which frameworks assess cost-effectiveness of capacity building and knowledge translation), and RQ4.6 (which metrics capture knowledge transfer, skill development and sustained behaviour change). The search strategy used primary terms such as knowledge valorisation evaluation, valorisation metrics, impact assessment, evaluation frameworks, outcome measures, KPIs, performance indicators, evaluation methodologies and assessment tools. Secondary terms covered social impact assessment, social value creation and SROI, economic impact and ROI, cost-benefit analysis, wellbeing outcomes, health equity, citizen empowerment, healthcare cost savings and regional economic development. The review focused on 2015–2025 (Horizon 2020 onwards, with priority to 2020–2025). Included sources were peer-reviewed methodological papers, EC official documents, evaluation reports and case studies dealing with valorisation evaluation frameworks, social/economic/scientific impact metrics, capacity-building evaluation and EC evaluation criteria and indicators, with a primary focus on European research and innovation projects and health/wellbeing programmes. Searches were conducted in a broad set of scientific and institutional repositories, including general and disciplinary databases, EU publication platforms and open-access evidence repositories. The review proceeded in stages: initial searches, title/abstract screening, rapid full-text screening, compilation of a final list of articles and data extraction. In total, 26 scientific articles were identified as relevant. Data extraction focused on framework characteristics, impact dimensions covered, indicator sets and KPIs, treatment of capacity building and behaviour change, and documented strengths and gaps in current evaluation practices.

## **Results:**

**Multi-dimensional impact frameworks (RQ4.1):** The analysed literature shows a clear shift from narrow economic or bibliometric indicators (e.g. publications, citations, patents) toward multi-dimensional evaluation models that integrate social, economic, scientific, environmental and wellbeing dimensions. Key approaches include “meaningful metrics” frameworks that co-create context-sensitive social value indicators with stakeholders; constructivist societal impact analyses that conceptualise impact as co-produced rather than as a linear pipeline from research to society; quadruple-helix indicator sets that capture contributions from academia, industry, government and civil society; composite knowledge-transfer benchmarking tools for research organisations; triple-bottom-line approaches aligning social, economic and environmental impacts; and wellbeing-adjusted life years that use subjective wellbeing as a central outcome measure. These frameworks collectively underline that knowledge valorisation cannot be reduced to economic returns or academic prestige; instead, they emphasise relational, behavioural and wellbeing outcomes, the quality of partnerships and changes in systems. However, operationalisation is often

inconsistent. Different frameworks propose overlapping but non-identical indicator sets, and institutions frequently adapt or partially apply them, resulting in fragmented practice and limited comparability. There is broad conceptual agreement on the need for integrated, multi-dimensional impact assessment, but no fully harmonised composite dashboard that is routinely used across EU/OECD contexts.

**EC and policy-level definitions of valorisation success (RQ4.2):** Recent EC policy developments redefine knowledge valorisation as the process of transforming research results into social and economic value through effective stakeholder linkages and sustainable knowledge use. In this perspective, success is not only measured by commercial outputs, but also by contributions to societal challenges, public policies, open science and citizen engagement. Emerging KPI domains in EC and related policy documents include:

- Co-creation and citizen engagement (extent and quality of involvement of citizens and other non-academic stakeholders).
- Multi-actor and quadruple-helix participation (breadth and depth of collaboration across sectors).
- Knowledge-transfer outputs (spin-offs, licences, collaborative projects, data and tool sharing).
- Organisational capacity building (skills, structures and cultures that support valorisation).
- Societal uptake and behavioural change (use of research-based tools, services and practices).

While the policy framing is ambitious and conceptually sophisticated, it remains relatively open in operational terms. EC frameworks signal what should be valued but rarely prescribe a single harmonised KPI set. As a result, projects and institutions enjoy flexibility but also face uncertainty about which indicators best capture citizen–researcher collaboration, behavioural outcomes or long-term societal effects. The lack of standardised, measurable indicators for engagement and uptake is a recurring concern.

**Measuring social impact, wellbeing and equity (RQ4.3, RQ4.4):** Public health and social evaluation literatures provide a range of tools for measuring social impact. SROI approaches attempt to monetise social outcomes (e.g., improved wellbeing, reduced service use, increased employment) by assigning monetary values to changes identified with stakeholders. Their strengths lie in the inclusion of multiple stakeholder perspectives and the ability to frame impacts in terms that are legible to decision-makers. However, methodological heterogeneity, attribution challenges and limited standardisation make cross-study comparison difficult. Beyond SROI, behavioural and normative metrics (attitudes, compliance, social norms, exposure) and validated psychometric instruments are commonly used to capture changes in knowledge, attitudes and behaviours. Wellbeing-oriented measures, including wellbeing-adjusted life years and quality-of-life scales, foreground subjective experience and non-clinical outcomes, and are increasingly used in economic evaluation and policy analysis. Indicators that specifically capture the value of citizen–researcher collaboration are less well developed. Many studies and frameworks acknowledge the importance of citizen engagement, co-production and empowerment, but few provide concrete, operational indicators such as changes in citizens' perceived agency, capacity to influence decisions, or sustained involvement

in research and governance processes. Equity-sensitive disaggregation (by gender, age, socioeconomic status, region or minority status) is also underused, limiting the ability to assess distributional impacts.

**Evaluating capacity building, knowledge transfer and behaviour change (RQ4.5, RQ4.6):** The evaluation of capacity-building interventions and knowledge-transfer processes is identified as a relatively weak area in the literature. Current practice tends to focus on proximal outputs such as training participation, satisfaction and short-term skill gains. Some studies include validated skill or competency scales, and a subset examines motivational drivers, organisational barriers and network-level learning outcomes (e.g. new collaborations, communities of practice).

However, several gaps are evident:

- Few models explicitly assess the cost-effectiveness of capacity-building programmes, for example via cost-per-skilled-participant or cost-per-behavioural-change indicators.
- Longitudinal tracking of skill retention, application in practice and downstream societal impact is rare.
- Linkages between training activities and higher-level impacts (improved services, reduced inequities, better outcomes) are seldom quantified.
- Metrics capturing sustained behavioural change (rather than one-off changes) are underdeveloped.

The literature suggests that hybrid models combining cost metrics, validated skill and behaviour scales, knowledge-transfer outputs (e.g. implementation of new protocols, co-authored guidelines, new services), behavioural persistence indicators and SROI-type valuation could provide a stronger basis for evaluating capacity building and knowledge translation. Such models, however, are mostly proposed rather than fully tested.

**Conceptual risks and structural weaknesses:** Several authors highlight that evaluation systems are performative: the indicators chosen shape organisational behaviour and what is perceived as “success”. There are risks that long indicator chains obscure meaning, that performance pressure leads to gaming or superficial compliance, and that easily measurable outputs (e.g. counts of events or publications) crowd out less tangible but important outcomes such as empowerment, relational quality and trust. This underscores the need for reflexive evaluation design that is transparent about values and trade-offs. Across the evidence, three structural weaknesses stand out. First, there is a standardisation gap: multi-dimensional frameworks exist, but there is no harmonised composite dashboard that consistently integrates social, economic, scientific, behavioural and wellbeing indicators for benchmarking across institutions and countries. Second, there is a capacity-building measurement deficit: few evaluations rigorously link capacity-building activities to downstream societal outcomes, cost-effectiveness or sustained behavioural change. Third, there is a conceptual–operational disconnect: rich theoretical models (co-creation, systems thinking, performative evaluation) have not yet been systematically translated into implementable toolkits that organisations can adopt at scale.

**Implications and solutions for MEDVIEW:** For MEDVIEW, the Domain 4 findings point toward a hybrid, multi-dimensional evaluation framework that addresses these gaps. Such a framework could integrate:

- Co-created KPIs developed with stakeholders in different domains.
- A composite impact dashboard combining scientific, economic, social, wellbeing and network-level indicators.
- Behavioural persistence tracking (longitudinal surveys, implementation follow-up, retention scales).
- Cost-effectiveness modules for capacity-building activities (e.g. cost per skill gain, cost per behavioural change, “SROI-lite” monetisation).
- Equity-sensitive wellbeing metrics with disaggregated reporting by key social groups.
- Indicators capturing network-level valorisation (e.g. emergence and density of collaborations, cross-sector partnerships).

Embedding this evaluation architecture across the policy and project cycle—from agenda setting and design, through implementation and monitoring, to review and adaptation—would enable MEDVIEW to operationalise knowledge valorisation, demonstrate sustained societal and behavioural change and provide harmonised, policy-relevant evidence for European and international stakeholders.

### 3.5 Digital Platform Enablement (INTRA)

**Methodology:** Domain 5 examined how digital platforms can enable collaboration, engagement and knowledge valorisation in health and wellbeing, with a particular focus on MEDVIEW's collaboration platform MEDSPACE. The domain was structured around three core themes: (1) digital collaboration tools; (2) online engagement platforms; and (3) hybrid (online–offline) delivery models. The specific aims were to: (1) synthesise evidence on digital collaboration tools that effectively support multi-stakeholder engagement in health, research and innovation contexts; (2) analyse hybrid delivery models for their effects on accessibility, inclusion and sustained participation in the post-COVID-19 period; (3) identify platform features and functionalities that support knowledge co-creation, Communities of Practice and learning activities; and (4) map user-centred strategies for personalisation, accessibility and engagement quality assessment beyond simple usage metrics. Expected outcomes included design principles for digital platforms for knowledge valorisation in wellbeing; best-practice guidance for hybrid models addressing the digital divide, accessibility and cross-border collaboration; functional requirements for supporting all four methodological building blocks (Action Learning, Value-Sensitive Design, Behavioural Change, Open Innovation); and technology-enabled collaboration strategies to inform MEDSPACE design and user experience. Research questions were: RQ5.1 (which platform features support multi-stakeholder engagement across diverse user types such as citizens, researchers, SMEs, practitioners and policymakers); RQ5.2 (how hybrid delivery models enhance or limit accessibility, engagement quality and learning outcomes); RQ5.3 (which functionalities support knowledge co-creation, including ideation, discussion, prototyping and validation); RQ5.4 (how platforms can facilitate Communities of Practice that sustain engagement beyond initial enthusiasm); and RQ5.5 (which personalisation strategies deliver relevant content to heterogeneous user profiles).

The literature review, led by INTRA as the technical partner responsible for MEDSPACE, followed a structured multi-stage filtering methodology. An initial broad

exploratory search across major databases and repositories (including, for example, PubMed, arXiv, open-access journal directories, social science repositories and general scholarly search engines) using “digital platform enablement” and related concepts returned 4,290 publications, reflecting the breadth of research on digital platforms and ecosystem-based innovation. To increase thematic precision and align with MEDSPACE’s scope, a second round of searches introduced more targeted terms focusing on collaboration, engagement and participatory digital infrastructures, such as “digital collaboration tools”, “online engagement platforms”, “hybrid delivery models” and “remote stakeholder participation technologies”. This refinement reduced the pool to 31 scientific papers closely aligned with co-creation, stakeholder engagement and knowledge valorisation objectives. A final screening phase applied additional eligibility criteria to ensure methodological strength and contextual relevance: publication within the last five years; explicit focus on health-related digital platforms; and availability under open access. This yielded a curated set of 11 scientific papers, which formed the analytical basis for Domain 5 and the methodological grounding of MEDSPACE’s design and implementation strategy. For each paper, INTRA extracted information on implementation setting, stakeholder groups, main contributions, identified best practices and explicit relevance to MEDVIEW. A quality assessment framework rated methodological rigour, recency, scalability, governance maturity and alignment with valorisation objectives. A cross-comparative synthesis then benchmarked findings against the MEDSPACE design and implementation plan, identifying alignments, gaps and strategic improvement areas.

## **Results:**

**RQ5.1 – Platform features for multi-stakeholder engagement:** Across the 11 selected publications, effective digital platforms for health and wellbeing are designed as socio-technical systems that combine robust technical features with structured engagement processes for diverse users (citizens, patients, clinicians, researchers, SMEs, policymakers). Common engagement-enabling features include: role-based spaces and permissions (e.g. dedicated areas for professionals, citizens, project teams); interactive discussion and feedback tools (forums, comment threads, polls, Q&A boards); synchronous and asynchronous communication channels (webinars, chat, messaging, announcements); shared workspaces for documents, protocols and co-authored materials; and community-oriented functions such as profiles, group creation and notification systems. Platforms that provide clear value propositions and tailored interaction modes for each user group are more likely to sustain participation and collaboration.

**RQ5.2 – Hybrid delivery models, accessibility and engagement quality:** The reviewed literature highlights hybrid (online–offline) models as a post-COVID norm for engagement and learning. Effective hybrid arrangements deliberately combine in-person workshops, meetings or Living Lab sessions with online follow-up, asynchronous collaboration and digital communities. This integration can enhance accessibility (reducing travel barriers, accommodating caring responsibilities and geographical dispersion) and support continuity of engagement over time. However, hybrid models also introduce challenges: unequal access to devices and connectivity; differing digital skills; “Zoom fatigue”; and the risk that online components become passive content repositories rather than active collaboration spaces. Studies emphasise that engagement quality and learning outcomes improve when hybrid

models are intentionally designed (e.g. clear pre- and post-event tasks, structured online reflection, small-group breakouts, blended facilitation) and when accessibility and inclusion (language, time zones, assistive technologies) are explicitly addressed.

**RQ5.3 – Functionalities for knowledge co-creation:** Functionalities that specifically support knowledge co-creation include: structured ideation tools (idea boards, challenges, innovation funnels); collaborative editing and annotation of documents and resources; workflow tools for co-design and prototyping (templates, canvases, versioning); and mechanisms for validation and feedback (surveys, rating systems, user testing modules, comment tagging). Successful platforms also embed evaluation loops (e.g. logging contributions, tracking iterations, capturing user feedback) so that co-creation outputs can be refined and assessed over time. In health and wellbeing contexts, these functionalities are often linked to real-world problem statements and Living Lab activities, where digital tools support face-to-face or in-situ co-creation, rather than replacing it. Platforms that integrate evidence repositories (guidelines, research summaries) with co-creation spaces help users ground innovation in existing knowledge, which is central to knowledge valorisation.

**RQ5.4 – Facilitating Communities of Practice and sustained engagement:** The literature consistently shows that digital platforms can host and strengthen Communities of Practice, but only when certain design and governance conditions are met. Key ingredients include: clearly scoped thematic communities with shared goals; identifiable community leads or facilitators; regular rhythms of interaction (events, campaigns, discussion prompts); easy-to-use tools for sharing cases, questions and resources; and recognition mechanisms for contributions (badges, highlights, invitations to co-present or co-author). Without facilitation and structure, platforms risk becoming static repositories or diffuse “channels” with declining participation after initial enthusiasm. Long-term engagement is also supported by linking online communities to concrete projects, training activities or organisational processes (e.g. quality improvement initiatives), so that participation is embedded in daily practice rather than “extra” work.

**RQ5.5 – Personalisation strategies for heterogeneous user profiles:** Personalisation emerges as a key strategy for making digital platforms relevant to heterogeneous user groups. The reviewed studies describe several approaches: profiling and segmentation (user roles, interests, competencies) used to filter and recommend content; configurable dashboards that allow users to see relevant communities, resources and events at a glance; adaptive learning paths that adjust content and difficulty based on prior activity; and targeted notifications based on user preferences and behaviour. Some platforms experiment with conversational agents or guided wizards to help users navigate complex functionality or identify suitable opportunities (e.g. projects, training, collaborations). Importantly, personalisation is not limited to algorithmic recommendation; it also involves human-centred design choices such as clear language, multiple formats (text, video, infographics), multilingual support and accessibility features that accommodate diverse needs and contexts.

**Synthesis and implications for MEDSPACE:** Taken together, the Domain 5 findings indicate that MEDSPACE should: (1) offer role-sensitive engagement features and dedicated spaces for different stakeholder groups (RQ5.1); (2) be embedded in carefully designed hybrid engagement journeys that combine in-person and online

activities with a focus on accessibility and learning quality (RQ5.2); (3) prioritise co-creation functionalities that support ideation, collaborative work, prototyping and validation grounded in evidence (RQ5.3); (4) explicitly design for Communities of Practice with clear facilitation roles, interaction rhythms and links to MEDVIEW activities (RQ5.4); and (5) implement personalisation strategies—both technical and design-driven—to deliver relevant content and interactions to heterogeneous user profiles (RQ5.5).

### 3.6 IP Protection and Commercialization (INTRA)

**Methodology:** Domain 6 examined how intellectual property (IP) protection and commercialization can support knowledge valorisation in health and wellbeing, with a focus on academic–industry–citizen collaborations and SME uptake. The domain was structured around three themes: IP management, Proof-of-Concept (PoC) support and SME uptake pathways. The specific aims were to: (1) map IP management strategies that support knowledge valorisation in collaborative settings; (2) identify PoC support mechanisms and funding instruments for health research commercialisation; (3) synthesise “smart use of IP” practices aligned with the ERA Policy Agenda Code of Practice; and (4) document SME uptake pathways that address barriers such as IP complexity, costs, risk and knowledge gaps. Expected outcomes included an IP management framework for collaborative knowledge creation, best-practice- guidance on smart IP use aligned with EC rules, commercialisation roadmaps and funding opportunities for researchers and SMEs, practical guidelines for handling IP challenges in co-creation contexts, PoC support models and a directory of relevant European funding instruments. Research questions were: RQ6.1 (which IP management strategies balance intellectual asset protection with open knowledge sharing in collaborative research), RQ6.2 (how PoC support mechanisms bridge research outputs to market-ready wellbeing solutions), RQ6.3 (which funding instruments and financial pathways support researchers and SMEs in commercialising health innovations in Europe), RQ6.4 (which SME uptake pathways address barriers related to IP, costs, risk and awareness) and RQ6.5 (how “smart use of IP” manifests in practice, with successful examples).

As Exploitation Manager, INTRA led the Domain 6 review. The process followed a multistep screening methodology. An initial broad exploratory search across major databases and repositories (including health, social science and open access platforms) using general keywords on IP, commercialisation and technology transfer in health innovation returned approximately 37,000 publications, illustrating the scale of the IP and commercialisation literature. A second, more targeted search used project-relevant terms such as “intellectual property management”, “proof of concept support”, “funding instruments for researchers”, “SME uptake pathways” and “commercialisation guidelines”, reducing the pool to 119 papers focused on mechanisms that facilitate the transition from research outputs to market-ready or socially deployed solutions. In the final screening stage, stricter inclusion criteria were applied: publication within the last five years; clear focus on health or wellbeing ecosystems; and open-access availability to enable transparent use within the consortium. This resulted in a final curated selection of six scientific papers forming the evidence base for Domain 6. Each paper was analysed in terms of commercialisation setting, stakeholder focus (researchers, SMEs, technology transfer entities, public sector actors), principal contributions, transferable best practices and specific relevance to MEDVIEW’s exploitation framework. A quality assessment considered scientific robustness, governance reliability and consistency with

MEDViEW's knowledge valorisation and IPR objectives; scores and ratings were recorded in the project's QA template. Finally, a comparative synthesis aligned the consolidated insights with MEDViEW's exploitation roadmap (T5.3) and IPR management approach, identifying coherence, gaps, risks and enhancement opportunities.

## **Results:**

**RQ6.1 – IP management strategies in collaborative research:** Across the six publications, “effective exploitation” in wellbeing and digital health is described as a pipeline that begins early-well before a final product exists-and integrates structured capacity building, ecosystem partnerships and fit for purpose IP governance. IP management is framed not only as legal protection, but also as a strategic tool to enable collaboration, incentivise investment and support knowledge valorisation. The literature stresses the importance of:

- Early IP landscaping and freedom-to-operate analysis to avoid later conflicts.
- Clear agreements on background and foreground IP, ownership shares, licensing rights and revenue sharing among partners.
- Differentiated protection strategies (e.g. patents, copyrights, trade secrets, open licensing) tailored to the type of asset and intended valorisation pathway.
- Governance arrangements that clarify inventorship, decision-making processes, data rights and responsibilities in multipartner and data-intensive projects (including those using AI and digital tools).

In collaborative health innovation ecosystems, “balanced” IP strategies often combine protection of core assets with openness in other layers (e.g. open standards, open APIs, shared data models or toolkits) to foster uptake and ecosystem growth. The reviewed AI-biomedical IP landscape analyses highlight legal uncertainty around AI-generated outputs (e.g. inventorship, ownership and licensing of models and data) and recommend multistakeholder governance and stable contractual regimes to ensure predictable, shared benefits. Blockchain-based frameworks are proposed as one way to strengthen traceability, trust and security in IP transactions, though these remain emerging and exploratory. Overall, the evidence suggests that careful, transparent IP planning is essential to support both protection and collaboration.

**RQ6.2 – Proof of concept support mechanisms:** Evidence from PoC centres, particularly in life sciences, emphasises the value of timebound PoC funding combined with structured translational support. These centres provide small, targeted grants and expert guidance to move promising research outputs from early proof of concept to a stage where they are attractive to investors, partners or public adopters. Key components include:

- Access to technical and regulatory expertise (e.g. clinical, regulatory, quality).
- Support for prototype development, validation studies and early user testing.
- Business and market analysis to clarify value propositions and target segments.
- IP and commercialisation advice (e.g. patenting strategies, licensing options, spin-off creation).

PoC mechanisms are presented as particularly important in health and wellbeing, where development cycles are long, regulatory requirements are strict and perceived risk is high. They help derisk technologies, generate intermediate outcomes (e.g. prototypes, pilot data, early partnerships) and create a pipeline of more mature opportunities for further investment or adoption. The literature suggests that integrating PoC style maturation tracks into projects can substantially increase the

likelihood that research results progress beyond the “valley of death” between proof-of-concept and real-world deployment.

**RQ6.3 – Funding instruments and financial pathways in Europe:** The reviewed studies and policy analyses map a range of European and national funding instruments that support health innovation commercialisation. At EU level, these include schemes analogous to the European Innovation Council instruments, innovation actions and transition instruments under research framework programmes, as well as structural and regional funds that can be mobilised for health and digital innovation. National and regional programmes provide PoC grants, innovation vouchers, start-up acceleration funds and co-funding for public–private partnerships. For researchers, typical pathways involve progressing from research grants to PoC funding, followed by early-stage investment (seed, venture capital) or licensing and co-development agreements with industry or health providers. SMEs can access a combination of grants, loans, equity and innovation support services, but often face information and capacity gaps in navigating this landscape. The literature notes that funding instruments are most effective when coupled with advisory and brokerage services (e.g. technology transfer offices, innovation agencies, incubators) that help align projects with suitable schemes, prepare applications and coordinate consortia.

**RQ6.4 – SME uptake pathways and barriers:** SMEs are central actors in health innovation ecosystems but frequently encounter structural barriers to engaging with academic outputs and public systems. The analysed publications highlight recurring challenges:

- Complexity of IP and legal frameworks, including unclear ownership, licensing conditions and data-sharing rules.
- High transaction and compliance costs relative to SME resources.
- Risk perceptions and uncertainty about regulatory approval and reimbursement pathways.
- Limited access to evaluation settings and evidence generation opportunities in public healthcare systems.
- Misaligned incentives and slow decision-making within public organisations, making adoption difficult even when solutions are promising.

Successful SME uptake pathways often involve intermediaries such as Technology Transfer Centres (TTCs), innovation hubs or specialised accelerators that help translate research into SME-relevant outputs. These intermediaries provide industry liaison, practical business support, standardised processes for due diligence and licensing, and structured access to testbeds and pilot sites. Open-innovation experiences during the COVID-19 crisis reinforce that cross-boundary collaboration and flexible partnership models can accelerate solution development and scale-up, but only when supported by clear governance and coordinated orchestration.

**RQ6.5 – “Smart use of IP” in practice:** The ERA Policy Agenda’s emphasis on “smart use of IP” is reflected in practices that treat IP not as an end in itself but as a tool to maximise knowledge use, impact and fairness. In the reviewed literature, smart IP use includes:

- Strategic selection of protection levels (e.g. deciding when to patent, when to use open licences, when to keep trade secrets) based on expected impact pathways.
- Collaborative IP arrangements that enable joint ownership or shared access while defining clear rules for exploitation and revenue sharing.

- Licensing strategies that promote uptake in public health contexts, such as non-exclusive licences, tiered pricing, humanitarian clauses or socially responsible licensing models.
- Proactive management of data rights and access, especially in AI and digital health, balancing privacy, security and innovation potential.
- Integration of IP considerations into early research design and co-creation processes, so that stakeholders understand constraints and opportunities from the start.

AI-focused analyses underline that smart IP management in data-intensive health innovation must address issues such as ownership of trained models, rights over training data, and responsibilities for algorithm performance, often through multi-party agreements and adaptive governance. Overall, smart IP use is portrayed as a dynamic, context-sensitive practice that supports both valorisation and public interest.

**Comparison with MEDViEW's exploitation plan and implications:** INTRA's exploitation plan for MEDViEW, as presented in the project's exploitation and dissemination planning, is structured as a phased, process-driven roadmap that integrates business modelling, IPR management and sustainability planning from early project stages through post-project deployment. Exploitation is treated as a continuous process with milestones (e.g. market exploration, KER validation, value-proposition refinement, business plan development, post-project scalability preparation). The plan embeds IPR considerations throughout, with the MEDViEW Innovation Management Log (.xlsx tool) used to track background and foreground IP, manage technical components and services, and support both exploitation tasks and technical integration.

The literature broadly supports this approach. Evidence on PoC centres reinforces the need for translation mechanisms that move results from “validated concept” to deployable solutions, aligning with MEDViEW's staged exploitation model. Open innovation research suggests that exploitation benefits when cross sector collaboration pathways are actively curated; this aligns with MEDViEW's ecosystem logic and the use of MEDSPACE and MEDCOMM networks to connect actors. TTC analyses imply that MEDViEW should operationalise intermediary functions (matchmaking, capability building, business support) to help SMEs and knowledge owners cross adoption barriers. AI IP analyses underscore the importance of explicit data rights, licensing options and governance for inventorship and ownership, consistent with MEDViEW's IPR management under the consortium and IPR plans. Evidence on business model barriers in public systems highlights that exploitation plans must include validation and adoption pathways, not only market messaging.

From this synthesis, several gaps, challenges and opportunities emerge for MEDViEW. A common weakness in exploitation plans is the gap between “results and messaging” and repeatable commercialisation mechanics. MEDViEW has the opportunity to embed PoC-style maturation tracks for selected key exploitable results (e.g. methods, tools, training modules, platform features) and connect these to stakeholder validated deployment pathways. IP and data governance complexity, especially around AI-related innovations, is a key challenge; MEDViEW can mitigate this by making the IPR plan operational through clear templates for licensing, ownership and contribution tracking. Ecosystem coordination is another challenge: partnerships accelerate results only with active orchestration. By positioning exploitation as ecosystem enablement, using MEDSPACE and networks to secure

early adopters and test exploitation paths in real settings, MEDVIEW can strengthen its impact. Finally, explicitly incorporating public system adoption enablers into its exploitation narrative will respond to barriers faced by SMEs and align with the project's aim of delivering tangible, sustainable and scalable wellbeing benefits.

### 3.7 Research-to-Practice Translation (UMA)

**Methodology:** Domain 7 was structured around three interconnected themes: knowledge transfer frameworks, implementation science, and innovation diffusion. The domain aimed to synthesize evidence on how wellbeing research can be effectively translated into practice and scaled across diverse healthcare and community settings. Five research questions structured the review:

**RQ7.1:** What knowledge translation frameworks effectively bridge the research–practice gap in wellbeing?

**RQ7.2:** How does implementation science guide the adoption of evidence-based wellbeing interventions in real-world settings?

**RQ7.3:** What contextual factors (organizational, individual, systemic) facilitate or hinder innovation diffusion in healthcare?

**RQ7.4:** How can research outputs be made user-friendly and directly applicable to practitioners, industry, and communities?

**RQ7.5:** What strategies support scaling interventions while maintaining fidelity and adapting to local contexts?

The search employed a comprehensive set of primary and secondary keywords across three major databases: Web of Science, PubMed, Scopus.

The Domain 7 dataset synthesized implementation and translation evidence for health and psychosocial interventions spanning 2014–2026, including digital health, integrated care, school and community programmes, telehealth, and mental health services. Evidence quality was mixed: a small high-quality subset (quality appraisal scores 8–9/9) contained limited extractable implementation detail, while the broader corpus was predominantly low-to-medium quality (typical scores 3–7/9). A recurring limitation across records was uncertain transferability to EU and OECD contexts, indicating the need for local context-checking before scale-up.

## Results

**RQ7.1: Knowledge Translation Frameworks:** Effective knowledge translation frameworks for bridging the research–practice gap in wellbeing combine structured translation steps with explicit attention to context and end-user participation. The most commonly applied and effective frameworks identified include:

- **Knowledge-to-Action (KTA) cycle:** Provides a practical backbone for moving from evidence inquiry and synthesis to locally tailored tools and implementation guidance, supported by multi-source evidence including literature, routine data (e.g., electronic health records), and stakeholder deliberation.
- **RE-AIM framework:** Repeatedly used to design for Reach, Effectiveness, Adoption, Implementation, and Maintenance from the outset, improving the likelihood that digital and brief skills interventions can scale while tracking engagement, feasibility, and early outcomes.
- **Consolidated Framework for Implementation Research (CFIR):** Often paired with Theory of Change to diagnose determinants and guide context-sensitive adaptation; provides a common structure for identifying barriers and facilitators.

- **Integrated-Promoting Action on Research Implementation in Health Services (i-PARIHS):** A facilitation-oriented framework to align the innovation, recipients, and setting.
- **Implementation Research Logic Model (IRLM):** Links determinants, strategies, and outcomes transparently, improving replicability.

Participatory co-design (including lived experience, families, and frontline staff) and "goodness of fit" assessments strengthen feasibility, acceptability, relevance, and sustained engagement by aligning intervention goals with wellbeing outcomes (e.g., enjoyment, functioning) rather than narrow performance metrics. A detailed high-quality example from physical activity programmes for youth with social, emotional, and behavioural difficulties highlighted that participatory adaptation, enjoyment-focused goals, accessibility accommodations, Universal Design for Learning principles, and explicit consideration of parent and child "reserve capacity" significantly improved reach and adherence.

**RQ7.2: Implementation Science Guidance:** Implementation science guides adoption by shifting emphasis from efficacy alone to how interventions work in real settings: reach, recruitment, retention, adherence, workflow integration, and sustainability. Practical guidance emerging from the literature includes:

- **Pre-implementation assessment:** CFIR-informed interviews, process mapping, and premortem sessions to identify potential barriers before launch.
- **Staged pilots and hybrid designs:** Effectiveness–implementation hybrid designs that test both intervention outcomes and implementation processes simultaneously.
- **Iterative quality improvement:** Plan-Do-Study-Act (PDSA) cycles, continuous feedback loops, and routine service monitoring.
- **Strategy selection and operationalization:** Use of the Expert Recommendations for Implementing Change (ERIC) taxonomy and CFIR–ERIC mapping to match implementation strategies to diagnosed barriers.
- **Training and support structures:** Training and coaching, champions, workflow redesign (referral pathways, role clarity, documentation templates).
- **Implementation outcome measurement:** Validated measures such as the Acceptability of Intervention Measure (AIM), Intervention Appropriateness Measure (IAM), and feasibility and fidelity instruments, alongside routine service and quality data (dashboards, uptake metrics, statistical process control).

Across studies with populated implementation fields, consistent best-practice recommendations emerged: implementation should be structured using established frameworks, stakeholder engagement and co-design should be continuous, training models should be practical and standardized yet adaptable (e.g., train-the-trainer approaches, competency-based training with supervision and coaching, communities of practice), and programmes should be embedded into routine workflows through clarified roles, redesigned pathways, and integrated documentation and referral processes.

**RQ7.3: Contextual Factors in Innovation Diffusion:** Innovation diffusion in healthcare is shaped by interacting factors at multiple levels:

- **Organizational determinants:** Leadership engagement, protected time, staffing and training capacity, space and IT infrastructure, connectivity, implementation

climate, and supervision or technical assistance. Resource constraints (time, staffing, funding, turnover, protected time for training) and infrastructure limitations were pervasive barriers.

- **Individual factors:** Knowledge and beliefs, confidence and skills (including digital literacy), motivation, stigma and bias (including toward "invisible" conditions such as social, emotional, and behavioural difficulties), and perceived workload burden. Stigma (mental health, addiction, vulnerability) and negative provider beliefs reduced adoption in several contexts.
- **Systemic and outer-setting factors:** Funding and commissioning structures, policy and legal constraints (privacy, telehealth regulations), cross-organization coordination, supply-chain and service availability constraints, and structural inequities (language support, rurality, socioeconomic status, biased recruitment and under-reporting). Coordination failures (unclear responsibilities, fragmented pathways, cross-organization complexity) and fragmented inter-organizational systems repeatedly disrupted implementation.

A major identified gap is that many implementation frameworks and studies insufficiently address power, structural racism, and inequity. There is under-representation of minoritized groups in research and limited evidence on equity-sensitive implementation in mental health and wellbeing settings. Several interventions showed skewed reach (e.g., gender imbalance in digital programmes), and equity-oriented framework adaptations are rarely tested for effectiveness.

**RQ7.4: Making Research Outputs User-Friendly:** Research outputs become user-friendly and directly applicable when packaged as concise, workflow-embedded products co-designed with end users. Effective formats identified across the literature include:

- One-page evidence sheets and quick-reference "cheat sheets"
- Standard operating procedures (SOPs) and protocols
- Checklists (including accessibility and accommodation guidance such as Universal Design for Learning principles)
- Modular toolkits with clear role definitions
- Point-of-care decision supports (e.g., dashboards, alerts, infographics)
- Embedded feedback tools and warm handoff procedures to integrated teams
- Standardized documentation templates to coordinate complex care

Successful examples included suicide prevention protocol implementation in primary care using brief scalable training (webinars), clear tools (SOPs and infographics), preambles to sensitive screening questions, champions, and strengthened referral networks. Digital mental health implementations emphasized accessibility design, technical constraint anticipation, staffing workload planning, and reminder and support systems.

**RQ7.5: Scaling While Maintaining Fidelity:** Scaling interventions while maintaining fidelity requires defining core functions and components (practice profiles) and permitting structured adaptation of forms, with adaptations tracked and justified. The Framework for Reporting Adaptations and Modifications-Enhanced (FRAME) was repeatedly cited as a tool for systematically documenting modifications. Effective scaling strategies include:

- **Train-the-trainer models:** With mentorship and refresher training to build local capacity.
- **Communities of practice:** Peer learning networks that support problem-solving and shared learning.
- **Ongoing supervision:** Including hybrid digital supervision models for geographically dispersed sites.
- **Continuous measurement and feedback:** Routine monitoring of implementation outcomes (acceptability, appropriateness, feasibility, fidelity, penetration, sustainability) and equity-relevant outcomes (reach, adoption patterns across populations).
- **Capacity resourcing:** Ensuring that scale-up does not increase burden on providers, families, or communities, which can erode engagement and equity.

Successful scale-up balances standardization (what must remain) with structured local adaptation (what can change), guided by continuous monitoring and explicit measurement of both implementation and equity-relevant outcomes.

**Cross-Cutting Gaps and Challenges:** Common barriers identified across the literature include:

- **Limited rigorous real-world evaluation:** Many implementation strategies and adapted frameworks lack effectiveness testing; reporting of strategies is often incomplete, limiting replicability.
- **Incomplete reporting:** Reduces transparency and the ability to replicate successful implementations in new settings.
- **Under-measurement of key outcomes:** Reach, fidelity, sustainability, and equity outcomes are frequently not measured or reported.
- **Technology and usability issues:** Platform limitations, technical errors, low automation requiring manual work, privacy and security concerns, unequal access to devices and private space, and low digital literacy often require hybrid delivery models.
- **Child-level and family-level barriers:** Low motivation, peer exclusion, sensory or behavioural dysregulation, medication side effects, negative prior experiences, and parental capacity constraints undermine recruitment, retention, and adherence, particularly in interventions targeting vulnerable populations.
- **Transferability uncertainty:** Many studies do not clearly specify whether findings are transferable to EU or OECD contexts, requiring local feasibility and adaptation assessment.

**Relevance for MEDViEW:** The evidence from Domain 7 strongly supports a MEDViEW-aligned approach that combines framework-informed planning, co-design, standardized training and workflow integration, and continuous monitoring while explicitly addressing equity and context fit. Key actionable insights for MEDViEW include:

- Using implementation frameworks (CFIR, RE-AIM, KTA, IRLM, FRAME) to build MEDViEW implementation playbooks and guide structured adaptation.
- Operationalizing stakeholder co-design and readiness assessment as standard components of capacity building.
- Standardizing training toolkits, workflow-integrated decision support tools, and monitoring systems that can be adapted to partner contexts.

- Addressing equity gaps by measuring equity-relevant implementation outcomes (reach, adoption, sustainment across populations) and piloting feasibility in under-served groups and real-world settings.
- Incorporating validated implementation outcome measures (AIM, IAM, feasibility, fidelity) into MEDViEW evaluation workflows.
- Designing user-friendly outputs (checklists, SOPs, toolkits, brief guides) co-created with practitioners, service users, and families.
- Applying participatory methods and Universal Design for Learning principles to improve accessibility, acceptability, and sustained engagement.

Overall, the Domain 7 evidence base is broad and practically informative, though often not strong enough methodologically to support definitive conclusions about which implementation strategies work best in which contexts. Local context-checking, adaptation, and rigorous evaluation within MEDViEW partnerships will be essential to translate these insights into effective, equitable, and sustainable practice.

### 3.8 Capacity Building Approaches (UMA)

**Methodology:** Domain 8 examined capacity building approaches that enable stakeholders to develop the competencies required for knowledge valorisation and co-creation in wellbeing and health-related contexts. The domain was structured around four core themes: training methodologies, skill development, cross-sector collaboration, and competencies. Building on these themes, the work focused on five heterogeneous stakeholder groups: citizens, researchers and students, SMEs and entrepreneurs, physicians and other health professionals, and policymakers/administrators.

The specific aims of Domain 8 were to: (1) synthesise training methodologies and pedagogical approaches that develop knowledge valorisation competencies across diverse stakeholders; (2) analyse how cross-sector collaboration (academia–industry–policy–civil society) enhances capacity building effectiveness and sustainability; (3) map essential skills, competencies and learning progression pathways for the five target groups; and (4) identify multi-modal learning approaches (e.g., workshops, online, peer learning, experiential formats) that sustain engagement and behaviour change over time. To address these aims, five research questions were formulated:

RQ8.1: What training methodologies effectively develop valorisation competencies across heterogeneous stakeholders with different baselines?

RQ8.2: How does cross-sector collaboration enhance capacity building processes and outcomes?

RQ8.3: What specific skills and competencies are essential for each stakeholder group to effectively participate in knowledge co-creation?

RQ8.4: How can programs be designed to be inclusive and participatory, ensuring accessibility across diverse populations?

RQ8.5: What approaches sustain capacity beyond initial training, fostering continued engagement in Communities of Practice?

The search strategy combined primary keywords (capacity building, capacity development, training methodologies, professional development, competency frameworks, learning approaches, training effectiveness, knowledge valorisation skills) with secondary terms capturing stakeholder- and context-specific elements (e.g., citizen science training, researcher training, SME capacity, physician education, policymaker training, co-creation skills, cross-sector training). Searches were conducted in three major databases (Web of Science, PubMed and Scopus),

complemented where necessary by snowballing from reference lists and relevant reviews.

Quality appraisal categorised studies as low, medium or high quality, based on clarity of design, appropriateness of methods, transparency of reporting, and robustness of outcome assessment. Most included records fell into the low-to-medium quality range, with a smaller set of more rigorously evaluated programs and consensus/validation studies.

## **Results:**

**Training methodologies for heterogeneous stakeholders (RQ8.1):** Across the included studies, effective capacity building for knowledge valorisation and co-creation is consistently associated with active, practice-based, and socially supported learning rather than stand-alone didactic teaching. Programs that rely primarily on lectures or one-off seminars show limited evidence of sustained changes in behaviour or practice, even when short-term satisfaction and self-reported confidence are high. In contrast, more successful approaches combine multiple elements:

- Interactive, project- or problem-based learning, where participants work on real or realistic innovation, quality improvement or research-to-practice projects relevant to their own settings.
- Case-based discussions and simulations (including interprofessional clinical cases, innovation cases, or policy scenarios) that require joint decision-making and reflection.
- Workplace-based learning structures such as interdisciplinary rounds, structured huddles, or improvement meetings that embed learning into routine practice.
- Blended formats mixing short, targeted workshops with online modules, digital communities, or resource repositories, enabling flexible pacing and repeated engagement.

A recurring feature of stronger programs is explicit competency mapping. Learning outcomes are framed against defined competency frameworks (e.g., interprofessional collaboration competencies, innovation/entrepreneurship competency sets, or domain-specific research skills frameworks), and progression is scaffolded into phases (baseline to intermediate to advanced), often with milestones and formative feedback. Programs that provide psychologically safe learning environments—where participants can ask questions, share uncertainty and experiment—appear particularly important for less-confident groups and for cross-disciplinary cohorts.

At the same time, the evidence base remains methodologically modest: many evaluations rely on pre–post self-report and short follow-up periods, with fewer examples of robust, longitudinal or controlled designs. Nonetheless, there is consistent convergence around the value of experiential, team-based, and blended learning in developing valorisation-relevant skills across stakeholder groups with heterogeneous starting points.

**Role of cross-sector collaboration (RQ8.2):** Cross-sector and interprofessional collaboration emerges as a central enabler of effective capacity building. Programs that intentionally involve multiple sectors—academia, healthcare services, industry/SMEs, civil society organisations, and policy institutions—are reported to generate richer learning experiences and more practice-relevant outputs than single-sector training alone. Typical models include university–service partnerships, innovation ecosystems linking universities and SMEs, and multi-disciplinary teaching teams that combine clinical, technical, and community or patient perspectives.

These collaborative arrangements contribute in several ways:

- They make learning tasks more realistic and complex, exposing participants to real constraints and diverse viewpoints.
- They create opportunities for networking, boundary-spanning roles and future collaborations beyond the course.
- They support role understanding: participants gain clearer insights into each other's responsibilities, constraints and expertise, which is crucial for later co-creation and implementation efforts.

Multi-mentor models, where learners are supervised or coached by mentors from different sectors (e.g., clinician–engineer–entrepreneur triads), are frequently highlighted as particularly effective, though resource-intensive. However, the impact of cross-sector collaboration is strongly context-dependent. Organisational pressures (time, staffing, service demands), logistical complexity across institutions, and variable leadership support can either enable or undermine the translation of newly acquired skills into practice and organisational change. Where governance structures, shared goals, and protected time are lacking, collaborative training risks remaining an isolated educational experience rather than a driver of systemic capacity building.

**Essential skills and competencies (RQ8.3):** Despite variation in context and stakeholder mix, there is convergence around a set of core competencies that underpin effective participation in knowledge valorisation and co-creation:

- Interprofessional communication and listening skills.
- Role clarification and the ability to negotiate responsibilities.
- Teamwork and collaborative problem-solving.
- Stakeholder- or patient-centred attitudes and behaviours.
- Reflective practice and openness to feedback.

Beyond these shared foundations, stakeholder-specific emphases emerge:

- Students, early-career researchers and trainees benefit from capacity building in research literacy (study design, methods, ethics, critical appraisal), innovation and design thinking, and confidence/self-efficacy for engaging with non-academic partners.
- Healthcare professionals require practice-change skills, including using data and quality indicators, behaviour change techniques in situ, collaborative leadership, conflict management and digital/AI literacy to work with new tools and platforms.
- Educators, supervisors and mentors need competencies in interdisciplinary facilitation, feedback and assessment, fostering psychological safety, and systems thinking to bridge education and service realities.
- Community members, patient representatives and civil society/industry partners need support to articulate needs and values, understand research and innovation processes, and participate in governance, co-creation and communication activities.
- Entrepreneurs, SMEs and under-served groups benefit from skills in opportunity recognition, market and stakeholder analysis, resource mobilisation, financial literacy, risk management and resilience, alongside access to enabling technologies and digital skills.

Several studies and framework-development exercises underline that these competencies must be made explicit, operationalised into observable behaviours and linked to assessment tools if they are to guide curriculum design, evaluation and investment decisions.

**Inclusive and participatory program design (RQ8.4):** Designing capacity building that is inclusive and participatory is a recurring concern across the literature, though often more as a stated aim than as rigorously evaluated practice. Features associated with increased inclusivity include:

- Offering blended or fully online participation options to accommodate geographic distance, work schedules and caring responsibilities, while also paying attention to digital divides.
- Culturally and linguistically adapting materials and assessment tools, including validated translations of teamwork or competency instruments, and ensuring examples reflect diverse populations and contexts.
- Using small-group structures, peer learning and co-teaching models that amplify diverse voices, normalise uncertainty and reduce power differentials between disciplines or seniority levels.
- Aligning new content with existing curricula or workflows to avoid overload, for example by reframing current modules rather than simply adding new ones.
- Reducing participation barriers through institutional recognition (credits, certificates, promotion criteria), scheduling that respects workload constraints, and visible leadership endorsement.

Participatory design practices—co-defining objectives with participants, involving target groups in curriculum development, and integrating informal social learning—are increasingly recommended, but evidence of their differential impact on outcomes remains limited. Equity issues such as gender gaps in entrepreneurship experiences, geographic/resource disparities, and under-representation of certain groups are documented, yet few studies demonstrate systematically evaluated equity-sensitive adaptations.

**Sustaining capacity and Communities of Practice (RQ8.5):** A consistent message in the literature is that one-off trainings, even when well-designed, are insufficient to sustain capacity for knowledge valorisation and co-creation. Approaches that appear more promising for long-term impact and continued engagement include:

- Establishing formal or informal Communities of Practice, professional societies or learning communities that bring participants together on a recurring basis to share cases, reflect on practice and co-develop solutions.
- Creating mentorship networks and longitudinal supervision structures, where early-career professionals or students receive ongoing support from more experienced colleagues across sectors.
- Integrating regular interprofessional or cross-sector meetings (e.g., case conferences, project review boards, innovation rounds) into organisational routines.
- Providing shared digital platforms, repositories and communication channels where materials, tools and experiences can be accessed and updated over time.
- Embedding multi-method evaluation beyond self-report, including observation, audits, output indicators (e.g., projects delivered, publications, innovations implemented) and, where possible, longer-term follow-up to track sustained practice change.

However, robust evidence for long-term impact remains scarce. Many studies report outcomes at the level of self-efficacy, perceived competence or satisfaction within one year of program completion; few document organisational or system-level changes

over longer periods. Recurring prerequisites for sustainability include stable leadership support, adequate resourcing (time, staffing, funding), faculty/mentor capacity, and alignment with institutional priorities and incentive structures.

**Cross-cutting gaps and implications for MEDViEW:** Across the different evidence sources, several cross-cutting gaps are apparent. Methodologically, many capacity building initiatives lack rigorous evaluation designs, standardized assessment tools and longitudinal follow-up. Conceptually, while competency frameworks are increasingly available, their operationalisation into measurable, context-sensitive learning outcomes remains uneven. Equity considerations are recognised but often insufficiently integrated into program design and evaluation.

For MEDViEW, the Domain 8 findings support a capacity building approach that: (1) prioritises experiential, project-based and team-based learning embedded in real workflows; (2) leverages cross-sector mentorship and multi-disciplinary teaching to connect research, practice, policy and innovation; (3) articulates clear, stakeholder-specific competency frameworks for knowledge valorisation and co-creation; (4) designs training to be inclusive and accessible through blended formats, cultural/linguistic adaptation and institutional support; and (5) invests in ongoing Communities of Practice, mentorship structures and mixed-method evaluation to sustain capacity and monitor practice change over time.

### 3.9 Stakeholder Engagement Practices (EUROCAM)

**Methodology:** Domain 9 examined how stakeholders are meaningfully engaged in health and wellbeing research and innovation, with a focus on citizen and patient participation, multi-stakeholder co-creation and Quadruple Helix engagement. The domain was structured around three themes: (1) citizen participation and patient involvement; (2) multi-stakeholder co-creation; and (3) engagement of academia, industry, government and civil society.

The specific aims were to: (1) map citizen participation and patient involvement models that engage diverse populations, including marginalised groups, in health research and innovation; (2) analyse multi-stakeholder co-creation processes that enhance the quality, relevance and uptake of knowledge valorisation; (3) synthesise Quadruple Helix engagement strategies integrating the four main stakeholder groups; (4) identify mechanisms that build and sustain trust among stakeholders with different priorities, languages and power positions; and (5) ensure authentic participation and co-production rather than tokenistic consultation. Expected outcomes included evidence-based engagement techniques; participatory research models adapted to wellbeing and valorisation; descriptions of stakeholder collaboration dynamics (including power relations, trust-building and conflict-resolution strategies); Quadruple Helix engagement frameworks; inclusion strategies for marginalised groups; and trust-building mechanisms and sustained engagement models.

The review addressed five research questions: RQ9.1 (citizen participation and patient involvement models that effectively engage diverse populations), RQ9.2 (how multi-stakeholder co-creation enhances valorisation outcomes compared with traditional approaches), RQ9.3 (strategies for implementing Quadruple Helix engagement), RQ9.4 (factors that build and sustain trust among stakeholders with different priorities and power dynamics) and RQ9.5 (how to achieve genuine participation and co-production versus tokenistic consultation).

A systematic screening process identified 90 articles as High Match (score 9) for MEDViEW relevance. Of these, 73 full-text articles were accessible and analysed; the remaining 17

were available only as abstracts and are documented separately. The 73 full-text articles form the basis of this synthesis, covering citizen and patient engagement, community-based participatory research (CBPR), multi-stakeholder co-creation, Quadruple Helix collaboration and trust-building in health research and innovation.

The evidence base is recent and methodologically diverse. Among the 73 full-text articles, 17 were systematic reviews, 21 scoping reviews, 15 empirical or mixed-methods studies, 9 framework/guideline/tool papers and 11 rapid reviews or other evidence syntheses. More than half were published between 2023 and 2025, with the overall timeframe spanning 2018–2025 and showing a clear increase in participatory and equity-centred engagement research. Data extraction focused on engagement models, stakeholder types, processes and mechanisms, reported outcomes (including quality of participation) and identified gaps.

## **Results:**

**RQ9.1-Citizen participation and patient involvement models:** Across the evidence base, community-based participatory research (CBPR) emerges as the dominant paradigm for engaging citizens and patients, particularly from historically marginalised populations. More than half of the analysed studies explicitly reference CBPR principles, frameworks or applications. CBPR models emphasise equitable partnership between communities and researchers, shared decision-making, co-ownership of data and results, and a commitment to translating findings into action. The literature shows that CBPR is effective in engaging Indigenous communities, racial and ethnic minorities, migrants and refugees, people with disabilities, vulnerable youth and older adults. Engagement approaches that are culturally responsive, language-adapted and co-governed by community structures are particularly successful. Other citizen and patient involvement models include patient and public involvement (PPI) structures, citizen science initiatives, patient advisory councils and community steering committees; these are most effective when they adopt CBPR-like elements such as early involvement, co-design of research questions and shared governance, rather than limiting participation to feedback on pre-defined plans. A key cross-cutting insight is that equity, diversity and inclusion are not add-on considerations but methodological imperatives: successful models deliberately address structural barriers (e.g. transport, childcare, language, digital access), recognise lived experience as expertise, and provide appropriate compensation and capacity-building. Intersectional analysis (e.g. overlapping gender, class, ethnicity, disability) remains limited, representing a gap for future work.

**RQ9.2-Multi-stakeholder co-creation and valorisation outcomes:** Multi-stakeholder co-creation approaches—such as co-design workshops, consensus conferences, living labs, participatory action research and deliberative forums—are widely described as improving the relevance, contextual fit and perceived legitimacy of research and innovation outputs. Studies report that co-created interventions and tools better reflect community needs and preferences, are more acceptable to users and providers, and have higher potential for uptake. However, evidence linking co-creation processes to concrete valorisation outcomes (e.g. implementation, spread, policy change) is still relatively weak. Many studies provide rich descriptive accounts and positive participant feedback but lack robust, longitudinal or comparative designs that would clearly demonstrate causal impact on research uptake or long-term outcomes. Industry, SMEs and innovation actors are less frequently included than patients, communities and professionals, and there are few EU-wide or cross-country co-creation models with documented impacts. Nevertheless, the literature consistently suggests that co-creation supports knowledge valorisation by: (i) integrating lived experience with scientific evidence; (ii) revealing context-specific

constraints and enablers; (iii)improving trust in research outputs; and (iv)building shared ownership among stakeholders who later act as champions. For MEDViEW, this points to co-creation as a necessary, though not sufficient, ingredient in effective valorisation, and underscores the need to embed evaluation of uptake and impact into co-creation designs.

**RQ9.3-Quadruple Helix engagement strategies:** Quadruple Helix (QH) engagement—integrating academia, industry, government and civil society—is comparatively less developed in the health literature. Only a small subset of the analysed articles (around seven full texts) focuses explicitly on QH models in health or health-related innovation. These cases typically describe regional or city-level innovation ecosystems where universities, health providers, companies, public authorities and citizen groups collaborate on ageing, chronic disease management, digital health or smart city initiatives. Documented QH strategies include: multi-helix steering committees or “quad-labs”; co-creation arenas where all four stakeholder groups jointly set agendas, design solutions and negotiate implementation; shared scorecards that track both tangible outputs (e.g. tools, services) and intangible outcomes (e.g. trust, health literacy, civic engagement); and formal mechanisms for conflict resolution and power-sharing (e.g. rotating facilitation, weighted voting, time-boxed negotiation). These examples show that QH collaboration can generate both tangible innovations and intangible benefits, such as distributed leadership and stronger local social capital. Despite these promising cases, practical guidance on QH governance in health remains limited. There is little operational detail on how to balance conflicting interests, align incentive structures, or integrate commercial and public-interest goals. No examples are specific to complementary and integrative health, and few offer transferable models for multicultural EU contexts. This makes QH engagement a key area where MEDViEW can contribute new operational frameworks.

**RQ9.4 and RQ9.5-Trust-building, power dynamics and authentic participation:** Trust-building and power dynamics are central concerns throughout the evidence. The literature highlights several mechanisms associated with authentic participation and sustained trust: long-term relationship-building; early and continuous involvement of communities; transparency about goals, constraints and decision-making; meaningful compensation and resource sharing; cultural safety practices; and community governance over research processes and data. Many articles describe a spectrum from tokenistic consultation (e.g. one-off surveys or information sessions) to genuine co-production and community control. Tokenism is frequently critiqued, particularly in patient and public involvement. Common risk patterns include: involving only a narrow, unrepresentative group of participants; late involvement in the project after key decisions have been made; and lack of influence over outcomes. Moving beyond tokenism is described as requiring deliberate power-sharing, such as co-chairing committees, co-authorship, community voting rights, and shared responsibility for dissemination and implementation. The evidence on digital trust-building is less developed. While digital and hybrid engagement can broaden participation and convenience, concerns are raised about privacy, surveillance, digital divides and the absence of embodied cues for trust. Validated tools to measure “authentic participation” or trust levels across different modes (online/offline) are rare, and few studies address trust in multi-country or cross-cultural European settings. Structural inequities and long-term trust dynamics receive limited systematic analysis, pointing to another gap where MEDViEW can innovate.

**Cross-cutting gaps and implications for MEDViEW:** The Domain 9 evidence base is substantial and contemporary but reveals several important gaps. There is a lack of

scalable, EU-wide engagement models tailored to multicultural contexts and to complementary and integrative health. Causal pathways from co-creation to research uptake and valorisation outcomes are not well documented, with few longitudinal or comparative studies. Quadruple Helix engagement practices in health remain under-operationalised, with limited guidance on governance, power-sharing and conflict resolution. Tools for assessing authentic participation, digital trust and cross-country engagement quality are under-developed. For MEDViEW, these gaps translate into strategic opportunities. The evidence strongly supports adopting CBPR principles—equitable partnership, shared ownership, co-learning, capacity building and commitment to action—as a foundation for stakeholder engagement. It challenges the project to move from consultation to co-production, invest in sustained, relationship-based engagement and embed equity as a methodological imperative by addressing structural barriers, cultural safety, accessibility and compensation. It also underlines the importance of designing and applying evaluation frameworks that assess engagement quality and impact from project inception. By responding to these insights—developing EU-adapted CBPR-inspired frameworks, operationalising Quadruple Helix engagement, and creating tools to evaluate participation quality and trust—MEDViEW can build a coherent, evidence-based and transferable approach to stakeholder engagement that strengthens research valorisation and inclusive, trust-based participation across Europe.

### 3.10 Co-Creation and Participatory Design (EUROCAM)

**Methodology:** Domain 10 examined how co-creation and participatory design can be used to involve patients, citizens and other stakeholders in health and wellbeing innovation. The domain was structured around three main themes: user-centred design, Living Lab implementations and participatory tools and methods. The specific aims were to: (1) synthesise user-centred and participatory design approaches that meaningfully involve end-users in health and wellbeing innovation; (2) analyse Living Lab methodologies that support real-world experimentation, testing and validation; (3) map participatory tools, techniques and facilitation methods that enable genuine co-creation with diverse stakeholders; (4) identify value-sensitive approaches that embed ethical values such as equity, inclusivity, fairness, transparency and sustainability into co-creation; and (5) understand how to manage power dynamics so that diverse and marginalised voices are genuinely heard. Expected outcomes included practical co-creation frameworks with implementation guidance for wellbeing and Communities of Practice, Living Lab methodologies adapted to MEDViEW’s four engagement areas, participatory tools with facilitation guidance, operationalisation of Value-Sensitive Design (VSD) within co-creation contexts and facilitation approaches for inclusive participation.

The evidence synthesis for Domain 10 focused on the highest-quality, most relevant literature. An expanded 1–10 relevance scoring scale was used to identify papers most suitable for MEDViEW. Forty-five articles with “High Match” (score 9) were selected, and to fully address RQ10.4, six additional papers with score 7 (the highest rating available for that question) were included, resulting in 51 papers. Of these, 47 full-text articles were accessible and form the basis of this synthesis; four could not be fully accessed. Papers with low match scores were excluded from the high-quality evidence synthesis.

Across the 47 full-text articles, the evidence base is dominated by systematic and scoping reviews, indicating methodological maturity in participatory design research. About 81% of the included papers are systematic or scoping reviews that synthesise co-design, co-creation and patient/public involvement (PPI) methodologies across

diverse health contexts; 6% are framework/guideline papers providing structured models and evaluation approaches; and 13% are empirical studies offering real-world insights into co-design processes, implementation challenges and stakeholder experiences. Publication recency is strong: nearly half of the articles were published between 2024 and 2026, ensuring access to the latest methodological innovations, digital co-design practices and equity-centred approaches.

The review addressed five research questions: RQ10.1 (user-centred and participatory design approaches that meaningfully involve patients/citizens), RQ10.2 (how Living Labs facilitate real-world experimentation and validation), RQ10.3 (effective co-design tools and techniques in health/wellbeing contexts), RQ10.4 (how co-creation can embed ethical values consistent with VSD) and RQ10.5 (facilitation approaches that manage power dynamics and ensure inclusive participation). PubMed and Google Scholar were the primary databases, supplemented by design and Living Lab sources. While RQ10.1–RQ10.3 are well covered by high-match articles, RQ10.4 is represented by a smaller set of moderate-match papers and RQ10.5 has no high-match articles, indicating a notable evidence gap. Nevertheless, many studies across the first three questions address power, equity and inclusion as cross-cutting themes, providing transferable insights.

## **Results:**

**RQ10.1 – User-centred and participatory design approaches:** The evidence shows that user-centred and participatory design approaches can meaningfully involve patients and citizens in health innovation when they treat end-users as partners rather than as passive informants. Common approaches include co-design workshops, experience-based co-design (EBCD), design thinking processes and service design methods adapted to healthcare. These approaches typically involve patients and citizens in defining problems, prioritising needs, generating ideas, developing prototypes and evaluating solutions.

High-quality reviews and empirical studies highlight several conditions for meaningful involvement:

- Engagement across the full design cycle, not just at the feedback stage.
- Recognition of lived experience as expertise, with patients/citizens helping to shape research questions and design criteria.
- Use of accessible, creative methods (storytelling, visualisation, role-play, mock-ups) to enable participation regardless of literacy or technical background.
- Governance arrangements that give end-users real influence over decisions, not just consultation.

User-centred design is also applied in digital health innovation, where user journeys, personas and usability testing are central. Evidence emphasises that user involvement must be continuous and iterative; one-off sessions rarely lead to outcomes that reflect real needs or constraints. When these principles are respected, participatory approaches can improve the relevance, usability and acceptability of interventions, and lay the groundwork for better uptake.

**RQ10.2 – Living Labs and real-world experimentation:** Living Lab methodologies are presented as a way to conduct co-creation, experimentation and validation in real-world settings. In health and wellbeing contexts, Living Labs often take the form of community-based or service-embedded environments where innovations are developed and tested with users in their everyday contexts (homes, clinics, communities). The one high-match article specifically focused on Living Labs,

supported by related reviews, describes key features such as multi-stakeholder participation, iterative testing cycles, and the combination of qualitative and quantitative data. Living Labs facilitate real-world experimentation by:

- Allowing early testing of prototypes under real use conditions, revealing practical barriers and unintended consequences.
- Supporting rapid iteration and co-adaptation of solutions with patients, professionals and other stakeholders.
- Providing a space where governance, ethical and organisational issues can be addressed alongside technical design.
- Linking local experimentation to broader innovation ecosystems (e.g. municipalities, regions, networks).

The evidence indicates that Living Labs can enhance ecological validity, user acceptance and system-level learning. However, they require considerable coordination, clear roles and sustained resources. There is also limited empirical evidence that directly links Living Lab activities to long-term outcomes such as widespread adoption or policy change, which is a gap MEDVIEW can address.

**RQ10.3 – Co-design tools and techniques:** The largest cluster of evidence addresses specific co-design tools and techniques. Commonly used tools include:

- Personas and user profiles to represent different user types and needs.
- Journey maps and experience maps to visualise patient or citizen pathways and identify pain points and opportunities.
- Storyboards, scenarios and role-playing exercises to explore alternative futures and experiences.
- Low-fidelity and high-fidelity prototyping (paper prototypes, mock-ups, digital prototypes) to make ideas tangible and open to feedback.
- Design workshops and hackathons that combine divergent idea generation with convergent prioritisation.
- Card sorting, canvases and other structured tools to organise ideas and priorities.

Systematic and scoping reviews emphasise that tools are most effective when embedded in clear process frameworks (e.g. staged design cycles, EBCD phases) and when facilitators are trained in inclusive, trauma-informed and culturally responsive methods. In digital health, additional techniques such as usability testing, think-aloud protocols and A/B testing are used, but the literature warns against over-reliance on technical usability at the expense of meaningful co-creation.

Evaluation frameworks and validated instruments exist to assess co-design quality and impact, including measures of PPI quality, engagement depth and perceived influence on outcomes. These tools give MEDVIEW a way to systematically assess co-creation beyond anecdotal success stories.

**RQ10.4 – Embedding values via Value-Sensitive Design:** Although no high-match articles were found specifically for RQ10.4, a small group of moderate-match papers and broader participatory design literature address how ethical values can be embedded in co-creation. VSD-aligned approaches typically combine:

- Explicit identification of relevant values (e.g. equity, inclusion, fairness, transparency, sustainability, autonomy, privacy) with stakeholders.
- Analysis of how design choices support or undermine these values in different contexts.
- Iterative co-design and evaluation loops that surface ethical tensions and trade-offs and allow values to be negotiated and re-interpreted.

In practice, value embedding occurs through: inclusive recruitment and representation; accessibility features and universal design; transparency about data use and decision processes; and attention to long-term sustainability (environmental and social). Many equity-focused co-design studies—particularly with Indigenous communities, migrants and minoritised groups—embody VSD principles even when they do not use that label: they prioritise sovereignty, cultural safety, decolonial approaches and community control over data and outputs.

The evidence suggests that MEDViEW can operationalise VSD within co-creation by making values explicit from the outset, co-defining value priorities with stakeholders, and using values as criteria for design decisions and evaluation.

**RQ10.5 – Facilitation and power dynamics:** No high-match articles were found specifically on facilitation and power dynamics, but many studies across RQ10.1–10.3 discuss these issues as cross-cutting concerns. Key insights include:

- Power imbalances (between professionals and patients, researchers and communities, or majority and marginalised groups) can undermine co-creation if not addressed explicitly.
- Effective facilitation involves creating psychologically safe spaces, using accessible language, actively inviting quieter voices, and balancing contributions from different stakeholder groups.
- Equity-centred practice includes compensating participants fairly, accommodating logistics (transport, timing, childcare), and recognising that participation can be burdensome.
- Frameworks from CBPR and decolonial methodologies highlight the importance of community control, shared decision-making and sovereignty over data and narratives.

Some studies describe specific facilitation techniques, such as rotating chairing, small-group work, use of peer facilitators, co-facilitation with community partners, and consensus-building methods that prevent domination by more powerful actors. However, validated tools to assess “power-sensitive facilitation” or to measure the extent to which marginalised voices are genuinely heard remain limited, representing a clear gap for MEDViEW to address.

**Cross-cutting gaps and implications for MEDViEW:** The Domain 10 evidence base is methodologically strong and current, particularly for user-centred design, co-design tools and evaluation frameworks. It shows that co-creation has evolved from rhetoric to a practice with rigorous methods, validated tools and documented implementation experiences. It also highlights the centrality of equity and inclusion, and the need for context-sensitive adaptation. At the same time, several gaps remain. There is limited causal evidence linking co-creation and Living Labs to actual uptake, policy adoption and long-term impact; few operational, step-by-step valorisation models; sparse empirical work in integrative and complementary health contexts; and under-developed tools for evaluating value embedding, power dynamics and facilitation quality. Digital co-design is well covered, but digital valorisation pathways, governance and sustainability require further exploration.

For MEDViEW, this means:

- Drawing on existing frameworks and tools for user-centred and participatory design, while explicitly embedding CBPR and equity principles.
- Designing Living Lab-style activities that are tightly linked to implementation and evaluation, not only experimentation.

- Selecting and adapting co-design tools and evaluation frameworks from the literature to MEDViEW's four engagement areas, with clear process guidance.
- Making values explicit and co-defined, and using them as design and evaluation criteria.
- Investing in facilitation training, power-sensitive methods and the development of practical indicators to assess authentic, inclusive participation.

By addressing these gaps, MEDViEW can turn a strong methodological evidence base into a coherent, operational and equity-centred co-creation approach that supports robust knowledge valorisation across European wellbeing contexts.

### 3.11 Gaps and Opportunities (KINNO)

**Methodology:** Domain 11 synthesises insights across Domains 1–10 to identify unmet needs, cross-cutting barriers, enabling conditions and innovation opportunities in knowledge valorisation for wellbeing, while also adding a short literature review. Domain 11 acts as an integrative step that draws together conceptual, methodological and practical lessons from the preceding 10 domains. The specific aims were to: (1) identify critical unmet needs and “white spaces” in knowledge valorisation for wellbeing across research, practice, policy and society; (2) synthesise all barriers and facilitators identified in Domains 1–10 into an integrated taxonomy spanning individual, organisational, system and policy levels; (3) extract lessons on what has worked, what has not worked and what has only partially worked in related initiatives; (4) identify gaps emerging at the intersections of multiple domains that are not visible when each domain is considered in isolation; and (5) map emerging technological, methodological, policy and social opportunities for advancing knowledge valorisation. Four overarching research questions guided this synthesis: RQ11.1 (critical unmet needs and white spaces across research–practice–policy–society), RQ11.2 (barriers at individual, organisational, systemic and cross-border levels, and how they interconnect), RQ11.3 (facilitators and success factors of sustainable valorisation across diverse contexts and stakeholders) and RQ11.4 (lessons from successes, failures and partial successes that should inform MEDViEW's design, implementation and sustainability strategy). Databases used for the short literature review: Scopus, Web of Science, Google Scholar, Policy and EU Repositories.

#### Results:

**RQ11.1 – Critical unmet needs and white spaces:** Across Domains 1–10, several critical unmet needs in knowledge valorisation for wellbeing emerge:

- **Integrated, interdisciplinary wellbeing frameworks in practice.** Conceptual models that integrate physical, mental, social, environmental and governance dimensions exist, but are not consistently operationalised in policy and practice. There is an unmet need for indicator systems and decision tools that link wellbeing research directly to policy and service design.
- **Robust, transferable models for research-to-practice translation.** Many interventions and methodologies show promise, but there are relatively few clearly documented, step-by-step models that reliably move evidence into routine practice across different European health systems.
- **Scalable, equity-centred engagement models for multicultural EU contexts.** Engagement, CBPR and co-design approaches are often context-specific; scalable models that work across diverse European settings, including integrative/complementary health, remain underdeveloped.

- **Operational Quadruple Helix models in health and wellbeing.** While QH concepts are widely referenced, practical, health-specific models that integrate academia, industry, government and civil society with clear governance, power-sharing and conflict-resolution mechanisms are scarce.
- **Digital valorisation pathways.** Digital tools and platforms (e.g., MEDSPACE-type environments) are recognised as enablers, but there is limited evidence on long-term governance, equity, trust and sustainability of digital valorisation ecosystems.

These white spaces define where MEDViEW can make distinctive contributions: by developing operational, EU-adapted frameworks that integrate wellbeing concepts, research-to-practice pathways, digital platforms, co-creation and governance.

**RQ11.2 – Barrier taxonomy and interconnections:** Barriers to effective knowledge valorisation cluster at four levels:

- **Individual level.** Limited skills and confidence in implementation, co-creation, digital tools and IP; competing time demands; burnout and emotional strain (especially post-COVID); and distrust or scepticism among citizens and professionals. These factors limit engagement in capacity building, co-creation and adoption of new practices.
- **Organisational level.** Resource constraints (time, staffing, space, funding); fragmented workflows and unclear roles; weak support for interprofessional and cross-sector collaboration; limited evaluation and monitoring capacity; and institutional cultures that undervalue engagement, co-creation and implementation work relative to traditional academic outputs.
- **System and policy level.** Siloed governance structures, misalignment between research and policy cycles, regulatory and data-governance complexity, uneven digital infrastructure, and lack of harmonised KPI systems. Structural inequities and “unfair knowledge practices” marginalise some actors and knowledge types, limiting whose evidence is recognised and translated.
- **Cross-border and ecosystem level.** Variable capacity among Member States and regions; differing legal and funding frameworks; challenges coordinating cross-country initiatives; and inconsistent application of European guidance (e.g. knowledge valorisation principles, smart use of IP, Health in All Policies).

These barriers are interconnected. For example, system-level underinvestment in implementation capacity translates into organisational resource constraints, which in turn limit individual participation and burn out early champions. Digital divides at system level reduce the inclusivity and reach of platform-based engagement. Fragmented IP and regulatory regimes increase transaction costs for SMEs and universities, reducing willingness to engage in cross-sector valorisation.

**RQ11.3 – Facilitators, enabling conditions and success factors:** Despite these challenges, Domains 1–10 identify a range of facilitators and success factors:

- **Strong conceptual and policy frameworks.** Multidimensional wellbeing, One Health, Health in All Policies, European Health Union and knowledge valorisation guidance provide a normative and strategic foundation.
- **Participatory and equity-centred methodologies.** CBPR, co-design, co-creation, value-sensitive design, Living Labs and Communities of Practice, when implemented with attention to equity and power, enhance relevance, acceptability and trust.

- **Implementation and behavioural frameworks.** Use of implementation science (e.g. CFIR, RE-AIM, KTA, i-PARIHS) and behavioural theories improves the design, planning and evaluation of interventions, linking determinants, strategies and outcomes.
- **Digital platforms as socio-technical ecosystems.** Well-governed, participatory digital platforms can support learning communities, co-creation and dissemination, especially when combined with offline engagement and clear user journeys.
- **Structured capacity building.** Competency-based training, mentoring, communities of practice and cross-sector learning programmes build skills and networks needed for sustained valorisation.
- **Intermediary structures and PoC mechanisms.** Technology transfer centres, PoC funds and advisory services help bridge gaps between research, SMEs and public systems.

Effective initiatives typically combine several of these elements: a clear value orientation (e.g., equity, wellbeing, sustainability), participatory and transdisciplinary methods, supportive governance structures, robust evaluation and long-term relationship building.

**RQ11.4 – Lessons learned: what works, what doesn't, what partially works:** From across the domains and the additional synthesis sources, several lessons emerge:

**What tends to work well:**

- Early, continuous co-creation with diverse stakeholders, especially when grounded in CBPR and equity principles.
- Embedding implementation and evaluation frameworks from the start, rather than retrofitting them.
- Providing practical PoC support and intermediary facilitation between research, SMEs, health services and policymakers.
- Building long-term Communities of Practice and mentorship structures that sustain engagement beyond project timelines.
- Using digital platforms as enablers of relationships and workflows, not as standalone “solutions”.

**What tends not to work or often fails:**

- Treating valorisation as an end-of-project dissemination activity rather than as a continuous process.
- Relying solely on economic or bibliometric indicators, ignoring social, behavioural and equity outcomes.
- Tokenistic engagement (one-off consultations, unrepresentative panels, no real decision power).
- Overly rigid IP or governance arrangements that deter collaboration and adaptation.
- Stand-alone trainings without follow-up, mentoring or structural changes.

**What partially works but needs strengthening:**

- Multi-stakeholder and Quadruple Helix models that lack clear governance, power-sharing and conflict-resolution mechanisms.
- Hybrid digital–offline engagement that is inclusive in principle but limited by digital divides and unequal resources.
- Evaluation frameworks that are conceptually multi-dimensional but operationally fragmented, with inconsistent KPIs.
- Equity commitments that are stated in policy but not fully implemented in practice (e.g. limited disaggregation, insufficient resources).

These lessons suggest that MEDViEW's design and sustainability strategy should prioritise integration (across methods and levels), depth of engagement, and long-term structures over one-off activities.

**Cross-domain gaps and innovation opportunities for MEDViEW:** Synthesising across Domains 1–10, Domain 11 highlights several innovation opportunities where MEDViEW can create added value:

- **Integrated methodological framework.** MEDViEW can combine wellbeing research, implementation science, co-creation methods, capacity building, digital platforms, and smart IP management into a unified, practical toolset for “engagement through learning”, explicitly designed for EU health and wellbeing contexts.
- **Multi-level evaluation and impact architecture.** By integrating social, economic, scientific and behavioural indicators, co-created KPIs, and equity-sensitive wellbeing measures into a composite dashboard, MEDViEW can operationalise multi-dimensional impact assessment rather than treating it as a conceptual ideal.
- **Digital collaboration ecosystem (MEDSPACE) as a valorisation accelerator.** If designed with clear governance, user journeys, co-creation workflows and sustainability planning, MEDSPACE can become a reusable platform for connecting research, practice, SMEs and citizens, demonstrating how digital infrastructures can support long-term valorisation.
- **Operational Quadruple Helix models in wellbeing.** MEDViEW can prototype and document practical QH engagement models in its four engagement areas (mental health, metabolic challenges/cancer/diabetes, environment, governance), including concrete governance arrangements, facilitation practices and conflict-resolution strategies.
- **EU-adapted engagement and co-creation frameworks.** Building on CBPR, PPI and co-design evidence, MEDViEW can develop scalable, culturally adaptable engagement frameworks and tools for European multi-country, multi-sector settings, with explicit attention to CAM/integrative health where evidence is sparse.

These opportunities constitute the strategic focus for MEDViEW's capacity-building content and methodology integration. Domain 11 thus serves as a bridge from the state-of-the-art review to MEDViEW's own innovation agenda, ensuring that project activities respond directly to documented gaps and leverage known success factors for equitable, impactful knowledge valorisation.

## 4. Results synthesis – gaps and opportunities

This chapter summarises cross-cutting gaps, barriers, facilitators and opportunities emerging from Chapter 3 – results per domains (1–11 literature review), focusing on where MEDViEW can add the most value in advancing knowledge valorisation for wellbeing.

### 4.1 Cross-Domain Unmet Needs and White Spaces

Across domains, wellbeing and knowledge valorisation are understood as multidimensional and systemic, yet several critical unmet needs remain.

- **From concepts to operational models.** Multidimensional wellbeing and One Health frameworks are well developed conceptually, but rarely translated into routinely used indicators, dashboards and decision tools that inform policy and

practice across sectors. Governance aspects (institutional capacity, policy coherence, trust, participation) are recognised but under-measured.

- **Robust research-to-practice pathways.** Implementation frameworks and behavioural theories are widely referenced, but there is a lack of clearly documented, stepwise models that show, in practice, how evidence moves into routine care, public services or community settings in different European contexts.
- **Scalable equity-centred engagement.** CBPR, PPI, co-design and participatory approaches successfully engage specific communities, yet transferable EU-adapted models for multicultural, multi-country settings—and for complementary/integrative health—are limited.
- **Operational Quadruple Helix and open innovation.** Quadruple Helix and Open Innovation 2.0 are common reference points, but practical health-specific governance models integrating academia, industry (including SMEs), government and civil society remain scarce.
- **Digital valorisation ecosystems.** Digital platforms are seen as key infrastructures for collaboration and learning, but evidence on long-term governance, digital trust, equity and sustainability is thin.

These white spaces define priority directions for MEDViEW: turning conceptual strengths into operational frameworks and tools that are demonstrably usable across diverse European settings.

#### 4.2 Barrier Landscape and Enabling Conditions

Barriers identified across domains cluster at four interconnected levels.

- **Individual:** limited skills in implementation, co-creation, digital tools and IP; time pressure and burnout (especially post-COVID); stigma and low trust among citizens and professionals.
- **Organisational:** resource constraints; fragmented workflows and roles; weak support for interprofessional and cross-sector work; underdeveloped monitoring and evaluation capacity; incentive systems that privilege publications over engagement and implementation.
- **System/policy:** siloed governance; misaligned research and policy cycles; complex data and regulatory environments; uneven digital infrastructure and analytical capacity; structural inequities and “unfair knowledge practices” that marginalise some actors and epistemologies.
- **Cross-border/ecosystem:** varying legal and funding frameworks; coordination challenges in multi-country initiatives; high transaction costs for SMEs and community actors; uneven application of EU knowledge valorisation and smart IP principles.

At the same time, several enabling conditions recur across successful initiatives: strong conceptual and policy frameworks (wellbeing, One Health, Health in All Policies, EU knowledge valorisation), participatory and equity-centred methodologies (CBPR, co-design, VSD, Living Labs), robust implementation and behavioural science, digital platforms conceived as socio-technical ecosystems, structured experiential capacity building and intermediary infrastructures such as PoC funds and technology transfer centres.

#### 4.3 Lessons Learned: What Works and What Does Not

The cross-domain analysis suggests clear patterns relevant to MEDViEW’s design.

- **Works well:** early and continuous co-creation with diverse stakeholders; embedding implementation and evaluation frameworks from the outset; PoC-style

support and intermediaries connecting research, SMEs, services and policy; sustained Communities of Practice and mentorship; digital platforms used to support relationships and workflows rather than as stand-alone repositories.

- **Tends to fail:** treating valorisation as an end-of-project dissemination activity; relying only on economic/bibliometric indicators; tokenistic engagement with limited decision power; rigid IP/data arrangements that deter collaboration; one-off trainings without follow-up or organisational change.
- **Partially works, needs strengthening:** Quadruple Helix initiatives without clear governance and power-sharing; hybrid digital–offline engagement constrained by digital divides; conceptually rich but operationally fragmented evaluation systems; equity commitments not fully translated into practice or resourced adequately.

These lessons underscore the need for integrated, long-term, power-sensitive approaches rather than isolated activities.

#### 4.4 Strategic Opportunities for MEDViEW

Building on this synthesis, MEDViEW has several strategic opportunities:

1. **Integrated methodological framework:** combine action learning and Communities of Practice, participatory and value-sensitive design, behavioural and implementation science, and open innovation/smart IP into a coherent “engagement through learning” framework with concrete playbooks and tools.
2. **Multi-level impact architecture:** design a composite dashboard that integrates scientific, economic, social, behavioural, equity and wellbeing indicators (including co-created KPIs and disaggregation), embedding evaluation across the project lifecycle.
3. **Digital collaboration ecosystem (MEDSPACE):** develop MEDSPACE as a reusable socio-technical infrastructure for role-sensitive engagement, hybrid journeys, co-creation workflows and Communities of Practice, with clear governance and attention to digital equity and sustainability.
4. **Operational Quadruple Helix models:** prototype and document practical QH engagement models in MEDViEW’s four engagement areas (mental health, metabolic challenges/cancer/diabetes, environmental determinants, governance), including governance structures, facilitation and conflict-resolution approaches.
5. **EU-adapted engagement frameworks and capacity building:** create scalable engagement and co-creation frameworks tailored to European multi-country, multi-sector contexts, and align capacity building with identified competencies, linking training to organisational processes and incentives.

Pursuing these opportunities will allow MEDViEW not only to respond to identified gaps, but to offer a coherent, evidence-based and transferable model of knowledge valorisation for wellbeing across Europe.

## 5. Methodological Building Blocks Integration

This chapter outlines how MEDViEW’s four methodological building blocks are integrated into a coherent framework for “engagement through learning” that supports knowledge valorisation across research, practice, policy and society. The building blocks are: (1) Action Learning and Communities of Practice, (2) Value-Sensitive Design through co-creation, (3) Behavioural Change through education and Living Labs, and (4) Open Innovation for SME engagement. Together, they provide

complementary lenses and tools that can be orchestrated across MEDViEW's work packages and engagement areas.

### 5.1 Action Learning and Communities of Practice

**Principles and theoretical foundation:** Action Learning and Communities of Practice (CoPs) provide the social and organisational backbone for MEDViEW's valorisation activities. Action Learning is grounded in experiential learning theory: small groups work on real-world problems through iterative cycles of planning, action, reflection and adaptation. CoPs build on social learning theory, viewing learning as participation in a shared practice where members develop a common repertoire of tools, stories and norms over time. In this perspective, knowledge valorisation is not a one-off transfer of findings but an ongoing, collective learning process. Action Learning structures focus attention on concrete challenges and opportunities in specific health and wellbeing contexts, while CoPs sustain relationships, tacit knowledge exchange and peer support beyond individual projects.

#### **Application to knowledge valorisation**

Within MEDViEW, Action Learning and CoPs are used to:

- Bring together practitioners, researchers, policymakers, citizens and SMEs around real problems (e.g. mental health of young people, metabolic and cancer-related challenges, environmental determinants, governance resilience).
- Embed evidence into practice by linking research outputs to local priorities, constraints and resources.
- Support iterative testing, reflection and adaptation of interventions and tools in real settings.
- Create "social infrastructures" where lessons and methods spread horizontally across organisations and countries.

Each CoP is expected to develop its own shared repertoire (guides, tools, case stories, templates), feeding both into the MEDSPACE platform and into local practice.

#### **Community-building strategies**

To ensure CoPs are vibrant and impactful, MEDViEW will adopt explicit community-building strategies, including:

- Clear purpose and thematic focus aligned with the four engagement areas.
- Role clarity (core group, active members, peripheral participants) and rotating leadership to reduce dependence on single champions.
- Regular, structured interaction formats (online sessions, local learning sets, cross-site exchanges) linked to concrete tasks and outputs.
- Skilled facilitation to foster psychological safety, inclusivity and productive conflict.
- Recognition and visibility mechanisms (badges, contributions to outputs, opportunities to present work) to sustain motivation.

These strategies ensure that Action Learning and CoPs function as the "engine room" for continuous knowledge valorisation in MEDViEW.

### 5.2 Value-Sensitive Design through Co-Creation

#### **VSD principles and ethical considerations**

Value-Sensitive Design (VSD) ensures that MEDViEW's tools, processes and interventions are aligned with ethical and societal values. Core VSD principles include:

- Explicit identification of relevant values (e.g. equity, inclusivity, fairness, transparency, privacy, sustainability, autonomy).

- Recognition that values are plural, context-dependent and sometimes conflicting.
- Integration of value considerations throughout the design lifecycle, not only at the end.

Ethical considerations are particularly salient in areas such as mental health, digital platforms, data governance and AI-enabled tools, as well as in work with marginalised groups and integrative/complementary health.

### **Co-creation methodology framework**

To operationalise VSD, MEDViEW adopts a co-creation framework structured in stages:

- Framing and scoping: Jointly define the problem, stakeholders and context; identify candidate values and potential tensions.
- Exploration and insight generation: Use participatory methods (interviews, focus groups, journey mapping, ethnographic probes) to understand lived experiences and value priorities.
- Co-design and prototyping: Develop solution concepts and prototypes (e.g., processes, tools, platform features, training modules) in mixed stakeholder groups, making value choices explicit.
- Iterative testing and refinement: Test prototypes in real settings (often via Action Learning sets or Living Labs), gather feedback on both usability and value alignment, adjust accordingly.
- Embedding and governance: Agree on how values will continue to be monitored and negotiated (e.g. governance structures, codes of conduct, equity and ethics indicators).

This framework is applied consistently across MEDViEW's engagement areas and linked to CoP activities.

### **Stakeholder value mapping**

Stakeholder value mapping is used to make explicit how different groups interpret and prioritise values, and where tensions may arise. Steps include:

- Identifying key stakeholder groups (e.g. patients, carers, clinicians, CAM practitioners, SMEs, policymakers, community organisations).
- Mapping perceived benefits, risks and value priorities for each group.
- Visualising value tensions (e.g. efficiency vs equity, openness vs privacy, innovation speed vs safety) and exploring design options that balance them.
- Using these maps as living documents within CoPs and governance structures to guide decisions and conflict resolution.

By embedding stakeholder value mapping into co-creation, MEDViEW ensures that ethical and social considerations are not peripheral but integral to design and implementation.

## **5.3 Behavioural Change through Education and Living Labs**

### **Learning-based behavioural change strategies**

Behavioural change in MEDViEW is approached as a learning process that combines individual capabilities, opportunities and motivations with supportive environments. Educational strategies are grounded in established theories (e.g. COM-B, self-determination theory, social cognitive theory), and include:

- Competency-based training modules for different target groups (clinicians, CAM practitioners, managers, policymakers, citizens).

- Experiential learning formats (simulations, case-based learning, reflective practice) that link abstract concepts to real challenges.
- Feedback and coaching mechanisms that support application of new skills over time.

Education is integrated with CoP activities, so that training is directly connected to ongoing projects and peer support.

### **Living Lab methodology**

Living Labs complement educational strategies by providing real-world environments where behaviours and practices can be tested and adjusted. In MEDViEW, Living Lab principles are applied flexibly across the four engagement areas:

- Mental health: co-design and test new service pathways or digital tools with young people, families and professionals.
- Metabolic challenges/cancer/diabetes: experiment with integrative care models, self-management tools and community supports.
- Environmental determinants: pilot interventions that link environmental exposures, lifestyle and wellbeing in community settings.
- Governance and resilience: test new participatory governance mechanisms, feedback loops and data-informed decision processes.

Living Labs are characterised by multi-stakeholder participation, iterative cycles, mixed-method evaluation and strong links to local organisations.

### **Participatory learning approaches**

Participatory learning methods are used within both educational activities and Living Labs, including:

- Co-interpretation of data and evidence with practitioners and citizens.
- Joint development of change hypotheses and small-scale tests of change (“learning by doing”).
- Reflective sessions where stakeholders analyse successes, failures and unexpected consequences.

This integration of behavioural science, education and Living Labs ensures that knowledge valorisation is anchored in real practice changes and not only in cognitive awareness.

## **5.4 Open Innovation for SME Engagement**

### **Open Innovation 2.0 framework**

MEDViEW adopts an Open Innovation 2.0 perspective, viewing innovation as a co-created process among four main actor groups: academia, industry (especially SMEs), government and civil society. This Quadruple Helix approach emphasises:

- Shared innovation spaces and testbeds.
- Joint agenda setting and co-investment.
- Open data and knowledge sharing under clear governance and IP arrangements.

In this framework, SMEs are not peripheral suppliers but core partners in developing, testing and scaling wellbeing innovations.

### **SME-specific engagement strategies**

To make SME participation feasible and attractive, MEDViEW will implement SME-tailored strategies, such as:

- Clear articulation of value propositions for SMEs (access to testbeds, clinical partners, user insights, policy networks).
- Simplified entry points and standardised collaboration templates (MoUs, NDAs, data-sharing and IP guidelines).
- Dedicated support for navigating regulatory, data protection and reimbursement issues.
- Time-boxed co-creation sprints and pilot projects that match SME cycles.

These strategies are closely linked to the digital platform (e.g. MEDSPACE) and to Living Lab and CoP structures, providing SMEs with visible, navigable pathways into MEDViEW.

### Trigger points and development pathways

Finally, MEDViEW defines “trigger points” and development pathways for SME-relevant knowledge valorisation:

- Trigger points might include promising project results (methods, tools, digital components), expressed needs from practice or policy, or gaps identified by CoPs.
- For each trigger, MEDViEW can define a pathway that includes: initial exploration and feasibility assessment with SMEs; PoC-style testing in Living Labs; refinement and IP/contracting decisions; and routes to adoption (e.g. integration into services, licensing, partnerships, spin-offs).

By making these pathways explicit and linking them to the other methodological building blocks, MEDViEW ensures that SME engagement is structured, transparent and aligned with its broader goals of equitable, sustainable knowledge valorisation.

Table 6 summarises how the four methodological building blocks are distributed and integrated across the MEDViEW domains and engagement areas.

*Table 6: Methodological Building Blocks Integration Matrix*

| Domain | Focus                               | Methodological Building Blocks (MBBs) addressed                           | Main engagement areas / uses                                                |
|--------|-------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 1      | Wellbeing concepts & research       | MBB1 – Action Learning & CoPs (conceptual focus for learning themes)      | Mental health; metabolic/cancer/diabetes; environmental; governance framing |
| 2      | Policy–research integration         | MBB1, MBB2, MBB3, MBB4 (policy interfaces for all four MBBs)              | Policy implementation, Health in All Policies, governance & resilience      |
| 3      | Methodological building blocks      | MBB1–MBB4 (core theoretical and design foundation)                        | All engagement areas; overall MEDViEW methodological framework              |
| 4      | Evaluation & impact metrics         | MBB1–MBB4 (monitoring learning, values, behaviour change, SME innovation) | Performance measurement, impact/KPIs, feedback loops for all MBBs           |
| 5      | Digital enablement tools (MEDSPACE) | MBB1 (online CoPs), MBB2 (digital co-creation), MBB3                      | Online co-creation, hybrid engagement, Communities of Practice, SME access  |

| Domain | Focus                              | Methodological Building Blocks (MBBs) addressed                                                         | Main engagement areas / uses                                                 |
|--------|------------------------------------|---------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
|        |                                    | (digital Living Lab support), MBB4 (SME collaboration)                                                  |                                                                              |
| 6      | IP protection & commercialisation  | MBB1 (learning on IP use), MBB2 (value-sensitive IP choices), MBB4 (Open Innovation & SME pathways)     | SME engagement, PoC pathways, smart IP use, commercialisation roadmaps       |
| 7      | Research translation pathways      | MBB1 (practice-based learning), MBB3 (behaviour change & Living Labs), MBB4 (innovation ecosystems)     | Practitioner adoption, scaling, integration into services and care pathways  |
| 8      | Capacity building & training       | MBB1–MBB4 (all as content and pedagogy for training and mentoring)                                      | Multi-stakeholder skill development, “engagement through learning”           |
| 9      | Stakeholder engagement practices   | MBB1 (participatory CoPs), MBB2 (equity- and trust-oriented co-creation), MBB3 (participatory learning) | Citizen/patient involvement, multi-stakeholder collaboration, trust building |
| 10     | Co-creation & participatory design | MBB2 (VSD & co-design), MBB3 (Living Lab-oriented co-creation)                                          | User-centred wellbeing innovation in all four engagement areas               |
| 11     | Gaps & opportunities synthesis     | MBB1–MBB4 (identifies integration needs and white spaces across all MBBs)                               | Strategic focus, priority areas for methodological development               |

## 6. Stakeholder Needs Assessment (EUROCAM)

Stakeholder needs were assessed in a two-step way. First, a questionnaire was prepared and created as an online form with GoogleForms (some screen captures available in Annex B, while the whole questionnaire is available upon request) for easy access. Communication for stakeholders to participate in the short online questionnaire was performed by partner Eurocam with social media posts. Second, after the questionnaire closure, and online open dialogue session with stakeholders was held. Both activities are presented in the bellow subchapters.

### 6.1 Stakeholder questionnaire - summary of findings

Between 10-20 March 2026, EUROCAM collected 60 responses to a stakeholder questionnaire. The questionnaire was designed to:

- Identify existing knowledge, methodologies, and best practices in well-being research and knowledge valorisation;
- Surface gaps in current capacity; and,

- Gather community feedback to inform the development of the T3.2 Capacity Building Programme.

Respondents represented a diverse international community including practitioners, researchers, advocates, and educators—predominantly from the complementary and integrative medicine (CAM) sector—across Europe, South America, and beyond. The findings provide direct evidence base for WP3 and feed into Project Objective 2 (PO2): the design and implementation of inclusive, participatory capacity-building programmes that generate cutting-edge, practically applicable knowledge and support long-term project impact. Summary of findings are structured around different topics.

### **1. Familiarity with Well-Being Research and Knowledge Valorisation**

Respondents demonstrated a broad spectrum of knowledge levels, which has direct implications for how the T3.2 Capacity Building Programme may be tiered and differentiated. Approximately 43% described themselves as “very familiar” or at “expert level” in well-being research and knowledge valorisation, while a further 33% were “somewhat familiar”. A smaller but notable cohort (~24%) reported being “a little” or “not at all” familiar, underscoring the need for accessible entry-level resources alongside more advanced materials.

Confidence in using structured tools largely mirrored this pattern where 45% of respondents felt “confident” or “very confident”, while others expressed hesitation, particularly those newer to formalised research frameworks. Importantly, even those with “expert level” self-assessment identified practical gaps, further suggesting that confidence alone does not guarantee access to the right tools, networks, or methodological frameworks. This finding directly supports the rationale for WP3's capacity-building approach: a single-tier programme will not meet the needs of this diverse community.

### **2. Current Methods and Approaches in Use**

Task 3.1 calls for an analysis of existing methodologies and best practices. The questionnaire reveals that respondents already draw on a rich and pluralistic methodological toolkit consisting of workshops and group discussions, informal conversations, case studies, and clinical or therapeutic assessments were among the most frequently cited. A significant proportion of respondents also use body-based and experiential methods (e.g., movement, mindfulness, and somatic practices), as well as creative and arts-based approaches, peer-led sessions, and community or participatory mapping.

This diversity is significant in two ways: first, it confirms that the MEDVIEW community already has substantial practical knowledge that can be mobilised within the project's learning network; and second, it signals that the T3.2 programme must accommodate for a wide range of methodological traditions, including, but not only academic or clinical frameworks, if it is to be genuinely inclusive. The findings also validate the project's adoption of methodological building blocks such as Value-Sensitive Design, Behavioural Change through Education, and Action Learning, all of which resonate with approaches already in use among this respondent community.

### **3. Capacity Gaps and Learning Needs**

A central aim of T3.1 is to identify gaps, challenges, and opportunities within the existing landscape. The questionnaire surfaces several interconnected capacity gaps that should directly shape the T3.2 Capacity Building Programme:

### **Knowledge and Materials Gaps**

- Shortage of accessible learning materials: Numerous respondents identified a shortage of easily accessible, non-paywalled learning materials in well-being and complementary and integrative medicine research. One noted that “high prices of relevant books and textbooks” present a barrier (which, of course, neither EUROCAM nor MEDVIEW holds sway over); another highlighted a need for “materials to teach in schools and to engage young people”.
- Existing materials are often outdated or discipline-siloed: Several respondents noted that current tools are outdated or fail to integrate across disciplines. A call for “a good comparison of all things available with categorisation as to which methods have enhanced well-being” reflects demand for synthesised, cross-disciplinary resources and is directly aligned with T3.1's task of integrating the project's methodological building blocks.
- Complementary and integrative medicine-specific evidence base is a priority gap: Multiple respondents—including some working in policy-adjacent roles—highlighted the lack of accessible, credible evidence summaries on complementary medicine for non-specialist decision-makers. This gap presents a concrete opportunity for MEDVIEW's knowledge valorisation outputs.
- Narrative and experiential knowledge is undervalued: One respondent noted that “the main gap is valuing narratives”, pointing to a systemic issue in how evidence is defined and whose knowledge counts in well-being research, a challenge that the project's co-creation and Action Learning approaches are well-placed to address.

### **Skills and Confidence Gaps**

- Unfamiliarity with co-creation: 20% of respondents (12/60) were “not sure what co-creation involves”, pointing to a need for foundational capacity-building before deeper participatory activities can be launched under T3.2.
- Limited confidence with structured tools: A significant minority of respondents expressed low confidence in using structured well-being frameworks and research tools, indicating that the T3.2 programme should include practical guidance on these methods in plain language.
- Isolation and lack of networks: 27% of respondents (16/60) noted they “do not have partners or networks to co-create with,” representing a skills-adjacent gap that the project's learning network structure can directly address by connecting practitioners, researchers, citizens, and entrepreneurs.

### **Multilingual and Accessibility Gaps**

- Multilingual and culturally adapted materials are needed: Responses in Spanish and French, combined with explicit requests for translated materials, confirm that language is a significant barrier to knowledge access and participation across the EU. The T3.2 programme must include multilingual provisions (in plain, accessible language) if it is to achieve genuine European reach.
- Digital access barriers: 12% of respondents cited digital or technical barriers to participation, with multiple respondents identifying people with limited digital access as among the hardest-to-reach community groups. Programme design must account for both online and non-digital delivery pathways.

## **4. Stakeholder Engagement: Barriers, Motivations, and Preferred Formats**

PO2 identifies the learning network as the core interaction model for MEDViEW. The questionnaire provides detailed intelligence on how to make this network function effectively.

**Barriers to Engagement:** Time constraints emerged as the single most consistently cited barrier, appearing in 35% of responses to Q6 and 43% of responses to Q7. Unclear purpose or expectations (47%; 28/60) was the second most prominent concern, followed by lack of networks and partners (27%; 16/60), trust-related barriers including fear that contributions would not be valued (18%; 11/60), and digital or technical barriers (12%). Language and communication barriers were cited by 12% of respondents across both questions, with additional evidence from multilingual responses. Notably, several respondents cited lack of financial support or funding as a barrier, reflecting wider structural pressures within the complementary and integrative medicine and integrative health sector.

**Hard-to-Reach Groups:** At the institutional and organisational level, national government bodies, health and social care providers, and EU-level institutions were most frequently identified as difficult to engage with. Among community populations, respondents highlighted people experiencing financial hardship, those with limited digital access, minority and marginalised groups, people with limited time, and younger adults as particularly challenging to reach. This finding directly informs the equity design principles for T3.2: any capacity-building programme must explicitly account for differential access across these groups.

**Motivations for Participation:** The questionnaire reveals a community strongly motivated by professional vocation and personal mission. Practitioners and researchers described their engagement in well-being as a core commitment with recurring themes around bridging the gap between evidence and practice, supporting patient empowerment, and advancing recognition of complementary medicine. Several respondents also expressed personal motivations: curiosity, lifelong learning, and the aspiration to contribute to positive change at scale. These motivators are valuable assets for the T3.2 programme as they suggest participants will engage deeply if the programme is well-designed, presents clear purpose, and is genuinely co-produced.

**Preferred Learning and Feedback Formats:** The questionnaire asked respondents both what types of support would help them participate and how they would prefer to give feedback. Short videos (57%; 34/60) and digital platforms (60%; 36/60) were the most frequently selected support resources, followed by simple written guides (50%; 30/60), mentoring or facilitation (43%; 26/60), templates or step-by-step instructions (43%; 26/60), and in-person workshops and peer-to-peer sessions (both 37%; 22/60). For feedback, short online questionnaires and email were the most preferred channels, with group discussions and one-to-one interviews also well-supported. This pattern suggests the T3.2 programme may continue a blended delivery model, combining short-form digital content with structured facilitated sessions and peer learning.

## **5. Conditions for Effective Knowledge Valorisation**

Respondents were clear about the conditions under which research findings and capacity-building outputs would be most useful. The top-ranked preferences were:

findings shared in plain, everyday language (73%; 44/60); clear examples of how findings apply to specific situations (65%; 39/60); being involved in shaping what is researched (62%; 37/60); practical tools or resources based on findings (68%; 41/60); and findings shared via trusted local organisations or figures (50%; 30/60).

These preferences collectively reinforce the core logic of WP3, that knowledge valorisation is not a passive transfer process but an active, co-produced one. The community's strong preference for participatory agenda-setting—62% (37/60) expressed interest in a role shaping what is researched—directly validates the project's adoption of co-creation and Action Learning methodologies. The equally strong preference for practical, accessible outputs confirms that T3.2 programme materials must be designed with end-users in mind from the outset.

## **6. Existing Community Assets**

An important finding from the questionnaire is the extent of existing knowledge assets within the respondent community. 42% of respondents (25/60) have produced, or are actively developing, learning or training materials in well-being research and knowledge valorisation, including webinars, articles, training modules, books, case reports, and digital resources. A further 42% (25/60) provided substantive responses identifying specific gaps in learning materials, demonstrating a reflective and analytically engaged community.

These existing assets represent a significant opportunity for MEDViEW: rather than reinventing the wheel or building pre-existing assets from scratch, T3.1 and T3.2 can identify, curate, and build upon materials already circulating within the network. This approach aligns with the project's commitment to genuine co-creation and avoids duplication of effort.

## **7. Implications for T3.2 Capacity Building Programme Design**

Drawing together the findings above, the following design principles emerge for the T3.2 Capacity Building Programme:

- **Tiered and differentiated content:** The programme must serve both novice and expert participants. Entry-level modules on co-creation, knowledge valorisation, and structured research tools are needed alongside more advanced content for experienced practitioners and researchers. Language matters in this environment and may be the very driver that engages or drives away participants.
- **Blended delivery:** A combination of short videos, digital platforms, written guides, peer-to-peer sessions, and in-person or facilitated workshops will best serve the diverse needs and access profiles of the target community.
- **Multilingual provision:** As the European Union recognises 24 official languages, core materials should be made available in at least the three major EU working languages (English, German, French) with representation in Spanish and other respondent community languages, with translation and cultural adaptation built into the programme design.
- **Trust and clarity as preconditions:** Before co-creation activities can be launched, the programme must invest in clearly communicating purpose, expectations, and how outputs will be used, including explicitly addressing psychological safety and power dynamics.
- **Building the learning network:** The programme should actively facilitate connections between practitioners, researchers, citizens, and entrepreneurs, addressing the significant isolation reported by respondents and enabling the knowledge co-creation process described in PO2.

- Co-produced agenda-setting: Given that 62% (37/60) of respondents want to help shape what is researched, the programme may incorporate structured mechanisms for participatory agenda-setting, not just participatory delivery, given the scope and timeframe of the current project.
- IP, funding, and SME engagement: T3.2 includes training for researchers on IP protection and funding instruments, and guidelines for SME uptake. The questionnaire confirms appetite for practical, actionable content, suggesting these modules will be well-received if framed in accessible terms.
- Follow-up and continuity: Respondents consistently expressed a desire for ongoing engagement. The programme should build in structured follow-up mechanisms and make explicit commitments about how participant contributions will be used and valued.

## 8. Engagement Potential and Next Steps

70% of respondents (42/60) expressed willingness to take part in follow-up conversations or group sessions with 40% confirming (24/60) and a further 30% indicating they would like more information first (18/60). This represents a strong and motivated cohort for deeper participatory work under T3.2. The 30% who want more information before committing signals that clarity of purpose and expectations—one of the top barriers identified in the questionnaire—remains a key communication priority for the project team.

Recommended next steps include:

- Conducting targeted follow-up interviews with willing respondents to deepen the gap analysis initiated in T3.1 (EUROCAM will conduct a round-table with 19 interested respondents and multiple 1:1 follow-ups);
- Using the findings to draft the Engagement through Learning guidelines called for in Task 3.1; and,
- Convening a small co-design group drawn from respondents to shape the structure and content of the T3.2 programme prior to full development.

**Conclusion:** The MEDViEW stakeholder questionnaire has provided an informative community-grounded evidence base for WP3. It confirms both the depth of expertise within the MEDViEW community and the significant structural barriers that any effective capacity-building programme must address, including time, access, language, trust, and isolation. The findings also validate the project's core methodological commitments: co-creation, participatory agenda-setting, Action Learning, and accessible, practically-framed knowledge outputs. They also reveal a community ready and willing to engage, provided the programme is clear, inclusive, and genuinely responsive to their needs.

### 6.2 Open dialogue session with stakeholders

On 24 March 2026, MEDViEW hosted its first Open Dialogue Session as part of Work Package 3 (T3.1 Engagement through Learning). The one-hour online session brought together 14 participants from across the well-being and complementary medicine ecosystem, including health practitioners, researchers, patient advocates, representatives of professional associations, and SME stakeholders. The session was facilitated by Cristal Skaling-Klopstock, Lina Lisithiotaki, and Kayla King (partner

EUROCAM) and structured around two rounds of open dialogue followed by a collective reflection exercise.

The 14 participants represented a cross-section of stakeholders relevant to MEDVIEW's mission, including:

- Health practitioners from complementary and integrative medicine disciplines (including homeopathy, classical medicine, and holistic health practice)
- Researchers working at the intersection of evidence, practice, and policy
- Patient advocates and patient community representatives
- Professional association leads and educators
- SME and sector organisation representatives
- Media and policy-adjacent stakeholders with experience engaging EU and national ministries

### **Round 1: What Gaps Matter Most?**

The first dialogue round focused on barriers to integrating well-being practices into mainstream health pathways and the kinds of knowledge currently undervalued or overlooked. Many of these participants also answered the questionnaire developed by EUROCAM, and they again identified a core tension between the quality and credibility of complementary and integrative medicine (TCIH) practitioners, well-being approaches and the public and institutional perception of those qualifications. Several contributors noted that many TCIH modalities are self-regulated or entirely unregulated, with no standardised qualification framework visible to the public, policymakers, or mainstream health providers. This was seen as a significant obstacle to integration at Universal Health Coverage (UHC) level.

Key themes emerging from Round 1 included the need for targeted media and research campaigns to elevate both the evidence base and the professional qualifications of CAM practitioners and well-being practices; the importance of educating practitioners first, with community-level integration seen as the pathway to systemic change; the challenge that holistic health and well-being capacities are often split across different government ministries, limiting coherency in policy engagement; and the potential value of cross-disciplinary dialogue and honest collaboration as a precondition for credibility.

### **Round 2: Making Participation and Co-Creation Easier**

The second round explored what would make participation, collaboration, and co-creation more accessible and sustainable. Participants were more hesitant to speak but highlighted the importance of shared language as a foundational requirement. Without common terminology and framing, co-creation efforts risk stalling at the level of mutual misunderstanding. A pre-session training prior to co-creation workshops was proposed as a practical solution.

Other key outputs included the value of communities of practice which may connect individuals across disciplines around shared interests and challenges; the importance of transparency as some organisations were noted to withhold codes of ethics and occupational standards from public view, which undermines collective credibility; the role MEDVIEW and the upcoming MEDSPACE platform could play as a trusted intermediary and moderator of cross-community knowledge exchange; and the potential to embed well-being literacy in schools and educational curricula as a long-term integration strategy.

### Collective Reflection: Priorities and What We Take Forward

Participants closed the session by identifying what they considered their “top” priorities for the MEDViEW learning programme. **The most strongly voiced themes were: the recognition of TCIH and holistic health at ministerial and policy level; respect and equality of educational and professional qualifications across disciplines; communities of practice that facilitate relationship-building and shared interests; open and honest collaboration across disciplines and silos; bridging the gap between pharmaceutical and medical insurance systems and complementary and well-being approaches; and the need for grant funding or training on how to access such funding to support genuine co-creation work.**

Participants identified shared language across disciplines as both a tension and an opportunity, again a necessary precondition for co-creation that is currently absent in many settings.

## 7. Conclusions and Next Steps

Task 3.1 constitutes the foundational methodological activity of WP3. By systematically mapping the existing knowledge base, highlighting methodological gaps and opportunities, and assembling MEDViEW’s methodological building blocks into a unified “engagement through learning” framework, it provides the reference point for all subsequent work on knowledge valorisation and capacity building within the project.

The outputs of T3.1 are designed to directly inform and guide the design of the Capacity Building Programme in T3.2 and its implementation in T3.3, while also supporting other WPs that rely on robust, participatory and impact-oriented methodologies. In this way, T3.1 helps ensure that MEDViEW’s activities are conceptually grounded, methodologically consistent, policy-relevant and explicitly geared towards effective, equitable knowledge valorisation.

### 7.1 Implementation Roadmap for WP3

T3.1 (D3.1) is the methodological and evidence base for the entire WP3 “engagement through learning” pipeline, and directly feeds both T3.2 and T3.3.

### Connection to Task 3.2 – Capacity Building Program Design

The work in T3.1 delivers three key inputs for T3.2.

- **State-of-the-art and gap map.** The Domain-based literature review and synthesis in D3.1 identify existing knowledge, methods and best practices in wellbeing research and knowledge valorisation, as well as gaps, challenges and opportunities. These findings define what competencies, topics and methods the Capacity Building Programme must address (e.g. co-creation, stakeholder engagement, IP and funding for PoC, digital platforms, evaluation and impact).
- **Integrated methodological building blocks.** Chapter 5 of D3.1 specifies how the four Methodological Building Blocks (Action Learning & CoPs, Value-Sensitive Design & co-creation, Behavioural Change & Living Labs, Open Innovation & SME engagement) fit together into a unified “engagement through learning” framework. This framework becomes the structuring logic for T3.2: training modules, learning

pathways and materials are designed around these building blocks and the 12 thematic areas derived from T3.1.

- **Engagement through Learning guidelines and stakeholder needs.** T3.1 also includes initial Engagement through Learning guidelines and stakeholder-needs insights (from literature and forthcoming consultations), which define how capacity building should be delivered: participatory, equity-sensitive, hybrid (online/offline), and tailored to different groups (citizens/patients, clinicians, CAM practitioners, SMEs, policymakers).

On this basis, T3.2 re-uses existing training resources where possible and develops possible new materials explicitly aligned with the gaps, priorities and methods identified in D3.1. The D3.2 Capacity Building Program Materials thus operationalise the methodological framework and priorities established in T3.1.

### **Connection to Task 3.3 – Training Implementation**

T3.3 implements, tests and refines what T3.1 and T3.2 have designed.

- **Content and structure for the 24 workshops/webinars.** The topics, learning objectives and formats of the 24 planned workshops/webinars are directly derived from the D3.1 findings (domains, gaps, methodological building blocks) and the programme architecture created in D3.2. T3.3 essentially “deploys” the Engagement through Learning methodology in real settings, with citizens, researchers, SMEs and policymakers.
- **Action Learning and Communities of Practice in practice.** The Action Learning & CoP model conceptualised in D3.1 becomes the core delivery model in T3.3: workshops and webinars are designed as iterative, problem-focused learning cycles rather than stand-alone lectures, and they are embedded in emerging Communities of Practice across the four engagement areas.
- **Feedback loop for further refinement.** Evidence and feedback collected during T3.3 (participation data, learner feedback, practice changes, barriers) are interpreted against the expectations and indicators outlined in D3.1. This informs the Engagement through Learning Report (D3.3) and the Capacity Building Evaluation Report (D3.4), closing the loop between the initial methodological design (T3.1), programme design (T3.2) and real-world implementation (T3.3).

In summary, D3.1 defines what matters and how MEDViEW should approach engagement through learning; T3.2 turns this into concrete capacity-building programmes; and T3.3 brings these programmes to life with stakeholders, generating practice-based evidence that validates and further enriches the original methodology.

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[The whole literature list of the literature that was used for summaries generation for all 11 domains – 1467 literature items in the form of journal papers, books, reports and similar – is available upon request.]

## Annexes

Annex A: Literature review specification (aims, expected outcomes, research questions, search keywords, inclusion criteria, content focus)

### **Domain 1: Wellbeing Research (Narrative Review)**

Domain 1 was structured around the following themes: healthcare, psychology, economics perspectives; multidimensional health; post-COVID challenges.

#### Specific aims:

- Synthesize multidisciplinary perspectives on wellbeing across healthcare, psychology, and economics to establish common conceptual ground
- Document the evolution of wellbeing conceptualization, particularly post-COVID-19 challenges and the One Health approach
- Identify successful research approaches integrating physical, mental, and social health dimensions

#### Expected outcomes:

- Conceptual framework defining wellbeing for the MEDVIEW community, moving beyond "absence of illness" to "ability to adapt and self-manage"
- Evidence base justifying the four engagement areas (mental health, metabolic challenges/cancer/diabetes, environmental factors)
- Integration model aligning wellbeing research with European Health Union priorities and "Health in All Policies" approach

#### Research questions:

- RQ1.1: How is wellbeing conceptualized across healthcare, psychology, and economic disciplines, and what common definitional elements can create shared understanding among diverse stakeholders?
- RQ1.2: What are the documented immediate, short-term, and long-term wellbeing impacts of COVID-19 across different population groups (women, youth, people with pre-existing conditions, healthcare workers)?
- RQ1.3: What multidimensional frameworks successfully integrate physical, mental, social, and spiritual health dimensions in research and practice?
- RQ1.4: How does the One Health approach (people-animals-ecosystems) manifest in contemporary wellbeing research and what are its implications for citizen engagement?

#### Search keywords:

- Primary: wellbeing OR well-being OR wellness, multidimensional health, quality of life, holistic health, One Health approach, biopsychosocial model.
- Secondary: healthcare perspectives wellbeing, psychological wellbeing, economic wellbeing, social determinants health, integrative health.
- Post-COVID: COVID-19 wellbeing impact, pandemic mental health, post-pandemic challenges, permacrisis, anxiety depression prevalence, healthcare worker burnout.
- Frameworks: multidimensional health assessment, wellbeing measurement, quality of life frameworks, health status indicators, WHO wellbeing definition.

#### Inclusion criteria:

- Timeframe: Publications from 2018-2025 (prioritizing post-COVID period 2020-2025 for pandemic impact).
- Language: English (primary); French, German, Greek, Spanish (if relevant and accessible to team).

- Publication Type: Peer-reviewed articles, systematic/narrative reviews, meta-analyses, WHO/EU policy documents, reports from European Observatory on Health Systems and Policies.

#### Content focus:

- Multidimensional conceptualizations of wellbeing (physical, mental, social, spiritual dimensions).
- Healthcare, psychology, economics, or sociology perspectives on wellbeing.
- Post-COVID-19 wellbeing impacts and challenges.
- One Health approach integrating human-animal-ecosystem health.
- European Health Union and "Health in All Policies" frameworks Context: European or OECD countries (for transferability); global studies if foundational concepts.

#### **Domain 2: Policy integration (Narrative Review)**

Domain 2 was structured around the themes: policy-research interfaces, regulatory frameworks, health policy implementation.

#### Specific aims:

- Map mechanisms effectively bridging policy-research interfaces in EU health/wellbeing sectors to ensure MEDGUIDE is policy-relevant.
- Analyse regulatory frameworks and governance models that facilitate or hinder knowledge valorisation across EU Member States.
- Identify health policy implementation pathways involving multi-stakeholder engagement aligned with European Health Union and "Health in All Policies".

#### Expected outcomes:

- Policy integration framework connecting research → practice → policy in wellbeing.
- EU regulatory landscape analysis (barriers/enablers to knowledge valorisation).
- Multi-stakeholder policy implementation models with evidence of effectiveness.
- Alignment pathways with European Health Union priorities and Health in All Policies approach.
- Guidance for MEDGUIDE's policy implementation section.

#### Research questions:

- RQ2.1: What mechanisms and interfaces effectively connect research evidence with policy development and implementation in health/wellbeing?
- RQ2.2: How do regulatory frameworks across EU Member States facilitate or create barriers to knowledge valorisation in healthcare?
- RQ2.3: What models successfully implement "Health in All Policies" integrating wellbeing across policy domains?
- RQ2.4: How can policymakers be effectively engaged in co-creation with researchers, citizens, and industry for policy-relevant valorisation?

#### Search keywords:

- Primary: health policy implementation, policy-research interface evidence-based policy, health governance, regulatory frameworks healthcare, policy translation, research uptake policy, policy integration.
- Secondary: European Health Union, Health in All Policies, ERA Policy Agenda, health policy adoption, stakeholder engagement policy, governance innovation health, policy-relevant research, regulatory innovation, smart use IP.

#### Inclusion criteria:

- Timeframe: 2015-2025 (ERA Policy development period; prioritize 2020-2025).
- Language: English, French, German, Greek (if relevant and accessible to team - EU policy languages).

- Type: Peer-reviewed, policy analyses, EU official documents, white papers, government reports, think tanks.
- Content: Policy-research interfaces, regulatory frameworks, health policy implementation, multi-stakeholder engagement, ERA/EU Health Union alignment.
- Context: EU Member States, EU Commission policies, comparative European studies.

### **Domain 3: Knowledge Valorisation Methodologies**

Domain 3 was structured around the themes: action learning, communities of practice, value-sensitive design, behavioural change, open innovation.

#### Specific aims:

- Review and synthesize the four methodological building blocks (MBBs) that form MEDVIEW's methodological core.
- Identify integration strategies combining distinct approaches into unified, coherent methodological toolset.
- Document successful applications in health/wellbeing contexts demonstrating practical effectiveness and conditions for success.

#### Expected outcomes:

- Integrated methodological framework synthesizing all four MBBs with implementation pathways.
- Evidence-based validation of each approach's effectiveness in knowledge valorisation contexts.
- Integration strategies addressing complementarities between MBBs (learning enabler for co-creation and behavioural change).
- Best practice compendium from health, wellbeing, and related sectors.

#### Research questions:

- RQ3.1: How do Action Learning approaches foster Communities of Practice in health/wellbeing, and what conditions enable sustained engagement and osmosis?
- RQ3.2: How does Value-Sensitive Design embed ethical values (fairness, transparency, inclusivity, sustainability) into co-creation, and what are documented outcomes?
- RQ3.3: What behavioural change theories and Living Lab methodologies effectively promote adoption of evidence-based wellbeing practices?
- RQ3.4: How do Open Innovation 2.0 frameworks engage SMEs in health valorisation, addressing barriers (costs, IP complexity, risk)?

#### Search keywords:

- Primary: knowledge valorisation, knowledge valorisation, knowledge transfer, action learning, action research, Communities of Practice, CoP, value-sensitive design, VSD, co-creation, co-design, participatory design, behavioural change, health behaviour, behaviour modification, Living Lab, open innovation, Open Innovation 2.0, SME innovation, quadruple helix.
- Secondary: social learning, collaborative learning, peer learning, user-centered design, participatory innovation, co-production, innovation ecosystems, technology transfer, user innovation, methodology integration, mixed methods, hybrid methodologies.

#### Inclusion criteria:

- Timeframe: 2010-2025 (foundational methodological work; prioritize 2018-2025).
- Language: English, other EU languages for key frameworks.
- Type: Peer-reviewed, methodological papers, case studies, evaluation reports, handbooks, EU project deliverables.

- Content: At least one of four MBBs, integration of multiple methodologies, practical implementation.
- Context: Health, wellbeing, social innovation, transferable sectors.
- Application: Practical implementation guidance, case studies, effectiveness evidence.

Exclusion criteria: generic organizational development without knowledge valorisation focus, purely theoretical without implementation guidance or empirical evidence, Commercial innovation without knowledge valorisation/co-creation, Technology-focused without user/stakeholder engagement. Traditional methods only (RCTs, surveys) without, participatory/collaborative elements, Non-European/OECD contexts with limited transferability.

#### **Domain 4: Evaluation and Impact Assessment**

Domain 4 was structured around the themes: valorisation metrics, capacity building evaluation, outcome measures, KPIs.

##### Specific aims:

- Synthesize state-of-the-art frameworks for measuring knowledge valorisation across social, economic, and scientific impact dimensions.
- Analyse European Commission evaluation approaches for Horizon Europe projects aligned with ERA Policy Agenda Action 7 indicators.
- Map KPIs and metrics for capacity building effectiveness across heterogeneous stakeholders (citizens, researchers, SMEs, physicians, policymakers).
- Identify social and economic value creation mechanisms (societal wellbeing, health equity, SME innovation, cost-effectiveness, ROI).

##### Expected outcomes:

- Evaluation framework integrating social (wellbeing, equity, empowerment), economic (ROI, commercialization, job creation), and scientific (research quality, translation) impact.
- Social valorisation metrics: Wellbeing improvements, health equity, citizen empowerment, community capacity, behavioural change, quality of life.
- Economic valorisation metrics: SME innovation, commercialization outcomes, healthcare savings, job creation, regional economic development.
- EC-aligned KPI taxonomy consistent with Horizon Europe and ERA Policy Agenda indicators.

##### Research questions:

- RQ4.1: What state-of-the-art evaluation frameworks integrate multiple impact dimensions (social, economic, scientific)?
- RQ4.2: How do EC evaluation frameworks define knowledge valorisation success, and what KPIs are prioritized
- RQ4.3: How can social impact be measured (health outcomes, health equity, citizen empowerment, behavioural change, community capacity, QOL)?
- RQ4.4: What indicators capture value of citizen-researcher collaboration beyond traditional research outputs?
- RQ4.5: What frameworks assess cost-effectiveness of capacity building and knowledge translation?
- RQ4.6: What metrics capture knowledge transfer, skill development, and sustained behaviour change?

##### Search keywords:

- Primary: knowledge valorisation evaluation, valorisation metrics, impact assessment, evaluation frameworks, outcome measures, KPIs, performance

indicators, state-of-the-art evaluation, evaluation methodologies, assessment tools.

- Secondary: Social impact assessment, societal impact, social value creation, SROI, Economic impact assessment, economic value creation, ROI, cost-benefit analysis, wellbeing outcomes, quality of life assessment, health equity, citizen empowerment, healthcare cost savings, cost-effectiveness, regional economic development.

Inclusion criteria:

- Timeframe: 2015-2025 (Horizon 2020 onwards; prioritize 2020-2025).
- Language: English, other EU languages for EC documents.
- Type: Peer-reviewed, methodology papers, EC official documents, evaluation reports, case studies.
- Content: Valorisation evaluation frameworks, social/economic/scientific impact metrics, capacity building evaluation, EC evaluation criteria, KPIs.
- Context: European research/innovation projects, health/wellbeing programs, multi-stakeholder initiatives.
- EC Documentation: Official EC evaluation frameworks, impact assessment guidelines, ERA monitoring indicators.

Exclusion criteria: Clinical trials without broader knowledge valorisation context, Single dimension only (publications/citations only, without social/economic), Financial audit only without impact assessment, Process evaluation only without outcome/impact measurement, Non-transferable contexts vastly different from European research.

**Domain 5: Digital Platform Enablement**

Domain 5 was structured around the themes: digital collaboration tools, online engagement platforms, hybrid delivery models.

Specific aims:

- Synthesize evidence on digital collaboration tools effectively facilitating multi-stakeholder engagement in health/research/innovation contexts.
- Analyse hybrid delivery models (online-offline integration) for accessibility, inclusion, and sustained participation post-COVID-19.
- Identify platform features and functionalities supporting knowledge co-creation, Communities of Practice, and learning activities.
- Map user personalization, accessibility strategies, and engagement quality assessment beyond simple usage metrics.

Expected outcomes:

- Digital platform design principles for knowledge valorisation in wellbeing.
- Hybrid model best practices addressing digital divide, accessibility, cross-border collaboration.
- Platform feature requirements for supporting all four MBBs (Action Learning, VSD, Behavioural Change, Open Innovation).
- Technology-enabled collaboration strategies (personalization, accessibility, engagement quality).
- MEDSPACE design guidance and user experience strategies.

Research questions:

- RQ5.1: What platform features support multi-stakeholder engagement across diverse user types (citizens, researchers, SMEs, practitioners, policymakers)?
- RQ5.2: How do hybrid delivery models enhance/limit accessibility, engagement quality, and learning outcomes?
- RQ5.3: What functionalities support knowledge co-creation (ideation, discussion, prototyping, validation)?

- RQ5.4: How can platforms facilitate Communities of Practice sustaining engagement beyond initial enthusiasm?
- RQ5.5: What personalization strategies deliver relevant content to heterogeneous user profiles?

Search keywords:

- Primary: digital collaboration tools, online engagement platforms, digital health platforms, virtual collaboration, e-participation, digital stakeholder engagement, hybrid delivery models, blended learning, phygital engagement, online-offline integration.
- Secondary: community platforms, learning management systems, collaboration software, knowledge sharing platforms, innovation platforms, Living Lab platforms, platform functionalities, user engagement features, collaborative tools, personalization chatbots, knowledge management, remote participation technologies.

Inclusion criteria:

- Timeframe: 2018-2025 (recent technology; prioritize 2020-2025 post-COVID hybrid models).
- Language: English, other languages if unique European platforms.
- Type: Peer-reviewed, HCI conferences (ACM, IEEE), case studies, platform evaluation reports.
- Content: Digital collaboration tools, online engagement platforms, hybrid delivery, platform functionalities, personalization, accessibility.
- Context: Health, research, citizen science, Living Labs, transferable platform models.
- Users: Platforms serving diverse stakeholders (researchers, citizens, practitioners, SMEs, policymakers).

Exclusion criteria: Pure e-commerce or social media without knowledge co-creation focus, Clinical systems only (EHR, hospital IS) without engagement/collaboration features, Internal enterprise tools (corporate intranets) for single organization only, Pure technical specifications without UX/user engagement considerations.

**Domain 6: IP Protection and Commercialization**

Domain 6 was structured around the themes: IP management, proof-of-concept support, SME uptake pathways.

Specific aims:

- Map IP management strategies supporting knowledge valorisation in academic-industry-citizen collaborations.
- Identify proof-of-concept support mechanisms and funding instruments for health research commercialization.
- Synthesize "smart use of IP" practices aligned with ERA Policy Agenda Code of Practice for smart use of IP.
- Document SME uptake pathways addressing barriers (IP complexity, costs, risk, knowledge gaps).

Expected outcomes:

- IP management framework for collaborative knowledge creation involving diverse stakeholders.
- "Smart use of IP" best practices aligned with EC Code of Practice.
- Commercialization roadmaps and funding opportunities for researchers and SMEs.
- Practical guidelines for handling IP challenges in co-creation contexts.
- Proof-of-concept support models and fidelity considerations.
- European funding instrument directory (EIC, national schemes).

### Research questions:

- RQ6.1: What IP management strategies balance intellectual asset protection with open knowledge sharing in collaborative research?
- RQ6.2: How do proof-of-concept support mechanisms bridge research outputs to market-ready solutions in wellbeing?
- RQ6.3: What funding instruments and financial pathways support researchers and SMEs in commercializing health innovations in Europe?
- RQ6.4: What SME uptake pathways address barriers (IP complexity, costs, risk, awareness)?
- RQ6.5: How does "smart use of IP" (ERA Policy Agenda) manifest in practice with successful examples?

### Search keywords:

- Primary: intellectual property management, IP strategy research, technology transfer, research commercialization, proof-of-concept support, "smart use of IP" patent strategy, licensing models, IP rights, intellectual assets management.
- Secondary: commercialization pathways, research to market, innovation commercialization, startup creation, spin-offs universities, venture capital health
- research funding instruments, proof-of-concept funding, innovation funding EU, SME uptake, SME commercialization, technology adoption SMEs.

### Inclusion criteria:

- Timeframe: 2015-2025 (ERA Policy Agenda development; prioritize 2020-2025).
- Language: English, other EU languages for national IP frameworks.
- Type: Peer-reviewed, policy documents, IP office guidelines, EC documents, TTO publications, case studies.
- Content: IP management in collaborations, "smart use of IP," proof-of-concept, commercialization pathways, SME uptake, funding instruments.
- Context: European universities, research orgs, SMEs, health/wellbeing innovations.
- Guidance: Actionable frameworks, best practices, case examples.
- EC Alignment: ERA Policy Agenda Code of Practice, Horizon Europe IP rules.

Exclusion criteria: Pure legal IP case law without valorisation context, Large pharma IP strategies (not relevant to SMEs/academics), Patent litigation without lessons for proactive management, Non-European IP frameworks with limited European transferability, Pure IP theory without practical application

### **Domain 7: Research-to-Practice Translation**

Domain 7 was structured around the themes: knowledge transfer frameworks, implementation science, innovation diffusion.

### Specific aims:

- Synthesize knowledge translation frameworks bridging research-practice gap in health/wellbeing.
- Analyse implementation science approaches guiding adoption of evidence-based interventions in real-world settings.
- Map facilitators, barriers, and contextual factors influencing innovation diffusion across diverse healthcare systems.
- Identify strategies making research outputs "user-friendly and directly applicable to practitioners, industry, communities".

### Expected outcomes:

- Translation framework connecting research → practice → impact in wellbeing contexts.

- Implementation science models and strategies (CFIR, PARIHS, KTA, etc.) adapted to wellbeing.
- Evidence on barriers (theoretical complexity, poor applicability, organizational inertia) and facilitators.
- Adaptation vs. fidelity guidance for scaling interventions across cultural/organizational contexts.
- Integration with behavioural change and capacity building approaches.

#### Research questions:

- RQ7.1: What knowledge translation frameworks effectively bridge research-practice gap in wellbeing?
- RQ7.2: How does implementation science guide adoption of evidence-based wellbeing interventions in real-world settings?
- RQ7.3: What contextual factors (organizational, individual, systemic) facilitate or hinder innovation diffusion in healthcare?
- RQ7.4: How can research outputs be made "user-friendly and directly applicable" to practitioners, industry, communities?
- RQ7.5: What strategies support scaling interventions while maintaining fidelity and adapting to local contexts?

#### Search keywords:

- Primary: knowledge translation, implementation science, research-to-practice, translational research, knowledge transfer health, evidence-based practice, research utilization, research uptake.
- Secondary: implementation frameworks (KTA, PARIHS, CFIR), adoption barriers, facilitators implementation, innovation diffusion, diffusion of innovations, scaling innovations, spread sustainability, practice change interventions, behaviour change practitioners, clinical practice guidelines, real-world implementation, pragmatic trials, effectiveness research, implementation outcomes.

#### Inclusion criteria:

- Timeframe: 2015-2025 (Implementation science maturation; prioritize 2018-2025).
- Language: English, other EU languages for European implementation frameworks.
- Type: Peer-reviewed, systematic reviews, implementation science journals, case studies, evaluation reports.
- Content: Knowledge translation frameworks, implementation science, barriers/facilitators, diffusion, practice change, adaptation, scaling.
- Context: Health, wellbeing, public health, healthcare systems (European preferred).
- Evidence: Empirical studies, case studies, systematic reviews, implementation evaluations.
- Outcomes: Documented effectiveness, real-world implementation, scaling success.

Exclusion criteria: Pure basic research without translation considerations, Efficacy trials (controlled conditions) without effectiveness/implementation evidence, Single-site cases without transferable lessons, Theoretical papers without empirical implementation evidence, Medical devices/pharmaceuticals without behavioural/organizational change, Highly specialized clinical procedures without broader relevance.

### **Domain 8: Capacity Building Approaches**

Domain 8 was structured around the themes: training methodologies, skill development, cross-sector collaboration, competencies.

#### Specific aims:

- Synthesize training methodologies and pedagogical approaches developing knowledge valorisation competencies across five diverse stakeholder groups.
- Analyse how cross-sector collaboration (academia-industry-policy-civil society) enhances capacity building effectiveness and sustainability.
- Map essential skills, competencies, and learning progression pathways for citizens, researchers, SMEs, physicians, and policymakers.
- Identify multi-modal learning approaches (workshops, online, peer learning, experiential) sustaining engagement and behaviour change.

#### Expected outcomes:

- Evidence-based training approaches tailored to five distinct stakeholder groups (citizens, researchers, SMEs, physicians, policymakers) and train-the-trainer models.
- Competency frameworks defining knowledge valorisation skills and learning progression (baseline → intermediate → advanced).
- Multi-modal learning methodologies combining synchronous (workshops) and asynchronous (online) delivery.
- Integration with Action Learning, Communities of Practice, and behavioural change principles.

#### Research questions:

- RQ8.1: What training methodologies effectively develop valorisation competencies across heterogeneous stakeholders with different baselines?
- RQ8.2: How does cross-sector collaboration enhance capacity building processes and outcomes?
- RQ8.3: What specific skills and competencies are essential for each stakeholder group to effectively participate in knowledge co-creation?
- RQ8.4: How can programs be designed to be "inclusive and participatory" ensuring accessibility across diverse populations?
- RQ8.5: What approaches sustain capacity beyond initial training, fostering continued engagement in Communities of Practice?

#### Search keywords:

- Primary: capacity building, capacity development, training methodologies, skill development, professional development, competency frameworks, learning approaches, training effectiveness, knowledge valorisation skills.
- Secondary: knowledge valorisation skills, research skills training, innovation skills, entrepreneurship training, co-creation skills, collaborative competencies, citizen science training, researcher training, SME capacity, physician education, policymaker training, practitioner development, cross-sector training.

#### Inclusion criteria:

- Timeframe: 2015-2025 (prioritize 2018-2025).
- Language: English, other EU languages for European programs.
- Type: Peer-reviewed, education journals, training evaluation reports, curriculum frameworks, competency frameworks.
- Content: Training methodologies, capacity building, cross-sector collaboration, competency frameworks, multi-modal learning, learning outcomes.
- Context: Health, research, innovation, citizen engagement, adult education.
- Stakeholders: Programs serving heterogeneous groups or tailored to specific stakeholders.
- Outcomes: Evidence of effectiveness (skills, competencies, behaviour change), learning evaluation.
- Application: Practical implementation, not purely theoretical.

## **Domain 9: Stakeholder Engagement Practices**

Domain 9 was structured around the themes: citizen participation, multi-stakeholder co-creation, quadruple helix engagement.

### Specific aims:

- Map citizen participation and patient involvement models engaging diverse populations (including marginalized groups) in health research and innovation.
- Analyse multi-stakeholder co-creation processes enhancing knowledge valorisation quality, relevance, and uptake.
- Synthesize Quadruple Helix engagement strategies integrating academia, industry, government, and civil society.
- Identify mechanisms building and sustaining trust among stakeholders with different priorities, languages, power dynamic.
- Ensure authentic participation and co-production rather than tokenistic consultation.

### Expected outcomes:

- Evidence-based engagement techniques for recruiting, involving, and sustaining diverse stakeholders.
- Participatory research models adapted to wellbeing and knowledge valorisation contexts.
- Stakeholder collaboration dynamics including power relations, trust-building, conflict resolution strategies.
- Quadruple Helix engagement frameworks balancing diverse stakeholder needs.
- Inclusion strategies for reaching marginalized groups, ensuring equity in participation.
- Trust-building mechanisms and sustained engagement models.

### Research questions:

- RQ9.1: What citizen participation and patient involvement models effectively engage diverse populations in health research and valorisation?
- RQ9.2: How does multi-stakeholder co-creation enhance valorisation outcomes (relevance, quality, uptake) vs. traditional approaches?
- RQ9.3: What strategies successfully implement Quadruple Helix engagement, balancing academia-industry-government-society needs?
- RQ9.4: What factors build and sustain trust among diverse stakeholders with different priorities and power dynamics?
- RQ9.5: How can engagement achieve genuine participation and co-production vs. tokenistic consultation?

### Search keywords:

- Primary: stakeholder engagement, citizen participation, patient involvement, public engagement research, community engagement, participatory research, community-based participatory research (CBPR), multi-stakeholder co-creation, multi-stakeholder collaboration, cross-sector partnerships.
- Secondary: patient and public involvement (PPI), citizen science, participatory action research, Quadruple Helix innovation, academia-industry-government-society, innovation ecosystems, authentic participation, genuine engagement, power sharing, stakeholder empowerment, inclusive engagement, equity participation, marginalized groups engagement.

### Inclusion criteria:

- Timeframe: 2015-2025 (patient engagement movement; prioritize 2018-2025).
- Language: English, other EU languages for European models.

- Type: Peer-reviewed, engagement guidelines, case studies, participatory research reports, patient org publications.
- Content: Citizen/patient participation models, multi-stakeholder co-creation, Quadruple Helix, engagement quality, trust-building, authentic participation.
- Context: Health, wellbeing, research, innovation, policy (European preferred).
- Stakeholder Diversity: Multiple stakeholder types, especially citizens/patients.
- Quality: Evidence of engagement quality, not just quantity (numbers only insufficient).
- Outcomes: Documented engagement effectiveness, stakeholder outcomes, participation quality.

### **Domain 10: Co-Creation and Participatory Design**

Domain 10 was structured around the themes: user-centered design, living lab implementations, participatory tools.

#### Specific aims:

- Synthesize user-centered and participatory design approaches involving patients, citizens, and stakeholders in health/wellbeing innovation.
- Analyse Living Lab methodologies supporting real-world experimentation, testing, and validation.
- Map participatory tools, techniques, and facilitation methods enabling genuine co-creation with diverse stakeholders.
- Identify Value-Sensitive Design approaches embedding ethical values (equity, inclusivity, fairness, transparency, sustainability) into co-creation.
- Manage power dynamics ensuring diverse voices (including marginalized) are genuinely heard.

#### Expected outcomes:

- Practical co-creation frameworks with implementation guidance for wellbeing contexts and Communities of Practice.
- Living Lab methodology adapted to MEDVIEW's four engagement areas (mental health, metabolic challenges, cancer/diabetes, environmental).
- Participatory tools and techniques (personas, journey mapping, prototyping, design workshops) with facilitation guidance.
- Value-Sensitive Design operationalization within co-creation contexts.
- Facilitation approaches managing power dynamics and ensuring inclusive participation.

#### Research questions:

- RQ10.1: What user-centered and participatory design approaches effectively involve patients/citizens in health innovation, ensuring meaningful input shapes outcomes?
- RQ10.2: How do Living Lab methodologies facilitate real-world experimentation, testing, and validation of wellbeing innovations?
- RQ10.3: What co-design tools and techniques are most effective in health/wellbeing contexts?
- RQ10.4: How can co-creation embed values (equity, inclusivity, fairness, transparency, sustainability) consistent with Value-Sensitive Design?
- RQ10.5: What facilitation approaches manage power dynamics ensuring diverse and marginalized voices are heard?

#### Search keywords:

- Primary: co-creation, co-design, participatory design, user-centered design, co-production, participatory innovation, collaborative design, collaborative innovation,

design thinking health, Living Lab, Living Lab health, Living Lab wellbeing, real-world experimentation.

- Secondary: human-centered design, experience-based co-design (EBCD), service design health, user involvement, user participation, end-user involvement, patient co-design, design thinking healthcare, participatory healthcare innovation, patient-centered design, value-sensitive design, values in design, ethical design, inclusive design, equity design.

Inclusion criteria:

- Timeframe: 2015-2025 (design thinking & Living Labs maturation; prioritize 2018-2025).
- Language: English, other EU languages for European Living Labs/design initiatives.
- Type: Peer-reviewed, design journals/conferences, case studies, Living Lab reports (ENoLL), toolkits/guides.
- Content: User-centered design, participatory design, co-creation, Living Labs, VSD, design tools, facilitation, power dynamics.
- Context: Health, wellbeing, social innovation, public services, transferable design.
- User Involvement: Genuine end-user/citizen involvement in design process (not just consultation).
- Tools: Actionable tools, techniques, facilitation methods with guidance.
- Outcomes: Evidence of effectiveness or documented best practices.

**Domain 11: Gaps and Opportunities**

Unmet needs, challenges in knowledge valorisation, barriers to engagement, innovation opportunities.

Specific aims:

- Synthesize findings from Domains 1-11 to identify critical unmet needs in knowledge valorisation for wellbeing.
- Synthesize all barriers and facilitators identified across 11 domains into integrated taxonomy.
- Systematically extract lessons from Domains 1-11 on what HAS worked, what has NOT worked, what PARTIALLY worked.
- Identify gaps emerging at intersections of multiple domains (not visible within single domain).
- Identify emerging opportunities (technological, methodological, policy, social) for advancing knowledge valorisation.

Expected outcomes:

- Gap analysis across all 11 preceding domains synthesizing current knowledge and practice limitations.
- Barrier taxonomy categorizing obstacles at individual, organizational, systemic, and policy levels.
- Innovation opportunity map identifying priority areas for MEDVIEW development and research directions.
- Lessons learned compendium from related initiatives (successes and failures).
- White spaces identification—underexplored areas where MEDVIEW can make unique contributions.
- Strategic focus for capacity building content and methodology integration.

Research questions:

- RQ12.1: What are the most critical unmet needs and white spaces in knowledge valorisation for wellbeing across research, practice, policy, and society?

- RQ12.2: What barriers at individual, organizational, systemic, and cross-border levels prevent effective knowledge valorisation, and how do these barriers interconnect?
- RQ12.3: What facilitators, enabling conditions, and success factors characterize knowledge valorisation initiatives that achieve sustainable impact across diverse contexts and stakeholder groups?
- RQ12.4: What lessons learned from related initiatives (successes, failures, partial successes) should inform MEDVIEW's design, implementation, and sustainability strategy?

## Annex B: Stakeholder Questionnaire

## MEDViEW EU Project - Questionnaire

As part of the [MEDViEW project](#), we are gathering insights from stakeholders across our community to better understand current practices, needs, and perspectives on well-being and knowledge transfer.

We would be grateful if you could take a few minutes to complete this short questionnaire. Your responses will directly influence how we design our engagement activities and ensure the project reflects real community needs.

The project aims to deliver a complete practical guide and a set of tools comprising methods, practices, and procedures for the deployment of an open innovation space for effective knowledge valorisation (turning knowledge into real-world value, making sure that research, experience, and insights are used in practice) in the field of well-being.

*This project has received funding from the European Union's Horizon Europe Research and Innovation Programme under the call HORIZON-WIDERA-2024-ERA-02-and the Grant Agreement No 101217136.*

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\* Indicates required question

## Section 1

### Understanding and Familiarity

1. How familiar are you with well-being research or knowledge valorisation (turning knowledge into real-world value; making sure that research, experience, and insights are used in practice)? \*

- ☐ Not at all familiar
- ☐ A little familiar
- ☒ Somewhat familiar
- ☐ Very familiar
- ☐ Expert level

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\* Indicates required question

## Section 2

Current  
Practice and Capabilities

2. In your work or community, what methods do you currently use to understand or support well-being? (Select all that apply) \*

- ☐ Surveys
- ☐ Interviews
- ☐ Workshops or group discussions
- ☐ Digital tools or apps
- ☐ Informal conversations
- ☐ Observations or field notes
- ☐ Case studies or reflective practice
- ☐ Creative or arts-based methods (e.g., drawing, storytelling, photovoice)
- ☐ Body-based or experiential methods (e.g., movement, mindfulness, somatic practices)
- ☐ Community mapping or participatory mapping
- ☐ Peer-led or co-facilitated sessions
- ☐ Clinical or therapeutic assessments
- ☐ Standardised well-being scales or screening tools
- ☐ None
- ☐ Other: \_\_\_\_\_

 This is a required question

3. How confident do you feel using structured tools (e.g., surveys, frameworks, guidelines) to explore well-being? \*

- ☒ Not confident
- ☐ Somewhat confident
- ☐ Confident
- ☐ Very confident

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Annex C: Literature Review Specific topics, purpose, expectations

| Area                                 | Specific Topics to Cover                                                                                                                                                 | Purpose                                                                            | Expected Insights                                                                                       |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| Wellbeing Research Domains           | Healthcare, psychology, economics, sociology perspectives on wellbeing; physical, mental, and social health dimensions; post-COVID-19 wellbeing challenges               | Identify current state of wellbeing research across multiple disciplines           | Comprehensive understanding of wellbeing as multidimensional concept; successful research approaches    |
| Knowledge Valorisation Methodologies | Action Learning approaches; Communities of Practice frameworks; Value-Sensitive Design methods; Behavioural Change through Learning; Open Innovation for SMEs            | Analyse and integrate the four methodological building blocks into unified toolset | Validated methodological frameworks; integration strategies; best practice synthesis                    |
| Stakeholder Engagement Practices     | Citizen participation models; patient involvement in research; multi-stakeholder co-creation; Quadruple Helix engagement (academia, industry, government, civil society) | Map effective engagement strategies for diverse stakeholders                       | Evidence-based engagement techniques; participatory research models; stakeholder collaboration dynamics |
| Co-Creation and Participatory Design | User-centered design approaches; co-design methodologies; Living Lab implementations; real-world experimentation environments                                            | Understand how to effectively involve stakeholders in solution development         | Practical co-creation frameworks; participatory tools; validation approaches                            |
| Research-to-Practice Translation     | Knowledge transfer frameworks; implementation science; bridging academic-clinical-policy gaps; innovation diffusion models                                               | Identify mechanisms for translating research into actionable solutions             | Effective translation pathways; barriers and facilitators; scaling strategies                           |
| IP Protection and Commercialization  | Intellectual property management; proof-of-concept support; funding instruments for researchers; SME uptake pathways; commercialization guidelines                       | Support researchers and SMEs in valorisation process                               | IP management best practices; funding opportunities; commercialization roadmaps                         |
| Capacity Building Approaches         | Training methodologies; skill development programs; cross-sector collaboration training; knowledge valorisation competencies                                             | Design effective capacity building programs for diverse audiences                  | Evidence-based training approaches; competency frameworks; learning methodologies                       |
| Digital Platform Enablement          | Digital collaboration tools; online engagement platforms; hybrid delivery models; remote stakeholder participation technologies                                          | Leverage technology for stakeholder engagement and knowledge sharing               | Digital platform best practices; hybrid model effectiveness; technology-enabled collaboration           |

|                                          |                                                                                                                                                      |                                                               |                                                                                     |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Evaluation and Impact Assessment         | Valorisation metrics; capacity building evaluation methods; stakeholder outcome measures; knowledge transfer indicators                              | Establish frameworks for measuring success and impact         | KPIs for valorisation; evaluation methodologies; impact measurement tools           |
| Cross-Border and Cultural Considerations | Multi-country collaboration models; cultural adaptation strategies; diverse healthcare system integration; language and accessibility considerations | Address geographical and cultural diversity in implementation | Cultural adaptation frameworks; cross-border best practices; inclusivity strategies |
| Policy Integration                       | Policy-research interfaces; regulatory frameworks for innovation; health policy implementation; stakeholder engagement in policymaking               | Ensure solutions are policy-relevant and implementable        | Policy integration pathways; regulatory considerations; governance frameworks       |
| Gaps and Opportunities                   | Unmet needs in current methodologies; challenges in knowledge valorisation; barriers to stakeholder engagement; emerging opportunities               | Identify where innovation and improvement are needed          | Priority areas for development; innovation opportunities; research gaps to address  |

#### Annex D: Search Strings for Wellbeing Research and Knowledge Valorisation Review

| Area                                      | Primary Search String                                                                                                                              | Alternative Search String                                                                                                         | Database-Specific Refinements                                                                                 |
|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| Wellbeing Research Domains                | (wellbeing OR "well-being" OR wellness) AND (health OR "quality of life" OR "life satisfaction") AND (multidimensional OR holistic OR integrat*)   | ("mental health" OR "physical health" OR "social health") AND (wellbeing OR wellness) AND (COVID-19 OR pandemic OR post-pandemic) | PubMed: Add MeSH terms "Quality of Life"[Mesh] AND "Health Status"[Mesh]; Scopus: TITLE-ABS-KEY for all terms |
| Knowledge Valorisation Methodologies      | ("knowledge valorisation" OR "knowledge valorization" OR "knowledge transfer" OR "knowledge translation") AND (method* OR framework* OR approach*) | ("research impact" OR "research translation" OR "value creation") AND (innovation OR commercialization) AND (best practice*)      | Web of Science: TS= for topic search; PubMed: Use "Translational Research, Biomedical"[Mesh]                  |
| Action Learning & Communities of Practice | ("action learning" OR "action research") AND ("community of practice" OR "communities of practice" OR CoP) AND (stakeholder* OR participant*)      | ("social learning" OR "collaborative learning" OR "peer learning") AND (engagement OR capacity building)                          | ERIC: Add descriptor "Action Research"; Scopus: Use AND TITLE-ABS-KEY for stakeholder terms                   |
| Value-Sensitive Design                    | ("value-sensitive design" OR "value sensitive design" OR VSD) AND (co-creation OR "co-design" OR "participatory design")                           | (human W/3 value*) AND (design OR innovation) AND (ethic* OR fairness OR transparency*)                                           | ACM Digital Library: [All: "value-sensitive design"]; IEEE: Use "User-                                        |

|                                   |                                                                                                                                                 |                                                                                                                                      |                                                                                                                                          |
|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
|                                   |                                                                                                                                                 |                                                                                                                                      | Centered Design" combined with ethics terms                                                                                              |
| Behavioural Change & Living Labs  | ("living lab*" OR "living laboratory*") AND ("behavioral change" OR "behaviour change" OR "behavior change") AND (intervention* OR experiment*) | ("real-world" OR "real world") AND (learning OR training OR education) AND (wellbeing OR health) AND (participatory OR experiential) | PubMed: "Health Behavior"[Mesh] AND "Community-Based Participatory Research"[Mesh]                                                       |
| Open Innovation for SMEs          | ("open innovation" OR "user innovation") AND (SME* OR "small medium enterprise*" OR startup*) AND (valorisation OR commercialization)           | (innovation W/5 ecosystem*) AND (industry OR business) AND ("technology transfer" OR "knowledge exchange")                           | Business Source Complete: SU "Open Innovation" AND SU "Small Business"; Scopus: limit to Business, Management fields                     |
| Stakeholder Engagement            | (stakeholder* W/3 engagement) AND (participation OR involvement OR collaboration) AND (health* OR wellbeing)                                    | ("quadruple helix" OR "multi-stakeholder" OR "citizen engagement") AND (co-creation OR "participatory research")                     | PubMed: "Community-Based Participatory Research"[Mesh] OR "Stakeholder Participation"[Mesh]                                              |
| Research-to-Practice Translation  | ("knowledge translation" OR "implementation science" OR "research translation") AND (practice OR policy OR clinical) AND (framework* OR model*) | ("research to practice" OR "evidence-based practice" OR EBP) AND (barrier* OR facilitate* OR uptake) AND (health* OR wellbeing)      | PubMed: "Translational Research, Biomedical"[Mesh] AND "Evidence-Based Practice"[Mesh]; CINAHL: Use "Evidence-Based Practice" descriptor |
| IP Protection & Commercialization | ("intellectual property" OR IP OR patent* OR copyright) AND (commercialisation OR "technology transfer") AND (research* OR innovation)          | ("proof of concept" OR prototype*) AND (funding OR investment OR venture) AND (SME* OR startup* OR spin-off*)                        | Espacenet: Patent-specific searches; Google Scholar: focus on business/economics sources                                                 |
| Capacity Building                 | ("capacity building" OR "capacity development") AND (training OR education OR skill*) AND (stakeholder* OR researcher* OR practitioner*)        | ("professional development" OR "competency development") AND (knowledge W/3 valorisation) AND (cross-sector OR interdisciplinary*)   | ERIC: "Capacity Building"[descriptor]; Scopus: limit to Social Sciences, Education fields                                                |
| Digital Platform Enablement       | (digital W/3 platform*) AND (collaboration OR engagement OR participation) AND (health* OR wellbeing OR research)                               | ("online platform*" OR "web-based" OR e-health OR telehealth) AND (stakeholder* OR community) AND (knowledge W/3 sharing)            | IEEE Xplore: "Digital Platforms" AND "Collaborative Work"; ACM: focus on Human-Computer Interaction                                      |
| Evaluation & Impact Assessment    | (evaluation OR assessment OR measurement) AND (impact OR outcome*)                                                                              | (metric* OR KPI* OR "performance indicator*") AND (innovation OR                                                                     | Scopus: TITLE-ABS-KEY with research evaluation terms; Web of Science: add                                                                |

|                                        |                                                                                                                                             |                                                                                                                            |                                                                                                    |
|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
|                                        | OR indicator*) AND<br>("knowledge valorisation" OR "knowledge transfer")                                                                    | research) AND (stakeholder* OR capacity building)                                                                          | "Research & Experimental Medicine" categories                                                      |
| Cross-Border & Cultural Considerations | (cross-border OR international OR transnational) AND (collaboration OR cooperation) AND (health* OR wellbeing) AND (cultural OR contextual) | ("cultural adaptation" OR "cultural sensitivity") AND (implementation OR translation) AND (multi-country OR multi-nation*) | PubMed: "Cross-Cultural Comparison"[Mesh]; PsycINFO: "Cross Cultural Differences" descriptor       |
| Policy Integration                     | (policy OR governance OR regulate*) AND (health* OR wellbeing) AND (implementation OR integration) AND (research OR evidence)               | ("health policy" OR "public policy") AND (stakeholder* OR participant*) AND (innovation OR valorisation)                   | PolicyFile: Use policy-specific databases; PubMed: "Health Policy"[Mesh] AND "Policy Making"[Mesh] |